PDA, Inc.
P.O. Box 12844
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Suite 210
Raleigh, NC 27605
919.754.0303
kivey@pda-inc.net

January 7, 2026

Ewurama Shaw-Taylor
Maryland Health Care Commission
Health Care Planning and Development
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Certificate of Need Application – First Healthcare Consultants LTD, Proposed Medicare-Certified Home Health Agency

Dear Ms. Shaw-Taylor:

On behalf of our client, First Healthcare Consultants LTD, PDA, Inc. respectfully submits a Certificate of Need application for the establishment of a Medicare-certified Home Health Agency serving Anne Arundel, Montgomery, Prince George's, and Southern Jurisdictions.

In accordance with Commission instructions, six hard copies of the application are being submitted via UPS concurrently with this correspondence. All required electronic materials, including digital exhibits and supporting documentation, have also been transmitted via email as requested.

Should the Commission require any additional information or clarification during its review, please do not hesitate to contact us. PDA, Inc. appreciates the Commission's consideration of this application.

Sincerely,

Kelly Ivey

Kelly Ivey
Project Manager

First Healthcare Consultants LTD

Certificate of Need Application for

Medicare-Certified Home Health Agency

Anne Arundel, Montgomery, Prince George's, and Southern Jurisdictions

January 9, 2026

Application and Exhibits

MARYLAND
Health Care
Commission

Randolph S. Sergent Esq, Chairman

Ben Steffen, Executive Director

Revised July 2024

INSTRUCTIONS FOR
APPLICATION FOR CERTIFICATE OF NEED
HOME HEALTH AGENCY PROJECTS

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

REQUIRED FORMAT:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively.

The Table of Contents must include:

- **Responses to PARTS I, II, III and IV of this application form**
- **Responses to PART II must include responses to the standards in the State Health Plan chapter, COMAR 10.24.16, STATE HEALTH PLAN FOR FACILITIES AND SERVICES: HOME HEALTH AGENCY SERVICES.**
- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.)

SUBMISSION FORMATS:

We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215
- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.
- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to mhcc-confilings@maryland.gov

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

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APPLICATION SECTIONS

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LIST OF FIGURES

LIST OF EXHIBITS

For ease of use, Exhibits are independently page numbered beginning at 201.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. APPLICANT

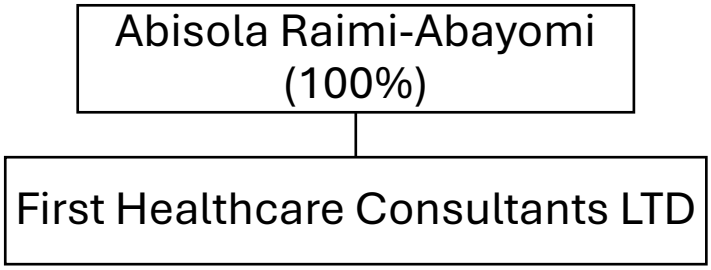
If the application has a co-applicant, provide the following information for that party in an attachment.

Legal Name of Project Applicant (Licensee or Proposed Licensee)	First Healthcare Consultants LTD d/b/a Abidaref Regal Healthcare Solutions
Address	12906 North Point Lane
City, State, ZIP, County	Laurel, MD, 20708, Prince George's
Telephone	301-725-1800
Name of Owner / Chief Executive Officer	Abisola Raimi-Abayomi

2. NAME OF OWNER

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

First Healthcare Consultants LTD d/b/a Abidaref Regal Healthcare Solutions ("FHC" or "Applicant") is a **privately held corporation** that is **100% owned by Ms. Abisola Raimi-Abayomi**. There are no additional individuals or entities with a 5% or greater ownership interest in the applicant. The company has no parent organizations or related entities with ownership interests.



3. FACILITY

Name of HHA Provider	First Healthcare Consultants LTD
Address	12906 North Point Lane
City, State, ZIP, County	Laurel, MD, 20708, Prince George's
Name of Owner (if different from Applicant)	

4. NAME OF LICENSEE OR PROPOSED LICENSEE
if different from the applicant:

Response: The licensee is the same as the Applicant, First Healthcare Consulting, LTD. Please see Exhibit 1 for a copy of FHC's existing Residential Services Agency license (R5352).

5. LEGAL STRUCTURE OF APPLICANT
(and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☒	Date and State of Incorporation: *November 16, 2012, Maryland*
	Partnership	☐	
C.	General		
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):	☐	
	Limited Liability Company	☐	
D.	Other (Specify):	☐	
E.	To be formed:	☐	
	Existing:	☐	

Response: Please see Exhibit 2 for a copy of the Articles of Incorporation for FHC.

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or Primary Contact:

Name and Title:	Abisola Raimi-Abayomi, Clinical Services Director
Address:	12906 North Point Lane
City, State, ZIP:	Laurel, MD, 20708
Telephone:	301-725-1800
Email (required):	abi.r@fheconsultantsus.com
Fax:	301-458-8175

B. Additional or Alternate Contact:

Name and Title	Nancy Lane, President
Company Name	PDA, Inc.
Address:	P.O. Box 12844
City, State, ZIP:	Raleigh, NC 27605
Telephone:	919-754-0303
Email (required):	nlane@pda-inc.net
Fax:	919-754-0328

If company name is different than applicant briefly describe the relationship

Response: PDA, Inc. is a healthcare consulting firm in Raleigh, NC. The Applicant, First Healthcare Consultants LTD, engaged PDA to assist with the certificate of need application process.

7. PROPOSED AGENCY TYPE: ☑

a. Health Department _____

b. Hospital Based _____

c. Nursing Home Based _____

d. Continuing Care Retirement Community Based _____

e. HMO Based _____

f. Freestanding X

g. Other (Please specify) _____

8. AGENCY SERVICES

(Please check ☑ all applicable.)

Service	Currently Provided	Proposed to be Provided in the Jurisdiction(s) that are the subject of this Application*
Skilled Nursing Services	X (R5352)	X
Home Health Aide	X (R5352)	X
Occupational Therapy	X (R5352)	X
Speech, Language Therapy		X
Physical Therapy	X (R5352)	X
Medical Social Services		X

* If proposing different services in different jurisdictions, note that accordingly.

9. OFFICES

Identify the address of all existing main office, and branch office locations and identify the location (city and county) of all proposed main office, and branch offices, as applicable. (Add rows as needed.)

Response: First Healthcare Consulting LTD is not an existing home health agency. It is an existing Residential Service Agency in Maryland. The information in the table below pertains to the existing Residential Service Agency and the proposed new home health agency.

	Street	City	County	State	Zip Code	Telephone
Existing Main Office	12906 North Point Lane	Laurel	Prince George's	MD	20708	301-725-1800
Existing Branch Offices						
Locations of Proposed HHA Main Office	12906 North Point Lane	Laurel	Prince George's	MD	20708	301-725-1800
Locations of Proposed Branch Office						

10. PROJECT IMPLEMENTATION SCHEDULE FOR AN HHA

d) A project that does not involve construction or renovation shall document that the approved project is complete and operational within 18 months.

Response: In completing this question, please note that Commission regulations at COMAR 10.24.01.12 state that *"home health agencies have up to 18 months from the date of the certificate of need to: (i) become licensed and Medicare certified; and (ii) begin operations in the jurisdiction for which the certificate of need was granted."*

As an existing Residential Service Agency providing skilled nursing care, First Healthcare Consulting LTD ("FHC") can pursue Maryland home health agency licensure and CMS Medicare certification once the Certificate of Need is issued. The project requires no construction as the proposed home health agency will operate from the existing Residential Service Agency office. FHC employs or contracts with staff in skilled nursing, home health aides, and occupational and physical therapy. FHC has identified candidates for the two other disciplines, speech therapy and medical social work, and expects to hire qualified candidates within weeks of receiving the CON. FHC is accredited by Community Health Accreditation Partner ("CHAP"); see Exhibit 1 for a copy of its accreditation certificate, which is valid through November 29, 2028. FHC has operating policies that meet the requirements for Maryland Home Health Agency licensure under COMAR 10.07.10, Home Health Agencies.

Therefore, FHC can apply for licensure shortly after receiving the CON, expects to obtain licensure within six months, and will begin offering home health agency services upon licensure. FHC will pursue Medicare Certification in parallel with its licensure pursuit. CMS will not certify a home health agency until it holds a state home health agency license.

For Home Health projects, please also provide:

A. Licensure 6 months from CON approval date.

B. Medicare Certification 9 months from CON approval date*

* to facilitate this schedule, FHC intends to pursue Deemed Status with the Community Health Accreditation Partner ("CHAP").

11. PROJECT DESCRIPTION:

Provide a summary description of the project immediately below. At minimum, include the jurisdictions to be served and all of the types of home health agency services to be established, expanded, or otherwise affected if the project receives approval.

Overview

First Healthcare Consulting, LLC ("FHC"), seeks approval to develop a new Medicare-Certified Home Health Agency ("HHA") serving Anne Arundel, Montgomery, Prince George's, and Southern Maryland (Calvert, Charles, and St. Mary's) jurisdictions ("primary service area" or "PSA"). This project will expand FHC's existing Residential Service Agency ("RSA"), which is licensed by the Maryland Department of Health, into a fully certified Medicare HHA consistent with COMAR 10.24.16.06(B)(3). Expanding services to include Medicare clients will improve access to cost-effective, high-quality, and patient-centered home health agency services for chronically ill, aging, and underserved residents in the proposed Maryland jurisdictions.

This initiative aligns with recent COMAR updates that permit RSAs to apply for CONs and obtain Medicare certification as HHAs, thereby enhancing continuity of care and access to skilled home health services for Maryland residents. Through this project, FHC aims to build upon its existing three-year foundation of high-quality, skilled nursing and supportive care, enabling the organization to serve a broader population of patients who need comprehensive, coordinated home-based health services. Over the past two years, FHC has provided RSA services to patients in all target HHA jurisdictions.

When fully licensed and CMS-certified, FHC will have on-call nurses and accept patient referrals at any time of day, seven days a week, 365 days a year.

FHC proposes to offer all Medicare- and Medicaid-covered home health agency services. These include items and services furnished to individuals on a visiting basis in accordance with the patients' care plans:

- Skilled nursing care provided by or under the supervision of a registered nurse;
- Physical therapy services;

- Speech therapy;
- Occupational therapy;
- Home health aide and other therapeutic services; and,
- Medical social services under the supervision of a master's-prepared Medical Social Worker.

Upon receipt of the Certificate of Need, FHC will begin implementation immediately, with receipt of Maryland HHA licensure targeted for Month 6, Medicare certification by Month 9, and full-service launch by Month 12. FHC has the financial stability, administrative infrastructure, and experienced leadership necessary to support a seamless transition to Medicare-certified operations without disrupting current services.

FHC is committed to expanding access to home-based clinical services for low-income, minority, and medically complex populations identified by MHCC data as disproportionately underrepresented among home health service users in the proposed four-jurisdiction service area.

FHC operates with a culturally competent workforce representative of its client base and the jurisdictions in which it provides services. This practice will extend to the proposed HHA. Policies and procedures promote better care coordination, fewer avoidable hospital stays, and improved patient outcomes.

FHC will continue to collaborate with and expand its reach to new hospital discharge planners, primary care practices, and community-based organizations across the PSA, ensuring timely access to skilled home health services. Exhibit 4 identifies the continuum of care providers in the jurisdiction and notes those with whom FHC has an existing referral relationship.

First Healthcare Consultants Background

FHC was established in Laurel, Maryland, in 2022 as a licensed RSA authorized to provide personal care, nursing, therapy, and aide services. In 2024, FHC served 282 clients and, at the time of this application, employs or contracts with more than 48 staff. Clients include pediatric patients, older adults, and individuals with disabilities.

FHC is a Maryland Medicaid vendor with contracts with the Maryland Department of Health to provide services covered by state-funded programs, such as the Community First Choice Program. FHC also contracts with approved Maryland Medicaid MCOs. An active member of the Capital Area Healthcare Alliance Business Advisory Council (Prince George's County Chapter). FHC regularly uses the resources of the Maryland-National Capital Homecare Association for staff training; FHC staff are currently enrolled in MNCHA's Leadership Program.

FHC's RSA license permits it to serve private and Medicaid personal care services, private duty nursing, physical therapy, and community alternative programs for adults and children. In this role, FHC is regularly asked by patients, families, and other providers to provide home health services for Medicare beneficiaries. Without a home health agency license, FHC cannot provide or bill for skilled care for Medicare and certain insurance programs. Some Maryland Medicaid MCOs are also making Medicare Certification an HHA a prerequisite to Medicaid service.

A Registered Nurse, Licensed Practical Nurse, Certified Nurse Aide I or II, Personal Care Assistant, or Licensed Physical Therapist provides all FHC RSA home care services.

FHC RSA home care agency has professionals with experience in public health, geriatrics, social work with people with disabilities, information services, and home health services.

FHC Leadership

An experienced interdisciplinary management team leads FHC. The team has extensive backgrounds in home- and community-based care, clinical operations, regulatory compliance, and healthcare administration. The leadership structure reflects both the organization's history as a Residential Service Agency and its readiness to operate as a Medicare-Certified Home Health Agency.

Abisola Raimi-Abayomi, R.N., MSN/MBA-HCM, serves as **Chief Executive Officer and Clinical Services Director**. Ms. Raimi-Abayomi brings nearly three decades of nursing and executive leadership experience across home health, correctional health, acute care, education, and community-based settings. Her background includes senior clinical and administrative roles overseeing large multidisciplinary teams, statewide nursing operations, regulatory compliance, quality improvement, and financial risk management. She holds dual graduate degrees in nursing and healthcare management. She has extensive experience in licensure, accreditation, and quality oversight, and provides strong clinical and operational leadership for FHC's transition to home health agency services.

