

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

*emailed validation
letter 5/24/11*

For Office Use Only Received <u>5-16-11</u> Amount \$ <u>1350-</u>
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CH#2952

I. IDENTIFICATION

Name Charleston Health Care Center
 Address 203 Bruct. Ct.
 City/County/Zip Danville / Boyle / 40422
 Telephone number 859-2309292
 Administrator Marlin Sparks
 Date facility operation began at current address _____
 Date facility began operation under current owner _____

RECEIVED
 MAY 16 2011
 OFFICE OF INSPECTOR GENERAL

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>90</u>	<u>90</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

Marlin Sparks 135 Balem G. Danville, KY 40422
Troy Sparks 5505 Leblanck Rd. Danville, KY 40422
Jill Brown 462 Clubside Dr. Stamford, KY 40484

(OVER)

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

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
N/A

Management Company
N/A

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.

Mahli K. Sparks
Signature of authorized representative

Owner/admin 4/30/11
Title Date

Return Application and fee to:

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

OIG 5
(10/2002)