

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

For Office Use Only Received <u>2/20/13</u> Amount <u>510.00</u>
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# 116615

**I. IDENTIFICATION**

Name The James B Haggin Memorial Hospital  
 Address 464 Linden Avenue  
 City/County/Zip Harrodsburg Ky 40330  
 Telephone number 859 733 4801  
 Administrator Victoria L. Reed, LNHA, DAA, FACHE  
 Date facility operation began at current address 1991  
 Date facility began operation under current owner 1991

**II. TYPE BEDS**

	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>34</u>	<u>34</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

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

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

*Var*

**II. OWNERSHIP**

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

The James B Haggin Memorial Hospital

*2/23*

(OVER)

<p><b>RECEIVED</b></p> <p>FEB 20 2013</p> <p>OFFICE OF INSPECTOR GENERAL</p>
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If facility owned or leased by a corporation, complete the following:

Name of corporation The James B. Haggin Memorial Hospital  
Address of corporation 464 Linden Ave, Harrodsburg Ky, 40330  
President or Chairman James G. Ingram  
Vice President Pete Chiericozzi / Jo Elizabeth Wickliffe  
Secretary Doug Greenburg  
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>Alliant Management Svcs.</u>
_____	<u>Louisville Ky</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] DHA, FACHE CEO / KNHA 2/12/13  
Signature of authorized representative Title Date

Return Application and fee to:

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

OIG 5  
(10/2002)



**BOARD OF DIRECTORS**

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