

emailed Validation letter 9/1/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 8/2/11
Amount \$450.-

Chk# 091525

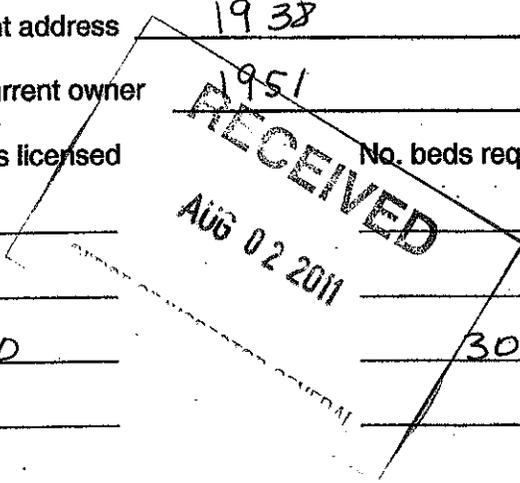
I. IDENTIFICATION

Name Pineville Community Hospital Assoc. Inc.
 Address 850 Riverview Ave.
 City/County/Zip Pineville Bell 40977
 Telephone number 606-337-3051 tc@Pinevillehospital.com
 Administrator J. Milton Brooks

Date facility operation began at current address 1938
 Date facility began operation under current owner 1951

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	<u>30</u>	<u>30</u>
Intermediate Care		
ICF/MR		
Personal Care		



II. CONTROL (check one in each column)

State	<u>Profit</u>	Individual
County	<u>Nonprofit</u>	Partnership
City		<u>Corporation</u>
<u>Private</u>		

II. OWNERSHIP

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

8/31

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	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.

William Beards
Signature of authorized representative

CEO
Title

7/25/11
Date

Return Application and fee to:

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

OIG 5
(10/2002)

PINEVILLE COMMUNITY HOSPITAL ASSOCIATION, INC.
850 RIVERVIEW AVENUE
PINEVILLE, KENTUCKY 40977

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