

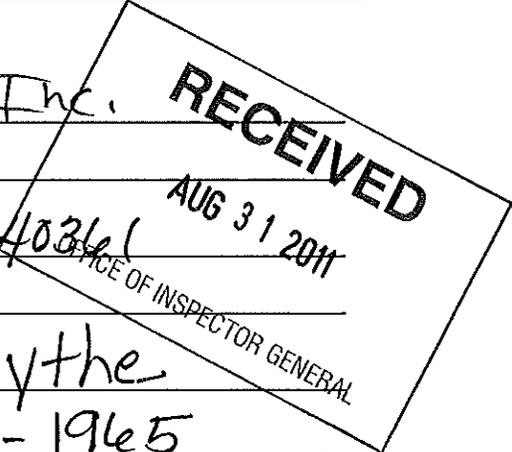
**Application for License to
Operate a Long-term Care Facility**

For Office Use Only	
Received	8/31/11
Amount	1005.00

#048570

I. IDENTIFICATION

Name Bourbon Heights, Inc.
 Address 2000 S. Main St.
 City/County/Zip Paris, Bourbon, 40361
 Telephone number 859-987-5750
 Administrator Angela G. Forsythe
 Date facility operation began at current address 07-1965
 Date facility began operation under current owner 07-1965



II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>67</u>	<u>67</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit	Individual
County	<u>Nonprofit</u>	Partnership
City		Corporation
<u>Private</u>		

II. OWNERSHIP

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

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

Name of corporation Bourbon Heights, Inc.
Address of corporation 2000 S. Main St., Paris, Ky. 40361
President or Chairman Bill Harney
Vice President _____
Secretary Barbara Thornton
Treasurer Barbara Thornton

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.

[Signature]
Signature of authorized representative

Administrator 8-26-11
Title Date

Return Application and fee to:

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

OIG 5
(10/2002)