

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

For Office Use Only Received <u>4/30/12</u> Amount <u>180.00</u>
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*Call to Hayden, PSC # 10139*

**I. IDENTIFICATION**

Name Flaget Memorial Hospital NF  
 Address 4305 New Shepherdsville Road  
 City/County/Zip Bardstown/Nelson/40004  
 Telephone number 502-350-5000  
 Administrator Sue Downs  
 Date facility operation began at current address 2005  
 Date facility began operation under current owner 1951

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>12</u>	<u>12</u>
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.

Flaget Healthcare, Inc.  
424 Lewis Hargett Circle, Suite 160  
Lexington, Kentucky 40503

<b>RECEIVED</b>
APR 30 2012
OFFICE OF INSPECTOR GENERAL

*JL*

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

Name of corporation Flaget Healthcare, Inc.

Address of corporation 424 Lewis Hargett Circle, Suite 160, Lexington, KY 40503

President or Chairman Please see attached.

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
* <u>KentuckyOne Health, Inc.</u>	_____
<u>200 Abraham Flexner Way</u>	_____
<u>Louisville, KY 40202</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.

Sue Downs/ky Hk  
Signature of authorized representative

President  
Title

4/30/12  
Date

Return Application and fee to:

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

OIG 5  
(10/2002)