

emailed validation letter

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 2-2-12
Amount \$1875.-

2/29/12

ckf

0013727

I. IDENTIFICATION

Name Williamsburg Health and Rehabilitation Center
Address 287 North 11th Street
City/County/Zip Williamsburg / Whitley / 40769
Telephone number loop 549-4321
Administrator Michelle Jarboe
Date facility operation began at current address March 27th 1978
Date facility began operation under current owner March 27th 1978

II. TYPE BEDS

No. beds licensed

No. beds requested

Skilled

125

PERSONS

Nursing Home

Nursing Facility

125

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.

Williamsburg Nursing Home, DBA
Williamsburg Health and Rehabilitation Center, Inc
PO Box 1450
Corbin Ky 40902

(OVER)

RECEIVED
FEB 02 2012
OFFICE OF INSPECTOR GENERAL

2/29
RB

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

Name of corporation Williamsburg Health and Rehabilitation Center Inc

Address of corporation PO Box 719 Williamsburg Ky 40769

President or Chairman Kathy Han

Vice President _____

Secretary Roger Alsip

Treasurer David Witt

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>PO 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.

Michelle Gabe
Signature of authorized representative

Administrator
Title

1/24/12
Date

Return Application and fee to:

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