Crystal Clark serves as **Chief Operating Officer and Administrator**. Ms. Clark has more than 30 years of experience in healthcare operations, organizational governance, and regulatory readiness. Her expertise includes operational infrastructure development, compliance oversight, performance management, budgeting, and executive reporting. She has held senior leadership roles supporting healthcare organizations, including home health and consulting entities. She has proven experience in aligning clinical and administrative functions to support sustainable growth and regulatory compliance.

Joviel Tumenta, R.N., BSN, serves as **Director of Nursing and Quality Assurance/Performance Improvement (QAPI) Lead**. Mr. Tumenta has clinical and leadership experience in home health, skilled nursing, and long-term care settings, including serving as interim Director of Nursing and Clinical Director at large facilities. His responsibilities include oversight of day-to-day clinical operations, staff education, intake review, care planning, and quality improvement activities. His background includes Medicare compliance, staff supervision, and regulatory plan-of-correction development, supporting FHC's ability to meet Conditions of Participation requirements.

Donabelle Cadatal-Abellana, PT, serves as **Therapy Lead**. Ms. Cadatal-Abellana is a licensed physical therapist with more than 25 years of experience in home health, rehabilitation, and acute and post-acute care settings. Her background includes extensive home care experience with large Maryland providers and a demonstrated history of interdisciplinary collaboration, patient education, and evidence-based care planning. She provides leadership for therapy services and coordination with contracted therapy disciplines as FHC expands its service offerings.

Latame Aheto, R.N., BSN, serves as **Intake Coordinator and RN Case Manager**. Ms. Aheto brings significant experience in home health nursing, OASIS-E assessments, wound care, chronic disease management, and care coordination. Her background includes hands-on Medicare-compliant documentation, interdisciplinary communication, and supervision of nursing staff and aides. She supports intake review, assessment accuracy, and continuity of care across service transitions, contributing directly to quality and compliance functions.

Together, FHC's leadership team demonstrates the clinical expertise, operational capacity, and regulatory experience necessary to establish and sustain a Medicare-Certified Home Health Agency while maintaining continuity with the organization's existing service model.

Programming

All home health agency services will be furnished pursuant to a physician-approved plan of care, developed in collaboration with the patient and interdisciplinary care team. Plans of care will be reviewed and updated as clinically indicated, but no less frequently than every 60 days, in accordance with CMS Conditions of Participation. Services will be individualized to address each patient's medical condition, functional status, and goals of care.

FHC proposes to offer a comprehensive range of skilled home health services capable of addressing a broad spectrum of medical, post-acute, and post-surgical conditions, including but not limited to cardiac, pulmonary, dermatological, endocrine (including diabetes mellitus), digestive, musculoskeletal, neurological, psychiatric (including Alzheimer's disease and other dementias), urological, and complex chronic conditions. Services will be provided across the lifespan, including age-appropriate care for pediatric and geriatric populations. When clinically appropriate, FHC will use a multidisciplinary approach to care delivery for patients requiring rehabilitative services, complex medical management, support for neurodegenerative conditions, or recovery from acute exacerbations of chronic illnesses such as congestive heart failure and chronic obstructive pulmonary disease ("COPD").

Home health agency services will be available seven days per week, as required to meet patient needs and support the timely initiation of care following hospital or facility discharge.

Skilled Nursing Services

Licensed registered nurses will provide skilled nursing services and, when appropriate, licensed practical nurses will provide this care under physician direction. Nursing services will include comprehensive assessment, care planning, medication management, disease education, wound care, post-surgical monitoring, chronic disease management, and coordination with physicians and other members of the interdisciplinary team. Nurses will work closely with patients, families, and caregivers to promote recovery, prevent avoidable hospitalizations, and support safe care management at home.

Pediatric Home Care Services

FHC will provide skilled nursing services to pediatric patients when ordered by a physician and clinically appropriate. Nurses providing pediatric home care will be trained to address the unique medical, developmental, and communication needs of children and their families. Pediatric services will emphasize family education, caregiver support, and coordination with pediatric providers to ensure continuity of care in the home setting.

Physical Therapy

Physical therapy services will focus on restoring mobility, improving functional independence, reducing pain, and preventing further injury. Services may include, but are not limited to:
Orthopedic rehabilitation

- Pain management
- Education on body mechanics and injury prevention
- Training in the use of assistive devices
- Hand therapy
- Range-of-motion improvement
- Muscle re-education
- Sports and activity-related rehabilitation
- Flexibility and strengthening exercises
- Back and neck care
- Pre- and post-surgical rehabilitation

Physical therapists will collaborate with nursing and other disciplines to support patient-centered recovery and functional improvement.

Occupational Therapy

Occupational therapy services will support patients' ability to perform activities of daily living safely and independently. Services may include, but are not limited to:

- Functional assessments and re-education
- Home safety evaluations and recommendations
- Energy conservation and fatigue management strategies
- Training in adaptive techniques for self-care tasks
- Education and training in the use of adaptive equipment
- Therapeutic program development and implementation
- Assistance with simplifying daily activities, including meal preparation, bathing, grooming, and household tasks.

Speech Therapy *(New Service)*

As a Medicare-Certified Home Health Agency, FHC will expand its scope of care to include speech-language pathology services. This service will be provided through qualified contracted providers. Speech therapy services will address communication, cognitive, and swallowing disorders resulting from stroke, neurological disease, injury, or other medical conditions. Services may include evaluation and treatment of speech and language deficits, cognitive-communication impairments, and dysphagia, to improve safety, functional communication, and quality of life.

Medical Social Work *(New Service)*

FHC will incorporate medical social work services into its interdisciplinary home health program. Medical social workers will assist patients and families in addressing psychosocial, environmental, and financial factors that affect health outcomes. Services may include counseling, resource coordination, advanced care planning support, referral to community-based services, and assistance with care transitions. Medical social work services will support patients' stability at home and help address non-medical barriers to successful treatment and recovery.

Personal Care Services

FHC recognizes that Medicare-Certified home health agencies place primary emphasis on skilled nursing and therapy services rather than long-term personal care. When ordered as part of a physician-approved plan of care and consistent with regulatory requirements, home health aide services may be provided to assist with activities of daily living, including bathing, dressing, hygiene, and mobility. These services will be delivered under the supervision of licensed nursing staff and will support, but not replace, skilled clinical care.

Special Programs

As an RSA, FHC has extensive experience delivering specialized in-home services to medically complex patients. Building on this foundation, FHC's proposed Medicare-certified Home Health Agency will formalize and expand these capabilities through structured clinical programs designed to address high-utilization, high-risk conditions commonly managed in the home setting. These special programs will be delivered under physician orders, integrated into the interdisciplinary plan of care, and monitored through the agency's Quality Assessment and Performance Improvement (QAPI) process to ensure safe, effective, and continuous care.

Wound Care Program

FHC's Homecare Wound Care Program provides evidence-based, physician-ordered wound care services in the home to promote healing, prevent infection and complications, and reduce avoidable emergency department visits and hospital readmissions. Services are provided by licensed nursing staff with wound care competency and are coordinated by an interdisciplinary team.

The program serves patients with acute, chronic, post-operative, and complex wounds, including pressure injuries, diabetic foot ulcers, venous and arterial ulcers, surgical wounds, skin tears, and minor burns. Licensed nurses conduct comprehensive wound assessments at initiation and throughout the episode of care, including wound measurement, tissue evaluation, infection surveillance, pain assessment, and documentation of healing progress. Individualized wound care plans are developed and updated in accordance with physician orders, assessment findings, and evidence-based practice.

Interventions may include skilled dressing selection and modification, infection prevention and control, aseptic technique, pressure relief and offloading strategies, compression therapy when indicated, and coordination of wound care supplies and equipment. Patient and caregiver education focuses on wound care techniques, nutrition and hydration, pressure injury prevention, medication adherence, and early recognition of complications. Program oversight and outcomes are monitored through QAPI activities and implemented in compliance with Maryland Office of Health Care Quality requirements and professional standards of practice.

Diabetes Care Program

FHC's Diabetes Care Program provides skilled nursing services to help patients with diabetes mellitus manage their condition safely at home. Services focus on glycemic monitoring, medication management (including insulin administration when ordered), assessment for complications, and patient education to improve self-management and reduce preventable hospitalizations.

Nursing interventions include blood glucose monitoring; evaluation of symptoms related to hypo- or hyperglycemia; medication reconciliation; nutritional education coordinated with physician guidance; and monitoring for diabetes-related complications, such as neuropathy, skin breakdown, and foot wounds. Patient and caregiver education emphasizes understanding of the disease, medication adherence, dietary considerations, and early identification of symptoms requiring medical attention. Care is coordinated with the patient's physician and other members of the interdisciplinary team as appropriate.

Post-Surgical Care Program

FHC's Post-Surgical Care Program supports patients transitioning home following surgical procedures by providing skilled nursing and therapy services designed to promote recovery and prevent complications. Services may include postoperative assessment, incision monitoring, pain management support, medication education, mobility and safety evaluations, and coordination of rehabilitative services, as ordered.

Nurses monitor for signs of infection, complications, or delayed healing and provide education to patients and caregivers regarding activity restrictions, wound care, symptom monitoring, and follow-up appointments. When appropriate, therapy services are integrated into the plan of care to support functional recovery and safe return to daily activities. The program emphasizes timely initiation of care, patient education, and coordination with surgeons and referring providers to ensure continuity and quality of care.

Importance of Home Health Services to the Community

In-Home Visits as a Means to Reduce Hospital Readmissions

Home health agency services play a critical role in supporting patients after hospital discharge by providing skilled clinical care at home, promoting functional recovery, and improving self-management of chronic conditions. Patients discharged from acute care are often still vulnerable, requiring ongoing nursing care, therapy, and monitoring that cannot be safely deferred; without these services, they face elevated risk for deterioration and return to the hospital.

Recent research on the impact of home health care on post-discharge hospital utilization yielded nuanced findings. Still, many studies support the value of coordinated transitional care in reducing readmissions when implemented effectively. For example, a cohort study found that home health care following hospital discharge was associated with a lower hazard of readmission and death than among patients not receiving home health services, suggesting that structured home-based care can improve outcomes.[2]

Home health care also improves functional status and patient-centered outcomes at a lower cost than institutional care. A systematic review of home care services compared with hospital care found that home-based services were cost-saving in several studies and at least as effective, indicating that home health can be both economically efficient and clinically beneficial.[3]

MHCC has determined that residents of FHC's Primary Service Area ("PSA") counties are underserved with regard to home health agency services. Adding FHC, a Medicare-Certified home health agency, to the PSA's HHA provider pool will expand access to skilled, in-home clinical care for patients who might otherwise be discharged with limited post-acute support. This expanded capacity can help ensure that more patients benefit from evidence-based transitional care, reducing unnecessary hospital utilization and supporting continuity of care. It will also improve the quality of life and support improvements in health status. HHA care plans intend to improve health status.

Lower-Cost Alternative to Hospital Care

Evidence also supports the cost-effectiveness of home health and other home-based care models relative to traditional hospital and long-term institutional care. Comparative analyses have shown fewer hospitalization days and lower direct costs for patients managed with home-based care models than inpatient care, particularly among older and medically complex patients.[4]

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[2] O'Connor, Maura, et al. "Impact of Home Health Care on Health Care Resource Utilization Following Hospital Discharge: A Cohort Study." *Journal of the American Medical Directors Association*, vol. 19, no. 1, Jan. 2018, pp. 84-92. PubMed, https://pubmed.ncbi.nlm.nih.gov/29180024/

[3] Leitao, Joana, et al. *"The Cost-Effectiveness of Homecare Services for Adults and Older Adults: A Systematic Review." International Journal of Environmental Research and Public Health*, vol. 19, no. 5, 2022, https://pubmed.ncbi.nlm.nih.gov/36834068/

[4] Szylit, Charles J., et al. "Cost-Effectiveness of Home Care Versus Hospital Care: Retrospective Analysis." *Cost Effectiveness and Resource Allocation*, vol. 21, 2023, https://pubmed.ncbi.nlm.nih.gov/36732792/

These findings are especially relevant in the PSA, where approximately 8.0 percent of the population lives below the poverty level, making affordable care options essential (see details in Exhibit 7).[5] Home health services, delivered in patients' homes and focused on stabilization and recovery, can lower total system costs while enhancing patient comfort and independence.

FHC complements this evidence-based care approach with a strong operational record as a Residential Service Agency and a commitment to quality, patient-centered care. Its transition to a Medicare-certified home health agency will enable it to offer broader access to Medicare-covered services, strengthen care transitions, and expand cost-effective alternatives to hospitalization and institutional care for vulnerable residents of the service area.

For older adults in particular, home-based care offers essential benefits: recent evidence from a 2022 study shows that well-structured home care programs can reduce readmissions and hospital stays in both the short and long term. In the context of a growing older population in the PSA, investing in home-health capacity ensures that the evolving clinical needs and care preferences of seniors, like allowing them to remain in their homes, maintain independence, and potentially reducing avoidable hospital utilization, are being well met.[6]

Care Coordination

FHC uses an electronic medical record platform, Alora Plus, that will permit it to transition quickly to home health agency care. This platform supports both home care and home health agency services, and FHC staff are trained to use it.

FHC intends to establish a small contact office in Walford (Charles County) where staff can store supplies and conduct in-person meetings. To serve this large geography, FHC will hire staff who live in the area. This will minimize travel time and maximize familiarity with the cultural and environmental issues of patients' local communities. It will also support closer working relationships with patients and other health care providers.

Exhibit 4 identifies agencies / providers with whom FHC works or intends to work.

[5] U.S. Census Bureau American Community Survey Selected Economic Characteristics, 1-Year Estimates Table DP03, 2024
[6] U.S. Department of Legislative Services, State of Maryland. *"Overview of Services for Older Adults."* 2022

PART II - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. These criteria follow, 10.24.01.08G(3)(b) through 10.24.01.08G(3)(h).

