CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Matthew G. Bevin
Governor

Division of Certificate of Need
275 E. Main Street, 5 E-A
Frankfort, Kentucky 40621-0001
(502) 564-9592
Fax: (502) 564-6546
https://chfs.ky.gov/agencies/os/oig

Adam M. Meier
Secretary

Steven D. Davis
Inspector General

October 24, 2018

Dipendra Tiwari, Controller
Grace Home Care
640 Zorn Avenue Unit 9C
Louisville, KY 40206

RE: CON #056-06-5885(1)
Grace Home Care, Inc.
Louisville, Jefferson County
Establish a home health care agency to serve Jefferson County
Capital Expenditure: $80,000.00

Dear Dipendra Tiwari:

It has been determined that the above referenced application is complete for review. Declaring the application complete means only that the applicant has responded to the necessary items in the application. It does not speak to the accuracy, quality, clarity or rationale of the proposal.

With this finding of completeness, additional information concerning the application will not be accepted nor considered in the review of the proposal unless introduced at a public hearing. The application will be included in the review cycle which begins with public notice being given in the November 15, 2018 Certificate of Need Newsletter which will be posted on the Division of Certificate of Need's website: https://chfs.ky.gov/agencies/os/oig/dcn/Pages/cn.aspx . A decision will be made by February 13, 2019.

If you have any questions, please contact this office.

Sincerely,

Molly Nicol Lewis
Deputy Inspector General

Grace Home Care, Inc.

October 15, 2018

Attn:Ms Michele Bushong
Center for Health and Family services
Office of Health Policy
275 E Main Street 4W-E
Frankfort, KY 40621

Reference: CON#056-06-5885 (1)

Dear Ms. Bushong:

This is in response to your letter to provide Certificate of Need. I have stipulated my response based on section you mentioned as follows:

Section A: General Information

2. The Name of Corporation is **Grace Home Care, Inc**. I have already provided the registration documents. Revised page will be sent along with this letter.

Section C: Review Criteria

Review Criteria

1. An application to establish a home health service shall be consistent with this Plan if there is a projected need for at least 250 additional patients needing home health care services in the county for which the application is made as shown in the most recent edition of the Kentucky Annual Home Health Services Report;

   We went through the state health plan. Our ground to apply for the certificate need is based on niche area. Jefferson County, Kentucky has a large elderly Bhutanese Refugees Population who speaks only Nepali language and have different cultural background. It is well known fact that people have difficulty to get the service due to language and culture barriers. These underserved aged population need home health services. We have strength to provide the service they need with the language

7721 Wood Duck Way, Louisville, KY 40218
Phone: 502-785-4123, Fax: 502-398-6340
Email: info@gracehomecareinc.com

ADDITIONAL INFORMATIO

interpretation all their health need, take them to the doctors and any other need. At the same time, we have plan to serve any patients of any available.

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

2. An application to expand a home health service currently licensed in Kentucky shall be consistent with this Plan if there is a projected need for at least 125 additional patients needing home health care services in the county for which the application is made as shown in the most recent edition of the Kentucky Annual Home Health Services Report;

   Not Applicable

3. Notwithstanding criteria 1 and 2, an application submitted by an existing home health agency that has met the emergency circumstances provision as outlined in 900 KAR 6:080, Section 2, and has received notice from the Office of Health Policy that an emergency exists shall be consistent with this Plan only if the application is restricted to the limited purpose of alleviating the emergency;

   Not Applicable

4. Notwithstanding criteria 1 and 2, an application by a licensed Kentucky acute care hospital or critical access hospital proposing to establish a home health service with a service area no larger than the county in which the hospital is located and contiguous counties shall be consistent with this Plan if the hospital documents, in the last twelve (12) months, the inability to obtain timely discharge for patients who reside in the county of the hospital or a contiguous county and who require home health services at the time of discharge; and

   Not Applicable

5. Notwithstanding criteria 1 and 2, an application by an existing licensed Kentucky home health agency to expand to one (1) or more contiguous counties of its October 1, 2015 licensed service area shall be consistent with this Plan if the following conditions are met:

   Not Applicable

a. For an application filed prior to July 1, 2016:

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ADDITIONAL INFO...

