**FOR AGENCY USE ONLY. CON NUMBER:** 056-06-5885(1)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED

# APPLICATION

## FORMAL AND ADMINISTRATIVE OR NON-SUBSTANTIVE REVIEW


**SECTION A: GENERAL INFORMATION**

1. FACILITY, PROGRAM OR SERVICE:

NAME: Grace Home Care, Inc.

ADDRESS (Exact location – not PO Box #): 7721 Wood Duck Way

CITY/STATE/ZIP: Louisville, KY 40218

COUNTY: Jefferson

2. OWNER OF THE FACILITY, PROGRAM, OR SERVICE:
(Legally responsible person, corporation or other entity who is or will be the license holder)

NAME: Agni Kharel/Chandra Kharel

ADDRESS: 5512 Bannon Crossings Dr

CITY/STATE/ZIP: Louisville, KY 40218

3. CONTACT PERSON:

NAME: Dipendra Tiwari Controller (TITLE)

ADDRESS: 640 Zorn Ave Unit 9C

CITY/STATE/ZIP: Louisville, KY 40206

TELEPHONE NUMBER: 859-539-6306

EMAIL ADDRESS: info@gracehomecareinc.com

4. ATTORNEY'S NAME (If applicable) _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE NUMBER _____

5. Identify type of ownership for the proposed health facility/service.

| | |
|---|---|
| _____ | Sole Proprietorship |
| _____ | Partnership limited _____ general _____ |
| _____ | Limited Liability Partnership |
| _____ | Limited Liability Company |
| _____ | Professional Service Corporation |
| X | Private (for profit) Corporation |
| _____ | Non-Profit Corporation |
| _____ | Governmental (The Commonwealth and its instrumentality's and political subdivisions |

6. List the name and business address of any owner, investor, or stockholder whose ownership interest is greater than 10%.
Agni Kharel
Kishor Sapkota
Hemanta Bhetwal
Dipendra Tiwari
Chandra Kharel

7. If the owner is a corporation, attach evidence of incorporation.
(See Appendix # 1 )

8. If the owner is a partnership, submit a copy of the partnership agreement.
(See Appendix # NA )

9. If the owner is an out of state corporation, attach evidence of Kentucky registration and identify the process agent.
(See Appendix # NA )

10. If the existing facility or service or the proposed facility or service will be managed by someone other than the owner, identify and explain the relationship.
N/A

## SECTION B - PROJECT DESCRIPTION

1. Clearly define and describe the proposed project. This description must include all components of the proposed project, i.e., services to be provided, details of construction/renovation projects with square footages before and after construction or renovation, the size proposed for the area(s) after completion, present and proposed location of each affected department for renovation projects, the use planned for any vacated areas for relocated departments, etc.

   **Grace Home Care, Inc. proposes to establish a home health Agency in Jefferson county, Kentucky that will focus on elderly Asian Bhutanese and Nepalese community along with other elderly people to live in their home and provide the care they need to live in the community. Majority of the people in the community do not speak English language. Our care providers speak both the language to help them settle in the community.**

   **Grace Home Care is newly set up organization to provide home health services such as home health aid services, Skilled Nursing services pertaining to home and community based waiver. We will have plan to go for support for community living waiver in the future. The agency will be leasing the property to run its office smoothly. We have plan to expand our services to provide private duty nursing and many more in the future. The proposed registered office location is as follows:**

   **7721 Wood Duck Way**
   **Louisville, KY, 40218**

   **This location may change based on the future requirement.**

2. If the proposal includes a request for long-term care beds, please complete the following:

   A. Total number of beds requested:

| | |
|---|---|
| Nursing Facility Beds | NA |
| Intermediate Care Beds | NA |
| Skilled Nursing Beds | NA |
| Total number of Beds | NA |

   B. Total Number of beds to be certified for Medicaid participation

| | |
|---|---|
| Nursing Facility Beds | NA |
| Intermediate Care Beds | NA |
| Skilled Nursing Beds | NA |
| Total number of Beds | NA |

   C. Expected date that Medicaid Certification will be sought

| | Date |
|---|---|
| Nursing Facility Beds | NA |
| Intermediate Care Beds | NA |
| Skilled Nursing Beds | NA |

3. If you are an existing facility or your proposal involves beds or the services listed below, please complete the following table. (Identify deletions or conversions of beds by placing a negative sign (-) before the number proposed to be deleted or converted from and a positive sign (+) before the number proposed to be added or converted to.)

