

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

For Office Use Only Received <u>2/20/12</u> Amount <u>375.00</u>
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# 2247553

**I. IDENTIFICATION**

Name CLARK REGIONAL MEDICAL CENTER

Address 1107 W LEXINGTON AVE

City/County/Zip WINCHESTER CLARK 40391

Telephone number 859.745.3500 Kathy.bachman@lpnt.net

Administrator KATHY BACHMAN

Date facility operation began at current address 6/30/1996

Date facility began operation under current owner 5/1/2010

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>25</u>	<u>0</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL** (check one in each column)

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

**II. OWNERSHIP**

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

LIFE POINT INC.  
102 POWELL COURT STE 200  
BRENT WOOD TN 37027

(OVER)

<b>RECEIVED</b>
FEB 20 2012

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

Name of corporation LIFE POINT INC  
Address of corporation 102 POWELL COURT STE 200  
BRENTWOOD TN 37027  
President or Chairman MR WILLIAM CARPENTAR  
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.

Kathy Bachman TCU Administrator \_\_\_\_\_ 2/03/2012  
Signature of authorized representative Title Date

Return Application and fee to: Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

Clark Regional Medical Center  
Ownership Structure

