

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

For Office Use Only
Received 9/22/11
Amount 690770-

*emailed validation
letter 10/4/11
Ch# 10777*

I. IDENTIFICATION

Name Clinton-Hickman County Nursing Facility
 Address 366 South Washington St.
 City/County/Zip Clinton KY 42031
 Telephone number 270-653-2461 e-mail clintonicf@earthlink.net
 Administrator William B. Little
 Date facility operation began at current address 1968
 Date facility began operation under current owner 1968

RECEIVED
 SEP 22 2011
 OFFICE OF INSPECTOR GENERAL

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	46	46
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	10	10

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.

(OVER)

9/30

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

Name of corporation Clinton-Hickman County Hospital, Inc.
Address of corporation same
President or Chairman Jerry Peery
Vice President Robert Black
Secretary Bill Little
Treasurer Scott Smith

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.

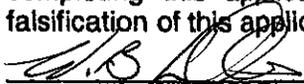
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

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.


Signature of authorized representative

administrator
Title

8/19/11
Date

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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Clinton-Hickman County Nursing Facility
Board of Directors

Jerry Peery, Chairman

Robert Black, Vice-Chairman

Bill Little, Secretary

Scott Smith, Treasurer

Larry Lewis, Member

Kenny Davis, Member

David Kimbell, Member