

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

For Office Use Only
Received 7.23.12
Amount 1990.-

emailed validation letter 8/2/12
Ch # 12263

I. IDENTIFICATION

Name Brighton Cornerstone Health Care
 Address 55 E. North Street
 City/County/Zip Madisonville / Hopkins / 42431
 Telephone number 270/821-1492 viki@kih.net
 Administrator Viki Thomasson
 Date facility operation began at current address 11-1-1967
 Date facility began operation under current owner 11-1-2004

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>66</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit <input checked="" type="checkbox"/>	Individual
County	Nonprofit	Partnership
City		Corporation
Private <input checked="" type="checkbox"/>		

II. OWNERSHIP

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

Viki Thomasson, Managing Member
685 Oak Street
Madisonville Ky 42431

(OVER)

RECEIVED
 JUL 23 2012
 OFFICE OF INSPECTOR GENERAL

RB
7/31

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

Name of corporation Brighton Cornerstone Health Care
 Address of corporation 55 E. North Street
 President or Chairman Viki Thomasson, President
 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
_____	_____
_____	_____
_____	_____

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 6-20-12

 Title Date

Return Application and fee to:

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

OIG 5
(10/2002)

