

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

For Office Use Only Received <u>2/26/13</u> Amount <u>3000.00</u>

#17916

I. IDENTIFICATION

Name HAZARD NURSING HOME, INC. dba HAZARD HEALTH AND REHABILITATION CENTER

Address P.O. BOX 1329, HAZARD, KY 41702

City/County/Zip HAZARD, PERRY, 41702

Telephone number 606-439-2306 CHHAYES@HSIMAI.COM

Administrator CHARLOTTE C. HAYES

Date facility operation began at current address DECEMBER 13, 1974

Date facility began operation under current owner JULY 1, 2003

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>200</u>	_____
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.

HAZARD NURSING HOME, INC
P.O. BOX 1329
HAZARD, KY 41702

RECEIVED

FEB 26 2013

OFFICE OF INSPECTOR GENERAL

(OVER)

2/28

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

Name of corporation HAZARD NURSING HOME, INC.

Address of corporation P.O. BOX 1329, HAZARD, KY 41702

President or Chairman KATHY HALL

Vice President _____

Secretary DAVID WITT

Treasurer ROGER ALSIP

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>P.O. BOX 1450</u>	_____
<u>CORBIN, KY 40501</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.

Charlotte C. Hayes, RN, MSW
Signature of authorized representative

Administrator
Title

2/25/13
Date

Return Application and fee to:

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

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(10/2002)