

mailed validation letter

3/30/12

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 3.15.12
Amount \$1275

Ch# 99005951

I. IDENTIFICATION

Name Tri-Cities Nursing and Rehabilitation Center
Address 19101 N. US 119
City/County/Zip Cumberland, Harlan Co. 40823
Telephone number 606-589-5421
Administrator Jeff Wilder
Date facility operation began at current address March 3, 1997
Date facility began operation under current owner January 1, 2011

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>85</u>	<u>85</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
Hanging Rock LTC, LLC
P.O. Box 6249
Kinston, NC

(OVER)

3/31

Rec'd 3/15/12

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

Name of corporation Hanging Rock LTC, LLC
Address of corporation P.O. Box 6249, Kinston, NC
President or Chairman N. Randy Uzzell
Vice President Raymond J. Baker
Secretary Raymond J. Baker
Treasurer Dianne Johnson

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>Principle LTC, LLC</u>	_____
<u>Principle IT Services, LLC</u>	_____
<u>* Address and officers</u> <u>same as above</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

Administrator 2/21/12
Title Date

Return Application and fee to:

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

OIG 5
(10/2002)