Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 8/9/12
Amount $100.00

Corespring Leasing, LLC #21804

I. **IDENTIFICATION**

Name: Villaspring Health Care Center

Address: 630 Viox Drive

City/County/Zip: Erlanger, Kenton 41018

Telephone number: 859-727-6700

Administrator: John Muller

Date facility operation began at current address: June 2000

Date facility began operation under current owner: N/A

II. **TYPE BEDS**

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

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

State
County
City
Private

Profit
Nonprofit

Individual
Partnership
Corporation

II. **OWNERSHIP**

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

Barry N. Bortz 390 Wards Corner Rd. Loveland, OH 45430
David Eppers 390 Wards Corner Rd. Loveland, OH 45430

(OVER)

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

Name of corporation _____

Address of corporation _____

President or Chairman _____

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
	Villa Spring HealthCare center, Inc.

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	Date
	Administrator	7-30-12

Return Application and fee to:

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

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(10/2002)