

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

For Office Use Only Received <u>5/4/12</u> Amount <u>1/40.00</u>
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# 94626

**I. IDENTIFICATION**

Name Home of the Innocents  
 Address 1100 E. Market St.  
 City/County/Zip Louisville, KY (Jefferson) 40206  
 Telephone number 502-596-1000  
 Administrator Jeff F. Lewis  
 Date facility operation began at current address May 22, 2003

Date facility began operation under current owner 1880/1975 (Convalescent Center)

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>76</u>	<u>76</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL (check one in each column)**

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

**II. OWNERSHIP**

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

Home of the Innocents, Inc.  
1100 E. Market Street  
Louisville, KY 40206

**RECEIVED**

MAY 04 2012

OFFICE OF INSPECTOR GENERAL

(OVER)

32

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

Name of corporation Home of the Innocents

Address of corporation 1100 E. Market St.

Gordon Brown, President & CEO

President or Chairman Bruce Dudley, Chairman

Vice President Maureen Brekka, 1st Vice Chair, Al Cornish

2nd Vice Chair

Secretary Ms. Chambers Moore

Treasurer Joni Way

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. N/A

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. N/A

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.



Signature of authorized representative

President CEO 4/30/12

Title

Date

Return Application and fee to:

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

OIG 5  
(10/2002)