

unmailed validation letter  
6/28/12

Application for License to  
Operate a Long-term Care Facility

For Office Use Only  
Received 6/28/12  
Amount \$1800.-

Ch # 0015883

I. IDENTIFICATION

Hillcrest Health & Rehabilitation

Name Hillcrest Nursing Home of Corbin, Inc. DBA  
Address 1245 American Greeting Card Rd.  
City/County/Zip Corbin, Laurel, 40701  
Telephone number 606-528-8917  
Administrator Gail M. Gibbs  
Date facility operation began at current address 1973  
Date facility began operation under current owner 1973

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>120</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	<input checked="" type="checkbox"/> Profit	Individual
County	<input type="checkbox"/> Nonprofit	Partnership
City		<input checked="" type="checkbox"/> Corporation
<input checked="" type="checkbox"/> Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.  
Hillcrest Nursing Home of Corbin, Inc. DBA  
Hillcrest Health & Rehabilitation Center  
P.O. Box 556 Corbin, KY 40701

RECEIVED  
JUN 08 2012  
OFFICE OF INSPECTOR GENERAL

(OVER)

6/30  
AB

If facility owned or leased by a corporation, complete the following: Health & Rehabilitation Ctr.

Name of corporation Hillcrest Nursing Home of Corbin, Inc.; DBA Hillcrest

Address of corporation P.O. Box 556 Corbin, KY 40702

President or Chairman Kathy Hall

Vice President Michelle Jacobo & Susan Arnold

Secretary David With

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</u>	_____
<u>P.O. Box 1450</u>	_____
<u>Corbin, KY 40702</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]

Administrator

5-4-12

Signature of authorized representative

Title

Date

Return Application and fee to:

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

OIG 5  
(10/2002)