10.24.01.08G(3)(a). "The State Health Plan" Review Criterion
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria. (Note:
HHA CON review standards may be found in COMAR 10.24.16.08. Furthermore, in a comparative review, CON preference rules may be found in COMAR 10.24.16.09

10.24.16.08 CERTIFICATE OF NEED REVIEW STANDARDS FOR HOME HEALTH AGENCY SERVICES.

The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new home health agency in Maryland or expand the services of an existing Maryland home health agency to one or more additional jurisdictions.

The following standards must be addressed by all home health agency CON applicants, as applicable. Provide a direct, concise response explaining the proposed project's consistency with each standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

10.24.16.08A. Service Area.

An applicant shall:

(1) Designate the jurisdiction or jurisdictions in which it proposes to provide home health agency services; and

Response: FHC proposes to develop a new Medicare-Certified HHA serving four jurisdictions / regions: Anne Arundel, Montgomery, Prince George's, and Southern Maryland (Calvert, Charles, and St. Mary's Counties). For purposes of this application, these are collectively referred to as the "primary service area" or the "PSA."

Figure A: FHC Proposed HHA Primary Service Area Jurisdictions Map

(2) Provide an overall description of the configuration of the parent home health agency and its interrelationships, including the designation and location of its main office, and each branch, as defined in this Chapter, or other major administrative offices recognized by Medicare.

Response: Please see Exhibit 3 for FHC's organizational chart. Its main office is located at 12906 North Point Lane, Unit A, Laurel, MD, 20708. It does not have any branch offices at this time. However, to accommodate the distance from Southern Maryland to Laurel, FHC will open a small contact office in Wolford, Charles County. This will be in a time-share office complex and will provide space to store supplies and support documentation, coordinate care plans, and enable staff to participate in virtual meetings with the main office. See Exhibit 5 for additional information regarding the proposed site.

10.24.16.08B. Populations and Services.

An applicant shall describe the population to be served and the specific services it will provide.

Response:

FHC proposes to provide care to clients of all ages and payer sources within the proposed PSA. The following sections detail the population to be served and FHC's services to those clients.

Proposed Services

FHC will be consistent with the COMAR 10.24.16.02 D, as well as COMAR 10.24.16.06A, the requested scope of services, and 10.24.16.08B. It proposes to establish a new Medicare-Certified home health agency office to serve the Anne Arundel, Montgomery, Prince George's, and Southern Maryland jurisdictions. The new proposed Medicare-Certified agency office will provide an expanded scope of skilled services (including nursing, physical therapy, speech therapy, occupational therapy, medical social work, and home health aide services), a wide range of treatments, availability seven days a week, and a highly trained workforce to provide care to special needs populations. See Part I.11, page 15 above, the section called "Programming," for additional details regarding its proposed services.

Population Growth and Aging in the PSA

Population in the PSA is aging: The share of Maryland's residents aged 65 and older has risen in recent years, and state projections indicate continued growth in the number of older adults over the next two decades. This pattern will increase demand for local services for older residents.[7]

National survey data demonstrate that need for home-based support increases with age: in 2021, about 11.9 percent of U.S. adults age eighteen and older received care at home from a friend or family member in the prior twelve months, compared with **13.8 percent of adults aged sixty-five to seventy-four, 19.4 percent of those aged seventy-five to eighty-four, and nearly 40 percent of adults aged eighty-five and older** — illustrating that older age groups have substantially higher rates of home health care needs.

National and Maryland home health agency statistics demonstrate that most home health agency patients are Medicare beneficiaries. The most common qualifier for Medicare is age 65 or older. A small percentage of Medicare beneficiaries qualify based on disability. This suggests that older adults are more likely than younger adults to require assistance and, as they age, to benefit from formal home health agency services.[8] According to the CMS Medicare Enrollment Dashboard, in September 2025, there were 521,568 Medicare Enrollees in the PSA – 17.4 percent of the population.

[7] Maryland Department of Planning. "Analysis Of The 2024." 2024, planning.maryland.gov/MSDC/Documents/Trends_Report/Population_Estimates_Report_AGR.pdf.

[8] *"QuickStats: Percentage of Adults Aged ≥18 Years Who Received Care at Home From a Friend or Family Member in the Past 12 Months, by Sex and Age Group — United States, July–December 2020."* MMWR, vol. 71, no. 2, 2022.

In 2025, the PSA jurisdictions have a combined population of more than 3 million people – 17 percent of whom are over age 65. More importantly, the over-65 cohort is growing substantially faster than all other age groups in the PSA. By FY 2030, the state demographer forecasts that 19 percent of the population will be in this older age cohort, approximately 591,000 people. See details in Table A below.

Table A: Population by Age Group by Year, FHC Primary Service Area Jurisdictions, CY2025-CY2030

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY25-CY30 CAGR
0 to 4	188,267	189,062	189,861	190,663	191,468	192,277	0.4%
5 to 14	369,029	370,092	371,158	372,227	373,300	374,375	0.3%
15 to 24	360,689	362,878	365,080	367,295	369,524	371,766	0.6%
25 to 44	815,793	815,147	814,502	813,857	813,213	812,569	-0.1%
45 to 64	754,695	752,998	751,304	749,614	747,928	746,246	-0.2%
65 to 74	294,695	300,368	306,149	312,042	318,049	324,171	1.9%
75 to 84	160,325	166,197	172,284	178,594	185,135	191,915	3.7%
85+	58,790	61,731	64,819	68,061	71,466	75,041	5.0%
Total	**3,002,283**	**3,018,472**	**3,035,156**	**3,052,354**	**3,070,082**	**3,088,360**	**0.6%**
Total 65+	**513,810**	**528,296**	**543,252**	**558,697**	**574,650**	**591,127**	**10.60%**
%65+	**17.11%**					**19.14%**	

Source: Maryland Department of Planning State Data and Analysis Center, Population Projections; MDP provides data for 2025 and 2030, and the Applicant interpolates all other years.

This trend is consistent across all PSA counties. In many PSA counties, the over-65 groups are growing faster than the state as a whole. This is particularly true in Prince George's and Southern Maryland.

Table B: 2025 to 2030 Compound Annual Growth Rate of Population by Age Group by Primary Service Area Counties Compared to Maryland

Age Group	Anne Arundel	Montgomery	Prince George's	Calvert	Charles	St. Mary's	Maryland
0 to 4	0.6%	0.5%	-0.2%	0.1%	1.4%	1.5%	0.6%
5 to 14	0.3%	0.6%	-0.6%	1.1%	1.5%	1.0%	0.5%
15 to 24	0.7%	0.7%	0.8%	-1.9%	0.3%	0.4%	0.2%
25 to 44	-0.1%	-0.1%	-0.5%	0.8%	1.4%	1.1%	0.1%
45 to 64	-0.4%	0.3%	-0.3%	-2.2%	-1.1%	-0.2%	-0.4%
65 to 74	1.8%	1.6%	1.5%	3.3%	4.7%	4.0%	1.7%
75 to 84	2.9%	3.5%	4.2%	4.3%	4.1%	3.7%	3.6%
85+	4.4%	3.8%	7.1%	5.1%	5.4%	5.0%	4.1%
Total	**0.6%**	**0.5%**	**0.3%**	**0.4%**	**1.1%**	**1.2%**	**0.5%**

The aging of the PSA and, more importantly, the significant expansion in the number of people in older age groups will drive higher demand for home health agency services. The senior population segment has the highest prevalence of musculoskeletal, neurological, cardiovascular, and respiratory diseases. Across all age groups, barriers to health care access include lack of insurance coverage, limited culturally competent care, limited geographic availability, disabilities, and limited income.[9]

The pediatric population (under 18) uses fewer services per 1,000 residents. However, Table A demonstrates that this population is also a significant cohort in the PSA.

Pediatrics

Although home health services are most commonly associated with older adults, pediatric home health care represents an essential and growing component of the continuum of care for children with chronic health needs and complex medical conditions. National data indicate that home health use among children is more limited than among adults. Still, utilization patterns reflect the significant clinical and support needs of the pediatric population that receives these services. In an extensive Medicaid cohort study, approximately **0.8 percent of enrolled children under age eighteen used home health care**, with infants (<1 year) and adolescents accounting for a substantial proportion of pediatric users. Children receiving home health services often have multiple chronic conditions or technology dependence, demonstrating the clinical complexity typical of this population.[10]

Children who use home health services are heterogeneous but frequently experience chronic disease and functional limitations that require skilled nursing and ongoing support. Among Medicaid beneficiaries receiving pediatric home health care, nearly **one in five children with a complex chronic condition were hospitalized** during the study period, highlighting the vulnerability of pediatric patients without adequate home health support.[11]

Home health care also plays a crucial role in reducing hospital utilization and supporting family caregivers. Research has shown that home health services for medically complex populations are associated with lower inpatient costs and reduced readmissions when compared to similar patients without home health support, suggesting that pediatric patients who receive coordinated home care may avoid more costly and disruptive institutional care.[12] Additionally, children with special healthcare needs — nearly **19.4 percent of U.S. children according to national surveys — often depend on home- and community-based services** for ongoing management of their conditions, underscoring the broader need for accessible pediatric home health services.[13]

[9] HealthyPeople.gov; Access to Health Services, 2030 Topics and Objectives; accessed March 11, 2021
[10] Bergman, Dana A., et al. "Home Health Care Utilization in Children With Medicaid." *Pediatrics*, vol. 149, no. 2, American Academy of Pediatrics, 2022, https://pubmed.ncbi.nlm.nih.gov/35028664/
[11] Ibid
[12] Ibid
[13] Grand View Research, Inc. *U.S. Pediatric Home Healthcare Market Size & Outlook, 2030*. Grand View Research, 2024, https://www.grandviewresearch.com/horizon/outlook/pediatric-home-healthcare-market/united-states

Medicaid plays a central role in covering pediatric home health care, reflecting both the clinical intensity of needs and the socioeconomic profiles of many families with medically complex children. Families frequently provide extensive unpaid caregiving at home, with some reporting more than 21 hours per week devoted to direct care and care coordination responsibilities—a burden that skilled home health services help alleviate.[14]

In light of these utilization patterns and care demands, expanding access to high-quality pediatric home health services through the proposed FHC Home Health Agency will improve continuity of care, support complex pediatric care needs in the home setting, and potentially reduce avoidable hospitalizations for children with chronic and medically complex conditions.

Population Health

Health and prevention statistics from the Robert Wood Johnson County Health Rankings indicate that health providers in the PSA will likely see high demand for home health services. See Exhibit 6 for these detailed metrics on community health status and risk factors for the PSA jurisdictions. A few deserve special attention:

- Rates of preventable hospitalizations in Anne Arundel, Prince George's, and St. Mary's are higher than both the state and national averages (2022);
- Diabetes prevalence is as high as 13 percent (2022);
- Between 24 and 43 percent of adults are obese (2022); and,
- More than 10 percent of adults in all counties are current smokers (2022).

According to the Maryland Department of Planning population data, the PSA reflects substantial racial and ethnic diversity. In 2025, approximately 37.1 percent of the population identified as White or Caucasian, approximately 34.0 percent as African American, and approximately 16.7 percent as Hispanic or Latino (Exhibit 7). National and state research demonstrate that communities with greater racial and ethnic diversity are more likely to experience structural barriers to health care access, including gaps in insurance coverage, transportation challenges, language barriers, and shortages of community-based providers. These factors are associated with delayed care, higher disease burden, and increased reliance on acute-care settings.[15]

Research also indicates that culturally and linguistically responsive care— such as care delivered by a workforce trained to understand patients' cultural backgrounds and communication needs—is associated with improved patient engagement, satisfaction, and adherence to care plans. Accordingly, home health agencies serving diverse populations benefit from staffing models and care practices that promote cultural competence and effective communication, supporting equitable access and improved outcomes across all patient groups.[16]

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[14] Cohen, Ellen, et al. "Financing of Pediatric Home Health Care." *Pediatrics*, vol. 139, no. 3, American Academy of Pediatrics, 2017.
[15] Centers for Disease Control and Prevention. *Racial and Ethnic Disparities in Health Care Access and Outcomes*. CDC, 2023, www.cdc.gov/minorityhealth/racism-disparities/index.html
[16] U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. HHS, updated 2022, https://thinkculturalhealth.hhs.gov

Demographic data on social determinants of health status based on data from the U.S. Census Bureau, which are mutually related to poor health status and can indicate an increased need for home health services in specific communities. Poverty is the social determinant most closely correlated with poor health.[17] **In 2024, approximately 8.0 percent of PSA residents had incomes below the poverty level** (Exhibit 7)**.**[18] The cost of care is essential for people at the poverty level, and even those with incomes above the poverty level often struggle to address underinsurance. Price is a deterrent to access for this group. This area would benefit from affordable access to home health services.

These social snapshots support the clear need for preventive home health services in the PSA jurisdictions.

Home Health Use Rates

Residents of the PSA and their primary care providers recognize the benefits of home health services. Many people prefer to receive care at home rather than in a hospital because they feel more secure there, and home health services cost less than conventional hospital-based care.

Despite recent declines in home health utilization (see Table C below), the evidence overwhelmingly suggests that this trend reflects **limited access rather than diminished need**.

