

mailed validation letter 11/29/12

Application for License to Operate a Long-term Care Facility

For Office Use Only  
Received 11-13-12  
Amount \$930.-

Ch # 40601

I. IDENTIFICATION

Name Central City Enterprises, Inc. Belle Meade Home  
Address 521 Greene Drive, P.O. Box 565  
City/County/Zip Greenville, KY 42345 Muhlenberg County  
Telephone number 270-338-1523  
Administrator Gregory Sparks 1douglas0722@bellsouth.net  
Date facility operation began at current address 3/1/1967  
Date facility began operation under current owner 3/1/1967

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>62</u>	<u>62</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

Central City Enterprises, Inc., P.O. Box 565, Greenville, KY 42345

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**RECEIVED**  
NOV 13 2012  
OFFICE OF INSPECTOR GENERAL

(OVER)

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

Name of corporation Central City Enterprises, Inc.

Address of corporation 521 Greene Drive, P.O. Box 565, Greenville, KY 42345

President or Chairman Gregory Sparks

Vice President Beau Sparks

Secretary Muriel McRoy

Treasurer Muriel McRoy

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.

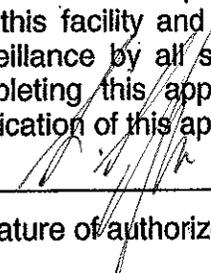
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

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
<hr/>	<hr/>
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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.

 <hr/>	<u>Administrator</u>	<u>11/5/12</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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(10/2002)