

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

For Office Use Only Received <u>3/11/13</u> Amount <u>525.00</u>
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#2982

I. IDENTIFICATION

Name Little Sisters of the Poor / St Joseph's Home for the Aged
 Address 15 Audubon Plaza Drive
 City/County/Zip Louisville / Jefferson / 40217
 Telephone number (502) 636-2300 adlouisville@littlesistersofthepoor.org
 Administrator Sister Maureen Courtney
 Date facility operation began at current address March 31, 1991
 Date facility began operation under current owner March 31, 1991

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	35	35
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

(OVER)

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 MAR 11 2013
 OFFICE OF INSPECTOR GENERAL

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

Name of corporation Home for the Aged of the Little Sisters of the Poor, Inc.

Address of corporation 15 Audubon Plaza Drive Louisville, KY 40217

President or Chairman Sister Chantal Peyton

Vice President Sister Maureen Courtney

Secretary Sister Grace Nemitz

Treasurer Sister Grace Nemitz

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.

S. Maureen Courtney
Signature of authorized representative

Administrator

Title

March 7, 2013

Date

Return Application and fee to:

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

OIG 5
(10/2002)