Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 8-16-10
Amount $1500-

Ck # 030010

RECEIVED
AUG 16 2010
OFFICE OF INSPECTOR GENERAL

I. IDENTIFICATION

Name: Village Care Center

Address: 2990 Riggs Ave.

City/County/Zip: Erlanger/ Kenton/ 41018

Telephone number: 859-727-9330

Administrator: Tony Zubrowski

Date facility operation began at current address: 2/4/02

Date facility began operation under current owner: 2/4/02

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	~~100~~	~~100~~
Nursing Home		
Nursing Facility	100	100
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County	X Nonprofit	Partnership
City		X Corporation
X Private		

II. OWNERSHIP

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

Baptist Convalescent Center, Inc
120 Main Street
Newport, KY 41071

(OVER)

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

Name of corporation Baptist Convalescent Center, Inc.

Address of corporation 120 Main St., Newport, KY 41071

President or Chairman Dr. Robert H. Long/CEO

Vice President Robert W. Kester

Secretary

Treasurer Robert W. Kester

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
Baptist Convalescent Center, Inc.	
120 Main St.	
Newport, KY 41071	

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.

Signature of authorized representative | Title | Date 7/31/10

Return Application and fee to:

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

OIG 5
(10/2002)

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