

**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 12.14.11
Amount \$1500.-

emailed validation
letter 12/28/11
CL#
0012416

I. IDENTIFICATION

Name Corbin Health & Rehabilitation
 Address 270 Bacon Creek Road
 City/County/Zip Corbin / Whitley / Ky 40701
 Telephone number (606) 528-8822 / cimesser@HSMAT.com
 Administrator Cindy L. Messer
 Date facility operation began at current address Jan. 1997
 Date facility began operation under current owner July 1, 2003

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	<input checked="" type="checkbox"/> Profit	Individual
County	<input type="checkbox"/> Nonprofit	Partnership
City		<input checked="" type="checkbox"/> Corporation
<input checked="" type="checkbox"/> Private		

II. OWNERSHIP

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

Corbin Nursing Home, Inc
270 Bacon Creek Road
Corbin, Ky. 40701

(OVER)

12/31

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

Name of corporation Corbin Nursing Home, Inc.
Address of corporation 270 Bacon Creek Road Corbin, Ky 40701
President or Chairman Terry E Forcht
Vice President Rodney Shockley
Secretary Jackie Willis
Treasurer Jackie Willis

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>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.

C. M. Massey Administrator 11/23/11
Signature of authorized representative Title Date

Return Application and fee to:

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

OIG 5
(10/2002)

Attachment:

Corporate Officers

Terry E Fortch

Rodney Shockley

Jackie Willis

Cindy L. Messer
Administrator