Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 4/30/12
Amount 1560.00

#99007297

I. IDENTIFICATION

Name	Johnson Mathers Nursing Home
Address	2323 Concrete Road
City/County/Zip	Carlisle, KY 40311
Telephone number	(859) 289-7181
Administrator	Doris Ecton
Date facility operation began at current address	3/1/1965
Date facility began operation under current owner	11/1/2010

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	104	
Nursing Home		
Nursing Facility		
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL

(check one in each column)

State	Profit √	Individual
County	Nonprofit	Partnership
City		Corporation √ LLC
Private √		

I. OWNERSHIP

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

Thames Healthcare Group, LLC
P O Box 6249
Kinston, NC 28501-0249

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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	**Thames Healthcare Group, LLC**
Address of corporation	**P O Box 6249, Kinston, NC 28501-0249**
President or Chairman	**N. Randy Uzzell**
Vice President	**Ray Baker**
Secretary	**Ray Baker**
Treasurer	**Dianne Johnson**

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
Principle Long Term Care, Inc.	
P O Box 6249	
Kinston, NC 28501-0249	

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.

Raymond P. Baker

Signature of authorized representative

Vice-President — Title

4/20/12 — Date

Return Application and fee to:

Office of Inspector General
Main
Frankfort, Kentucky 40621

OIG 5
(10/2002)