

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

For Office Use Only Received <u>10/3/12</u> Amount <u>1665.00</u>

1320315

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 Tim Donnelly
 Date facility operation began at current address October 1980
 Date facility began operation under current owner JAW 11, 2002

II. TYPE BEDS

No. beds licensed

No. beds requested

Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>111 (37 skilled 22 Title 19 52 NF)</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.

FS LEXINGTON TENANT TRUST
dba Lexington Country Place
700 MASON Headley Lexington Ky 40504

(OVER)

RECEIVED
OCT 03 2012
OFFICE OF INSPECTOR GENERAL

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 Rosemary Esposito / Mr. R Scott Herzig - 9/4/2012
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.

X [Signature] _____ Title ADMINISTRATOR Date 9/6,

Return Application and fee to:

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

OIG 5
(10/2002)