

JML

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 4/30/12
Amount 1830.00

#12177

I. IDENTIFICATION

Name Mount Washington Health Care Center LLC d/b/a Green Meadows Health Care Center I

Address 310 Boxwood Run Road

City/County/Zip Mount Washington, KY 40047

Telephone number 502-955-7600 ben@greenmeadowshealthcare.com

Administrator Everett Benjamin Bays

Date facility operation began at current address 10/23/1990

Date facility began operation under current owner 02/01/2006

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>122</u>	<u>n/a</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

n/a

(OVER)

RECEIVED

APR 30 2012

OFFICE OF INSPECTOR GENERAL

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

Name of corporation Green Meadows Health Care Center 1
Address of corporation 310 Boxwood Run Road
President or Chairman Single Member Limited Liability Company
Vice President James T. Sleadd
Secretary n/a
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>n/a</u>	<u>n/a</u>
<u> </u>	<u> </u>
<u> </u>	<u> </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.

James T. Sleadd Administrator 04/25/2012
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)