**Not Applicable**

| ACUTE CARE | CURRENT LICENSED BEDS | CON APPROVAL | PROPOSED ADDTIONS OR DELETIONS | PROPOSED CONVERSIONS | TOTAL AFTER COMPLETION OF PROJECT |
|---|---|---|---|---|---|
| Medical/Surgical | | | | | |
| Obstetrics | | | | | |
| Pediatric | | | | | |
| Neonatal Level II | | | | | |
| Neonatal Level III | | | | | |
| I C U | | | | | |
| C C U | | | | | |
| Other (Identify) | | | | | |
| TOTAL | | | | | |

| OTHER | CURRENT LICENSED BEDS | CON APPROVAL | PROPOSED ADDTIONS OR DELETIONS | PROPOSED CONVERSIONS | TOTAL AFTER COMPLETION OF PROJECT |
|---|---|---|---|---|---|
| Chem. Dependency Treatment | | | | | |
| Physical Rehab. | | | | | |
| Psychiatric | | | | | |
| Personal Care | | | | | |
| TOTAL | | | | | |

| LONG TERM CARE | CURRENT LICENSED BEDS | CON APPROVAL | PROPOSED ADDITIONS OR DELETIONS | PROPOSED CONVERSIONS | TOTAL AFTER COMPLETION OF PROJECT |
|---|---|---|---|---|---|
| Intermediate Care | | | | | |
| Skilled Nursing | | | | | |
| Nursing Facility | | | | | |
| ICF-IID | | | | | |
| Other | | | | | |
| TOTAL | | | | | |

| OTHER SERVICES | CURRENT LICENSED BEDS | CON APPROVAL | PROPOSED ADDITIONS OR DELETIONS | PROPOSED CONVERSIONS | TOTAL AFTER COMPLETION OF PROJECT |
|---|---|---|---|---|---|
| Operating Rooms (including cysto rooms) | | | | | |
| Cardiac Catheterization Labs | | | | | |
| Open Heart Surgery Operating Rooms | | | | | |
| Linear Accelerator/Cobalt | | | | | |
| MRI | | | | | |
| Lithotripter | | | | | |
| Other (Identify) | | | | | |
| TOTAL | | | | | |

4. If the proposal involves a new or relocated facility/service, attach a map which identifies the proposed location unless the new service is to be located in an existing licensed facility

(See Appendix # **Not Applicable** )

## SECTION C – NONSUBSTANTIVE REVIEW

If there are no review criteria in the State Health Plan for the health facility or service described in your application or your application meets the nonsubstantive review requirements of 900 KAR 6:075, you may request that your application be granted nonsubstantive review status. Please indicate if you are requesting nonsubstantive review.

YES __X___ I am requesting nonsubstantive review.

NO _____ I am not requesting nonsubstantive review.

If you are requesting nonsubstantive review, only Subsections 1 (if applicable), 2 A (1-5), 4 A, 4 B, 4 D, 4 F, 4 M, 4 N, 4 O, 4 P.(1) and 4 P.(2) of Section D (Certificate of Need Review Criteria) and Section E of the remainder of this application must be completed.

## SECTION D - CERTIFICATE OF NEED REVIEW CONSIDERATIONS

1. Consistency with Plans.

Explain in detail whether the proposal is consistent with the State Health Plan. Be sure to address each review criteria contained in the state health plan for the type of health facility or health service that is being proposed.

**We will comply with all the policy and regulation of state and any other agency. The detail of plan will be provided separately in the future if needed.**

**Each applicant shall set forth its plan of care of patients with out private insurance coverage and its plan for care of medically undeserved populations within the applicant proposed service area. Grace Home Care, Inc., will set forth a plan of care for of its patients without private insurance coverage for undeserved population with in Jefferson county or Other county if we are approved to provide the service.**

2. Need and Accessibility.

A. Need

(1) Identify the geographic area that this proposal seeks to serve and document how it was determined that there is a need for this proposal in the defined geographic area.

