

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

For Office Use Only Received <u>9/7/12</u> Amount <u>1005.00</u>
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# 49604

**I. IDENTIFICATION**

Name Bourbon Heights Nursing Home  
 Address 2000 S. Main St  
 City/County/Zip Paris, Bourbon, 40361  
 Telephone number 859-987-5750  
 Administrator Angela G. Forsythe  
 Date facility operation began at current address 07-1965  
 Date facility began operation under current owner 07-1965

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>67</u>	<u>67</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

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

State	Profit	Individual
County	<u>Nonprofit</u>	<u>Partnership</u>
City		Corporation
<u>Private</u>		

**II. OWNERSHIP**

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(OVER)

**RECEIVED**  
 SEP 07 2012  
 OFFICE OF INSPECTOR GENERAL

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

Name of corporation Bourbon Heights, Inc  
Address of corporation 2000 S Main St. Paris Ky 40361  
President or Chairman Bill Harney  
Vice President Barbara Thornton  
Secretary Barbara Thornton  
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.

[Signature] \_\_\_\_\_ Administrator 9-6-12  
Signature of authorized representative Title Date

Return Application and fee to: Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621