During the COVID-19 pandemic, MedPAC reports that Medicare home health use fell by more than 6 percent between 2021 and 2022, with in-person home health visits declining nearly 10 percent over the same period. This change coincided with widespread staffing shortages and agency capacity constraints, rather than with improvements in population health.[19] At the same time, nearly **one-third of patients discharged home fail to access home health services within seven days**, a delay associated with a **41 percent higher mortality rate**, indicating that needed care is not being delivered.[20] Industry analyses similarly find that falling admission volumes "indicate unmet demand and reduced access," driven by agency closures, labor shortages, and reimbursement pressure.[21]

[17] Woolf, Stephen H.; et al; "How are Income and Wealth Linked to Health and Longevity?"; https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf; accessed April 5, 2021

[18] https://hdpulse.nimhd.nih.gov/data-portal/social/table?age=001&age_options=ageall_1&demo=00009&demo_options=poverty_3&race=00&race_options=race_7&sex=0&sex_options=sexboth_1&socialtopic=080&socialtopic_options=social_6&statefips=24&statefips_options=area_states

[19] MedPAC report summary: https://www.hospicepalliativecaretoday.com/blogs/literature-review/2024/8/11/home-health-sees-spending-utilization-decline-as-hospice-equivalents-grow-medpac-reports--2

[20] HomeCare Magazine analysis on delayed access and mortality: https://www.homecaremag.com/news/cms-reduced-access-home-health

[21] McKnight's Home Care and Trella Health industry findings:

- https://www.mcknightshomecare.com/news/home-health-visits-admissions-fall-nationwide-industry-report-finds/
- https://www.trellahealth.com/wp-content/uploads/2023/05/Post-Acute-Care-Industry-Trend-Report-2023-Edition.pdf

Table C: Home Health Use Rate History in the FHC Primary Service Area 2019-2023 (per 1,000 population)

Age Group	CY19	CY20	CY21	CY22	CY23	CAGR 2019-2023
0 to 4	8.5	9.1	7.7	9.7	3.0	-23.0%
5 to 14	0.2	0.2	0.4	0.2	0.3	3.9%
15 to 24	0.7	0.7	1.0	0.7	0.6	-5.2%
25 to 44	2.1	2.0	2.3	1.8	1.4	-9.5%
45 to 64	12.6	12.0	10.7	10.1	8.8	-8.4%
65 to 74	46.2	45.1	47.6	43.9	41.9	-2.4%
75 to 84	115.4	111.9	116.7	112.8	114.6	-0.2%

Sources: MDP Population Data, MHCC HHA Utilization Table 13

As the older-adult population continues to grow in number and percentage, reduced utilization should be interpreted as evidence that the current home health infrastructure cannot meet needs, underscoring the importance of investing in adequate capacity within the PSA.

Summary of Need

The PSA faces a confluence of demographic and health-system pressures that point to a clear and growing need for expanded home health capacity. The population aged 65+ is increasing at the fastest rate of any age cohort across all PSA counties, with the 75–84 and 85+ groups growing by 3.7-5.0 percent annually. These older-adult populations have the highest prevalence of chronic conditions, functional limitations, and post-acute care needs—yet home health utilization in the PSA has steadily declined. Evidence indicates that this decline is not due to reduced demand but rather to strained access, driven by workforce shortages, agency capacity limits, and delayed transitions from hospital to home. At the same time, the PSA history shows elevated rates of preventable hospitalizations, diabetes, obesity, and smoking, as well as large low-income and minority populations who experience well-documented barriers to timely, culturally competent care. Collectively, these trends demonstrate that existing home health resources are no longer sufficient to meet the needs of a rapidly aging population with increasingly complex medical and social risk factors.

Pediatric demand for home health services in the PSA is driven by a distinct but equally compelling set of factors, including the growing prevalence of children with complex chronic conditions, developmental disabilities, and technology-dependent medical needs that require skilled clinical oversight in the home. National and state data show that children with medical complexity account for a disproportionate share of pediatric hospitalizations, emergency department use, and prolonged lengths of stay, underscoring the importance of effective post-acute and community-based care.

For these children, timely access to skilled nursing and therapy services at home supports clinical stability, caregiver capacity, and continuity of care after hospital discharge. Limitations in pediatric home health capacity—particularly staffing constraints and service availability—can result in delayed discharges, caregiver strain, and avoidable hospital utilization. Expanded home health capacity within the PSA is therefore essential to support medically fragile and high-risk pediatric patients, reduce unnecessary institutional care, and allow children to receive medically necessary services in the least restrictive and most appropriate setting.

FHC is well-positioned to address these gaps by establishing a Medicare-certified Home Health Agency that provides expanded clinical capacity, comprehensive service offerings, and a proven commitment to serving economically and medically vulnerable residents. FHC's longstanding experience delivering skilled in-home care to Medicaid, waiver, and dual-eligible beneficiaries positions the organization to reduce disparities in access—particularly for low-income seniors and communities of color who comprise a significant share of the PSA. With seven-day-per-week availability, multidisciplinary clinical services, and an established approach to managing financial access challenges, FHC will strengthen care transitions, reduce avoidable readmissions, and offer a lower-cost alternative to inpatient or facility-based care. By combining demographic need, demonstrated access gaps, and FHC's operational readiness, the proposed HHA will meaningfully expand capacity and ensure that PSA residents—especially the growing older-adult population—can access timely, high-quality home health services.

FHC's current staff are experienced in both geriatric and pediatric care, and a sustained history of patient referrals reinforces its positive reputation.

10.24.16.08C. Financial Accessibility.

An applicant shall be or agree to become licensed and Medicare- and Medicaid-certified and agree to maintain Medicare and Medicaid certification and to accept clients whose expected primary source of payment is either or both of these programs.

Response: As a licensed RSA in Maryland, FHC already accepts Medicaid, VA, and private-pay patients. FHC agrees to pursue Medicare Certification once it is licensed as an HHA. FHC will not discriminate against clients whose primary source of payment is Medicare or Medicaid.

10.24.16.08D. Fees and Time Payment Plan.

An applicant shall make its fees known to prospective clients and their families at the time of patient assessment, before services are provided, and shall:

(1) Describe its special time payment plans for an individual who is unable to make full payment at the time services are rendered; and

(2) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

Response: FHC has a Charity Care and Financial Policy (see Exhibit 8) that fully complies with COMAR 10.24.16.08E. The policy outlines the agency's commitment to providing transparent information on fees, charity care, discounted services, and time-payment plans to all prospective clients. FHC's HHA clients will receive a copy of this policy during the intake process. Fees, financial assistance options, and payment expectations will be disclosed at the time of patient assessment and before the initiation of services, as required.

FHC's policy ensures that clients who are unable to pay in full at the time services are rendered have access to structured, interest-free time-payment arrangements. The policy includes:

- **A sliding fee scale** offering full charity care for clients with income at or below one hundred percent of the Federal Poverty Level (FPL) and discounted services up to three hundred percent of FPL.
- **Interest-free payment plans** for clients who do not qualify for charity care or discounted services, with flexible terms, low minimum monthly payments, and no late fees or interest charges.
- **Written notice of payment plan options**, provided to clients at admission, during financial counseling, and in their welcome packet. The policy will be posted in public areas and available on the agency's website.
- **A requirement that services are never denied, delayed, or discontinued** due to inability to pay or while a financial assistance application is pending.
- **Clear procedures** for determining probable eligibility for charity care or discounted services within two business days, in accordance with COMAR.

A written copy of this policy—including detailed descriptions of the sliding fee scale, payment plan mechanisms, eligibility criteria, and application process—will be submitted to the Commission and provided to each client consistent with COMAR 10.24.16.08E.

10.24.16.08 E. Charity Care and Sliding Fee Scale.

Each applicant for home health agency services shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual's ability to pay, and shall provide home health agency services on a charitable basis to qualified indigent and low-income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

(1) Determination of Eligibility for Charity Care and Reduced Fees. Within two business days following a client's initial request for charity care services, application for medical assistance, or both, the home health agency shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client.

Response: FHC's Financial Policy includes both charity care and the opportunity to participate in a sliding fee schedule or time payments. The policy will be provided to clients at intake. Please see Exhibit 8 for a copy of the policy.

The policy includes a provision that FHC shall determine probable eligibility for medical assistance, charity care, reduced fees, and / or timed payments within two business days following a client's initial request and communicate the eligibility determination to the client.

(2) Notice of Charity Care and Sliding Fee Scale Policies. Public notice and information regarding the home health agency's charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA's service area, and in a format understandable by the service area population. Notices regarding the HHA's charity care and sliding fee scale policies shall be posted in the business office of the HHA and on the HHA's website, if such a site is maintained. Prior to the provision of HHA services, an HHA shall address clients' or clients' families concerns with payment for HHA services and provide individual notice regarding the HHA's charity care and sliding fee scale policies to the client and family.

Response: FHC recognizes that public notice and information about its charity care and sliding-fee scale policies are essential to ensuring equitable access for clients. In accordance with this rule, FHC will provide notice in the following ways:

1. **Onsite:** Notices outlining eligibility criteria, application procedures, and available financial assistance will be posted prominently in FHC's administrative office and client-facing areas. Posting materials will use clear, plain language and will include instructions for obtaining the full Charity Care and Sliding Fee Scale Policy (see Exhibit 8).
2. **Website:** Full copies of the Charity Care and Sliding Fee Scale Policy will be available on the FHC website in an easy-to-read and downloadable format optimized for both computer and mobile devices.

3. **In-Person**: Prior to the provision of services, each client—and/or their legally authorized representative—will receive individualized written notice and a verbal explanation of: FHC's Charity Care and Sliding Fee Scale Policy, eligibility requirements, required documentation, application instructions, and available payment support programs, including FHC's Time Payment Plan.

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each HHA's charity care policy shall include provisions for a sliding-fee scale and time-payment plans for low-income clients who do not qualify for full charity care but are unable to afford the full cost of services.

Response: FHC's charity care policy includes a comprehensive discounted care structure, a sliding fee scale based on Federal Poverty Guidelines, and an interest-free time-payment plan for clients who do not qualify for full charity care but cannot pay the full cost of services. A full copy of the policy is provided in Exhibit 8. Table D below summarizes the policy's major components, including eligibility thresholds, discount tiers, repayment terms, notification requirements, and protections for patients during financial assistance processing.

Table D: FHC Discounted Care / Sliding Fee Scale / Timed Payment Plan Policy Highlights

Topic	Summary Description
Sliding Fee Scale Eligibility	Discounts available for households from **one hundred percent to three hundred percent of the Federal Poverty Level (FPL)**; full charity care at or below one hundred percent of FPL.
Discount Tiers	Full (one hundred percent) discount for ≤ one hundred percent FPL; reduced fees for incomes between one hundred percent and three hundred percent FPL.
Probable Eligibility Determination	Determination issued **within two business days** of a request for assistance, a financial aid application, or a Medicaid application.
Notice to Clients	Policy provided during admission, in patient packets, on the website, and posted publicly in office areas; available in multiple languages.
Time-Payment Plan Availability	Clients who do not qualify for Medicaid or charity care may enroll in **interest-free payment plans** with flexible terms and low minimum monthly payments.
Minimum Monthly Payments	Payment plans may include monthly payments as low as **ten dollars**, depending on financial circumstances.
Maximum Repayment Period	Repayment terms may extend up to **eighteen months** to ensure affordability.
Protection from Service Denial	Care will **not be denied, delayed, or discontinued** during the financial-assistance application process.
Documentation Requirements	Proof of income, household size, Medicaid status, and financial hardship may be required; handled confidentially per HIPAA.
Appeals and Reconsideration	Clients may appeal determinations within fifteen days; FHC responds within ten business days.
Recordkeeping	All financial-assistance records are retained for **seven years**, in compliance with MHCC and Medicare regulations.
Annual Review	The policy is reviewed annually and updated as needed to reflect regulatory changes and operational updates.

Topic	Summary Description
Sliding Fee Scale Eligibility	Discounts available for households from **one hundred percent to three hundred percent of the Federal Poverty Level (FPL)**; full charity care at or below one hundred percent of FPL.
Discount Tiers	Full (one hundred percent) discount for ≤ one hundred percent FPL; reduced fees for incomes between one hundred percent and three hundred percent FPL.
Probable Eligibility Determination	Determination issued **within two business days** of a request for assistance, a financial aid application, or a Medicaid application.
Notice to Clients	Policy provided during admission, in patient packets, on the website, and posted publicly in office areas; available in multiple languages.
Time-Payment Plan Availability	Clients who do not qualify for Medicaid or charity care may enroll in **interest-free payment plans** with flexible terms and low minimum monthly payments.
Minimum Monthly Payments	Payment plans may include monthly payments as low as **ten dollars**, depending on financial circumstances.
Maximum Repayment Period	Repayment terms may extend up to **eighteen months** to ensure affordability.
Protection from Service Denial	Care will **not be denied, delayed, or discontinued** during the financial-assistance application process.
Documentation Requirements	Proof of income, household size, Medicaid status, and financial hardship may be required; handled confidentially per HIPAA.
Appeals and Reconsideration	Clients may appeal determinations within fifteen days; FHC responds within ten business days.
Recordkeeping	All financial-assistance records are retained for **seven years**, in compliance with MHCC and Medicare regulations.
Annual Review	The policy is reviewed annually and updated as needed to reflect regulatory changes and operational updates.

(4) Policy Provisions. An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve during the most recent year for which data is available. The applicant shall demonstrate that:

(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and

Response: FHC has extensive experience delivering skilled in-home services to individuals with limited financial resources, including those enrolled in Maryland Medicaid, Medicaid waiver programs, and Medicare–Medicaid dual-eligible coverage. Over several years of operating as an RSA, FHC has developed workflows and care-management practices to support residents who rely on publicly funded programs, coordinate benefits, and ensure that patients with limited financial means can access needed in-home care.

Although RSAs are not required to submit charity-care reporting to the Maryland Health Care Commission, as illustrated in the table below, FHC's history of serving high-need, publicly insured, and fixed-income clients reflects its ability to navigate financial-access barriers and consistently deliver care to populations that often struggle to pay for services. This organizational background provides a strong foundation for FHC's transition to a Medicare-certified Home Health Agency. It demonstrates its readiness to meet, monitor, and sustain the charity-care obligations outlined in COMAR 10.24.16.08E.

MHCC HHA utilization data indicate that charity care is limited. As shown in Table E below, across all six PSA counties, 104 clients and 433 visits were reported under charity care, resulting in charity care of 0.3 percent or less in each jurisdiction.

