

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

For Office Use Only Received <u>3/17/12</u> Amount <u>810.00</u>
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28702

I. IDENTIFICATION

Name Martins Rest Home, Inc dba Grand Haven Nursing Home
 Address 105 Rodgers Park
 City/County/Zip Cynthiana, KY 41031
 Telephone number 859-234-2050
 Administrator Beth Smith
 Date facility operation began at current address 1980
 Date facility began operation under current owner 1980

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>54</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

James A. Brown, c/o Richard M. Wehrle Conservator

(OVER)

<p>RECEIVED</p> <p>MAR 17 2012</p> <p>OFFICE OF INSPECTOR GENERAL</p>
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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.

Walter Smith
Signature of authorized representative

Adm.
Title

3-13-12
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)