

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

For Office Use Only Received <u>4/10/12</u> Amount <u>1020.00</u>
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**I. IDENTIFICATION**

# 113830

Name Wesley Manor Retirement Community

Address 5012 East Manslick Rd.

City/County/Zip Louisville, KY 40219  
502-969-3277

Telephone number \_\_\_\_\_

Administrator Jerry Hoganson

Date facility operation began at current address 1-2-1963

Date facility began operation under current owner 1-2-1963

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>68</u>	<u>68</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

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

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

**II. OWNERSHIP**

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

\_\_\_\_\_

\_\_\_\_\_

(OVER)

<p><b>RECEIVED</b></p> <p>APR 10 2012</p> <p>OFFICE OF INSPECTOR GENERAL</p>
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If facility owned or leased by a corporation, complete the following:

Name of corporation Wesley Manor Retirement Community Inc.

Address of corporation 5012 East Manslick Rd. Louisville, KY 40219

President or Chairman Alan Fryrear

Vice President Phil Gayhart

Secretary Norma Sledge

Treasurer Mike Stigler

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.

Jimmy L. Hoganson  
Signature of authorized representative

President  
Title

4-9-2012  
Date

Return Application and fee to:

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

OIG 5  
(10/2002)