

emailed validation letter 6/5/12

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 5.4.12
Amount \$240.00

ch#

30121

I. IDENTIFICATION

Name Knox County Hospital
Address 80 Hospital Drive
City/County/Zip Barbourville / Knox / 40906
Telephone number 606 546 4175 CMorgan@knoxcohospital.com
Administrator Craig Morgan CEO
Date facility operation began at current address 07-2001
Date facility began operation under current owner 10-2009

II. TYPE BEDS

No. beds licensed

No. beds requested

Type	No. beds licensed	No. beds requested
Skilled	<u>16</u>	<u>16</u>
Nursing Home	<u>∅</u>	<u>∅</u>
Nursing Facility	<u>∅ 16</u>	<u>∅ 16</u>
Intermediate Care	<u>∅</u>	<u>∅</u>
ICF/MR	<u>∅</u>	<u>∅</u>
Personal Care	<u>∅</u>	<u>∅</u>

II. CONTROL (check one in each column)

State
County
City
Private

Profit
Nonprofit

Individual
Partnership
Corporation

II. OWNERSHIP

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

Ashwini Anand - 1380 Hwy 192 E. London, KY 40741
Satp Brata Chatterjee - 1210 West 5th Street, London, KY 40741

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

Name of corporation N/A
Address of corporation _____
President or Chairman _____
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>N/A</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

CEO
Title

05-01-12
Date

Return Application and fee to:

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

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