Table E: Charity Care Clients and Visits by County, FY2023

County	Clients			Visits		
	Charity	Total	% Charity	Charity	Total	% Charity
Anne Arundel	-	11,770	0.0%	-	175,627	0.0%
Montgomery	57	19,575	0.3%	272	270,550	0.1%
Prince George's	45	14,616	0.3%	136	260,690	0.1%
Calvert	2	1,355	0.1%	25	17,358	0.1%
Charles	-	2,322	0.0%	-	29,238	0.0%
St. Mary's	-	1,620	0.0%	-	26,026	0.0%
Total PSA	**104**	**51,258**	**0.2%**	**433**	**779,489**	**0.1%**

Source: MHCC HHA Utilization Tables 13, 14, and 25

FHC's proposed commitment to 0.5 percent charity care already seems to exceed what is available in the PSA.

(b) It has a specific plan for achieving the level of charity care to which it is committed.

Response: Despite the PSA's low average charity care rate (0.1 percent), FHC will meet or exceed the benchmark by implementing the charity care program outlined in Exhibit 8. FHC's plan is designed to proactively identify eligible clients, ensure timely financial screening, and make discounted or no-cost services accessible to people who qualify. The program includes clearly defined processes for eligibility determination, payment alternatives, reporting, and oversight.

FHC's approach to achieving its charity care commitment includes four operational pillars:

1. **Financial Support:**
   FHC maintains dedicated funds for charity care and discounted services, supported by its sliding fee scale and interest-free time-payment plan. These mechanisms ensure that cost is never a barrier to receiving medically necessary home health services.

2. **Targeted Outreach:**
   FHC will consistently inform clients, families, referral partners, and community organizations about the availability of charity care and discounted services. Written materials are provided at intake, posted publicly, and included in welcome packets to ensure broad awareness.

3. **Staff Accountability:**
   Intake, billing, and clinical staff are trained to identify clients who may qualify for charity care or reduced fees. Staff are required to offer financial-assistance screening, explain the policy, and document all outreach and determinations in the patient record.

4. **Management Review:**
   Leadership will review charity care performance quarterly, monitor probable-eligibility determinations, and ensure continuous compliance with COMAR requirements and internal quality standards.

To ensure that clients with limited financial resources receive the care they need, FHC will implement the following operational strategies:

1. **Minimum Charity Commitment:**
   FHC will meet or exceed the required charity-care benchmark each year by tracking utilization, monitoring eligibility trends, and adjusting outreach and financial-assistance processes as needed.

2. **Structured Eligibility and Discount Systems:**
   The policy's sliding-fee scale (100 percent charity to 300 percent FPL discounts) and interest-free payment plans provide multiple access points for low-income clients who cannot pay the full charge but do not qualify for full charity care.

3. **Proactive Identification and Outreach:**
   FHC conducts financial screening during intake and within two business days of any request for assistance or Medicaid application. Staff are required to offer assistance without waiting for clients to self-identify financial hardship.

4. **Ongoing Monitoring and Reporting:**
   FHC will track charity care volume, discount levels, and payment-plan participation, with quarterly internal reports to ensure accountability and enable adjustments to outreach or support strategies.

Together, these processes ensure that charity care is not only available but actively delivered, supporting equitable access to home health services across the PSA.

10.24.16.08 F. Financial Feasibility.

An applicant shall submit financial projections for its proposed project that must be accompanied by a statement containing the assumptions used to develop projections for its operating revenues and costs. Each applicant must document that:

(1) Utilization projections are consistent with observed historic trends of HHAs in each jurisdiction for which the applicant seeks authority to provide home health agency services;

Response: FHC developed its utilization projections based on observed historical trends for HHAs in the PSA. Section 10.24.01.08G (page 48) includes the full methodology and assumptions used; all resulting projections are provided in the required Table 2B on page 84. The following is an overview of the methods and assumptions used to develop those projections:

1. FHC utilized population data from the Maryland Department of Planning and historical HHA utilization data from the Maryland Department of Public Health to calculate the FY2023 HHA use rate by age group by jurisdiction.
    a. FHC assumes that the data provided by Maryland is accurate and a reasonable source for projection.
2. The Applicant applied the FY2023 use rate to population by age for 2025 through 2030 to estimate the number of HHA clients in the PSA.
    a. The Applicant assumes that the HHA use rates by age group by jurisdiction will remain constant through 2030 at the 2023 rates.
3. FHC then subtracted the number of HHA clients expected to be served by existing providers from the estimated total number of clients. **This resulted in an unmet need of HHA clients in the PSA.**
    a. FHC assumes that existing providers are operating at capacity and will therefore be unable to capture the growth need in future years.
    b. Declining resident HHA use rates, as described in section "Home Health Use Rates" above on page 27, indicate insufficient access to services to support the calculated need.
4. FHC estimates it will capture 2.75 percent of the unmet need of HHA clients from the PSA by 2029, its third year of operation.
    a. A 2.75 percent market share is reasonable because FHC will be one of 36 total HHAs serving the PSA jurisdictions (35 existing + 1 new FHC = 36).
    b. Its estimated number of unduplicated clients from the PSA will represent only 0.6 percent of the total calculated need in 2029 (367 FHC clients / 64,451 estimated PSA clients = 0.006).
    c. Total estimated unduplicated clients in FHC's third project year do not exceed the number of reported unduplicated clients from any existing HHA in the PSA.

(2) Projected revenue estimates are consistent with current or anticipated charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction; and

Response: Projected revenue estimates are consistent with established charge levels, reimbursement rates, and contractual adjustments as follows:

Medicare Reimbursement Rates Medicare revenue projections use the CMS CY 2026 Home Health Prospective Payment System (HH PPS) rates as published in CMS-1828-F (Federal Register Vol. 90, No. 229, December 2, 2025). All Medicare-certified home health agencies in Maryland are subject to this same rate methodology. Rates were adjusted for each proposed jurisdiction using the applicable CBSA wage index. A conservative case-mix weight of 1.0 is applied with no acuity adjustment. LUPA (Low Utilization Payment Adjustment) per-visit rates are derived from CMS Table 16 and are wage-adjusted by jurisdiction.

Medicaid Reimbursement Rates: Per-visit rates are based on the Maryland Medicaid fee schedule, effective January 1, 2025, which varies by county. These published rates are applied without an inflation adjustment, per MHCC requirements.

Payor Mix Assumptions Payor mix percentages are derived from jurisdiction-specific data in the MHCC Home Health Agency Annual Survey, Fiscal Year 2023, Table 19: Total Number of Home Health Visits by Jurisdiction of Residence, Payment Source, and Geographic Region. Medicaid percentages were adjusted upward (to at least 2%) from raw survey data to reflect anticipated market positioning and community need focus.

Revenue Deductions: A 2.5 percent bad debt allowance is based on the applicant's existing home care experience and is supported by analysis of Medicare Cost Reports for comparable Maryland agencies, which confirms it is reasonable. A contractual allowance of 10 percent of gross revenue is deemed reasonable based on an analysis of Medicare Cost Reports for comparable agencies. Charity Care of 0.5 percent of net revenue exceeds the charity care levels reported in MHCC survey data (Table 25) for existing agencies in the proposed service area.

Commercial Rate Assumptions Per-visit rates for Medicare Advantage, Commercial Insurance, Self-Pay, and Other payers are set equal to the Medicare LUPA per-visit rates, which represent the Medicare fee schedule benchmark commonly used for commercial contract negotiations by Maryland HHAs.

Collectively, these revenue assumptions provide a realistic, data-supported financial foundation for FHC’s proposed Medicare-certified home health agency and demonstrate that the organization’s revenue model aligns with the reimbursement landscape of the PSA counties it intends to serve.

(3) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction.

Response: FHC's projected staffing levels and operating expenses are aligned with its anticipated utilization and reflect the cost structures currently observed among Medicare-certified home health agencies serving the PSA jurisdictions. As a newly proposed HHA, FHC developed its staffing model by analyzing recent MHCC-reported workforce patterns, wage levels, and visit volumes from comparable agencies operating in the PSA. These benchmarks ensure that projected full-time equivalents ("FTEs"), productivity expectations, and labor costs are appropriate for the agency's planned service mix and patient acuity.

Significantly, FHC's staffing projections are based directly on the organization's experience operating as an RSA. Through its RSA work, FHC has managed recruitment, scheduling, and retention of clinical staff across diverse patient needs—an experience that provides valuable insights into realistic staffing ratios, visit capacity, and workload distribution. This background enabled FHC to develop staffing assumptions grounded not only in statewide HHA norms but also in its history of maintaining a reliable clinical workforce and delivering consistent in-home services. FHC has experience with HHA episode-based care through its RSA contracts with Maryland Medicaid Managed Care Organizations, for example, Maryland Physician Care and JAI Medical.

Personnel assumptions incorporate regionally appropriate compensation levels for skilled nursing, therapy services, social work, home health aides, and administrative support, using prevailing wage data and current labor market conditions across the PSA. Non-labor operating expenses — including medical supplies, mileage, durable equipment, IT systems, and regulatory compliance — were similarly developed based on expenditure patterns from established Maryland HHAs and FHCs' experience running their RSA.

FHC has demonstrated the ability to recruit, hire, and retain qualified clinical and support staff through multiple established recruitment channels and professional relationships developed through its ongoing operations as an RSA. The majority of staff required for the proposed Medicare-certified HHA will transition from FHC's existing RSA workforce, providing continuity of care and minimizing the need for large-scale new hiring. As the census grows, FHC is well-positioned to add staff incrementally without adversely affecting the regional labor market.

FHC utilizes a diversified recruitment strategy that includes online job platforms such as LinkedIn and Indeed, professional networking, and—most successfully—word-of-mouth referrals from current staff and professional contacts. In addition, FHC benefits from direct connections to local workforce development pipelines. The agency's principal, Abisola Raimi-Abayomi, serves as an instructor at Anne Arundel Community College, where she regularly engages with nursing students and graduates, including registered nurses and certified nursing assistants reentering the workforce. This relationship provides FHC with access to newly trained clinicians and experienced professionals seeking flexible, community-based care roles.

FHC also maintains professional relationships within the therapy community, including connections through physical therapy professional associations and academic and career placement programs. One of them is Handshake, a widely used career development platform that connects employers with students and recent graduates in health care disciplines. These relationships support recruitment of therapy staff, including physical therapists and therapy assistants, as service demand increases.

Collectively, these recruitment channels, combined with FHC's existing workforce, positive organizational reputation, and leadership presence in local education and professional networks, provide a reliable and sustainable foundation for staffing the proposed HHA. FHC's incremental growth approach ensures that staffing expansion is aligned with utilization, maintaining service quality while avoiding disruption to other providers' staffing resources within the PSA.

By combining its prior RSA staffing experience with established HHA benchmarks, FHC believes that its operating budget is financially feasible, appropriately resourced, and capable of supporting high-quality care delivery. These assumptions reflect a realistic cost structure that aligns with anticipated utilization and positions the agency to meet staffing and service requirements under COMAR 10.24.16 while maintaining efficient, patient-centered operations.

10.24.16.08G. Impact.

An applicant shall address the impact of its proposed home health agency service on each existing home health agency authorized to serve each jurisdiction or regional service area affected by the proposed project. This shall include impact on existing HHAs' caseloads, staffing, and payor mix.

Response: MHCC has identified a need for additional HHA services in the PSA jurisdictions. As discussed in 10.24.16.08B, the PSA population has multiple risk factors that support the need for further access to home-based services.

According to MHCC HHA utilization data, approximately 35 HHAs served the PSA in FY2023. Together, these providers served 779,489 unduplicated clients – over 40 percent of all Maryland HHA clients that year. Providers include several large, well-established HHAs, such as Adventist, Bayada, Johns Hopkins, and Medstar Health. Data show that these HHAs often serve multiple counties and that no single provider dominates the market, ensuring clients have adequate choices.

Caseload Impact

FHC's utilization projections assume that existing home health agencies will continue to serve the majority of PSA residents who currently access care. However, MHCC utilization data and population projections indicate that these providers are not positioned to meet the full level of need, leaving a measurable portion of the PSA population without or with limited access to home health agency services. FHC intends to draw its projected volume from this unmet need rather than from the caseloads of established agencies. FHC has been reasonable and conservative in its forecasts of HHA need. In this context, focusing on the unmet and reasonable FHC capacity for growth, by Project Year Three (2029), FHC anticipates serving approximately 367 clients, representing only 2.75 percent of the estimated unmet **need and just 0.6 percent of the total projected need of 64,451 home health clients in the PSA.** See details in Tables I, M, and O in Section 10.24.01.08G(3)(b) beginning on page 48 below.

Given the scale of unmet demand relative to FHC's modest projected census, the proposed HHA will have little to no impact on existing providers' caseloads.

Staffing Impact

FHC does not anticipate any adverse impact on the staffing capacity of existing home health agencies in the PSA. Because FHC already delivers many of the same in-home disciplines through its established Residential Service Agency, it has the infrastructure to support the HHA expansion. The majority of clinical and administrative personnel required for the proposed HHA will transition from the current RSA operations, reducing the need for new hires. Additional staffing requirements include a medical social worker and a contracted speech therapy provider, both representing limited, targeted needs. FHC has already identified potential staff to fill these positions.

FHC projects requiring 5.8 direct-care FTEs (nurses, therapists, aides, and medical social workers) in Year 1 (2027), growing to 6.7 FTEs by Year 4 (2030). These staffing levels reflect the clinical capacity needed to deliver skilled nursing, therapy, aide, and social work services for the proposed home health agency.

Together, these new hires will not materially affect the labor supply available to other HHAs. Workforce data for the PSA jurisdictions demonstrate a strong, diverse pool of licensed nurses, therapists, and support staff, and the modest scale of FHC's incremental hiring ensures existing providers will retain sufficient access to qualified personnel.

