

RECEIVED

FEB 09 2011

emailed validation letter 2/25/11

OFFICE OF INSPECTOR GENERAL  
Application for License to Operate a Long-term Care Facility

For Office Use Only  
Received 2-9-11  
Amount \$3000.

Ch# 0014522

I. IDENTIFICATION

Name HAZARD NURSING HOME, INC. dba HAZARD HEALTH AND REHABILITATION CENTER  
Address P.O. BOX 1329, HAZARD, KY. 41702  
City/County/Zip HAZARD, PERRY, 41702  
Telephone number 606-439-2306  
Administrator SHEILA R. NOE  
Date facility operation began at current address DECEMBER 13, 1974  
Date facility began operation under current owner JULY 1, 2003

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	200	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

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.

HAZARD NURSING HOME, INC  
P.O. BOX 1329  
HAZARD, KY. 41702

(OVER)

2/28

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

Name of corporation HAZARD NURSING HOME, INC.

Address of corporation P.O. 1329, HAZARD, KY. 41702

President or Chairman KATHY HALL

Vice President \_\_\_\_\_

Secretary DAVID WITT

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. (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
<u>FIRST CORBIN LONG TERM CARE, INC</u>	_____
<u>P.O. BOX 1450</u>	_____
<u>CORBIN, KY. 40501</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.

Shirley R. Noe  
Signature of authorized representative

Administrator  
Title

2-4-11  
Date

Return Application and fee to:

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

OIG 5  
(10/2002)

OFFICERS AND DIRECTORS

PRESIDENT/--Kathy Hall  
DIRECTOR

TREASURER---Roger Alsip

SECRETARY---David Witt  
R O N 1150

ASST. SECRETARY---Jackie Willis  
R O N 1150

DIRECTOR---Michelle Jarboe

DIRECTOR---Susan Arnold  
R O N 1150