

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

For Office Use Only Received <u>6/7/12</u> Amount <u>550.00</u>
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**I. IDENTIFICATION**

*# 49102  
Trilogy FSC Investors, LLC*

Name Westport Place Health Campus  
 Address 4247 Westport Road  
 City/County/Zip Louisville - Jefferson - 40207-2227  
 Telephone number 502/893-3033  
 Administrator Suzanne Rinne  
 Date facility operation began at current address 7/13/2011  
 Date facility began operation under current owner 6/3/2011

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>                    </u>	<u>                    </u>
Nursing Home	<u>                    </u>	<u>                    </u>
Nursing Facility	<u>50</u>	<u>50</u>
Intermediate Care	<u>                    </u>	<u>                    </u>
ICF/MR	<u>                    </u>	<u>                    </u>
Personal Care	<u>                    </u>	<u>                    </u>

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

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

Trilogy Healthcare of Louisville East, LLC  
303 N. Hurstbourne Parkway, Suite 200  
Louisville, KY 40222-5185

<b>RECEIVED</b>
JUN 07 2012
OFFICE OF INSPECTOR GENERAL

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

Name of corporation Trilogy Healthcare of Louisville East, LLC  
Address of corporation 303 N. Hurstbourne Pkwy. Suite 200, Louisville, KY 40222  
President or Chairman Randall J. Bufford  
Vice President Paul Plevyak  
Secretary Steven Van Camp  
Treasurer David McDonald

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.

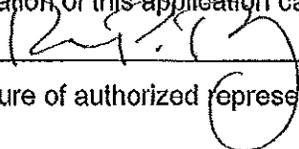
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

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
<u>Trilogy FSC Investors, LLC</u>	<u>N/A</u>
<u>303 N. Hurstbourne Pkwy., Suite 200</u> <u>Louisville, KY 40223-5185</u>	<u></u>

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.

<u></u>	<u>Paul Plevyak, Sr. Vice President</u>	<u>05/25/2012</u>
Signature of authorized representative	Title	Date

Return Application and fee to: Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

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(10/2002)