**Jefferson County, Kentucky has a large elderly Bhutanese Refugees and Nepali Population who speaks only Nepali languange. It is well know that due to language barrier and culture these underserved aged population need home health services. We provide the service with the language interpretation all their health need, take them to the doctors and any other need. This is niche services to start up with and will grow in the other population in the future.**

**Our focus area is in Jefferson County, Louisville, Kentucky and nearest county. We may expand the business based available resources in the other nearest county with the approval form the state. We are considering Fayette County as well. We would like to provide the best services for the people in need.**

(2) Document the applicant's ability to meet the need identified above.

**Grace Home Care, Inc. has the ability to meet the need identified above. We are group of individuals who have experiences in the various field that support the efficient management of Home Health Agency and its expansion in the future. Our board is formed by Registered Nurse, IT Professional, Management professional and Health professional.**

(3) If the proposal involves an existing facility or service, provide the % of occupancy based on licensed bed capacity, the number of procedures performed and the number of patients served during the last 12 months.

**Not Applicable**

Estimate, by type of bed or clinical service, the utilization of the proposed facility/services (% of occupancy, number of procedures to be performed and number of patient days and patients to be served) for the first and second year of operation following completion of the project. State whether your projections are on a cumulative or noncumulative basis. Document the method used to determine these projections.

**Not Applicable**

(4) Estimate the expected patient origin for the first and second years of operation in terms of patient and percentages of the total number of patients by county.

| 1year | 2nd year |
|---|---|
| 45 | 155 |

B. Accessibility.

Explain to what extent the proposed facility or service will be available to all residents of the geographic area that will be served.

**Our services will be provided to all the resident who needed home health care services irrespective of colors, gender and age. We can provide the specific need to services the clients as well.**

3. Interrelationships and linkages.

A. Explain in detail how this proposal will serve to accomplish appropriate and effective linkages with other services, facilities, and elements of the health care system in the region and state and provide documentation of efforts to secure linkages.

**We will work with local hospitals, social service agency, state agency and city administration and doctors to provide the services to needy patient and elderly. We have plan to expand in the areas of DDID and support for community living as our CEO is a trained professional and worked in that area for some years in the past.**

B. Explain in detail the applicant's efforts to achieve comprehensive care, proper utilization of services, and efficient functioning of the health care system.

**We focus on patient's requirement and hiring trained professional, by providing training and development to all our employees to serve better to the patients and clients. We try to acquire best available tools and technology to serve better service.**

4. Costs, Economic Feasibility and Resources Availability.

A. Does this proposal require a capital expenditure?
YES X NO _____

If yes, complete the following "Estimated Capital Cost". Do not include debt service reserve fund, as this is not a capitalized expenditure.

ESTIMATED CAPITAL COST

(1) Predevelopment Costs:

| | |
|---|---|
| a. Preliminary and programming costs | $ |
| b. Site acquisition | $ |
| c. Architectural/engineering costs | $ |

(2) Physical Plant Costs:

| | |
|---|---|
| a. Construction and/or renovation costs (Including fixed equipment) | $ |
| b. Building (purchase price or FMV, if leased*) | $ 30,000.00 (Lease) |
| c. Site improvement costs | $ |

(3) Other:

| | |
|---|---|
| a. Financing costs (e.g., underwriters discount fees, etc.) | $ |
| b. Interest during construction. | $ |
| c. Contingency (e.g., change orders, etc.) | $ 10,000.00 |
| d. Other (Specify) | $ |

(4) Equipment (include FMV, if leased):

| | |
|---|---|
| a. New | $ 40,000.00 |
| b. Replacement | $ |
| TOTAL | $ |

* Fair market value should be calculated by multiplying the annual lease payment by 7.

B. Does this proposal involve any lease arrangement (building, equipment, service, etc.)?

YES ____X____ NO _____

If yes, please explain the lease arrangements and identify all parties for each lease.

