

emailed validation letter  
8/2/12

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

For Office Use Only  
Received 7.6.12  
Amount \$1560.00

ch#

00142102

**I. IDENTIFICATION**

Name Summit Manor Health and Rehabilitation Center  
Address 400 Bomar Heights  
City/County/Zip Columbia, KY 42728  
Telephone number 270-384-2153  
Administrator Brenda Williams  
Date facility operation began at current address March 1966  
Date facility began operation under current owner July 1, 2005

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

**II. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.  
Summit Manor Health & Rehabilitation Center, LLC  
9510 Ormsby Station Road, Suite 101  
Louisville, KY 40223

(OVER)

**RECEIVED**  
JUL 06 2012  
OFFICE OF INSPECTOR GENERAL

7/31

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 T  
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.

*Robert L. Barber*  
Signature of authorized representative

Vice President  
Title

9/29/12  
Date

Return Application and fee to:

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



OIG 5  
(10/2002)