

emailed validation letter  
6/28/12

Application for License to  
Operate a Long-term Care Facility

For Office Use Only  
Received 6-28-12  
Amount \$180

CU# 02400465

I. IDENTIFICATION

Name Lake Cumberland Regional Hospital - SCU  
Address 305 Langdon Street  
City/County/Zip Somerset/Pulaski/42503  
Telephone number 606-678-3309 Tanya.Nelson-Hackney@lprt.net  
Administrator Tanya Nelson-Hackney  
Date facility operation began at current address 1996  
Date facility began operation under current owner 1999

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>12</u>	<u>0</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.  
Lake Cumberland Regional Hospital, LLC  
103 Powell Court, Ste 200  
Brentwood, TN 37027

(OVER)

RECEIVED  
JUN 22 2012  
OFFICE OF INSPECTOR GENERAL

*[Signature]* 6/30

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

Name of corporation Lake Cumberland Regional Hospital, LLC  
Address of corporation 103 Powell Court Ste 200, Brentwood TN 37027  
President or Chairman William F. Carpenter  
Vice President Jeffrey W. Sherman (Senior VP & Chief Financial Officer)  
Secretary Darice M. Dill (President & Chief Operating Officer)  
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
<u>L.R. Point Hospitals, Inc.</u>	_____
<u>103 Powell Court, Ste 200</u>	_____
<u>Brentwood, TN 37027</u>	_____

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.

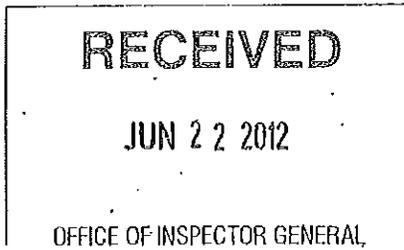
[Signature]  
Signature of authorized representative

RN, BSN, NHA  
Title

6/19/11  
Date

Return Application and fee to:

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



OIG 5  
(10/2002)