**Basic Lease for office and some equipment to run office smoothly.**

C. Submit documentation of the fair market value of any equipment to be acquired by purchase, lease, donation, transfer or other comparable arrangement.
(See Appendix # **Not Applicable** )

D. If this proposal involves a lease arrangement, complete the following:

| | | LEASE COST | |
|---|---|---|---|
| | | Annual Lease Payment | Years of Lease |
| (1) | Equipment (Specify) | $ _____ | _____ |
| | | $ _____ | _____ |
| | | $ _____ | _____ |
| | | $ _____ | _____ |
| (2) | Other (Building, Etc.) | $ **30,000.00** | **2 Years** |

E. List major equipment proposed to be acquired (purchased, leased, or donated) with a value that is equal to or greater than the major medical equipment expenditure minimum found at 900 KAR 6:030. Include costs of shipping and installation. For leased or donated equipment, list the appraised fair market value.

| Equipment Item | Cost/Fair Market Value |
|---|---|
| **Office Equpment** | **6,000.00** |
| **Office interiors set up** | **18,000.00** |
| **Computers** | **10,000.00** |
| **Basic Medical Device** | **6,000.00** |

F. Provide the following square footage and cost information for all construction and renovation projects reflecting total construction and/or renovation costs as reported in question 4 A (2) a.

**Not Applicable**

NEW CONSTRUCTION

| | Existing Gross Square Footage | New Construction Gross Square Footage | New Construction Costs | Construction Cost Per Gross Square Foot |
|---|---|---|---|---|
| Nursing Unit Areas | | | | |
| Ancillary Services Areas | | | | |
| Administration Areas | | | | |
| Circulation Spaces | | | | |
| Maintenance/Support Areas | | | | |
| TOTAL | | | | |

**Not Applicable**

RENOVATION

| | Existing Gross Square Footage | Renovated Gross Square Footage | Renovation Costs | Renovation Cost Per Gross Square Foot |
|---|---|---|---|---|
| Nursing Unit Areas | | | | |
| Ancillary Services Areas | | | | |
| Administration Areas | | | | |
| Circulation Spaces | | | | |
| Maintenance/Support Areas | | | | |
| TOTAL | | | | |

**Not Applicable**

G. If this proposal involves the addition of new beds, complete the following:

Construction/Renovation cost per bed* $ _____

Gross square feet per bed _____

*Use amount as stated in question 4 A (2) a.

**Not Applicable**

H. Explain any unusual factors that tend to increase project costs, (i.e., site preparation, type of construction, etc.).

**Licensing Process**

I. Indicate the proposed sources of capital funds for the expenditure reported in question 4.A.

| | | |
|---|---|---|
| Cash or Negotiable Securities | $ | 50,000.00 |
| Gifts of Bequests | $ | |
| Grant | $ | |
| (Specify type and timetable for application & commitment) | | |
| Mortgage/Loan | $ | |
| (Specify type and timetable for application & commitment) | | |
| Bonds | $ | |
| (Specify type and timetable for application & commitment) | | |
| Total Funds Available | $ | |

(Total MUST correspond to total from question 4 A, excluding fair market value of space and equipment)

I. If funds are to be generated externally, attach a letter from the funding source indicating that it has been contacted in regard to the possible financing of the project. If internally, attach a letter from the institution's chief executive or chief operating officer indicating that the funds are available for possible commitment to this project.

**Not Applicable** _____

K. Estimated terms of the debt.

| | | | | | |
|---|---|---|---|---|---|
| Mortgage/Loans | $ | | Bonds | $ | |
| Interest Rate | | % | Interest Rate | | % |
| Payment Period | | yrs. | Payment Period | | yrs. |
| Annual Debt Service | $ | | Annual Debt Service | $ | |
| | | | Tax Exempt ( ) yes | | ( ) no |
| | | | Debt service reserve fund | $ | |

L. What is the projected operational break-even level of this project? How is this determined? When is break-even expected to occur?

