

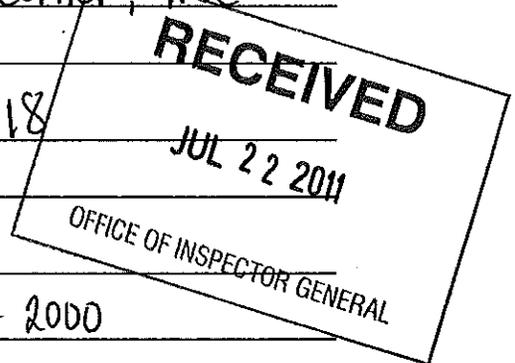
**Application for License to  
Operate a Long-term Care Facility**

For Office Use Only Received <u>7/22/11</u> Amount <u>2100.00</u>
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*Carespring Leasing, LLC  
#14749*

**I. IDENTIFICATION**

Name Villaspring Health Care Center, Inc.  
 Address 630 Viox Dr.  
 City/County/Zip Erlanger, Kenton 41018  
 Telephone number 859.727.6700  
 Administrator John Muller  
 Date facility operation began at current address August 2000  
 Date facility began operation under current owner August 2000



**II. TYPE BEDS**

	No. beds licensed	No. beds requested
Skilled	<u>140</u>	_____
Nursing Home	_____	_____
Nursing Facility	_____	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

**II. CONTROL** (check one in each column)

State	<input checked="" type="checkbox"/> Profit	Individual
County	<input type="checkbox"/> Nonprofit	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.

Barry N. Boetz  
David Eppers

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

Name of corporation Villaspring Inc.  
Address of corporation 1230 VIOX DR. Erlanger, KY 41018  
President or Chairman Barry Bortz  
Vice President David Eppers  
Secretary Barry Bortz  
Treasurer David Eppers

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]  
\_\_\_\_\_  
Signature of authorized representative

Administrator 7/12/11  
\_\_\_\_\_  
Title Date

Return Application and fee to:

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