COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED

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:

GENERAL PARTNERSHIP _____ LIMITED PARTNERSHIP_____ LIMITED LIABILITY PARTNERSHIP _____

GENERAL PARTNERS:	NAME:	PERCENTAGE:
	______________________________	____________________________
	______________________________	____________________________
	______________________________	____________________________
	______________________________	____________________________

LIMITED PARTNERS:	NAME:	PERCENTAGE:
	______________________________	____________________________
	______________________________	____________________________
	______________________________	____________________________
	______________________________	____________________________

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?

____

(PRINTED NAME)	(TITLE)
(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