

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

For Office Use Only Received <u>2/27/13</u> Amount <u>1560.00</u>

31478

I. IDENTIFICATION

Name J. J. Jordan Geriatric Center
 Address 270 East Clayton Lane
 City/County/Zip Louisa Lawrence 41230
 Telephone number (606) 638-4586
 Administrator David B. mckenzie davidjr@jjjordan.com
 Date facility operation began at current address 1974
 Date facility began operation under current owner 1983

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>104</u>	<u>104</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

David W. McKenzie
270 E. Clayton Lane
Louisa Ky 41230

RECEIVED

FEB 27 2013

OFFICE OF INSPECTOR GENERAL

2/28

(OVER)

JL

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

Name of corporation JJ. Jordan Geriatric Center
McKenzie Healthcare LLC

Address of corporation 270 E. Clayton Lane Louisa Ky 41230

President or Chairman David W. McKenzie

Vice President David B. McKenzie

Secretary M. Helen McKenzie

Treasurer M. Helen McKenzie

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>N/A</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]
Signature of authorized representative

ADMINISTRATOR 2/14/13
Title Date

Return Application and fee to:

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