

RECEIVED

APR 17 2013

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 4/17/13
Amount 1595.00

I. OFFICE OF INSPECTOR GENERAL IDENTIFICATION

745331

Name ~~Drion Marion LLC~~ Crittenden Co. # & R Center
Address 201 Watson St.
City/County/Zip MARION, KY 42064
Telephone number 270/965-2218 74-Admin@AtriumLivingCenters.com
dmilligan@AtriumLivingCenters.com
Administrator TAMMY WORKMAN
Date facility operation began at current address _____
Date facility began operation under current owner 11-1-2004

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>101</u>	<u>101</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	<u>4</u>	<u>4</u>

II. CONTROL (check one in each column)

State
County
City
Private

Profit
Nonprofit

Individual
Partnership
Corporation

II. OWNERSHIP

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

Atrium Centers Inc.
2 Easton Oval Suite 210
Columbus OH 43219

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

Name of corporation Atrium Centers Inc.
Address of corporation 2 Easton Oval Suite 210 Columbus OH 43219
President or Chairman Jason Reese
Vice President 1 N/A
Secretary Dennis Lockhart
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.

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>Atrium Centers Inc.</u>	<u>Atrium Centers Management LLC</u>
<u>2 Easton Oval Suite 210</u>	<u>2 Easton</u>
<u>Columbus OH 43219</u>	<u>Columbus OH 43219</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

CAO
Title

4-9-13
Date

Return Application and fee to:

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

Name _____ Address _____ Position _____

Essel Bailey

Director

Jason Reese

President

Dennis Lockhart

Treasurer