

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

For Office Use Only
Received <u>8/29/11</u>
Amount <u>1753.00</u>

1665.00 NP  
89.00 PC

Five Star Quality Care 1098168

**I. IDENTIFICATION**

Name FS Lexington TENANT TRUST dba Lexington Country Place  
 Address 700 MASON Headley Road  
 City/County/Zip Lexington, Fayette 40504  
 Telephone number (859) 276-1083  
 Administrator Timothy J. Donnelly  
 Date facility operation began at current address October 1980  
 Date facility began operation under current owner JAN 11, 2002

**II. TYPE BEDS**

No. beds licensed

No. beds requested

Skilled \_\_\_\_\_  
 Nursing Home \_\_\_\_\_  
 Nursing Facility 111 (37 skilled, 22 TITLE 19, 52 NF)  
 Intermediate Care \_\_\_\_\_  
 ICF/MR \_\_\_\_\_  
 Personal Care \_\_\_\_\_



**II. CONTROL (check one in each column)**

State	<input checked="" type="checkbox"/> Profit	Individual
County	<input type="checkbox"/> Nonprofit	Partnership
City		Corporation <input checked="" type="checkbox"/>
<input checked="" type="checkbox"/> Private		

**II. OWNERSHIP**

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

FS Lexington TENANT TRUST  
DBA Lexington Country Place  
700 MASON Headley Lexington Ky 40504

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

Name of corporation Five STAR Quality Care  
Address of corporation 400 Centre Street, Boston MA 02450  
President or Chairman MR. Bruce J. Mackey JR  
Vice President Ms. Rosemary Esposito  
Secretary MR. Bruce J. Mackey JR,  
Treasurer Paul V. Hoagland

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.

<u>Swan O. Patrick</u>	<u>Interim HCA</u>	<u>8/18/2011</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)