

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

For Office Use Only Received <u>10/31/11</u> Amount <u>1770.00</u>
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I. IDENTIFICATION

Name Cambridge Place Group, LLC

Address 2020 Cambridge Drive

City/County/Zip Lexington, KY 40504

Telephone number (859) 252-6747 cclark@cambridgepl.com

Administrator Cara W. Clark

Date facility operation began at current address 1976

Date facility began operation under current owner March 1, 2011

II. TYPE BEDS No. beds licensed No. beds requested

Skilled 118

Nursing Home _____ _____

Nursing Facility _____ _____

Intermediate Care _____ _____

ICF/MR _____ _____

Personal Care _____ _____

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<u>OCT 31 2011</u>
OFFICE OF INSPECTOR GENERAL

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

Cambridge Place Group, LLC See "Members" Attachment 1

26

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
Legacy Health Services, Inc.
4537 Ft. Campbell Blvd., Suite 101
Hopkinsville, KY 42240

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.

C. Carter
Signature of authorized representative

Administrator
Title

10/28/11
Date

Return Application and fee to:

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

OIG 5
(10/2002)

ATTACHMENT 1

**Cambridge Place Group, LLC
Members**

Mr. Jay Frances

Ms. Kim Mobley

Mr. Danny Frances

Mr. Jack Graham