

emailed validation letter 11/30/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 11.9.11
Amount \$125.

CK# 734166

I. IDENTIFICATION

Name Salem Springlake Health & Rehabilitation Center
Address 509 N. Hayden Ave
City/County/Zip Salem, Livingston, 42078
Telephone number 270-988-4572
Administrator Donna Davis 73-admin@atriumlivingcenters.com
Date facility operation began at current address _____
Date facility began operation under current owner 11/1/04

II. TYPE BEDS

No. beds licensed

No. beds requested

Type	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>75</u>	<u>75</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit <input checked="" type="checkbox"/>	Individual
County	Nonprofit	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.

Atrium Centers Inc
2 Easton Oval Suite 210
Columbus OH 42319

(OVER)

RECEIVED
NOV 07 2011
OFFICE OF INSPECTOR GENERAL

11/30

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 *Columbis. OH 42319*
President or Chairman Don Finney
Vice President _____
Secretary Dennis Lockhart
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>Atrium Centers Inc.</u>	<u>Atrium Centers Management LLC</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] _____ Controller 10-28-11
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)

**Atrium Centers Inc
Ownership**

Name	Address	Operating Units	Ownership %
Essel Bailey		7,500	68.5%

**Atrium Centers Inc
Ownership**

Name	Address
Essel Bailey	
Donald Finney	
Jason Reese	
Dennis Lockhart	
Pamela Meikle	
Gertie Dickey	
Robert Schmidt	