

emailed validation letter 11/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 9-30-11
Amount \$1410.

Ch# 0011546

I. IDENTIFICATION

Hyden Nursing Home d/b/a
Name Hyden Health and Rehabilitation Center
Address Post Office Box 618
City/County/Zip Hyden Leslie
Telephone number 606-672-2940
Administrator Melissa L. Sparks
Date facility operation began at current address 10/88
Date facility began operation under current owner 3/01/2005

417 **RECEIVED**
SEP 30 2011
OFFICE OF INSPECTOR GENERAL

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>94</u>	<u>94</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 <input checked="" type="checkbox"/>
Private <input checked="" type="checkbox"/>		<i>Limited liability</i>

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
Hyden Nursing Home d/b/a Hyden Health and Rehabilitation Center
P.O. Box 618
Hyden, KY 41749

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

Name of corporation Hyden Nursing Home LLC

Address of corporation P.O. Box 618 Hyden, KY 41749

^{MEMBER}
President or Chairman Terry E. Forcht

^{MEMBER}
Vice President Rodney Shockley

^{MEMBER}
Secretary Jackie Willis

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>First Corbin Long Term Care Inc</u>	_____
<u>PO Box 1450</u>	_____
<u>CORBIN, KY 40702</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.

Melissa L. Sparks
Signature of authorized representative

Administrator
Title

9-23-11
Date

Return Application and fee to:

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

Owner of First Corbin Long Term Care with more than 25% ownership Interest

Terry E. Forcht