

email license validation letter 9/1/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 8-22-11
Amount \$ 2490.

Ch # 99003008

I. IDENTIFICATION

Name Hanging Rock LTC, LLC
 Address d.b.a. Somerwoods Nursing & Rehabilitation CTR.
555 Bourn Ave
 City/County/Zip Somerset/Pulaski/42501
 Telephone number 606-679-7421 - SWD 24-Admin@Somerwoods.com
 Administrator Brian K. Jagers
 Date facility operation began at current address Unknown
 Date facility began operation under current owner 01/01/2011

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>166</u>	<u>166</u>
Nursing Home		
Nursing Facility	<u>166</u>	<u>166</u>
Intermediate Care		
ICF/MR		
Personal Care		

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 AUG 22 2011
 OFFICE OF INSPECTOR GENERAL

II. CONTROL (check one in each column)

State _____
 County _____
 City _____
 Private Profit Nonprofit Individual Partnership Corporation

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners:
Hanging Rock LTC, LLC
555 Bourn Ave
Somerset, KY 42501

(OVER)

8/31

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

Name of corporation Hanging Rock LTC, LLC
Address of corporation 555 Bourne Ave, Somerset, KY 42501
President or Chairman Randy Uzzell
Vice President Stephen Hill
Secretary Lucy Hill
Treasurer Steve Farrar, Assistant Sec.

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>Principle Long Term Care</u>	_____
<u>P.O. Box 6249</u>	_____
<u>Kinston, NC 28501</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]
Signature of authorized representative

Administrator 8/2/11
Title Date

Return Application and fee to:

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

OIG 5
(10/2002)