

RECEIVED

AUG 05 2011

Emailed Validation Letter 9/1/11

DEPARTMENT OF GENERAL
Application for License to
Operate a Long-term Care Facility

For Office Use Only
Received 1-3-11
Amount \$1200

Ch# 8206

I. IDENTIFICATION

Name Christian Care Center of Kuttawa, LLC
Address 1253 Lake Barkley Drive
City/County/Zip Kuttawa, Lyon County, Kentucky 42055
Telephone number (270) 388-2291
Administrator Cindy Bruton; email: administrator@cccokuttawa.com
Date facility operation began at current address 04/01/2009
Date facility began operation under current owner 04/01/2009

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>80</u>	<u>80</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State _____
County _____
City _____
Private Profit Individual
Nonprofit Partnership
Corporation - LLC

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
Jimmy (J.R.) R. Lewis
2020 Northpark Ste. 2D
Johnson City, TN 37604

(OVER)

8/31

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

Name of corporation Christian Care Center of Kuttawa, LLC
 Address of corporation 2020 Northpark Ste. 2D, Johnson City, TN 37604
 President or Chairman Jimmy (J.R.) R. Lewis - Chief Manager
 Vice President n/a
 Secretary n/a
 Treasurer Anita B. West

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
Care Centers Management Consulting, Inc.
2020 Northpark, Ste. 2D
Johnson City, TN 37604

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.

Debra Caldwell - Tracy
 Signature of authorized representative

Risk Consultant 07/25/11
 Title Date

Return Application and fee to:

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