

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

For Office Use Only Received <u>10/24/11</u> Amount <u>1020.00</u>	# <u>3802</u>
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I. IDENTIFICATION

Name Edgemont Healthcare
 Address 323 Webster Ave.
 City/County/Zip Cynthiana, Harrison, 41031
 Telephone number 859-234-4595
 Administrator Deborah Zuch
 Date facility operation began at current address April 1964
 Date facility began operation under current owner September 15, 2005

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>68</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

II. OWNERSHIP

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

BONNIE HOEFER
ERNEST MOORE
LARRIE MITCHELL

(OVER)

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OFFICE OF INSPECTOR GENERAL

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

Name of corporation _____

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

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

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.

A. Phillips

Co. Sec. Dr.

10/19/11

Signature of authorized representative

Title

Date

Return Application and fee to:

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

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(10/2002)