

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

For Office Use Only  
Received 10-5-11  
Amount \$2145.-

*emailed Validation*  
*letter 11/1/11*  
*ch# 0013500*

**I. IDENTIFICATION**

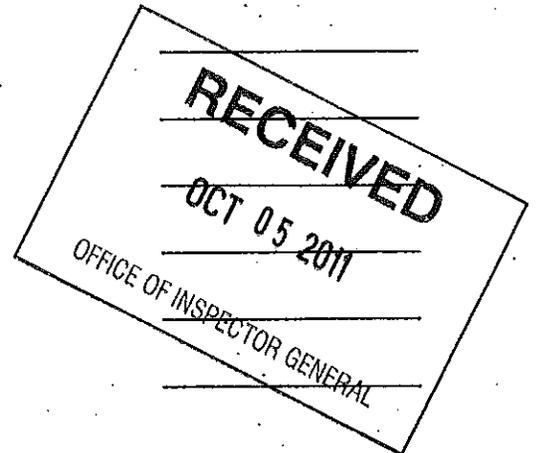
Name Narlan Health + Rehab  
Narlan Nursing Home  
 Address 200 Medical Center Drive  
 City/County/Zip Narlan, Kentucky 40831  
 Telephone number (606) 573-7250 cpocechsmai.com  
 Administrator Grail Pace  
 Date facility operation began at current address 4/1/79  
 Date facility began operation under current owner 3-1985

**II. TYPE BEDS**

No. beds licensed

No. beds requested

Skilled \_\_\_\_\_  
 Nursing Home \_\_\_\_\_  
 Nursing Facility 143  
 Intermediate Care \_\_\_\_\_  
 ICF/MR \_\_\_\_\_  
 Personal Care \_\_\_\_\_



**II. CONTROL (check one in each column)**

State \_\_\_\_\_  
 County \_\_\_\_\_  
 City \_\_\_\_\_  
 Private  Profit Nonprofit  Individual Partnership  Corporation

**II. OWNERSHIP**

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

Narlan Nursing Home, Inc.  
200 Medical Center Drive  
Narlan, Ky. 40831

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

Name of corporation Harlan Nursing Home, Inc.

Address of corporation 200 Medical Center Drive

President or Chairman Terry E. Jorch - Director

Vice President Rodney S. Shockley - Director

Secretary Jackie Willis

Treasurer Jackie Willis

Assistant Secretary - David Witt

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. - See attached -

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</u>	_____
<u>P.O. Box 1450</u>	_____
<u>Corbin, Ky. 40701</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.

Mae Pace  
\_\_\_\_\_  
Signature of authorized representative

Administrator 9/27/11  
\_\_\_\_\_  
Title Date

Return Application and fee to:

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

**ATTACHMENT:**

**1. Terry E. Forcht, chairman/member**

**2. Debra Reynolds, member**

**3. Rodney Shockley, member**