

RECEIVED

JUN 10 2011

OFFICE OF INSPECTOR GENERAL

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 6-10-11
Amount \$ 2785

emailed license val letter 6/24/11

Ch# 12709

I. IDENTIFICATION

Name Barbourville Health & Rehabilitation Center
Address P.O. Box 1090, 117 Shelby Street
City/County/Zip Barbourville, (Knox) 40906
Telephone number 606-546-5136 (email): jamases@hsimai.com
Administrator Janna Partin
Date facility operation began at current address _____
Date facility began operation under current owner 7-18-02

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>119</u>	_____
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.

Barbourville Health & Rehabilitation Center
P.O. Box 1090, 117 Shelby Street
Barbourville, Ky 40906

(OVER)

6/30
RB

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

Name of corporation Barbourville Health & Rehabilitation Center
 Address of corporation P.O. Box 1090, Barbourville, Ky 40906
 President or Chairman Terry E. Forcht
 Vice President Rodney Shockley
 Secretary Jackie Willis
 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. 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</u>	_____
<u>P.O. Box 1450</u>	_____
<u>Corbin, Ky. 40701</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.

Janna Partin _____ Administrator 5/18/11
 Signature of authorized representative Title Date

Return Application and fee to:

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

Attachment:

Corporate Officers

Terry E. Forcht

Rodney Shockley

Jackie Willis