FHC's staffing plan supports the viability of its proposed HHA without significantly impacting the staffing resources of other agencies operating in the region. Moreover, FHC maintains a waitlist of individuals for all HHA clinical positions who want to join the FHC staff. Until it has an HHA license and certification, FHC cannot attain the patient scale and size required to support these staff.

Payor Mix Impact

MHCC HHA Utilization Tables 11, 13, and 14 demonstrate that Medicare is, by a substantial margin, the predominant payor for home health agency services in both the PSA and the state overall. Because FHC's current RSA license does not permit it to serve Medicare beneficiaries, the organization's existing payor mix does not yet reflect the Medicare-driven distribution typical of certified HHAs in the PSA. With the transition to a Medicare-certified HHA, FHC anticipates a realignment of its payer mix to more closely reflect prevailing PSA patterns, consistent with the demographic and clinical needs of the populations it will serve.

The relatively modest census expected in the initial years of operation ensures that this shift will not alter or adversely affect the broader payer distribution in the PSA or the payer profiles of existing agencies.

10.24.16.08H. Financial Solvency.

An applicant shall document the availability of financial resources necessary to sustain the project. Documentation shall demonstrate an applicant's ability to comply with the capital reserve and other solvency requirements specified by CMS for a Medicare-certified home health agency.

Response: To enroll as a Medicare-certified home health agency, an applicant must demonstrate that it has **sufficient financial resources to sustain the operation**, including compliance with federally mandated capitalization and solvency standards. Under federal regulations, a new home health agency must maintain initial operating reserve **funds available at the time of Medicare application and throughout the enrollment process**, as well as for the first three months after Medicare billing privileges are granted. This requirement is intended to ensure the agency can operate reliably during its early service period without interruption, excluding projected Medicare accounts receivable.[22]

Specifically, 42 CFR § 489.28 establishes the capitalization requirements for new HHAs. Documentation of these funds must include **proof of availability**, such as bank statements or cash equivalents in readily liquid accounts, with an attestation from the financial institution confirming the funds are immediately accessible. At least **50 percent of the required reserve must consist of non-borrowed funds, with the remaining portion supported by borrowed funds or a line of credit, subject to** appropriate documentation.

Exhibit 9 includes a letter from Atlantic Union Bank attesting that the Applicant possesses the financial resources necessary to meet the FHC forecast of CMS capitalization requirement and sustain operations as a Medicare-certified HHA. This documentation includes verified cash and cash equivalents sufficient to cover expected operating costs for the initial three-month period, supported by a letter from FHC's CPA. FHC's financial plan also reflects prudent budgeting, operating reserves, and access to additional liquidity if needed, ensuring compliance with CMS solvency expectations and positioning the agency for stable, uninterrupted service delivery in the PSA.

[22] https://www.law.cornell.edu/cfr/text/42/489.28?utm_source=chatgpt.com

10.24.16.08I. Linkages with Other Service Providers.

An applicant shall document its links with hospitals, nursing homes, continuing care retirement communities, hospice programs, assisted living providers, Adult Evaluation and Review Services, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

(1) A new home health agency shall provide this documentation when it requests first use approval.

(2) A Maryland home health agency already licensed and operating shall provide documentation of these linkages in its existing service area and document its work in forming such linkages before beginning operation in each new jurisdiction it is authorized to serve.

Response: FHC is a new applicant for Medicare-certified home health services in Maryland and will establish formal linkages with hospitals, nursing homes, continuing care retirement communities, hospice providers, assisted living facilities, Adult Evaluation and Review Services, adult day programs, local Departments of Social Services, and home-delivered meal programs within its proposed service area upon approval.

Exhibit 4 provides a comprehensive inventory of entities in each category across the PSA jurisdictions, and FHC will use this list as the basis for developing formal relationships once its HHA is authorized. As an established RSA, FHC already maintains working relationships with several of these organizations, and Exhibit 4 identifies where these existing linkages are in place.

10.24.16.08J. Discharge Planning.

An applicant shall document that it has a formal discharge planning process including the ability to provide appropriate referrals to maintain continuity of care. It will identify all the valid reasons upon which it may discharge clients or transfer clients to another health care facility or program.

Response: FHC maintains a formal discharge planning process as part of its current RSA operations (Exhibit 10) and will implement an enhanced version of this process for its Medicare-certified Home Health Agency. The process is fully aligned with COMAR requirements and CMS Conditions of Participation, ensuring safe, orderly, and clinically appropriate transitions of care. FHC's discharge procedures are designed to maintain continuity of care, support patient and caregiver participation, and ensure referral to appropriate follow-up services whenever a client's needs change or home health services are no longer clinically indicated.

FHC's discharge planning process begins at admission and continues throughout the episode of care. The agency conducts ongoing assessments of each client's clinical status, functional abilities, home environment, and anticipated care needs. Discharge planning includes coordinated communication with the attending physician, all ordering providers, caregivers, and any post-discharge practitioners involved in the patient's continued care. The policy requires timely communication of all revisions to the discharge plan to the patient, representative, caregivers, and post-discharge providers.

FHC's HHA discharge policy also incorporates structured procedures for care coordination and transition planning. Discharge planning begins at admission and is revisited throughout care delivery, with documentation of reassessments and the expected discharge date. When transfer to another provider is required, the agency assists patients in selecting a post-acute care facility based on quality and resource-use measures. It ensures that all necessary medical information—including treatment course, goals of care, and patient preferences—is transmitted to the receiving provider.

The policy defines all valid circumstances under which a client may be discharged or transferred. These include, but are not limited to:

- Completion of treatment goals or clinical improvement such that home health services are no longer required.
- Patient or caregiver choice to discontinue services or request transfer.
- Physician discontinuation of orders for home health care.
- Changes in medical condition requiring a higher level of care (e.g., SNF, IRF, LTCH, or hospitalization).
- Safety concerns, unsafe home environment, or behavior that jeopardizes staff or patient safety after all interventions have failed.
- Patient relocation outside the geographic service area.
- Provision of care by another agency or duplication of services.
- Non-adherence to treatment or refusal of medically necessary supervision.

- Exhaustion of covered benefits when the agency cannot continue to provide no-cost care, with appropriate referral.
- Patient death or institutionalization.

The policy also includes the federally required delivery of the Notice of Medicare Non-Coverage (NOMNC) at least two days before the final visit, along with appeal instructions, contact information for the Quality Improvement Organization (QIO), and procedures for circumstances in which NDMC (CMS Form 1003) must be used instead.

Upon discharge, the attending physician is notified, and a written discharge summary—including patient status, services rendered, progress toward goals, education provided, and referrals made—is sent to the physician within five business days, with a copy maintained in the medical record.

Through this comprehensive policy, FHC ensures that every client experiences a coordinated, clinically appropriate, and patient-centered transition of care. The policy preserves patient autonomy, supports continuity, and meets all requirements for safe discharge and transfer under State and federal regulations.

10.24.16.08K. Data Collection and Submission.

An applicant shall demonstrate ongoing compliance or ability to comply with all applicable federal and State data collection and reporting requirements, including, but not limited to, the Commission's Home Health Agency Annual Survey, CMS' Outcome and Assessment Information Set (OASIS), and CMS' Home Health Consumer Assessment of Healthcare Providers (HHCAHPS).

Response: FHC is well-positioned to comply with all federal and State data collection and reporting requirements for Medicare-certified home health agencies, given the systems and processes it already maintains as a CHAP-accredited Residential Service Agency. As part of its RSA operations, FHC currently uses the Outcome and Assessment Information Set ("OASIS") during intake and clinical assessment, demonstrating familiarity with the tool and its role in care planning and quality monitoring. FHC also administers an established patient satisfaction survey that supports service evaluation, performance improvement, and responsiveness to patient needs.

Building on this foundation, FHC will expand its data infrastructure to meet all CMS and MHCC reporting obligations for an HHA. Upon certification, the agency will complete and transmit OASIS assessments in accordance with CMS Conditions of Participation, participate in the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey process, and submit timely and accurate data to the Maryland Health Care Commission through the Home Health Agency Annual Survey. FHC will use its current CHAP-compliant documentation systems, along with any enhancements needed for Medicare certification, to ensure clinical data, utilization statistics, and quality measures are captured and reported consistently.

Exhibits 1 and 11 include sample intake processes, patient satisfaction survey instruments, and current accreditation and licensure documentation, all of which demonstrate the organization's ability to maintain the data integrity, reporting accuracy, and quality monitoring required for a Medicare-certified home health agency.

10.24.16.09 CERTIFICATE OF NEED PREFERENCE RULES IN COMPARATIVE REVIEWS.

The Commission shall use the following preferences, in the order listed, to limit the number of CON applications approved in a comparative review.

10.24.16.09A. Performance on Quality Measures.

Higher levels of performance will be given preference over lower levels of performance.

10.24.16.09B. Maintained or Improved Performance.

An applicant that demonstrates maintenance or improvement in its level of performance on the selected process and outcome measures during the most recent three-year reporting period will be given preference over an applicant that did not maintain or improve its performance.

10.24.16.09C. Proven Track Record in Serving all Payor Types, the Indigent and Low-Income Persons.

An applicant that served a broader range of payor types and the indigent will be given preference over an applicant that served a narrower range of payor types and provided less service to the indigent and low-income persons.

10.24.16.09D. Proven Track Record in Providing a Comprehensive Array of Services.

An applicant that provided a broader range of services will be given preference over an applicant that provided a narrower range of services.

10.24.16.09E. These preferences will only be used in a comparative review

of applications when it is determined that approval of all applications that fully comply with standards in Regulation .08 of this Chapter would exceed the permitted number of additional HHAs provided for in a jurisdiction or multi-jurisdictional region as provided in Regulation .10.

Response: At the pre-application conference on November 19, 2025, and in a follow-up email on December 5, 2025, the MHCC Staff confirmed that the number of Applicants does not exceed the number of available HHAs in the Anne Arundel, Montgomery, Prince George's, and Southern jurisdictions.

This application is not competitive; therefore, COMAR 10.24.16.09A through E are not applicable.

10.24.01.08G CRITERIA FOR REVIEW OF APPLICATION

10.24.01.08G(3)(b). The "Need" Review Criterion

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated a need for the proposed project.

INSTRUCTIONS: Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan.

Please assure that all sources of information used in the need analysis are identified and identify all the assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), and the relevant population considered in the analysis with information that supports the validity of these assumptions. The existing and/or intended service area population of the applicant should be clearly defined.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

Overview

The Applicant, FHC, proposes to develop a new Medicare-certified HHA office in Laurel, Prince George's County, to serve four jurisdictions: Anne Arundel, Montgomery, Prince George's, and Southern Maryland. This project responds to MHCC's need for additional HHA services in the listed jurisdictions.

Figure B: FHC Proposed HHA Primary Service Area Jurisdictions Map

MHCC identified the need in these jurisdictions based on three criteria: has insufficient consumer choice of HHAs, a highly concentrated HHA service market, or an inadequate choice of HHAs with high-quality performance (COMAR 10.24.16.04). According to COMAR 10.24.16.10, the MHCC can "… limit the number of new entrants authorized by CON approval for any given review cycle to… [n]o more than 40 percent of the number of existing HHAs in a jurisdiction or multi-jurisdictional region with four or more agencies." This means that for the four jurisdictions in FHC's PSA, MHCC can approve the following number of new HHAs:

- Anne Arundel: 6
- Montgomery: 8
- Prince George's: 6
- Southern: 2

The Applicant forecasted the number of unduplicated clients and client visits for the first four years of operation using data from the following sources:

- Maryland Department of Planning State Data & Analysis Center: 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other, and Hispanic by Age and Gender[23]; and
- Maryland Health Care Commission Home Health Public Use Files, Tables 1 through 25 for 2019-2023.[24]

The Applicant assumes that MDP and MHCC data are reasonable sources for forecasting PSA need and utilization.

All data presented in this methodology are organized by age group, consistent with MHCC's HHA utilization reporting format. Maintaining these age cohorts allows the Applicant to account for differences in service use across the population, as home health utilization varies significantly by age. Using the same age groupings ensures that the projections more accurately reflect actual patterns of home health service demand.

The Applicant forecasts home health utilization separately for each jurisdiction within the PSA to account for geographic variations in population size, demographics, and existing service availability. Service use and access can vary significantly by jurisdiction, and projecting at this level enables a more precise estimate of both current and unmet need. Independent jurisdiction-level forecasts ensure the methodology accurately captures local patterns in home health demand and supports targeted service delivery planning.

FHC's fiscal year is January 1 through December 31. The project proposes to start on October 1, 2026. These three months will serve as a transition period from FHC's current RSA services to incorporate the newly proposed HHA services. FHC expects to be fully transitioned by January 1, 2027, and fully utilized within three years. Therefore, the methodology forecasts utilization from January 1, 2027, through December 31, 2029.

Throughout this methodology, "clients" refers to unduplicated HHA clients. The primary service area ("PSA") includes all four jurisdictions: Anne Arundel, Montgomery, Prince George's, and Southern. MHCC determined that Charles, Calvert, and St. Mary's created one region – Southern. As a result, any data referenced in this methodology as "Southern" is the aggregate of data from the three counties.

Population data is provided in calendar years by MDP; utilization data is provided in Federal Fiscal Years by MHCC. The Applicant forecasts all need and utilization in calendar years. FHC assumes any discrepancies between FFY and CY data are insignificant.

The following sections include all methodology steps and related assumptions used to estimate need and utilization for FHC. Required Table 2B: Statistical Projections - Projected Home Health Agency Services In The Proposed Project summarizes all final client and visit projections and is included in Part IV as requested. See page 84.