I. The agency's most recently published rate by CMS Home Health Compare preceding the date the application is filed for "How often home health patients had to be admitted to the hospital" is equal to or better than national average; and

ii. The agency's most recently published rate by CMS Home Health Compare preceding the date the application is filed for "How often patients receiving home health care needed any urgent unplanned care in the hospital emergency room – without being admitted to the hospital" is equal to or better than the national average; or

b. For an application filed on or after July 1, 2016, the agency's published rate by CMS Home Health Compare under "Quality of Patient Care Star Ratings" was 4 stars or higher for three (3) out of the last four (4) reported quarters preceding the date the application was filed.

Not Applicable

Section D: Certificate of Need Review Considerations

2. A (4): 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.

Our operation initially to provide Home Health Aid at the residence of the patients. We will extend ours services in the future as Two of our directors are Registered Nurse. This is not a facility to provide clinal services.

2.A. (5): 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.

We will approach local hospital and social service case worker. 100 % will be in Jefferson county for initial years then we will plan to expand in nearest counties.

4. A. (2) b. **I have attached the revised page 11 and page 12 in the original application. Please replace.**

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ADDITIONAL INFORMATI

4.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.

The office facility we are planning is own by two of the directors. Basic Lease for office smoothly. This is for initial set up may transfer to any other places if it requires once we are in formal operation.

Lesser: Kishor Sapkota and Chandra Kharel

4.C. Submit documentation of the fair market value of any equipment to be acquired by purchase, lease, donation, transfer or other comparable arrangement.

These are the cost of equipment such as Computers, Printers, Basic health Devices, Phone System, Furnitures, Fixtures etc. This is the estimate and we have not asked for any quotation.

4. J. 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.

All funds are generated from internal sources such as Shareholders.

4.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.

Please Refer Appendix- I

4. 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.

Please Refer Appendix- II

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ADDITIONAL INFORM/

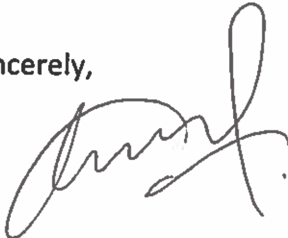
4. R: Indicate present and projected patient costs per adjusted patient day/unit of service and present and projected patient charges per adjusted patient day/unit of service. Identify units of service (i.e. 15 minutes, 30 minutes, etc.). Attach a present and projected fee schedule including break down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

We are not in operation yet. Once we are permitted to operate then the cost of service will be competitive and even a lower for some services.

Services	15 Minute	30 Minute
Home Health Aid	$4.50	$9.00

I hope that this letter will be fulfill all the requirements and take it as final clarification.

Sincerely,



(Dipendra Tiwari)

Controller

Enclosure:

1. Replacement page 1, 11, 12, 18 and 20
2. Appedix-I
3. Appendix- II

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Phone: 502-785-4123, Fax: 502-398-6340
Email: info@gracehomecareinc.com

ADDITIONAL INFORMATION

FOR AGENCY USE ONLY. CON NUMBER: 076-15-5695(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	Grace Home Care, Inc.
ADDRESS	7721 Wood Duckway
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	

DITIONAL INFORMATION

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*) **(Estimated)**	$ 28,000.00 (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.)	$ 12,000.00
d. Other (Specify)	$

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

a. New	$ 40,000.00
b. Replacement	$
TOTAL	$ 80,000.00

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

ADDITIONAL INFORMATION

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.

The office buildings we are planning is own by two of the directors. Basic Lease for office smoothly. This is for initial set up may transfer to any other places if it requires once we are in formal operation.

Lesser: Kishor Sapkota and Chandra Kharel

C. Submit documentation of the fair market value of any equipment to be acquired by purchase, lease, donation, transfer or other comparable arrangement.

These are the cost of equipment such as Computers, Printers, Basic health Devices, Phone System, Furnitures, Fixtures etc. detail is
(See Appendix # **NA**)

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.)	$ 28,000.00	2 Years

ADDITIONAL INFORM

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.

Please see Appedix - I

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

ADDITIONAL INFORMATION

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.

