

mailed validation letter

11/1/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 9.29.11
Amount \$1065.00

ch# 26610

I. IDENTIFICATION

Name Metcalf Health Care Center
Address PO Box 115 701 Skyline Dr
City/County/Zip Edmonton Metcalfe 42129
Telephone number (270) 432-2921 anighbors@metcalfehealthcare.org
Administrator Amy Neighbors
Date facility operation began at current address Mar 1977
Date facility began operation under current owner Mar 1977

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>71</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	<u>30</u>	_____

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OFFICE OF INSPECTOR GENERAL

II. CONTROL (check one in each column)

State County Profit Nonprofit Individual Partnership Corporation
City Private Corporation

II. OWNERSHIP

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

Metcalf Health Services, Inc.
PO Box 115 Edmonton, KY 42129

(OVER)

10/31

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

Name of corporation Metcalf Health Services, Inc.

Address of corporation PO Box 115 Edmonton, KY 42129

President or Chairman Greg Wilson

Vice President _____

Secretary Amy Neighbors

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
Wells Health Systems

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.

Amy Neighbors
Signature of authorized representative

Administrator 9/26/11
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

Greg Wilson, Chairman

Chris Huffman

Sharon Howard

Karen Linkous

Connie Coleman (home)

Pam Froedge (home)

Kaye Hope