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 OFFICE OF INSPECTOR GENERAL

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 ITA#

Application for License to Operate a Long-term Care Facility

For Office Use Only
 Received 9.15.11
 Amount \$2160.

729-721120000034

I. IDENTIFICATION

Name Western State Nursing Facility
 Address 2400 Russellville Road
 City/County/Zip Hopkinsville, Christian 42240
 Telephone number (270) 889-6025
 Administrator John Sumner
 Date facility operation began at current address March 16, 1978
 Date facility began operation under current owner March 16, 1978

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	144	
Nursing Home	144 (Beds are interchangeable)	
Nursing Facility	144	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

(OVER)

9/30

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.



Signature of authorized representative

NHA

Title

8/22/11

Date

Return Application and fee to:

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

OIG 5
(10/2002)