Please see Appedix-II

	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

ADDITIONAL INFORMATION

Appendix-I

Classified Revenue	Number of patients Days		Gross Revenue	
Services	2019	2020	2019	2020
Medicare	4,608	9,216	576,000.00	1,152,000.00
Medicaid	9,216	18,432	1,152,000.00	2,304,000.00
State Supplemental	3,686	7,372	460,800.00	921,600.00
Third party payor	922	1,843	115,200.00	230,400.00
Self Pay	1,382	2,764	172,800.00	345,600.00
Charity	461	922	57,600.00	115,200.00
	20,275	40,549	2,534,400.00	5,068,800.00

ADDITIONAL INFORMATION

Projected Expenses and Revenue

Appendix-II

	Amount $	Amount $
Gross Patient Revenue*	$ 2,534,400.00	$ 5,068,800.00
Non-Patient Revenue**	$ 76,032.00	$ 152,064.00
Income adjustments	$ -	$ -
Charity	$ -	$ -
Bad Debt	$ -	$ -
Contractual Allowances	$ -	$ -
Adjusted Gross Revenue	$ 2,610,432.00	$ 5,220,864.00
Operating Expenses:	$ 469,877.76	$ 730,920.96
Payroll (include all payroll taxes)	$ 1,827,302.40	$ 3,654,604.80
Interest		
Depreciation	$ 20,000.00	$ 20,000.00
Other Direct Expenses***	$ 130,521.60	$ 261,043.20
(include all non-payroll and non-income taxes)		
Indirect Expenses	$ 156,625.92	$ 261,043.20
Total Operating Expenses	$ 2,604,327.68	$ 4,927,612.16
Revenue Before Income Taxes	$ 6,104.32	$ 293,251.84
Federal and State Taxes****	$ 1,831.30	$ 87,975.55
(if applicable)		
Net Revenue (Loss)	$ 4,273.02	$ 205,276.29
Units of Service		
Patient Days		

ADDITIONAL INFORMATION

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY

Matthew G. Bevin
Governor

275 E. Main Street, 4W-E
Frankfort, KY 40621
Telephone: (502)564-9592
Fax: (502)564-0302
www.chfs.ky.gov/ohp/

Scott W. Brinkman
Acting Secretary

Molly Nicol Lewis
Executive Director

CORRECTED

October 22, 2018

Dipendra Tiwari, Controller
Grace Home Care
640 Zorn Avenue Unit 9C
Louisville, KY 40206

RE: CON #056-06-5885(1)
Grace Home Care, Inc.
Louisville, Jefferson County
Establish a home health care agency to serve Jefferson County
Capital Expenditure: $80,000.00

Dear Dipendra Tiwari:

Our office is in receipt of the additional information submitted via email on October 19, 2018. Per my October 19, 2018 reply to your email, all of the information requested was not provided. In order to declare the application complete and processed in this cycle, all of the requested information **must be submitted by October 26, 2018**. If you do not desire to provide the additional information requested, please inform this office accordingly (in writing) and state that you prefer that your application proceed through the process as originally submitted.

SECTION D: CERTIFICATE OF NEED REVIEW CONSIDERATIONS

4. A. (2) b. According to my calculations based on the annual lease payment amount provided on page 12, the fair market value of the building (annual lease payment x 7) is $210,000.00. Please revise the amount in this table. An estimated capital cost over $200,000.00 will require an additional CON filing fee.

4. A. Please provide the total at the bottom of the table.

An original and one (1) copy of the requested information must be filed **by October 26, 2018** with the Office of Inspector General, Division of Certificate of Need, Attn: Michele Bushong, 275 East Main Street 4WE, Frankfort, Kentucky 40621 in order to be included on the November 15, 2018 public notice.

Sincerely,

Michele Bushong

Michele Bushong
Health Policy Specialist II

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY

Matthew G. Bevin
Governor

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Scott W. Brinkman
Acting Secretary

Molly Nicol Lewis
Executive Director

April 12, 2018

Dipendra Tiwari, Controller
Grace Home Care
640 Zorn Avenue Unit 9C
Louisville, KY 40206

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Louisville, Jefferson County
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Sincerely,

Michele Bushong

Michele Bushong
Health Policy Specialist II

Grace Home Care, Inc.

