emailed validation letter 8/2/12

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 7.9.12
Amount $1210.-

Ck# 27175

I. IDENTIFICATION

Name: Fair Oaks Health Systems, LLC

Address: PO Box 740, 1 Sparks Ave.

City/County/Zip: Jamestown / Russell / 42629

Telephone number: (270) 343-2101 minnich270@yahoo.com

Administrator: Chris Minnich

Date facility operation began at current address: 1973

Date facility began operation under current owner: 6/1/1999

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	114	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit ✓	Individual
County	Nonprofit	Partnership
City		Corporation ✓
Private ✓		

II. OWNERSHIP

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

Chris Minnich
412 Autumn Stone Lane
Bowling Green, Ky. 42103

Greg Faulkner
906 Eagle Court
Bowling Green, Ky. 42103

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

Name of corporation Fair Oaks Health Systems, LLC

Address of corporation 1 Sparks Ave, PO Box 740, Jamestown, Ky. 42629

President or Chairman Greg Faulkner

Vice President Chris Minnich

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 | 7/6/12 Date

Return Application and fee to:

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

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