

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

For Office Use Only Received <u>5/9/12</u> Amount <u>1725.00</u>
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#2004.00 #1401152

I. IDENTIFICATION

Name Mercy Sacred Heart
 Address 2120 Payne Street
 City/County/Zip Louisville, Jefferson, 40206
 Telephone number 502-895-9425 kthieneman@health-partners.org
 Administrator Kim Thieneman
 Date facility operation began at current address 1892
 Date facility began operation under current owner 01/01/2007

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>115</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

Mercy Franciscan Senior Health and Housing Services, Inc.
4600 Meavy Place
Cincinnati, Ohio 45242

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

Name of corporation Mercy Franciscan Senior Health and Housing Services Inc.
Address of corporation 4600 Meauky Place Cincinnati, OH 45242
President or Chairman James E. May - President
Vice President Germaine Bennett - Chair
Secretary James E. May
Treasurer Todd Gardner

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
<u>Mercy Franciscan Senior Health and Housing Services, Inc.</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.

Rim T. [Signature] _____
Signature of authorized representative Title Date
Executive Director 4/25/2012

Return Application and fee to:

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

Mercy Franciscan Senior Health and Housing Services, Inc.
4600 McAuley Place
Cincinnati, Ohio 45242
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