

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

*Emailed validation letter*  
2/28/12  
CU# 00108249

For Office Use Only Received <u>2.3.12</u> Amount \$ <u>765</u>
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**I. IDENTIFICATION**

Name Jackson Manor

Address 121 State Road 3444, PO Box 194

City/County/Zip Annville, Jackson County, 40402

Telephone number 606-364-5197

Administrator Philip Gilkison

Date facility operation began at current address 7/1989

Date facility began operation under current owner 7/1/2005

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>                    </u>	<u>                    </u>
Nursing Home	<u>                    </u>	<u>                    </u>
Nursing Facility	<u>51</u>	<u>51</u>
Intermediate Care	<u>                    </u>	<u>                    </u>
ICF/MR	<u>                    </u>	<u>                    </u>
Personal Care	<u>                    </u>	<u>                    </u>

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

State <u>                    </u>	Profit <u>  X  </u>	Individual <u>                    </u>
County <u>                    </u>	Nonprofit <u>                    </u>	Partnership <u>                    </u>
City <u>                    </u>		Corporation <u>                    </u>
Private <u>  X  </u>		LLC <u>  X  </u>

**II. OWNERSHIP**

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

New Jackson Manor, LLC  
9510 Ormsby Station Road, Suite 101  
Louisville, KY 40223

(OVER)

**RECEIVED**

FEB 03 2012

OFFICE OF INSPECTOR GENERAL

*2/28*

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

Name of corporation United Rehab Realty Holding, LLC  
Address of corporation 10350 Ormsby Park Place, #300, Louisville, KY 40223  
President or Chairman \_\_\_\_\_  
Ex. Vice President T. Richard Riney and Raymond Lewis  
Secretary T. Richard Riney  
Treasurer Brian K. Wood, 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	Management Company
<u>Senior Care Operations Holdings, LLC</u>	_____
<u>9510 Ormsby Station Road #101</u>	_____
<u>Louisville, Kentucky 40223</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.

      Vice President      1/31/12  
Signature of authorized representative      Title      Date

Return Application and fee to:

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

OIG 5  
(10/2002)