

emailed validation letter  
4/27/12

Application for License to  
Operate a Long-term Care Facility

For Office Use Only  
Received 3-26-12  
Amount \$1515.-

Ch # 744210

I. IDENTIFICATION

Name Orion Marion LLC Crittenden Co. H&R  
Address 201 Watson St  
City/County/Zip Marion KY 42064-1824  
Telephone number 270-965-2218  
Administrator Donna Davis  
Date facility operation began at current address \_\_\_\_\_  
Date facility began operation under current owner 11/1/04

II. TYPE BEDS

No. beds licensed

No. beds requested

Skilled

101

101

Nursing Home

\_\_\_\_\_

\_\_\_\_\_

Nursing Facility

101

101

Intermediate Care

\_\_\_\_\_

\_\_\_\_\_

ICF/MR

\_\_\_\_\_

\_\_\_\_\_

Personal Care

4

4

II. CONTROL (check one in each column)

State  
County  
City  
Private

Profit  
Nonprofit

Individual  
Partnership  
Corporation

II. OWNERSHIP

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(OVER)

RECEIVED  
MAR 26 2012  
OFFICE OF INSPECTOR GENERAL

4/30

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

Name of corporation N/A

Address of corporation \_\_\_\_\_

President or Chairman \_\_\_\_\_

Vice President \_\_\_\_\_

Secretary \_\_\_\_\_

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  
Union Operating  
Services LLC

Management Company  
Atrium Centers LLC

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.

Dennis Lockhart  
Signature of authorized representative

Controller  
Title

3/23/12  
Date

Return Application and fee to:

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

**Orion Operating Services LLC  
Ownership**

<u>Name</u>	<u>Address</u>	<u>Birth Date</u>	<u>Social Security Number</u>	<u>Ownership %</u>
Essel Bailey		6/30/44		69.72%
Donald Finney		3/4/47		23.47%
Jason Reese		6/6/69		4.69%
Dennis Lockhart		12/16/65		0.47%
Pamela Meikle		9/18/58		0.70%
Gertie Dickey		7/28/51		0.47%
Robert Schmidt		3/30/57		0.47%