

Application for License to Operate a Long-term Care Facility

For Office Use Only
 Received 6-6-11
 Amount \$ 3390.-

emailed validation letter
 6/24/11
 Ch#
 0130022

I. IDENTIFICATION

Name Spring Creek Health Care

Address 1401 South 16th Street

City/County/Zip Murray, Kentucky 42071

Telephone number 270-752-2900

Administrator Sandra J. Dick

Date facility operation began at current address 1965

Date facility began operation under current owner 1993

RECEIVED

JUN 06 2011

OFFICE OF INSPECTOR GENERAL
 sdick@murrayhospital.org

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>226</u>	<u>226</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

rb

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

Name of corporation Murray Calloway County Hospital Corporation
(dba) Spring Creek Health Care
Address of corporation 1401 South 16th Street, Murray, Kentucky 42071
President or Chairman Ms. Sandra Parks
Vice President Mr. Steve Owens
Secretary Judge Larry Elkins
Treasurer Mr. Kenny Darnell

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.

Sandra J Dick

Signature of authorized representative

Administrator

Title

05-23-11

Date

Return Application and fee to:

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

OIG 5
(10/2002)