

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

For Office Use Only Received <u>4/18/12</u> Amount <u>480.00</u>
--

#3794

**I. IDENTIFICATION**

Name LP Augusta, LLC d/b/a Bracken County Nursing & Rehabilitation Center  
 Address 5269 Asbury Road  
 City/County/Zip Augusta, Bracken, 41002  
 Telephone number 606-756-2156  
 Administrator Laura N. Moore  
 Date facility operation began at current address \_\_\_\_\_  
 Date facility began operation under current owner 10-01-07

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>32</u>	<u>32</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

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

State	<u>Profit</u>	Individual
County	Nonprofit	Partnership
City		Corporation
<u>Private</u>		<u>LLC</u>

**II. OWNERSHIP**

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

_____	<b>RECEIVED</b>
_____	APR 18 2012
_____	OFFICE OF INSPECTOR GENERAL

(OVER)

SL

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

Name of corporation LP Augusta, LLC

Address of corporation 12201 Bluegrass Pkwy, Louisville, KY 40299

President or Chairman N/A

Vice President N/A

Secretary/CEO N/A

Treasurer N/A

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>LP CS Holdings, LLC.</u>	<u>Signature Consulting Services, LLC.</u>
<u>12201 Bluegrass Pkwy</u>	<u>12201 Bluegrass Pkwy</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>4/16/12</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