

mailed validation letter

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 2/28/12
Amount \$990.-

2/28/12

I. IDENTIFICATION

Name Auburn Health Care
Address 139 Pearl Str. P.O. Box 9
City/County/Zip Auburn Logan 42206
Telephone number 270-542-4111
Administrator Stephanie Semrick
Date facility operation began at current address 1964
Date facility began operation under current owner 3-01-2002

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>66</u>	<u>66</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
Bolster Health Care Group, LLC
Nancy and Robert Bolster - 101 Clay Cole Rd. Elkton, Ky 42220
Kathryne and William Jeffries - 322 Gray Hawk Rd Clarksville, TN 37043

(OVER)

RECEIVED
FEB 22 2012
OFFICE OF INSPECTOR GENERAL

RB 2/28

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

Name of corporation N/A
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
_____	_____
_____	_____
_____	_____

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.

Stephanie Vernice
Signature of authorized representative

Administrator
Title

1-24-2012
Date

Return Application and fee to:

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

OIG 5
(10/2002)

25% Robert Bolster

25% Nancy Bolster

25% William Jeffries

25% Kathryn Jeffries