Notice of Intent to Acquire a Health Facility or Health Service

Pursuant to KRS 216B.065, any person proposing to acquire an existing licensed health facility or service within the boundaries of the Commonwealth of Kentucky shall notify this office at least thirty (30) days prior to entering into a contract to acquire the facility or service.

1. Name of Health Facility or Service ________________________________________________

   License Number: ________________________________________________________________

   Address of Facility or Service ____________________________________________________

   (City) (State) (Zip) (County)

2. Name of Current Owner ____________________________________________________________

3. Name of Purchaser ________________________________________________________________

   Address of Purchaser _____________________________________________________________

   (City) (State) (Zip) (County)

4. Identify the type of ownership of Purchaser:

   Sole Proprietorship ______
   Partnership ______ (Complete Section 4.A.)
   Limited Liability Company ______
   Professional Service Corporation ______
   Private (for-profit) Corporation ______
   Non-Profit Corporation ______
   Governmental Entity ______
   Other (please explain) ______
A. Please complete if purchaser will be a partnership:

<table>
<thead>
<tr>
<th>Type of Partnership</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Partnership</td>
<td>_____</td>
</tr>
<tr>
<td>Limited Partnership</td>
<td>_____</td>
</tr>
<tr>
<td>Limited Liability Partnership</td>
<td>_____</td>
</tr>
</tbody>
</table>

General Partners:

<table>
<thead>
<tr>
<th>Name</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Limited Partners:

<table>
<thead>
<tr>
<th>Name</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Which of the following is applicable: Purchase _____ Lease _____ Stock Acquisition _____ Merger _____

If merger, please explain: ____________________________________________________________

6. Is the Capital Expenditure or fair market value less than or more than the amount set forth on the Office of Inspector General, Division of Certificate of Need Web site, https://chfs.ky.gov/agencies/os/oig/dcn?

**PLEASE CHECK ONE.**

Less than _____________ More than _____________

7. What percentage interest is being acquired? ________________________________________

8. Projected date of acquisition _____________________________________________

9. Licensed bed capacity of facility at time of purchase (number of beds by category)

10. Health Services (licensure categories) and service area offered by the facility and service area at the time of Purchase

11. Outstanding certificates of need that are held by the current owner and have not been deemed complete
12. What other health care facilities does the purchaser currently operate in Kentucky?

____________________________________________________

_________________________________

______________________________________________________________

(EMAIL ADDRESS) (AREA CODE-TELEPHONE NO-EXT)

______________________________________________________________

(Signature of Authorized Representative) (Date)

COMPLETE AND RETURN TO:

OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED
275 EAST MAIN STREET 5EA
FRANKFORT, KY 40621
Phone: (502) 564-9592
Email: CON@ky.gov
Fax: (502) 564-6546