

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

For Office Use Only Received <u>4/17/13</u> Amount <u>1,215.00</u>
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#12296

**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

<b>II. TYPE BEDS</b>	<b>No. beds licensed</b>	<b>No. beds requested</b>
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	<b>KY</b>	<b>Profit X</b>	Individual
County	<b>Taylor</b>	Nonprofit	Partnership
City	<b>Campbellsville</b>		<b>Corporation (LLC) X</b>
Private	<b>X</b>		

**II. OWNERSHIP**

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

300 Provider Court, Suite 100  
Richmond, KY 40475

(OVER)

**RECEIVED**  
 APR 17 2013  
 OFFICE OF INSPECTOR GENERAL

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.

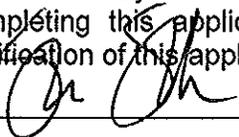
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

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
_____	<b>PMD Corporation</b>
_____	<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.

 \_\_\_\_\_ CFO 4/15/13  
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