

RECEIVED

JUN 23 2011

OFFICE OF INSPECTOR GENERAL

emailed validation letter 8/1/11

Application for License to Operate a Long-term Care Facility

For Office Use Only  
Received 6-23-11  
Amount \$1710.-

CL# 25560

I. IDENTIFICATION

Name Fair Oaks Health Systems  
Address PO Box 740  
City/County/Zip Jamesstown, Russell, 42629  
Telephone number 270 343 2101  
Administrator Chris Minnich (email) minnich270@yahoo.com  
Date facility operation began at current address 6/1/1973  
Date facility began operation under current owner 6/1/1999

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>0</u>	<u>0</u>
Nursing Home	<u>0</u>	<u>0</u>
Nursing Facility	<u>114</u>	<u>0</u>
Intermediate Care	<u>0</u>	<u>0</u>
ICF/MR	<u>0</u>	<u>0</u>
Personal Care	<u>0</u>	<u>0</u>

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

Chris Minnich Greg Faulkner  
412 Autumn Stone Lane 906 Eagle Court  
Bowling Green, Ky. 42103 Bowling Green, Ky. 42103

(OVER)

7/31

If facility owned or leased by a corporation, complete the following: *N/A*

Name of corporation \_\_\_\_\_

Address of corporation \_\_\_\_\_

President or Chairman \_\_\_\_\_

Vice President \_\_\_\_\_

Secretary \_\_\_\_\_

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.

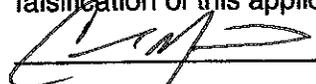
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

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
_____	_____
_____	_____
_____	_____

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

*Owner Administrator*  
\_\_\_\_\_  
Title

*6/21/2011*  
\_\_\_\_\_  
Date

Return Application and fee to:

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