

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

For Office Use Only
Received 3.22.12
Amount \$1350.

emailed validation letter 5/1/12 ch # 1082

I. IDENTIFICATION

Name Charleston Health Care Center
 Address 203 Bruce Court
 City/County/Zip Danville, Boyle, 40422
 Telephone number (859) 236-9292;
 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	90	90
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	<u>Profit</u>	Individual
County	Nonprofit	Partnership
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.

RECEIVED
 MAR 22 2012
 OFFICE OF INSPECTOR GENERAL

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RB*

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 Court, Danville, KY 40422
President or Chairman Marlin K. Sparks
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.

Marlin K. Sparks President 03/20/12
Signature of authorized representative Title Date

Return Application and fee to:

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

OIG 5
(10/2002)