emailed validation letter 6/29/12

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 6-4-12
Amount ~~$300~~ $1200.00
CK. # 25356

I. IDENTIFICATION

Name: Wellington Parc

Address: ~~2885 New Hartford Rd~~

City/County/Zip: Owensboro/Daviess/42303

Telephone number: ~~270-685-2374~~ philip@wellingtonparc.com

Administrator: Philip Travis

Date facility operation began at current address: August 1991

Date facility began operation under current owner: August 1991

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	20	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

II. OWNERSHIP

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

Wells Health Systems Inc.
725 Harvard Dr, Owensboro, KY 42301

RECEIVED
JUN 04 2012
OFFICE OF INSPECTOR GENERAL

(OVER)

6/30

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

Name of corporation Wellington Parc Health Systems Inc

Address of corporation 725 Harvard Dr, Owensboro, KY 42301

President or Chairman Jack Wells

Vice President Bobby Watson

Secretary Jean Wells

Treasurer Diane Watson

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**
	725 Harvard Dr Owensboro, KY 42301

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 of authorized representative	Title	Date
	Adm	5/29/12

Return Application and fee to:

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

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(10/2002)