**Total Monthly Operational Fixed Cost = 7200**
**Each patient Hourly Contribution Margin = $6.5**
**Break even Level number of hours service per month = 1200 Hours of Service which is 37 patients per months. Detail will be furnished if needed.**

M. If this proposal involves an existing facility or service, provide the following patient-payment classification for the previous two fiscal years including ancillaries. (If less than twelve months please indicate) The total gross revenue should equal the gross patient revenue from 4 P.(1). Contractual allowances should not be deducted from Medicare and Medicaid.

**NOT APPLICABLE**

| | Number of Patient Days/Encounters | | Gross Revenue | |
|---|---|---|---|---|
| | 20 _____ | 20 _____ | 20 _____ | 20 _____ |
| Medicare | | | | |
| Medicaid | | | | |
| SSI/State Supplemental Assistance | | | | |
| Third Party Payors | | | | |
| Self Pay | | | | |
| Charity | | | | |
| TOTAL | | | | |

N. If this proposal involves an existing facility or service, estimate the following patient-payment classification for the first two fiscal years of operation of the total facility and/or service including ancillaries after implementation of this proposal, if approved. (If less than twelve months please indicate) The total gross revenue should equal the gross patient revenue from 4 P.(1). Contractual allowances should not be deducted from Medicare and Medicaid.

**NOT APPLICABLE**

| | Number of Patient Days/Encounters | | Gross Revenue | |
|---|---|---|---|---|
| | 20 ____ | 20 ____ | 20 ____ | 20 ____ |
| Medicare | | | | |
| Medicaid | | | | |
| SSI/State Supplemental Assistance | | | | |
| Third Party Payors | | | | |
| Self Pay | | | | |
| Charity | | | | |
| TOTAL | | | | |

O. Estimate the following patient-payment classification for the first and second years of operation for this proposal including ancillaries. (If less than twelve months please indicate) The total gross revenue should equal the gross patient revenue from 4 P.(2). Contractual allowances should not be deducted from Medicare and Medicaid.

**NOT APPLICABLE**

| | Number of Patient Days/Encounters | | Gross Revenue | |
|---|---|---|---|---|
| | 20 ____ | 20 ____ | 20 ____ | 20 ____ |
| Medicare | | | | |
| Medicaid | | | | |
| SSI/State Supplemental Assistance | | | | |
| Third Party Payors | | | | |
| Self Pay | | | | |
| Charity | | | | |
| TOTAL | | | | |

P.(1) Complete the following income statement for the past two fiscal years of operation of the total facility and for the first two fiscal years of operation of the total facility after the proposal has been implemented, including the revenues and expenses of this proposal. (If less than twelve months please indicate.) Services such as home health, ambulance service, etc. must provide the following information for the total operation of the service. Also, indicate the number of patient days or units of service for the corresponding fiscal year. (If less than twelve months please indicate.) **Not Applicable if needed will be furnish in the future**

| | Expenses and Revenue | | | |
|---|---|---|---|---|
| | Previous Two Fiscal Years | | Projected Two Fiscal Years | |
| | 20 ____ | 20 ____ | 20 18 | 20 19 |
| Gross Patient Revenue* | | | | |
| Non-Patient Revenue** | | | | |
| Income adjustments | | | | |
| Charity | | | | |
| Bad Debt | | | | |
| Contractual Allowances | | | | |
| **Adjusted Gross Revenue** | | | | |
| Operating Expenses: | | | | |
| Payroll (include all payroll taxes) | | | | |
| Interest | | | | |
| Depreciation | | | | |
| Other Direct Expenses*** (include all non-payroll and non-income taxes) | | | | |
| Indirect Expenses | | | | |
| **Total Operating Expenses** | | | | |
| Revenue Before Income Taxes | | | | |
| Federal and State Taxes**** (if applicable) | | | | |
| **Net Revenue (Loss)** | | | | |
| Units of Service | | | | |
| Patient Days | | | | |

*Include revenue from sales of ancillary items.

**Include donations, investment/interest revenue, bequests, etc.

***Include expenses associated with ancillary items included in gross revenue

****Include benefits of net operating loss carrybacks and carryforwards

P. (2) Complete the following income statement for the specific proposed services for the first two fiscal years of operation. If the proposal pertains to an expansion, provide the previous two fiscal years of expenses and revenues. Also, indicate the number of patient days or units of service for the corresponding fiscal year.

