

emailed validation letter
9/1/11

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

For Office Use Only
Received <u>8.29.11</u>
Amount <u>\$540.-</u>

Ch# 31025

I. IDENTIFICATION

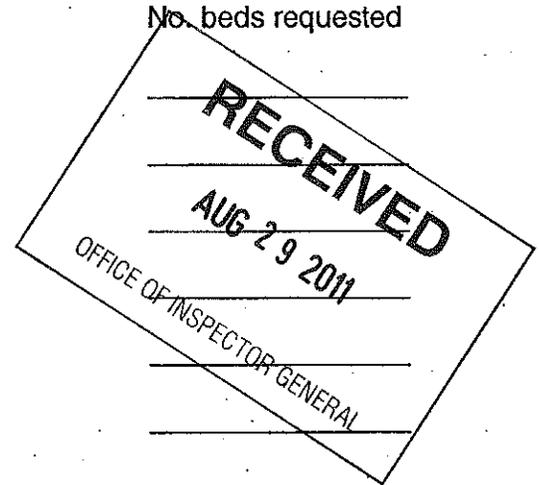
Name Carmel Home
 Address 2501 Old Hartford Road
 City/County/Zip Opensboro, KY 42303
 Telephone number 270-683-0227 Karb842@bellsouth.net
 Administrator Sr. M. Francis Teresa Scully
 Date facility operation began at current address 1952
 Date facility began operation under current owner 1952

II. TYPE BEDS

No. beds licensed

No. beds requested

Skilled _____
 Nursing Home _____
 Nursing Facility 36
 Intermediate Care _____
 ICF/MR _____
 Personal Care _____



II. CONTROL (check one in each column)

State _____
 County _____
 City _____
 Private

Profit _____
 Nonprofit

Individual _____
 Partnership _____
 Corporation

II. OWNERSHIP

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

Carmelite Sisters of the Divine Heart of Jesus of Missouri!
10341 Manchester Road
Kirkwood, MO 63122

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

Name of corporation Carmelite Sisters of the Divine Heart of Jesus of Missouri

Address of corporation 10341 Manchester Rd, Kirkwood, MO 63122

President or Chairman Sr. Mary Joseph Heister

Vice President Sr. M. Laura Le

Secretary Sr. Angela Therese Kim

Treasurer Sr. Angela Therese Kim

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>N/A</u>	<u>N/A</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.

Karla Osborne
Signature of authorized representative

Buss. Mgr.
Title

8-24-11
Date

Return Application and fee to:

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

OIG 5
(10/2002)