For Office Use Only
Received 7/27/11
Amount 1320.00

Application for License to Operate a Long-term Care Facility

Trilogy Health Services, LLC
#369714

RECEIVED
JUL 27 2011
OFFICE OF INSPECTOR GENERAL

I. IDENTIFICATION

Name: Park Terrace Health Campus

Address: 9700 Stonestreet Road

City/County/Zip: Louisville, KY 40272

Telephone number: (502) 995-6600

Administrator: Angie Decker

Date facility operation began at current address: 08/30/06

Date facility began operation under current owner: 08/30/06

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	88	88
Intermediate Care		
ICF/MR		
Personal Care		

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.

Trilogy Healthcare of Louisville Southwest, LLC
1650 Lyndon Farm Court, Suite 201
Louisville, KY 40223

(OVER)

8/31

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

Name of corporation Trilogy Healthcare of Louisville Southwest, LLC

Address of corporation 1650 Lyndon Farm Court, Suite 201

President or Chairman Randall J. Bufford

Vice President Steven Van Camp

Secretary

Treasurer Leigh Ann Barney

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
Trilogy Investors, LLC	N/A
1650 Lyndon Farm Court, Suite 201	
Louisville, KY 40223	

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
	Paul Plevyak, Sr. VP	7/19/2011

Return Application and fee to:

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