Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 5/3/12
Amount 1230.00

3990

I. IDENTIFICATION

Name: GC Home Holdings LLC (dba Providence Pavilion)

Address: ~~401 East 20th Street~~

City/County/Zip: Covington/Kenton/41014

Telephone number: 859-283-6600; email: ghagan@providencenky.com

Administrator: George Hagan

Date facility operation began at current address: December 1, 2009

Date facility began operation under current owner: August 12, 2009

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	82	82
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit X	Individual
County	Nonprofit	Partnership
City		Corporation X (LLC)
Private X		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
GC Home Holdings, LLC dba Providence Pavilion
401 East 20th Street, Covington, KY 41014
Sole Member/Manager
George S. Hagan IV; 401 East 20th Street, Covington, KY 41014

RECEIVED
MAY 03 2012
OFFICE OF INSPECTOR GENERAL

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(OVER)

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

Name of corporation GC Home Holdings, LLC

Address of corporation 401 East 20th Street, Covington KY 41014

President or Chairman George Hagan (Manager of LLC)

Vice President NA

Secretary NA

Treasurer NA

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
	H&L Enterprises, Inc
	40 Monument Square, Suite 301
	Urbana, OH 43078

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 of authorized representative	Title: Manager	Date: 04/19/2012

Return Application and fee to:

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

OIG 5
(10/2002)