

FEB 25 2013

OFFICE OF INSPECTOR GENERAL

Application for License to Operate a Long-term Care Facility

For Office Use Only  
Received 2/25/13  
Amount 990.00

#168258

I. IDENTIFICATION

Name Auburn Health Care  
Address 139 Pearl Street PO Box 9  
City/County/Zip Auburn Logan 42206  
Telephone number 270-542-4111 stephanies@bolster-jeffries.com  
Administrator Stephanie Semrick  
Date facility operation began at current address 1964  
Date facility began operation under current owner 3-01-2002

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	66	66
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		LLC

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.  
Bolster Health Care Group, LLC  
Nancy and Robert Bolster - 101 Clay Cole Rd Elkton, Ky 42220  
Kathrine and William Jeffries - 322 Gray Hawk Rd Clarksville, TN 37043  
attached

(OVER)

2/28

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	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.

<u>Stephanie Vernice</u>	<u>Administrator</u>	<u>2-19-2013</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)

NAME	ADDRESS	CITY/STATE	SS#	DOB	RELATIONSHIP	TITLE
ROBERT BOLSTER						SECRETARY
NANCY BOLSTER						PRESIDENT
WILLIAM JEFFRIES						TREASURER
KATHRYNE JEFFRIES						VICE-PRESIDENT