

Application for License to Operate a Long-term Care Facility

For Office Use Only  
Received 2/22/13  
Amount 1800.00

# 2737699

I. IDENTIFICATION

Name Richmond Place Rehabilitation and Health Center  
Address 2770 Palumbo Drive  
City/County/Zip Lexington, KY  
Telephone number 859-263-2410  
Administrator James Gitzinger

Date facility operation began at current address Since 1986 (Under previous ownership)

Date facility began operation under current owner July 1, 2007

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>120</u>	<u>120</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

*Van*

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.  
BLC Lexington SNF, LLC

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

*2/28*

RECEIVED  
FEB 22 2013  
OFFICE OF INSPECTOR GENERAL

(OVER)

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

Name of corporation American Retirement Corporation

Address of corporation 111 Westwood Place, Suite 200, Brentwood, TN

President or Chairman Co Presidents - John P. Rijos and Mark Ohiendorf

Vice President EVP - Kristin A. Ferge

Secretary \_\_\_\_\_

Treasurer Kristin A. Ferge

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. **N/A**

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

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>Brookdale Senior Living Inc</u>	<u>N/A</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.

  
\_\_\_\_\_  
Signature of authorized representative

Co-President  
\_\_\_\_\_  
Title

02/21/13  
\_\_\_\_\_  
Date

Return Application and fee to:

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