

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

For Office Use Only Received <u>2/1/20</u> Amount <u>510.00</u>

I. IDENTIFICATION

Name The James B. Haggard Memorial Hospital
 Address 464 Linden Avenue
 City/County/Zip Harrodsburg, KY 40330
 Telephone number (859) 733-4801 vreed@haggardhosp.org
 Administrator Victoria L. Reed, LNHA, DHA, FACHE
 Date facility operation began at current address 1991
 Date facility began operation under current owner 1991

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>34</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

The James B. Haggard Memorial Hospital

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

Name of corporation The James B. Hoggan Memorial Hospital
 Address of corporation 464 Linden Avenue
 President or Chairman James Ingram
 Vice President Pete Chiericozzi | Joana Wickliffe
 Secretary Doug Greenburg
 Treasurer N/A

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>Alliant Management Services</u>
_____	<u>Louisville, KY</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.

<u></u>	<u>LNHA</u>	<u>1/27/12</u>
Signature of authorized representative	Title	Date

Return Application and fee to: Office of Inspector General
 275 East Main Street, 5E-A
 Frankfort, Kentucky 40621



BOARD OF DIRECTORS

James Ingram, Chairman	JoEtta Wickliffe, Vice-	Pete Chiericozzi, Vice-
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