

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

For Office Use Only
Received <u>4/12/12</u>
Amount <u>\$1215.-</u>

emailed Validation letter 4/30/12
Ch# 10704

I. IDENTIFICATION

Name The Grandview Nursing and Rehabilitation Facility
640 Water Tower Bypass
 Address _____
 City/County/Zip Campbellsville / Taylor / 42718
270-465-4321
 Telephone number _____
 Administrator Cindy O'Banion
 Date facility operation began at current address March 27, 2008
 Date facility began operation under current owner May 1, 2005

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>81</u>	<u>81</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	KY	Profit X	Individual
County	Taylor	Nonprofit	Partnership
City	Campbellsville		Corporation (LLC) X
Private	X		

II. OWNERSHIP

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

300 Provider Court, Suite 100	RECEIVED
Richmond, KY 40475	
(OVER)	APR 06 2012
	OFFICE OF INSPECTOR GENERAL

4/30
[Signature]

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

Name of corporation CNRF, LLC
Address of corporation 300 Provider Court, Suite 100, Richmond, KY 40475
Member John D. Sword
Member Delbert Ousley
Member Carolyn Breeding
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.

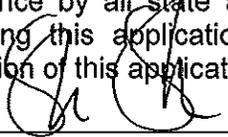
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

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
_____	PMD Corporation
_____	<u>300 Provider Court, Suite 100</u>
_____	<u>Richmond, KY 40475</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.

 _____	<u>CFO</u>	<u>4/3/12</u>
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)

Attachment

Schedule of Owners:

**CNRF, LLC, d.b.a.
The Grandview Nursing & Rehabilitation Facility**

Delbert Ousley Member

John D. Sword Member

Carolyn Breeding Member