Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 7/6/12
Amount 1560.00

#142108

I. IDENTIFICATION

Name: Hart County Health Care Center

Address: 1505 South Dixie Street

City/County/Zip: Horse Cave, Hart County, 42749

Telephone number: 270-786-2200 jreid@seniorcare-corp.com

Administrator: Jim Reid

Date facility operation began at current address: June, 1993

Date facility began operation under current owner: July 1, 2005

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	104	104
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State		Profit	X	Individual	
County		Nonprofit		Partnership	
City				Corporation	
Private	X			LLC	X

II. OWNERSHIP

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

New Hart County Health Care, LLC
9510 Ormsby Station Road, Suite 101
Louisville, KY 40223

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

Name of corporation United Rehab Realty Holding, LLC

Address of corporation 10350 Ormsby Park Place, #300, Louisville, KY 40223

President or Chairman

Ex. Vice President T. Richard Riney and Raymond Lewis

Secretary T. Richard Riney T

Treasurer Brian K. Wood, Treasurer

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.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

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

Parent	Management Company
Senior Care Operations Holdings, LLC	
9510 Ormsby Station Road #101	
Louisville, Kentucky 40223	

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.

Signature of authorized representative — Vice President, Title — 6/29/12, Date

Return Application and fee to:

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

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