

**Application for License to  
Operate a Long-term Care Facility**

For Office Use Only Received <u>2/25/13</u> Amount <u>1560.00</u>
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# 5603

**I. IDENTIFICATION**

Name LP Brodhead, LLC d/b/a Rockcastle Care & Rehabilitation Center

Address 371 West Main Street

City/County/Zip Brodhead, KY 40409-8893

Telephone number 606-758-8711 admin.rockcastle@shccs.com

Administrator Ed Hogan

Date facility operation began at current address \_\_\_\_\_

Date facility began operation under current owner March 1, 2008

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<b>104</b>	<b>104</b>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL (check one in each column)**

State	<input checked="" type="checkbox"/> Profit	Individual
County	<input type="checkbox"/> Nonprofit	Partnership
City		Corporation
<input checked="" type="checkbox"/> Private		<input checked="" type="checkbox"/> LLC

**II. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.  
N/A

*2/28*

(OVER)

RECEIVED  
FEB 25 2013  
OFFICE OF INSPECTOR GENERAL

*✓*

If facility owned or leased by a corporation, complete the following:

Name of corporation	<u>LP Brodhead, LLC</u>
Address of corporation	<u>12201 Bluegrass Parkway, Louisville, KY 40299</u>
President or Chairman	<u>N/A</u>
Vice President	<u>N/A</u>
Secretary	<u>N/A</u>
Treasurer	<u>N/A</u>

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. **None**

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. **None**

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. **None**

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
<u>Signature HealthCARE, LLC</u>	<u>Signature Consulting Service, LLC</u> <u>Signature Clinical Consulting Services, LLC</u>
<u>12201 Bluegrass Parkway</u>	<u>12201 Bluegrass Parkway</u>
<u>Louisville, KY 40299</u>	<u>Louisville, KY 40299</u>

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

<u></u>	<u>CFO</u>	<u>2-21-13</u>
Signature of authorized representative	Title	Date

Return Application and fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

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(10/2002)