

emailed validation letter 12/28/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 12-14-11
Amount \$7500-

Ch# 61123

I. IDENTIFICATION

Name Christian Health Center - Corbin

Address 116 South Commonwealth Ave., P.O. Box 1304

City/County/Zip Corbin, KY 40702 (Knox Co.)

Telephone number 606-258-2500

Administrator William H. Collins

Date facility operation began at current address April 6, 1983

Date facility began operation under current owner April 6, 1983

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>100</u>	<u>100</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	<u>Profit</u>	Individual
County	<u>Nonprofit</u>	<u>Partnership</u>
City		<u>Corporation</u>
<u>Private</u>		

II. OWNERSHIP

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

(OVER)

12/31

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

Name of corporation CHRISTIAN CARE COMMUNITIES, INC.

Address of corporation Cumberland Building 12710 Townepark Way, Suite #1000, Louisville, KY 40243

President or Chairman Scott Coburn

Vice President Alan Parsons

Secretary Audrey Powell

Treasurer Jane Burkes

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
CHRISTIAN CARE COMMUNITIES, INC
CUMBERLAND BUILDING
12710 TOWNEPARK WAY, SUITE 1000
LOUISVILLE, KY 40243

Management Company
SAME

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.

Bill Collins

Signature of authorized representative

ADMINISTRATOR 11-28-11

Title

Date

Return Application and fee to:

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

OIG 5
(10/2002)