Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 2/27/13
Amount 1650.00

#18297

I. IDENTIFICATION

Name: Cal Turner Rehab and Specialty Care

Address: ~~456 Burnley Road~~

City/County/Zip: Scottsville, Allen, 42164

Telephone number: ~~270-622-2800~~

Administrator: Eric A. Hagan

Date facility operation began at current address: April 09, 1996

Date facility began operation under current owner: January 01, 1995

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	110	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County	(Nonprofit)	Partnership
City		(Corporation)
(Private)		

II. OWNERSHIP

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

Bowling Green Warren County Community Hospital Corporation d/b/a Cal Turner Rehab and Specialty Care
~~250 Park Street, Bowling Green, KY 42102~~

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OFFICE OF INSPECTOR GENERAL

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(OVER)

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

Name of corporation Commonwealth Health Corporation

Address of corporation 800 Park Street, Bowling Green, KY 42102

President or Chairman Connie Smith

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
Commonwealth Health Corporation	
800 Park Street	
Bowling Green, KY 42102	

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 of authorized representative	Title	Date
	Administrator	02/25/2013

Return Application and fee to:

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

OIG 5
(10/2002)

Quick Links

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