

remailed validation letter  
3/30/12

Application for License to  
Operate a Long-term Care Facility

For Office Use Only  
Received 3-9-12  
Amount \$1440.00

Chk#  
99006373

I. IDENTIFICATION

Name Lake Way Nursing and Rehabilitation Center  
Address 2607 Main St P O Box 385  
City/County/Zip Benton Marshall 42025  
Telephone number 270 527 3296 1kw74-admin@lakewaycare.com  
Administrator Dena Bryant  
Date facility operation began at current address July 1979  
Date facility began operation under current owner 01 01 2011

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>96</u>	<u>96</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit <input checked="" type="checkbox"/>	Individual
County	Nonprofit	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.  
Thames Healthcare Group LLC

(OVER)

RECEIVED  
MAR 09 2012  
OFFICE OF INSPECTOR GENERAL

3/31  
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If facility owned or leased by a corporation, complete the following:

Name of corporation Thames Healthcare Group LLC  
Address of corporation PO Box 6249 Kinston NC  
President or Chairman N Randy Uzzell  
Vice President Raymond J Baker  
Secretary Raymond J Baker  
Treasurer Dianne Johnson

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.

*Diana Bynum*  
Signature of authorized representative

*Administrative*  
Title

*2/23/2012*  
Date

Return Application and fee to:

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

OIG 5  
(10/2002)