

emailed validation letter 5/4/12

Application for License to Operate a Long-term Care Facility

For Office Use Only  
Received 5.29.12  
Amount \$900.00

ck# 019327

I. IDENTIFICATION

Name Hearthstone Place  
Address 506 Allensville St, PO Box 427  
City/County/Zip EIKton, Ky 42220  
Telephone number (270) 265-5321 Katherineevans@bolster-jeffries.com  
Administrator Katherine C. Evans  
Date facility operation began at current address 4-2-1996  
Date facility began operation under current owner 3-1-2002

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

II. OWNERSHIP

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

Nancy & Robert Bolster PO Box 686 EIKton Ky 42220

Kathryn & William Jeffries 322 Gray Hawk Trail  
Clarksville TN 37043

(OVER)

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5/31

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

Name of corporation \_\_\_\_\_  
Address of corporation \_\_\_\_\_  
President or Chairman \_\_\_\_\_  
Vice President \_\_\_\_\_  
Secretary \_\_\_\_\_  
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  
\_\_\_\_\_  
\_\_\_\_\_  
N/A

Management Company  
\_\_\_\_\_  
\_\_\_\_\_  
N/A

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.

Katherine C. Evans  
Signature of authorized representative

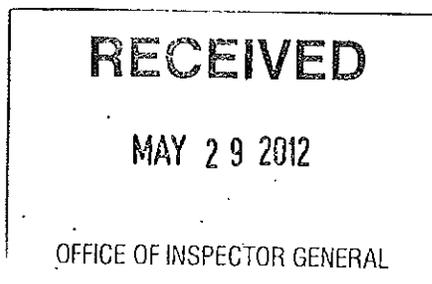
LNHA  
Title

4/25/2012  
Date

Return Application and fee to:

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

OIG 5  
(10/2002)



NAME	ADDRESS	CITY/STATE	SS#
ROBERT BOLSTER			
NANCY BOLSTER			
WILLIAM JEFFRIES			
KATHRYNE JEFFRIES			

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