

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

For Office Use Only Received <u>3/12/12</u> Amount <u>525.00</u>
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#1835

**I. IDENTIFICATION**

Name Little Sisters of the Poor

Address 15 Audubon Plaza Drive

City/County/Zip Louisville / Jefferson / 40217

Telephone number (502) 636-2300

Administrator Sister Maureen Courtney

Date facility operation began at current address March 31, 1991

Date facility began operation under current owner March 31, 1991

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>35</u>	<u>35</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL (check one in each column)**

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

**II. OWNERSHIP**

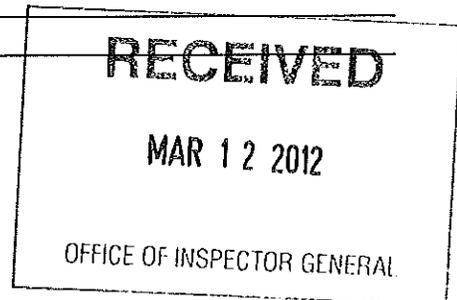
Name and address of individual owner, partners or corporation. If partnership, list partners.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(OVER)



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

Name of corporation Home for the Aged of the Little Sisters of the Poor

Address of corporation 15 Audubon Plaza Drive Louisville, KY 40217

President or Chairman Sister Isabel Londono

Vice President Sister Maureen Courtney

Secretary Sister Grace Nemitz

Treasurer Sister Grace Nemitz

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
_____	_____
_____	_____
_____	_____

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.

S. Maureen R. Courtney  
Signature of authorized representative

ADMINISTRATOR 03-06-2012  
Title Date

Return Application and fee to:

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

OIG 5  
(10/2002)