

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

For Office Use Only  
Received 9-30-11  
Amount \$ 2910.

*emailed validation  
letter 11/1/11*

*Ch# 28208*

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

**I. IDENTIFICATION**

Name NHC HealthCare, Glasgow  
Address 109 Homewood Blvd., P.O. Box 247  
City/County/Zip Glasgow/Barren/42142-0247  
Telephone number 270-651-6126 dbrown@nhccare.com  
Administrator Emogene Stephens  
Date facility operation began at current address March 1970  
Date facility began operation under current owner July 1, 2000

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>194</u>	<u>194</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

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

State	<input checked="" type="checkbox"/> Profit	Individual
County	<input type="checkbox"/> Nonprofit	Partnership
City		<input checked="" type="checkbox"/> Corporation
<input checked="" type="checkbox"/> Private		(limited liability company)

**II. OWNERSHIP**

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

N/A

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(OVER)

*10/31*

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

Name of corporation NHC HealthCare/Glasgow, LLC  
Address of corporation 109 Homewood Blvd., P.O. Box 247, Glasgow, KY  
42142-0247  
~~President or Chairman~~ Greg Bidwell, Managing Member, Regional Vice Pres.  
~~Vice President~~ Emogene Stephens, Administrator  
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.

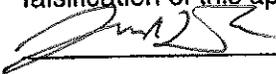
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

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
<u>NHC/OP, L.P.</u>	_____
<u>100 Vine Street</u>	_____
<u>Murfreesboro, TN 37130</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 of authorized representative

Authorized Rep. 9/27/11  
\_\_\_\_\_  
Title Date

Return Application and fee to:

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

OIG 5  
(10/2002)

The parent company (100% ownership) for the referenced legal entity (limited liability company) is:

NHC/OP, L.P.  
100 Vine Street  
Murfreesboro, TN 37130

It should be noted that the parent company of NHC/OP, L.P. is:

National HealthCare Corporation  
100 Vine Street  
Murfreesboro, TN 37130