

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

For Office Use Only Received <u>5/1/12</u> Amount <u>2175.00</u>

81461896

I. IDENTIFICATION

Name GGNSC Louisville Camelot LLC, d/b/a
Golden Living Center - Camelot

Address 1101 Lyndon Lane

City/County/Zip Louisville, KY 40222-4317

Telephone number 502-425-0331

Administrator Clifton Lake

Date facility operation began at current address 09/1982

Date facility began operation under current owner 06/2006

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>145</u>	<u>145</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

GGNSC Louisville Camelot LLC
c/o: 1000 Fianna Way
Fort Smith, AR 72919

<p>RECEIVED</p> <p>MAY 01 2012</p> <p>OFFICE OF INSPECTOR GENERAL</p>

(OVER)

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If facility owned or leased by a ^{LLC} corporation, complete the following:

Name of ^{LLC} corporation GGNSC Louisville Camelot LLC
Address of ^{LLC} corporation 40: 1000 Fianna Way, Fort Smith, AR 72919
President or Chairman David R. Stordy
Vice President Michael Karicher
Secretary Holly A. Rasmussen-Jones
Treasurer Ann Tawitt

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
<u>GGNSC Equity Holdings LLC</u>	_____
<u>40: 1000 Fianna Way</u>	_____
<u>Fort Smith, AR 72919</u>	_____

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]
Signature of authorized representative

Secretary
Title

04/25/2012
Date

Return Application and fee to:

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