

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

For Office Use Only  
Received 10-8-12  
Amount \$1425.

*mailed validation  
letter 10/30/12  
ch#  
40941*

**I. IDENTIFICATION**

Name Calvert City Convalescent Center INC  
 Address 1201 Fifth Ave  
 City/County/Zip Calvert City KY 42029  
 Telephone number 270-395-4124  
 Administrator Lynn B. Jones  
 Date facility operation began at current address February 1973  
 Date facility began operation under current owner Same as above

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>95</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL (check one in each column)**

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

**III. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.  
Self owned not for profit

(OVER)

**RECEIVED**  
 OCT 08 2012  
 OFFICE OF INSPECTOR GENERAL  
 10/31

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

Name of corporation Calvert City Convalescent Center Inc  
Address of corporation PO. Box 7 Calvert City Ky 42029  
President or Chairman Gene Colbaen  
Vice President \_\_\_\_\_  
Secretary Thomas Smith  
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
_____	_____
_____	_____
_____	_____

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

ADMINISTRATOR  
Title

10/3/12  
Date

Return Application and fee to:

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

OIG 5  
(10/2002)