[23] https://planning.maryland.gov/MSDC/Pages/5_projections/population-and-households.aspx
[24] https://mhcc.maryland.gov/public_use_files/homehealthdownload.html

Forecast Need

Step 1: Determine Population by Age Group by Jurisdiction, 2025-2030

MDP forecasts population by age group and county in five-year increments from the 2020 US Census through 2045. The Applicant interpolated population by year for CY2026 through CY2029 using the Compound Annual Growth Rate ("CAGR") for population between CY2025 and CY2030 for each PSA jurisdiction. Tables F 1 through 4 below summarize the populations by age group, year, and jurisdiction.

Table F: Population by Age Group by Year, CY2025 – CY2030

1. Anne Arundel

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CAGR '25-'30
0 to 4	36,590	36,822	37,056	37,291	37,528	37,766	0.6%
5 to 14	72,661	72,900	73,140	73,380	73,622	73,864	0.3%
15 to 24	70,697	71,165	71,637	72,111	72,589	73,070	0.7%
25 to 44	161,150	160,928	160,707	160,486	160,265	160,045	-0.1%
45 to 64	148,039	147,405	146,773	146,144	145,518	144,894	-0.4%
65 to 74	61,301	62,388	63,495	64,621	65,767	66,934	1.8%
75 to 84	33,967	34,969	36,000	37,062	38,155	39,280	2.9%
85+	10,600	11,064	11,549	12,054	12,582	13,133	4.4%
Total	**595,005**	**597,642**	**600,356**	**603,150**	**606,026**	**608,986**	**0.5%**

Notes:

a. *MDP provided population projections for CY2025 and CY2030*
b. *CY2026 – CY2029 were interpolated using the CY2025 to CY2030 CAGR*
CAGR = ((CY30 Population / CY25 Population)$^{(1/5)}$) - 1

2. Montgomery

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CAGR '25-'30
0 to 4	70,077	70,444	70,813	71,184	71,556	71,931	0.5%
5 to 14	135,448	136,261	137,078	137,900	138,728	139,560	0.6%
15 to 24	119,008	119,834	120,666	121,503	122,347	123,196	0.7%
25 to 44	297,103	296,852	296,602	296,352	296,102	295,852	-0.1%
45 to 64	274,175	274,873	275,572	276,274	276,977	277,682	0.3%
65 to 74	105,563	107,206	108,874	110,569	112,289	114,037	1.6%
75 to 84	60,520	62,655	64,865	67,152	69,521	71,973	3.5%
85+	25,395	26,353	27,347	28,379	29,449	30,560	3.8%
Total	**1,087,289**	**1,094,477**	**1,101,817**	**1,109,313**	**1,116,969**	**1,124,791**	**0.7%**

3. Prince George's

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CAGR '25-'30
0 to 4	57,012	56,919	56,827	56,734	56,642	56,550	-0.2%
5 to 14	110,498	109,848	109,201	108,558	107,919	107,284	-0.6%
15 to 24	121,651	122,611	123,578	124,552	125,535	126,525	0.8%
25 to 44	257,974	256,605	255,242	253,887	252,540	251,199	-0.5%
45 to 64	228,111	227,435	226,761	226,088	225,418	224,750	-0.3%
65 to 74	88,497	89,795	91,112	92,449	93,805	95,181	1.5%
75 to 84	45,839	47,761	49,763	51,849	54,023	56,288	4.2%
85+	16,442	17,611	18,864	20,206	21,643	23,182	7.1%
Total	**926,024**	**928,584**	**931,348**	**934,325**	**937,525**	**940,959**	**0.3%**

4. Southern

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CAGR '25-'30
0 to 4	24,588	24,870	25,155	25,443	25,735	26,030	1.1%
5 to 14	50,422	51,055	51,696	52,345	53,002	53,667	1.3%
15 to 24	49,333	49,261	49,189	49,118	49,046	48,975	-0.1%
25 to 44	99,566	100,720	101,888	103,069	104,264	105,473	1.2%
45 to 64	104,370	103,256	102,155	101,065	99,987	98,920	-1.1%
65 to 74	39,334	40,935	42,602	44,336	46,141	48,019	4.1%
75 to 84	19,999	20,806	21,646	22,520	23,428	24,374	4.0%
85+	6,353	6,680	7,024	7,386	7,766	8,166	5.1%
Total	**393,965**	**397,584**	**401,355**	**405,281**	**409,369**	**413,624**	**1.0%**

Step 2: Determine the HHA Use Rate per 1,000 Population by Age Group and Jurisdiction, CY2023

To establish baseline home health agency utilization, the Applicant analyzed Maryland's FY2023 HHA client data by age group and by jurisdiction. Using these data, the Applicant calculated the HHA client utilization rate per 1,000 population for each jurisdiction and age cohort. This methodology provides a consistent, population-adjusted measure of service use that informs the project's demand projections. Table G below details the final FY2023 use rates. Supporting data and methods for developing the use rates are in Exhibit 12.

Table G: HHA Client Use Rates by Age Cohort and Jurisdiction per 1,000 Population, FY2023

Age Group	Anne Arundel	Mont-gomery	Prince George's	Southern
0 to 4	4.4	11.3	7.4	2.3
5 to 14	0.4	0.3	0.2	0.2
15 to 24	0.7	0.7	0.7	0.7
25 to 44	1.6	1.7	2.2	2.4
45 to 64	10.2	9.7	12.0	11.9
65 to 74	42.4	42.7	50.8	41.8
75 to 84	126.8	110.6	115.7	101.0
85+	331.2	250.0	207.7	198.2
Total	**19.2**	**18.5**	**16.4**	**15.1**

Sources: See calculations in Exhibit 12

Step 3: Forecast Estimated Number of HHA Clients in the PSA by Age Cohort and Jurisdiction, CY2025 – CY2030

Using the FY2023 use rates developed in Step 2, the Applicant applied these rates to the projected populations identified in Step 1 to estimate the anticipated number of home health clients from CY2025 through CY2030. This approach produces a consistent, demand-driven forecast of future service need based on observed utilization patterns and expected demographic changes. Tables H 1 through 4 present the estimated home health client need for each projection year by age cohort and jurisdiction.

Table H: Estimated Number of HHA Clients by Age Group by Year by Jurisdiction, CY2025 – CY2030

1. Anne Arundel

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	159	160	162	163	164	165
5 to 14	32	32	32	32	32	32
15 to 24	48	48	49	49	49	50
25 to 44	251	251	250	250	250	249
45 to 64	1,516	1,510	1,503	1,497	1,491	1,484
65 to 74	2,602	2,648	2,695	2,743	2,792	2,841
75 to 84	4,307	4,434	4,565	4,699	4,838	4,981
85+	3,511	3,664	3,825	3,992	4,167	4,350
Total	12,427	12,748	13,081	13,425	13,782	14,152

*Calculation: Step 1: population by age group, year, and jurisdiction * Step 2: use rate by age group and jurisdiction / 1,000*

2. Montgomery

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	793	797	801	805	809	814
5 to 14	37	38	38	38	38	38
15 to 24	86	87	87	88	89	89
25 to 44	514	513	513	513	512	512
45 to 64	2,671	2,677	2,684	2,691	2,698	2,705
65 to 74	4,512	4,582	4,653	4,725	4,799	4,874
75 to 84	6,692	6,928	7,172	7,425	7,687	7,958
85+	6,348	6,587	6,836	7,094	7,361	7,639
Total	**21,652**	**22,209**	**22,785**	**23,379**	**23,994**	**24,629**

3. Prince George's

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	421	421	420	419	419	418
5 to 14	24	23	23	23	23	23
15 to 24	91	92	92	93	94	95
25 to 44	555	552	549	546	543	540
45 to 64	2,748	2,740	2,732	2,724	2,716	2,708
65 to 74	4,495	4,560	4,627	4,695	4,764	4,834
75 to 84	5,302	5,524	5,756	5,997	6,249	6,510
85+	3,415	3,658	3,918	4,197	4,495	4,815
Total	17,050	17,570	18,118	18,695	19,302	19,943

4. Southern

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	56	57	57	58	59	59
5 to 14	11	11	11	11	11	11
15 to 24	35	35	35	35	35	34
25 to 44	236	239	242	245	248	250
45 to 64	1,239	1,226	1,213	1,200	1,187	1,174
65 to 74	1,643	1,710	1,780	1,852	1,928	2,006
75 to 84	2,020	2,102	2,187	2,275	2,367	2,462
85+	1,259	1,324	1,392	1,464	1,539	1,619
Total	6,500	6,703	6,916	7,139	7,373	7,617

Table I below summarizes the estimated total number of HHA clients in the PSA by age group and year.

Table I: Estimated Number of HHA Clients by Age Group by Year, Entire PSA, CY2025 – CY2030

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	1,430	1,435	1,440	1,445	1,450	1,456
5 to 14	103	104	104	104	105	105
15 to 24	260	261	263	265	266	268
25 to 44	1,556	1,555	1,554	1,553	1,552	1,552
45 to 64	8,174	8,153	8,132	8,112	8,091	8,071
65 to 74	13,251	13,501	13,755	14,016	14,282	14,555
75 to 84	18,321	18,988	19,680	20,397	21,141	21,912
85+	14,533	15,234	15,971	16,747	17,563	18,422
Total	57,629	59,231	60,899	62,638	64,451	66,340

Calculation: Sum of estimated clients by age group by year, Table H 1 through 4

Assumptions

1. Using the FY2023 use rate through CY2030 is reasonable because FY2023 reflects the most recent, stable post-pandemic utilization patterns, capturing current referral behavior, care management practices, and patient preferences for home-based care.
2. Home health utilization trends have remained relatively consistent over time, with no significant regulatory or reimbursement changes anticipated that would materially alter demand patterns during the projection period.
3. Population growth—rather than changes in per-capita utilization—is expected to be the primary driver of increased home health need, making it appropriate to hold the use rate constant while allowing demographic shifts to influence future demand.
4. The FY2023 use rate is derived from a full statewide dataset, representing typical service use across all jurisdictions and age cohorts, which supports its continued application through the projection horizon.

Step 4: Determine the Number of HHA Clients Served by Existing HHAs in the PSA by Age Group and Jurisdiction, FY2023

To determine the number of home health clients in the PSA currently served by existing providers, the Applicant analyzed MHCC FY2023 home health utilization data. This dataset identifies HHA client volumes by provider and by jurisdiction, allowing the Applicant to quantify baseline service levels within the PSA. Table J summarizes the FY2023 utilization of existing providers serving the PSA.

Table J: HHA Clients Served by Existing HHA Providers in the PSA by Age Cohort and Jurisdiction, FY2023

Age Group	Anne Arundel	Mont-gomery	Prince George's	Southern
0 to 4	141	221	153	38
5 to 14	33	33	23	18
15 to 24	42	87	54	28
25 to 44	183	375	405	166
45 to 64	1,261	2,123	2,425	946
65 to 74	2,446	4,076	3,954	1,325
75 to 84	4,029	6,331	4,592	1,591
85+	3,635	6,240	2,994	1,185
Total	**11,770**	**19,486**	**14,600**	**5,297**

Sources: MHCC HHA Utilization Table 13: Total Number of Home Health Agency Clients (Unduplicated Count) by Jurisdiction of Residence, Payment Source, and Agency: Maryland

Step 5: Estimate the Number of Unserved HHA Clients by Age Group, Jurisdiction, and Year, CY2025-CY2030

To quantify unmet home health need within the PSA, the Applicant subtracted the number of clients served by existing providers in FY2023 (Step 4) from the projected client count for CY2025 through CY2030 (Step 3). This calculation was performed by jurisdiction and age cohort, yielding annual estimates of unmet need for the projection period. Tables K 1 through 4 present the Applicant's calculated unmet need by year, age group, and jurisdiction.

Table K: Estimated Number of Unserved HHA Clients by Age Group by Year by Jurisdiction, CY2025 – CY2030

1. Anne Arundel

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	18	19	21	22	23	24
5 to 14	-	-	-	-	-	-
15 to 24	6	6	7	7	7	8
25 to 44	68	68	67	67	67	66
45 to 64	255	249	242	236	230	223
65 to 74	156	202	249	297	346	395
75 to 84	278	405	536	670	809	952
85+	-	29	190	357	532	715
Total	**782**	**979**	**1,312**	**1,656**	**2,013**	**2,382**

Calculation: Step 3 estimated HHA clients by age group, year, and jurisdiction - Step 4 FY2023 served HHA clients by age group and jurisdiction

2. Montgomery

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	572	576	580	584	588	593
5 to 14	4	5	5	5	5	5
15 to 24	-	-	-	1	2	2
25 to 44	139	138	138	138	137	137
45 to 64	548	554	561	568	575	582
65 to 74	436	506	577	649	723	798
75 to 84	361	597	841	1,094	1,356	1,627
85+	108	347	596	854	1,121	1,399
Total	**2,167**	**2,723**	**3,298**	**3,893**	**4,508**	**5,143**

3. Prince George's

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	268	268	267	266	266	265
5 to 14	-	-	-	-	-	-
15 to 24	37	38	38	39	40	41
25 to 44	150	147	144	141	138	135
45 to 64	323	315	307	299	291	283
65 to 74	541	606	673	741	810	880
75 to 84	710	932	1,164	1,405	1,657	1,918
85+	421	664	924	1,203	1,501	1,821
Total	**2,450**	**2,970**	**3,517**	**4,094**	**4,702**	**5,343**

4. Southern

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	18	19	19	20	21	21
5 to 14	-	-	-	-	-	-
15 to 24	7	7	7	7	7	6
25 to 44	70	73	76	79	82	84
45 to 64	293	280	267	254	241	228
65 to 74	318	385	455	527	603	681
75 to 84	429	511	596	684	776	871
85+	74	139	207	279	354	434
Total	**1,210**	**1,413**	**1,626**	**1,849**	**2,082**	**2,327**

Assumptions

1. The Applicant assumes that the number of clients served by existing providers remains constant through CY2030, reflecting the fact that current providers are operating at or near capacity.
2. Because existing providers cannot absorb incremental population growth, holding their served client count constant provides a conservative estimate of unmet need in the PSA.
3. This approach isolates demographic growth as the primary driver of projected service demand, ensuring that unmet need estimates accurately reflect the portion of demand that cannot currently be met by existing capacity.

