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MAR 11 2013

Application for License to Operate a Long-term Care Facility

For Office Use Only  
Received 3/11/13  
Amount 1440.00

OFFICE OF INSPECTOR GENERAL

# 99012003

I. IDENTIFICATION

Name Lake Way Nursing and Rehabilitation Center  
Address 2607 Main Street P O Box 385  
City/County/Zip Benton/Marshall/42025  
Telephone number 270-527-3296  
Administrator Selina Beck  
Date facility operation began at current address 7/1979  
Date facility began operation under current owner 01/01/2011

Table with 3 columns: TYPE BEDS, No. beds licensed, No. beds requested. Rows include Skilled (96/96), Nursing Home, Nursing Facility, Intermediate Care, ICF/MR, Personal Care.

II. CONTROL (check one in each column)

State, County, City, Private (circled), Profit (circled), Nonprofit, Individual Partnership, Corporation (circled)

II. OWNERSHIP

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

Thames Healthcare Group LLC

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

Name of corporation Thames Healthcare Group LLC  
P O Box 6249 Kinston NC  
Address of corporation \_\_\_\_\_  
Randy Uzzell  
President or Chairman \_\_\_\_\_  
Ray Baker  
Vice President \_\_\_\_\_  
Ray Baker  
Secretary \_\_\_\_\_  
Dianne Johnson  
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.

Selma Beck  
Signature of authorized representative

Administrator  
Title

02-28-2013  
Date

Return Application and fee to:

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

OIG 5  
(10/2002)