

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

For Office Use Only Received <u>5/5/12</u> Amount <u>1500.00</u>
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I. IDENTIFICATION LP Louisville South, LLC # 7549

Name LP Louisville South, LLC d/b/a Signature HealthCARE of South Louisville

Address 1120 Cristland Road

City/County/Zip Louisville, KY 40214-4150

Telephone number 502-367-0104

Administrator Charles Mayer

Date facility operation began at current address _____

Date facility began operation under current owner November 1, 2007

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>100</u>	<u>100</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

N/A

<p>RECEIVED</p> <p>MAY 08 2012</p> <p>OFFICE OF INSPECTOR GENERAL</p>
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If facility owned or leased by a corporation, complete the following:

Name of corporation LP Louisville South, LLC
Address of corporation 12201 Bluegrass Parkway, Louisville, KY 40299
President or Chairman N/A
Vice President N/A
Secretary 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**

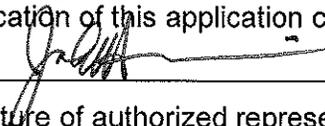
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. **None**

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>Signature HealthCARE, LLC</u>	<u>Signature Consulting Service, LLC</u> <u>Signature Clinical Consulting Services, LLC</u>
<u>12201 Bluegrass Parkway</u>	<u>12201 Bluegrass Parkway</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.



Signature of authorized representative

CFO

Title

5/2/12

Date

Return Application and fee to:

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

OIG 5
(10/2002)