

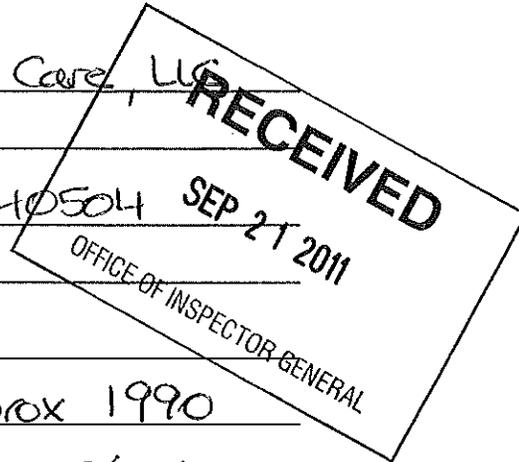
**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 9/21/11
Amount 1800.00

#035516

I. IDENTIFICATION

Name Pine Meadows Health Care, LLC
 Address 1608 Hill Rise Dr.
 City/County/Zip Lexington, Fayette 40504
 Telephone number 859-254-2402
 Administrator Mark Bauman
 Date facility operation began at current address Approx 1990
 Date facility began operation under current owner Approx. 9/30/1994



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	<input checked="" type="radio"/> Profit	<input type="radio"/> Individual
County	<input type="radio"/> Nonprofit	<input type="radio"/> Partnership
City		<input type="radio"/> Corporation
<input checked="" type="radio"/> Private		<input checked="" type="radio"/> LLC

II. OWNERSHIP

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

Pine Meadows Health Care, LLC
3147 Coster Dr. Suite A
Lexington Ky 40517

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

Name of corporation Pine Meadows Health Care, LLC

Address of corporation 3147 Coster Dr. Suite A, Lexington Ky 40517

President or Chairman Russell Louden - chairman Mark Bowman - President

Vice President Richard Slukich, Joan Louden

Secretary Joan Louden

Treasurer Richard Slukich

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.

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

N/A 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
_____	_____
_____	_____
_____	_____

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.

Mark Bowman
Signature of authorized representative

President
Title

8-29-11
Date

Return Application and fee to:

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

OIG 5
(10/2002)

Pine Meadows Health Care, LLC
Advisory Board Members/Officers

Russell Louden, Chairman

3147 Custer Drive, Suite A

Lexington, KY 40517

Mark Bowman, President

3147 Custer Drive, Suite A

Lexington, KY 40517

Joan Louden, Vice President/Secretary

3147 Custer Drive, Suite A

Lexington, KY 40517

Richard Slukich, Vice President/Treasurer

3147 Custer Drive, Suite A

Lexington, KY 40517

Joni Gosser, Director

3147 Custer Drive, Suite A

Lexington, KY 40517