October 15, 2018

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Center for Health and Family services
Office of Health Policy
275 E Main Street 4W-E
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Section D: Certificate of Need Review Considerations

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Please Refer Appendix- I

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Please Refer Appendix- II

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ADDITIONAL INFORMATION

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Sincerely,

(Dipendra Tiwari)

Controller

Enclosure:

1. Replacement page 1, 18 and 20
2. Appedix-I
3. Appendix- II

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Phone: 502-785-4123, Fax: 502-398-6340
Email: info@gracehomecareinc.com

ADDITIONAL INFORMATION

FOR AGENCY USE ONLY.	CON NUMBER: ______________

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: Grace Home Care, Inc.

ADDRESS: 7721 Wood Duckway

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

ADDITIONAL INFORMATION

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.

Please see Appedix - I

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

ADDITIONAL INFORMATION

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.

Please see Appedix-II

	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

ADDITIONAL INFORMATION

Appendix-I

Classified Revenue	Number of patients Days		Gross Revenue	
Services	2019	2020	2019	2020
Medicare	4,608	9,216	576,000.00	1,152,000.00
Medicaid	9,216	18,432	1,152,000.00	2,304,000.00
State Supplemental	3,686	7,372	460,800.00	921,600.00
Third party payor	922	1,843	115,200.00	230,400.00
Self Pay	1,382	2,764	172,800.00	345,600.00
Charity	461	922	57,600.00	115,200.00
	20,275	40,549	2,534,400.00	5,068,800.00

ADDITIONAL INFORMATION

Projected Expenses and Revenue

Appendix-II

	Amount $	Amount $
Gross Patient Revenue*	$ 2,534,400.00	$ 5,068,800.00
Non-Patient Revenue**	$ 76,032.00	$ 152,064.00
Income adjustments	$ -	$ -
Charity	$ -	$ -
Bad Debt	$ -	$ -
Contractual Allowances	$ -	$ -
Adjusted Gross Revenue	$ 2,610,432.00	$ 5,220,864.00
Operating Expenses:	$ 469,877.76	$ 730,920.96
Payroll (include all payroll taxes)	$ 1,827,302.40	$ 3,654,604.80
Interest		
Depreciation	$ 20,000.00	$ 20,000.00
Other Direct Expenses***	$ 130,521.60	$ 261,043.20
(include all non-payroll and non-income taxes)		
Indirect Expenses	$ 156,625.92	$ 261,043.20
Total Operating Expenses	$ 2,604,327.68	$ 4,927,612.16
Revenue Before Income Taxes	$ 6,104.32	$ 293,251.84
Federal and State Taxes****	$ 1,831.30	$ 87,975.55
(if applicable)		
Net Revenue (Loss)	$ 4,273.02	$ 205,276.29
Units of Service		
Patient Days		

ADDITIONAL INFORMATION

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Matthew G. Bevin
Governor

Division of Certificate of Need
275 E. Main Street, 5 E-A
Frankfort, Kentucky 40621-0001
(502) 564-9592
Fax: (502) 564-6546
https://chfs.ky.gov/agencies/os/oig

Adam M. Meier
Secretary

Steven D. Davis
Inspector General

July 30, 2018

Dipendra Tiwari, Controller
Grace Home Care
640 Zorn Avenue Unit 9C
Louisville, KY 40206

RE: CON #056-06-5885(1)
Grace Home Care, Inc.
Louisville, Jefferson County
Establish a home health care agency to serve Jefferson County
Capital Expenditure: $80,000.00

Dear Dipendra Tiwari:

On April 12, 2018, our office sent a request for additional information concerning the above-referenced Certificate of Need application received March 28, 2018. This office was unable to deem your application complete because we did not receive the additional information by the April 27, 2018 due date. Another letter was sent on May 3, 2018 providing notice that the additional information was due by July 27, 2018 in order to be included in the August 16, 2018 public notice. The requested information was not received by the deadline.

Pursuant to 900 KAR 6:065, an application will not be deemed complete and will not be placed on public notice until the applicant submits the information necessary to complete the application or the applicant requests in writing that its application be reviewed as submitted. In order for your application to be included in the next formal review batching cycle for home health (Public Notice November 15, 2018), you must submit your additional information or a request for the application to be reviewed as submitted by October 26, 2018. Please note that an application that is not deemed complete within one (1) year from the date that it is filed shall expire and shall not be placed on public notice or reviewed for approval.

Should you have any further questions, please do not hesitate to contact our office at (502) 564-9592.

