

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

For Office Use Only Received <u>4/22/13</u> Amount <u>\$240⁰⁰</u>
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I. IDENTIFICATION

#3749

Name Breckinridge Sevices Inc. d.b.a.Breckinridge Place

Address 170 Sykes Blvd

City/County/Zip Morganfield / Union County / 42437

Telephone number 270-389-1133

Administrator Dwight Justin Ladd

Date facility operation began at current address March 27, 2010

Date facility began operation under current owner March 27, 2010

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	16	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit	Individual
County	<input checked="" type="checkbox"/> Nonprofit	Partnership
City		<input checked="" type="checkbox"/> Corporation
<input checked="" type="checkbox"/> Private		

II. OWNERSHIP

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

501 (3) C Breckinridge Services Inc.
P.O. Box 109
Uniontown KY 42461

(OVER)

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

Name of corporation Breckinridge Services Inc
Address of corporation P.O. Box 109 Uniontown KY 42437
President or Chairman Jama Arnett
Vice President Mike Creasey
Jim Young
Secretary _____
Treasurer Jim Young

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
_____	<u>Eidetik Inc.</u>
_____	<u>236 Main St</u>
_____	<u>Uniontown KY 42461</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.

<u><i>Dwight J. L. Label</i></u>	<u>Administrator</u>	<u>4/16/2013</u>
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)