

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

For Office Use Only
Received 6.19.12
Amount \$1290.-

emailed validation letter 6/25/12
ck # 7195185

I. IDENTIFICATION

Name Paducah Care and Rehabilitation Center
 Address 501 North 3rd Street
 City/County/Zip Paducah, McCracken, KY 42001
 Telephone number 270-444-9661
 Administrator Cathy Ortega
 Date facility operation began at current address Approx. 1974
 Date facility began operation under current owner 07/01/2005

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>86</u>	
Nursing Home		
Nursing Facility	<u>86</u>	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

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

II. OWNERSHIP

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

HBR Paducah, LLC
101 Sun Avenue NE
Albuquerque, NM 87109

RECEIVED
 JUN 19 2012
 OFFICE OF INSPECTOR GENERAL

(OVER)

6/30

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

Name of corporation HBR Paducah, LLC
Address of corporation 101 Sun Avenue NE Abq, NM 87109
President or Chairman Sharon Warren, President
Vice President Debbie McLarty (VP Reimbursement)
Secretary Michael T. Berg
Treasurer Brandi Riddle

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
HBR Kentucky, LLC
101 Sun Avenue NE
Albuquerque, NM 87109

Management Company
N/A

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.

Michael T. Berg
Signature of authorized representative
Michael T. Berg

Secretary
Title

6-18-10
Date

Return Application and fee to:

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

OIG 5
(10/2002)