

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

For Office Use Only Received <u>4/23/13</u> Amount <u>\$1,350.00</u>
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#1443

I. IDENTIFICATION

Name Charleston Health Care Center

Address 203 Bruce Ct.

City/County/Zip Danville, Boyle 40422

Telephone number (859) 236-9292 ; jb.chcc@gmail.com

Administrator Marlin K. Sparks

Date facility operation began at current address _____

Date facility began operation under current owner June 1992

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	<u>Profit</u>	Individual
County	Nonprofit	<u>Partnership</u>
City		<u>Corporation</u>
<u>Private</u>		

II. OWNERSHIP

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

Marlin K. Sparks Management Company, Inc.

(OVER)

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

Name of corporation Marlin K. Sparks Management Co., Inc.
Address of corporation 203 Bruce Ct., Danville, Ky 40422
President or Chairman Marlin K. Sparks
Vice President Jill S. Brown
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.

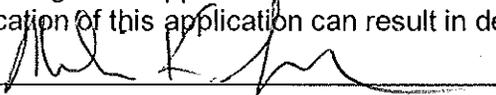
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

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>President</u>	<u>4/22/13</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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