100750

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10/25/11
Amount 225.00

#57600

I. IDENTIFICATION

Name: Nursing Facility of Hardin Memorial Hospital

Address: 913 North Dixie Ave.

City/County/Zip: Elizabethtown / Hardin / 42701

Telephone number: (270) 706-1604 rjoyce@hmh.net

Administrator: Linda Bragg lbragg@hmh.net

Date facility operation began at current address: July 29, 1996

Date facility began operation under current owner: July 29, 1996

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	15	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

II. OWNERSHIP

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

Hardin County, Kentucky
913 North Dixie Ave.
Elizabethtown, Ky 42701

RECEIVED
OCT 25 2011
OFFICE OF INSPECTOR GENERAL

(OVER)

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

Name of corporation _____

Address of corporation _____

President or Chairman _____

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.

Rhonda Joyce	Director, Planning	10-24-11
Signature of authorized representative	Title	Date

Return Application and fee to:

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