

RECEIVED

MAR 19 2013

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 3/19/13
Amount 900.00

OFFICE OF INSPECTOR GENERAL

#9999

I. IDENTIFICATION

Name Glenview Health Care Facility, Inc.
 Address 1002 Glenview Dr.
 City/County/Zip Glasgow, Barren, 42141
 Telephone number 270-651-8332
 Administrator Yvonne W. Cook
 Date facility operation began at current address April 1971
 Date facility began operation under current owner July 1989

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>60</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

KAY Bush, 2945 Dry Fork Rd, Austin, Ky 40123

LISA Howlett, 530 Lakeview Dr., Scottsville, Ky 42164

(OVER)

PL

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

Name of corporation Glenview Health Care Facility, Inc.
Address of corporation P.O. Box 1507, Glasgow, KY 40302
President or Chairman Kay Bush
Vice President _____
Secretary Lisa Howlett
Treasurer Lisa Howlett

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.

Kay Bush _____ President _____ 3/01/13
Signature of authorized representative Title Date

Return Application and fee to:

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

OIG 5
(10/2002)