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 OFFICE OF INSPECTION

mailed validation letter 11/1/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
 Received 10-21-11
 Amount \$1850.-

Ch# 027610

\$1770./1850-

I. IDENTIFICATION

Name Good Shepherd Community Nursing Center
 Address 60 Phillips Branch Road
 City/County/Zip Phelps, Ky 41553
 Telephone number 606-456-8705
 Administrator Priscilla Hager (phager@phsk.org)
 Date facility operation began at current address Oct 1979
 Date facility began operation under current owner May 1985

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>118</u>	<u>118</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	<u>2</u>	<u>2</u>

II. CONTROL (check one in each column)

State _____	Profit _____	Individual _____
County _____	<u>Nonprofit</u>	<u>Partnership</u>
City _____		<u>Corporation</u>
<u>Private</u>		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
Presbyterian Homes and Services of Ky, Inc.
1030 Alta Vista Rd
Louisville, Ky 40205

(OVER)

10/31

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

Name of corporation Presbyterian Homes and Services of Ky, Inc.
Address of corporation 1030 Alta Vista Rd
President or Chairman Mitch Garrett
Vice President Harold Smith
Secretary Doug Humphrey
Treasurer Patrick Cecil

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. N/A

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
_____	_____
_____	_____
_____	_____

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] _____ Title VP/CFD Date 10/17/11
Signature of authorized representative

Return Application and fee to:

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

OIG 5
(10/2002)

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5/1/11