Sincerely,

Molly Nicol Lewis
Deputy Inspector General

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY

Matthew G. Bevin
Governor

275 E. Main Street, 4W-E
Frankfort, KY 40621
Telephone: (502)564-9592
Fax: (502)564-0302
www.chfs.ky.gov/ohp/

Scott W. Brinkman
Acting Secretary

Molly Nicol Lewis
Executive Director

May 3, 2018

Dipendra Tiwari, Controller
Grace Home Care
640 Zorn Avenue Unit 9C
Louisville, KY 40206

RE: CON #056-06-5885(1)
Grace Home Care, Inc.
Louisville, Jefferson County
Establish a home health care agency to serve Jefferson County
Capital Expenditure: $80,000.00

Dear Dipendra Tiwari:

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Pursuant to 900 KAR 6:065, an application will not be deemed complete and will not be placed on public notice until the applicant submits the information necessary to complete the application or the applicant requests in writing that its application be reviewed as submitted. In order for your application to be included in the next formal review batching cycle for home health (Public Notice August 16, 2018), you must submit your additional information or a request for the application to be reviewed as submitted on or before July 27, 2018. Please note that an application that is not deemed complete within one (1) year from the date that it is filed shall expire and shall not be placed on public notice or reviewed for approval.

Should you have any further questions, please do not hesitate to contact our office at (502) 564-9592.

Sincerely,

Molly Nicol Lewis
Executive Director

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY

Matthew G. Bevin
Governor

275 E. Main Street, 4W-E
Frankfort, KY 40621
Telephone: (502)564-9592
Fax: (502)564-0302
www.chfs.ky.gov/ohp/

Scott W. Brinkman
Acting Secretary

Molly Nicol Lewis
Executive Director

April 12, 2018

Dipendra Tiwari, Controller
Grace Home Care
640 Zorn Avenue Unit 9C
Louisville, KY 40206

RE: CON #056-06-5885(1)
Grace Home Care, Inc.
Louisville, Jefferson County
Establish a home health care agency to serve Jefferson County
Capital Expenditure: $80,000.00

Dear Dipendra Tiwari:

Your application has been reviewed for completeness, and the following additional information is requested:

SECTION A: GENERAL INFORMATION

2. Please list the name of the corporation as it appears in the articles of incorporation rather than the names of Agni and Chandra Kharel.

SECTION C: NONSUBSTANTIVE REVIEW

Because there are review criteria in the State Health Plan for home health agencies, this application does not qualify for nonsubstantive review.

SECTION D: CERTIFICATE OF NEED REVIEW CONSIDERATIONS

1. Please address the home health agency review criteria in the State Health Plan on the Office of Health Policy's website, http://chfs.ky.gov/ohp/con/.

2. A. (4) and (5) It appears your numbering is incorrect for these two questions in the CON application submitted. Please correct.

2. A. (4) This question is applicable. Please provide a response.

4. A. (2) b. According to my calculations based on the annual lease payment amount provided on page 12, the fair market value of the building (annual lease payment x 7) is $210,000.00. Please revise the amount in this table. An estimated capital cost over $200,000.00 will require an additional CON filing fee.

4. A. Please provide the total at the bottom of the table.

4. B. Please identify all parties for each lease.

4. C. This question is applicable. Please provide a response.

4. J. This question is applicable. Please provide a response.

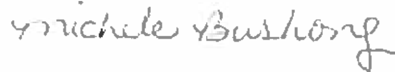
4. O. and 4. P. (2) These questions are applicable. Please respond.

4. R. This question is applicable. Please provide a response.

An original and one (1) copy of the requested information must be filed **by April 27, 2018** with the Office of Health Policy, Attn: Michele Bushong, 275 East Main Street 4WE, Frankfort, Kentucky 40621 in order to be included on the May 17, 2018 public notice. 900 KAR 6:090 Section 2 establishes the requirements for filing certificate of need documents with the Office of Health Policy.

Please note that you must respond to all of the questions listed above or our office cannot declare your application complete and it will not be processed in this cycle. If you do not desire to provide the additional information requested, please inform this office accordingly and state that you prefer that your application proceed through the process as originally submitted.

Sincerely,



Michele Bushong
Health Policy Specialist II