

emailed validation letter 4/4/12

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 5-4-12
Amount 475.00

2853

240/475 -

I. IDENTIFICATION

Name Breckinridge Place Retirement Community
Address 170 Sykes Boulevard
City/County/Zip Morganfield/Union/42437
Telephone number 270-389-1133 - E-mail: justin.ladd@breckinridgeservices.org
Administrator Dwight Justin Ladd
Date facility operation began at current address March 29, 2010
Date facility began operation under current owner March 29, 2010

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	<u>16</u>	<u>16</u>
Nursing Home	<u>6</u>	<u>6</u>
Nursing Facility	<u>16</u>	<u>16</u>
Intermediate Care		
ICF/MR		
Personal Care	<u>2</u>	<u>2</u>

II. CONTROL (check one in each column)

State _____ Profit _____ Individual Partnership _____
County _____ X Nonprofit _____ X Corporation _____
City _____
X Private _____

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
Breckinridge Services, Inc. P.O. Box 109 Uniontown, Kentucky 42461

\$240 for NF
\$155.00 for NH
\$ for PC

(OVER)

RECEIVED
MAY 04 2012
OFFICE OF INSPECTOR GENERAL

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
_____	Eidetik, Inc. _____
_____	P.O. Box 128 _____
_____	Uniontown, KY 42461 _____

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.

John Kadd _____ Administrator _____ April 26, 2012
Signature of authorized representative Title Date

Return Application and fee to:

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