

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

For Office Use Only Received <u>7/9/12</u> Amount <u>720.00</u>
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# 17129

**I. IDENTIFICATION**

Name Sansbury Care Center, Inc

Address 2625 Bardstown Road

City/County/Zip St. Catharine, KY 40061

Telephone number 859-336-3974

Administrator E. Darlene Herald

Date facility operation began at current address August, 1978

Date facility began operation under current owner July, 2008

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>48</u>	<u>48</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL (check one in each column)**

State	Profit	Individual
County	Nonprofit <input checked="" type="checkbox"/>	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.

Sansbury Care Center, Inc

2625 Bardstown Road

St. Catharine, KY 40061

(OVER)

<p><b>RECEIVED</b></p> <p>JUL 09 2012</p> <p>OFFICE OF INSPECTOR GENERAL</p>
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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.

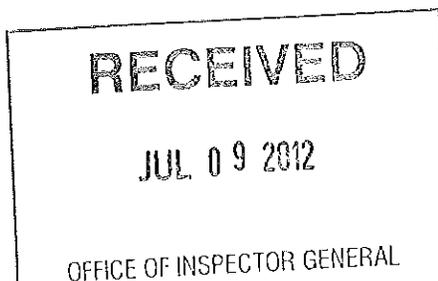
Parent	Management Company
_____	_____
_____	_____
_____	_____

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.

<u><i>Diane Herald, Administrator</i></u>	<u>Administrator</u>	<u>6/26/2012</u>
Signature of authorized representative	Title	Date

Return Application and fee to:

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



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