**Not Applicable if needed will be furnish in the future**

| | Expenses and Revenue | | | |
|---|---|---|---|---|
| | Previous Two Fiscal Years | | Projected Two Fiscal Years | |
| | 20 _____ | 20 _____ | 20 _____ | 20 _____ |
| Gross Patient Revenue* | | | | |
| Non-Patient Revenue** | | | | |
| Income adjustments | | | | |
| Charity | | | | |
| Bad Debt | | | | |
| Contractual Allowances | | | | |
| **Adjusted Gross Revenue** | | | | |
| Operating Expenses | | | | |
| Payroll (include all payroll taxes) | | | | |
| Interest | | | | |
| Depreciation | | | | |
| Other Direct Expenses*** (include all non-payroll and non-income taxes) | | | | |
| Indirect Expenses | | | | |
| **Total Operating Expenses** | | | | |
| Revenue Before Income Taxes | | | | |
| Federal and State Taxes**** (if applicable) | | | | |
| **Net Revenue (Loss)** | | | | |
| Units of Service | | | | |
| Patient Days | | | | |

*Include revenue from sales of ancillary items.

**Include donations, investment/interest revenue, bequests, etc.

***Include expenses associated with ancillary items included in gross revenue

****Include benefits of net operating loss carrybacks and carryforwards

Q.

(1) What types and number of personnel will be required to implement this proposal, if approved (RN's, LPN's, physicians, technicians, aides, etc.)? Indicate in Full Time Equivalents (FTE). If you are an existing health service provider, indicate the number and types of additional personnel that will be need to be hired.

| | |
|---|---|
| **Registered Nurse** | **1** |
| **LPN** | **1** |
| **CAN** | **10** |
| **Trained Home care professional** | **35** |

(2) Describe the availability of the skilled and supportive personnel required to staff components of this proposal and in-service training programs for staff.

**As I mention earlier, we need RN and LPN which are available in house and other Trained Professional will be hired and trained based on the company policy as needed basis.**

R. Indicate present and projected patient costs per adjusted patient day/unit of service and present and projected patient charges per adjusted patient day/unit of service. Identify units of service (i.e. 15 minutes, 30 minutes, etc.). Attach a present and projected fee schedule including break down by type of procedure, if applicable. (See Appendix #_____).

**Not Applicable**

5. Quality of Services

A. Provide information on previous health care experience, education, etc. for principals responsible for assuring that quality care will be provided.

**We are going to establish the policy and procedural manual for each of service with the continuous improvement plan. We are going to set up plan to handle patients complain to resolve the issues arises during operation.**
**One of the shareholder is a Licensed Registered Nurse other two nurses are readily available in house as needed basis. Two of the shareholders have bachelor degree and remaining one has a Master Degree. Two of the owner and CEO has been working in the health care fields.**

B. Identify the type(s) of license(s), certification(s) and accreditation(s) currently held by the facility/service and/or those required to implement the project.

**We have Licensed Registered Nurse and Personal Service Agency certification**.

C. If the applicant is accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting body, attach evidence of the current accreditation status. (Attach and identify as Appendix

**Not Applicable**

D. If the applicant is an existing health service provider, attach the most recent licensure inspection report. If deficiencies were noted in the report, attach the plan of correction. (Attach and identify as Appendix

**Not Applicable**

## SECTION E - PROJECT SCHEDULE

**Not Applicable**

1. Complete the following project schedule by filling in all dates that are applicable to the project.

| | | |
|---|---|---|
| A. | Land (site) acquisition | NA |
| B. | Plans and specifications completed | NA |
| C. | Plans and specifications submitted to the: | |
| | (1) Fire Marshall | NA |
| | (2) Office of Inspector General | NA |
| D. | Funding/financing secured | NA |
| E. | Contracts secured and signed | |
| | (1) construction | NA |
| | (2) equipment | NA |
| F. | Construction Time Frames | |
| | (1) commencement of construction | NA |
| | (2) completion of shelled-in structure | NA |
| | (3) completion of construction | NA |
| G. | Completion and Operation of Project | 30 days after licensing Approval |

2. Please sign and date the application.

I hereby declare that, to the best of my knowledge, the information provided in this application is true and accurate.

