

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

For Office Use Only Received <u>3/15/13</u> Amount <u>1425.00</u>
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# 1305908

**I. IDENTIFICATION**

Name Grant Manor Care and Rehabilitation Center

Address 201 Kimberly Lane

City/County/Zip Williamstown, KY 41097-9458  
859-824-7803

Telephone number \_\_\_\_\_

Administrator Thomas Nielander

Date facility operation began at current address unknown

Date facility began operation under current owner 07/01/2005

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>95</u>	<u>95</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

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

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
XPrivate		XLLC

**II. OWNERSHIP**

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

Grant Manor LLC  
101 Sun Avenue NE  
Albuquerque NM 87109

(OVER)

<p><b>RECEIVED</b></p> <p>MAR 15 2013</p> <p>OFFICE OF INSPECTOR GENERAL</p>
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JK

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

Name of corporation Grant Manor, LLC  
Address of corporation 101 Sun Avenue NE Albuquerque, NM 87109  
President or Chairman George V. Hager  
Vice President Michael S. Sherman  
Secretary Michael T. Berg (Asst. Secretary)  
Treasurer Robert A. Reitz

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. Attached

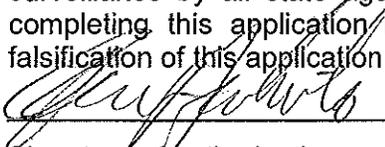
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. LLC - Attached

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
<u>HBR Kentucky, LLC</u>	<u>N/A</u>
<u>101 Sun Avenue NE</u>	<u></u>
<u>Abq, NM 87109</u>	<u></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.

  
Signature of authorized representative

Administrator 2/27/13  
Title Date

Return Application and fee to:

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

OIG 5  
(10/2002)