

remailed validation letter
6/4/12

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

For Office Use Only
Received 5-7-12
Amount \$1,340.00

ck # 35725

\$1260/1340.-

I. IDENTIFICATION

Name Cumberland Valley Manor
Address PO Box 438
City/County/Zip Burkesville KY 42717
Telephone number 270-864-4315
Administrator Paul Shepard
Date facility operation began at current address 4/7/1977
Date facility began operation under current owner 4/7/1977

II. TYPE BEDS

No. beds licensed

No. beds requested

Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>84</u>	<u>84</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State
County
City
Private

Profit
Nonprofit

Individual
Partnership
Corporation

II. OWNERSHIP

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

NA

RECEIVED

MAY 07 2012

OFFICE OF INSPECTOR GENERAL

(OVER)

5/31
LB

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

Name of corporation Cumberland Valley Manor, Inc
Address of corporation PO Box 438, Burkesville KY 42717
President or Chairman Dr. Robert Flowers
Vice President Judy Frederick
Secretary Dr. J.M. Stephenson
Treasurer Kenneth Ballou

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	N/A	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
Title

05-03-12
Date

Return Application and fee to:

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