03-27-2018

(Authorized Signature) (Date)

Chandra Kharel
(Name - Print)

CEO
(Title)

# Commonwealth of Kentucky
# Alison Lundergan Grimes, Secretary of St

PAOI
0987410.09
Alison Lundergan Grimes
Secretary of State
Received and Filed
6/5/2017 4:04:34 PM
Fee receipt: $50.00

Alison Lundergan Grimes
Secretary of State
P. O. Box 718
Frankfort, KY 40602-0718
(502) 564-3490
http://www.sos.ky.gov

## Articles of Incorporation

PAI

For the purposes of forming a business corporation in Kentucky pursuant to KRS Chapter 271B, the undersigned incorporator hereby submits the following Articles of Incoporation to the Office of the Secretary of State for filing:

**Article I:** The name of the company is

**Grace Home Care, Inc.**

**Article II:** The street address of the company's initial registered office in Kentucky is

**7721 Wood Duck Way, Louisville, KY 40218**

and the name of the initial registered agent at that address is **Kishor Sapkota**

**Article III:** The mailing address of the company's initial principal office is

**7721 Wood Duck Way, Louisville, KY 40218**

**Article IV:** The name and mailing address of each incorporator is

| | |
|---|---|
| Kishor Sapkota | 7721 Wood Duck Way, Louisville, KY 40218 |
| Kishor Sapkota | 7721 Wood Duck Way, Louisville, KY 40218 |

**Article V:** The number of shares the corporation is authorized to issue is **1000**

Executed by the Incorporators on Monday, June 05, 2017

Name of incorporator: **Kishor Sapkota**
Name of incorporator: **Kishor Sapkota**

Signature of individual signing on behalf of Incorporator: **Kishor Sapkota**

I, **Kishor Sapkota**, consent to serve as the Registered Agent on behalf of the corporation.

Signature of Registered Agent or individual signing on behalf of the company serving as Registered Agent:

Kishor Sapkota

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 06-06-2017

Employer Identification Number:
82-1764799

Form: SS-4

Number of this notice: CP 575 A

GRACE HOME CARE INC
% KISHOR SAPKOTA
7721 WOOD DUCK WAY
LOUISVILLE, KY 40218

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

## WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 82-1764799. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

| | |
|---|---|
| Form 941 | 10/31/2017 |
| Form 940 | 01/31/2018 |
| Form 1120 | 04/15/2018 |

If you have questions about the form(s) or the due date(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, *Accounting Periods and Methods*.

We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification, and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, *Entity Classification Election*. See Form 8832 and its instructions for additional information.

**IMPORTANT INFORMATION FOR S CORPORATION ELECTION:**

If you intend to elect to file your return as a small business corporation, an election to file a Form 1120-S must be made within certain timeframes and the corporation must meet certain tests. All of this information is included in the instructions for Form 2553, *Election by a Small Business Corporation*.

If you are required to deposit for employment taxes (Forms 941, 943, 940, 944, 945, CT-1, or 1042), excise taxes (Form 720), or income taxes (Form 1120), you will receive a Welcome Package shortly, which includes instructions for making your deposits electronically through the Electronic Federal Tax Payment System (EFTPS). A Personal Identification Number (PIN) for EFTPS will also be sent to you under separate cover. Please activate the PIN once you receive it, even if you have requested the services of a tax professional or representative. For more information about EFTPS, refer to Publication 966, *Electronic Choices to Pay All Your Federal Taxes.* If you need to make a deposit immediately, you will need to make arrangements with your Financial Institution to complete a wire transfer.

The IRS is committed to helping all taxpayers comply with their tax filing obligations. If you need help completing your returns or meeting your tax obligations, Authorized e-file Providers, such as Reporting Agents (payroll service providers) are available to assist you. Visit the IRS Web site at www.irs.gov for a list of companies that offer IRS e-file for business products and services. The list provides addresses, telephone numbers, and links to their Web sites.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

**IMPORTANT REMINDERS:**

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.

* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.

* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is GRAC. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.