

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received _____
Amount _____

I. IDENTIFICATION

Name * J. J. Jordan Geriatric Center
Address 270 East Clayton Lane
City/County/Zip Louisia Lawrence 41230
Telephone number (606) 638-4586 davidjr@jjjordan.com
Administrator David B. McKenzie
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	_____	_____

III. 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		

IV. OWNERSHIP

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

David W. McKenzie
270 East Clayton Lane
Louisia Ky 41230

(OVER)

RECEIVED
FEB 27 2012
OFFICE OF THE INSPECTOR GENERAL

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

Name of corporation J.J. Jordan Geriatric Center
McKenzie HealthCare LLC

Address of corporation 270 East Clayton Lane Louisville 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 2/6/12
Title Date

Return Application and fee to:

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

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

For Office Use Only Received <u>2/17/12</u> Amount <u>1560.00</u>

I. IDENTIFICATION

29042

Name * McKenzie HealthCare LLC
 Address 270 East Clayton Lane
 City/County/Zip Louisa Lawrence 41230
 Telephone number (606) 638-4586 davidjr@jjjordan.com
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David W. McKenzie
270 East Clayton Lane
Louisa Ky 41230

(OVER)

<p>RECEIVED</p> <p>FEB 17 2012</p> <p>OFFICE OF INSPECTOR GENERAL</p>
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Vice President David B. McKenzie
Secretary M. Helen McKenzie
Treasurer M. Helen McKenzie

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[Signature] _____ Title ADMINISTRATOR Date 2/6/12
Signature of authorized representative

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Frankfort, Kentucky 40621