

emailed validation letter  
3/30/12

Application for License to  
Operate a Long-term Care Facility

For Office Use Only  
Received 2-28-12  
Amount \$1500.-

ck#  
0013291

I. IDENTIFICATION

Name Wolfe County Health & Rehabilitation Center  
Address P.O. Box 370  
City/County/Zip Campton, KY 41301  
Telephone number 606 668-3216  
Administrator Susan Arnold  
Date facility operation began at current address 10/01/90  
Date facility began operation under current owner 10/01/90

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>100</u>	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State \_\_\_\_\_ Profit   
County \_\_\_\_\_ Nonprofit  
City \_\_\_\_\_ Individual  
Private  Partnership  
Corporation

II. OWNERSHIP

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

Wolfe County Health & Rehabilitation Center, Inc.  
P.O. Box 1450  
Corbin, KY 40701

(OVER)

RECEIVED  
FEB 27 2012  
OFFICE OF INSPECTOR GENERAL

3/31

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

Name of corporation Wolfe County Health + Rehabilitation Center, Inc.

Address of corporation P.O. Box 1450 Corbin, KY 40701

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.

*Juan Arnold*  
Signature of authorized representative

Administrator      02-16-12  
Title      Date

Return Application and fee to:

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

OIG 5  
(10/2002)

**Attachment**

**Corporate Officers**

**Terry E. Forcht**

**Rodney Shockley**

**Jackie Willis**