Table L below summarizes the total estimated unmet home health need in the PSA for CY2025 through CY2030. These totals represent the portion of projected client demand not currently met by existing providers and reflect the incremental need associated with population growth.

Table L: Estimated Number of Unserved HHA Clients by Age Group by Year, Entire PSA, CY2025 – CY2030

Age Group	CY25	CY26	CY27	CY28	CY29	CY30
0 to 4	877	882	887	892	897	903
5 to 14	4	5	5	5	5	5
15 to 24	50	51	52	54	55	57
25 to 44	427	426	425	424	423	423
45 to 64	1,419	1,398	1,377	1,357	1,336	1,316
65 to 74	1,450	1,700	1,954	2,215	2,481	2,754
75 to 84	1,778	2,445	3,137	3,854	4,598	5,369
85+	603	1,180	1,917	2,693	3,509	4,368
Total	**6,609**	**8,086**	**9,754**	**11,493**	**13,305**	**15,194**

Calculation: Tables J 1 through 4 summed

Forecast Utilization

Step 6: Estimate the FHC Market Share of Unserved HHA Clients from the PSA, CY2027-CY2030

To develop FHC's utilization forecast, the Applicant first estimated the portion of unmet need the agency expects to capture within the PSA. As an existing RSA, FHC already serves a portion of the population, making an initial market share of 2.06 percent reasonable. The projected market share gradually ramps to 2.48 percent in the second year and stabilizes at 2.75 percent by PY3 (CY2029). This phased growth allows FHC to expand and adjust its services over time, including building new referral relationships, enhancing operational capacity, and optimizing care delivery, before reaching full utilization of the targeted market share. This approach aligns with standard operational ramp-up practices observed for HHAs expanding into additional service areas.

Table M: Estimated FHC Market Share of Unserved HHA Clients in the PSA by Year, CY2027 – CY2030

Metric	CY27	CY28	CY29	CY30
Market Share	2.06%	2.48%	2.75%	2.75%

Assumptions

1. The projected market share ramp reflects FHC's ability to gradually expand services, build referral relationships, and optimize operations before reaching full utilization.
2. FHC is an existing RSA. It has established relationships with referring providers. Therefore, an initial market share of 2.06 percent is reasonable.
3. The market share stabilizes at 2.75 percent by PY3 (CY2029), consistent with the standard ramp-up observed for HHAs entering new service areas or expanding capacity.
4. These projections assume that FHC's operational capacity, staffing, and service delivery infrastructure will grow in step with the market share ramp and that no external factors (e.g., significant regulatory changes) will materially constrain the agency's ability to capture the projected portion of unmet need.

Step 7: Estimated Number of FHC HHA Clients by Age Group by Jurisdiction by Year, CY2027-CY2030

To estimate FHC's projected client volumes, the Applicant applied the market share assumptions developed in Step 6 to the annual unmet need identified in Step 5. This calculation was performed by jurisdiction and age cohort for each projection year, producing the anticipated number of clients FHC is expected to serve as it ramps up operations. Tables N 1 through 4 present the resulting forecasted utilization by year, age group, and jurisdiction.

Table N: Estimated Number of FHC HHA Clients by Age Group by Year by Jurisdiction, CY2027 – CY2030

1. Anne Arundel

Age Group	CY27	CY28	CY29	CY30
0 to 4	-	1	1	1
5 to 14	-	-	-	-
15 to 24	-	-	-	-
25 to 44	1	2	2	2
45 to 64	5	6	6	6
65 to 74	5	7	10	11
75 to 84	11	17	22	26
85+	4	9	15	20
Total	**26**	**42**	**56**	**66**

*Calculation: Step 5 estimated unserved HHA clients by age group, year, and jurisdiction * Step 6 estimated market share by year*

2. Montgomery

Age Group	CY27	CY28	CY29	CY30
0 to 4	12	14	16	16
5 to 14	-	-	-	-
15 to 24	-	-	-	-
25 to 44	3	3	4	4
45 to 64	12	14	16	16
65 to 74	12	16	20	22
75 to 84	17	27	37	45
85+	12	21	31	38
Total	**68**	**95**	**124**	**141**

3. Prince George's

Age Group	CY27	CY28	CY29	CY30
0 to 4	6	7	7	7
5 to 14	-	-	-	-
15 to 24	1	1	1	1
25 to 44	3	3	4	4
45 to 64	6	7	8	8
65 to 74	14	18	22	24
75 to 84	24	35	46	53
85+	19	30	41	50
Total	**73**	**101**	**129**	**147**

4. Southern

Age Group	CY27	CY28	CY29	CY30
0 to 4	-	-	1	1
5 to 14	-	-	-	-
15 to 24	-	-	-	-
25 to 44	2	2	2	2
45 to 64	5	6	7	6
65 to 74	9	13	17	19
75 to 84	12	17	21	24
85+	4	7	10	12
Total	**32**	**45**	**58**	**64**

Table O below summarizes the total estimated FHC home health clients from the PSA for CY2027 through CY2030.

Table O: Estimated Number of FHC HHA Clients by Age Group by Year, Entire PSA, CY2027 – CY2030

Age Group	CY27	CY28	CY29	CY30
0 to 4	18	22	25	25
5 to 14	-	-	-	-
15 to 24	1	1	1	1
25 to 44	9	10	12	12
45 to 64	28	33	37	36
65 to 74	40	54	69	76
75 to 84	64	96	126	148
85+	39	67	97	120
Total	**199**	**283**	**367**	**418**

Calculation: Tables N 1 through 4 summed

Step 8: Forecast FHC HHA Visits by Category, CY2027-CY2030

To forecast home health visits by billable versus non-billable status and by discipline, the Applicant first determined the Maryland five-year state average of visits per client for each category. These average visit rates were then applied to the projected client volumes developed in Step 6, generating a forecast of total visits by type and discipline for each projection year. Table P presents the resulting visit projections by year, discipline, and billing status, and agency comparisons are provided in Exhibit 13.

Table P: Forecast FHC HHA Visits by Billing Status and Service Discipline by Year, CY2027 – CY2030

Metric	Visits per Client	CY27	CY28	CY29	CY30
Total Clients		***199***	***283***	***367***	***418***
Billable	*15.9*	3,155	4,486	5,818	6,627
Non Billable	*0.5*	91	129	167	190
Total Visits		**3,245**	**4,615**	**5,985**	**6,817**
fService Discipline					
Skilled Nursing	*6.2*	1,235	1,757	2,278	2,595
Home Health Aide	*0.7*	133	189	245	279
Physical Therapy	*2.1*	419	596	773	880
Occupational Therapy	6.4	1,268	1,803	2,338	2,663
Speech Therapy	*0.4*	79	113	146	167
Medical Social Work	*0.1*	20	29	38	43

Note: See calculations for visits by billing status and service discipline in Exhibit 13

Assumptions

1. The Maryland five-year state average of visits per client is assumed to be a reasonable proxy for expected FHC utilization because it reflects stable, statewide practice patterns and accounts for variability across agencies and patient populations.
2. These visit rates are assumed to remain constant through CY2030, reflecting the expectation that FHC's care delivery patterns, client mix, and service intensity will generally align with established statewide norms.
3. The methodology assumes no significant changes in regulations, reimbursement policies, or clinical practice standards that would materially alter visit intensity over the projection period.

10.24.01.08G(3)(c). Alternatives to the Project Review Criterion

The Commission shall consider the alternative approaches to meeting the need identified for the project that were considered by the applicant in planning the project and the basis for the applicant's choice of the project among considered alternatives. In a comparative review of applications within the same review cycle, the Commission shall compare the costs and the likely effectiveness of alternative projects in meeting identified needs, improving the availability and accessibility of care, and improving the quality of care.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project, or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Response: FHC evaluated multiple alternatives to the proposed HHA project to determine the most effective approach for meeting the identified community need. Each alternative was assessed based on its expected effectiveness in achieving project goals, overall costs—including development, operations, and life-cycle costs—and its ability to address the identified problem.

1. Maintain the Status Quo

- **Effectiveness:** Maintaining current operations without expanding to a certified HHA would not allow the applicant to meet the growing need for home health services in the target area. Current operations as an RSA limit the ability to provide Medicare-certified services, reducing access for patients who rely on Medicare.
- **Costs:** Minimal upfront costs; however, this alternative fails to capture potential reimbursement from Medicare and other payers and does not address projected increases in demand. Long-term opportunity costs are significant.
- **Conclusion:** Ineffective in meeting project objectives; does not address community need.

2. Seek a Joint Venture with an Existing HHA

- **Effectiveness:** Partnering with an existing HHA could provide partial access to Medicare certification and reduce administrative burden. However, joint venture arrangements may limit operational autonomy, program design flexibility, and responsiveness to community-specific needs.

- **Costs:** Lower initial development costs than building a new agency; however, shared revenue models reduce long-term financial sustainability. Ongoing contractual or operational costs may be higher due to coordination requirements.
- **Conclusion:** Only partially effective; less control over programming design and long-term sustainability.

3. Continue as an RSA Without Medicare Certification

- **Effectiveness:** Operating solely as an RSA limits patient access to Medicare-funded home health services, restricting service availability to the community. The project goals of improving access and providing comprehensive home health care would not be fully achieved.
- **Costs:** Minimal development costs; ongoing operational costs remain unchanged. Life-cycle cost savings are offset by the inability to generate Medicare revenue or expand services.
- **Conclusion:** Not effective in achieving objectives or addressing community need.

4. Develop the Project as Proposed (Preferred Alternative)

- **Effectiveness:** The proposed project provides a Medicare-certified HHA in the PSA, directly addressing the identified community need. It enables complete operational control, flexible program design, and the expansion of services to meet current and projected demand. Historical performance as an RSA demonstrates readiness and capacity to operate a successful HHA.
- **Costs:** Development costs include necessary facility modifications, equipment, and staff training. Operational costs include ongoing staff, administrative, and compliance expenses. Life cycle cost analysis indicates that the investment in the proposed change from an RSA to an HHA will be offset by reimbursement from Medicare and other payers, ensuring long-term financial sustainability.
- **Conclusion:** Most effective solution in terms of goal achievement, problem resolution, and cost-effectiveness. Compared to other alternatives, the proposed project maximizes service access, operational control, and sustainability.

Conclusion

The comparative analysis of alternatives demonstrates that the proposed HHA project is the most effective and cost-efficient way to meet the identified community need. All other alternatives provide either limited effectiveness, reduced access, or less favorable financial sustainability over the project life cycle.

10.24.01.08G(3)(d). Project Financial Feasibility and Facility or Program Viability Review Criterion.

The Commission shall consider the availability of resources necessary to implement the project and the availability of revenue sources and demand for the proposed services adequate to ensure ongoing viability and sustainability of the facility to be established or modified or the service to be introduced or expanded.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- **Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required (Tables H and I for all applicants and Table F for existing facilities and/or Table G, for new facilities, new services, and when requested by MHCC staff). Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the health care facility exists or is proposed, explain why the projected Medicare percentages are reasonable.**

- **Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.**

- **If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.**

- **Describe and document relevant community support for the proposed project.**

- **Identify the performance requirements applicable to the proposed project (see Part I question 15) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).**

Response: The proposed HHA project will be funded through the applicant's existing equity, as documented in the letter from FHC's CPA in Exhibit 9. The letter attests that FHC has sufficient cash to cover all start-up costs and working capital needs. No external grants or philanthropic funding are currently required to initiate the project. The Applicant considered alternative financing mechanisms, including traditional debt financing, and determined that such methods were unnecessary given the availability of internal funds. This approach was chosen to ensure timely implementation and financial stability while minimizing financial risk.

All methods and assumptions for financial and staffing projections are detailed in Part IV immediately following required Tables 3, 4, and 5 (see page 93). These tables demonstrate that the proposed project is financially sustainable, with projected revenues covering ongoing operational costs and staffing requirements. Assumptions regarding staffing needs, recruitment, and retention are consistent with FHC's history as an RSA and its established capacity to manage and deliver home-based care. Where Medicare percentages exceed the jurisdictional median, the projections are based on documented referral patterns and historical experience, including a list of clients who could not be served previously due to the lack of Medicare certification, supporting the reasonableness of projected Medicare utilization.

The applicant has significant experience in managing a similar project – operation of its existing RSA – which supports both operational feasibility and financial planning.

Community support for the proposed HHA is inherent in FHC's existing referral sources, longstanding community involvement, and demonstrated unmet need. Exhibit 14 includes community letters of support for FHC's proposed project. Additionally, the established client base, community relationships, documented referrals, and list of unserved Medicare clients reflect the community's implicit endorsement of the transition to a Medicare-certified HHA. Linkages with existing healthcare providers and referral sources are detailed in Section 10.24.16.08I and Exhibit 4, which further support the project's anticipated success and sustainability.

In summary, the proposed funding plan leverages FHC's existing resources to fully support the start-up and ongoing operations of the HHA, ensuring financial sustainability, readiness for implementation, and continued ability to meet the identified community need.

10.24.01.08G(3)(e). The "Compliance with Terms and Conditions of Previous Certificates of Need" Review Criterion.

An applicant shall demonstrate compliance with all terms and conditions of each previous CON granted to the applicant.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Response: Neither FHC, its parent organization, nor any related affiliates have been issued a CON in the state of Maryland. Therefore, it has no obligations to any terms or conditions set forth by MHCC. This criterion is not applicable.

10.24.01.08G(3)(f). Project Impact Review Criterion.

The Commission shall consider the impact of the proposed project on the costs and charges of existing providers of the facilities and services included in the project and on access to those facilities and services in the service area of the project.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs of the health care delivery system.

If the applicant is an existing health care facility, provide a summary description of the impact of the proposed project on costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Response: FHC anticipates that the proposed Medicare-certified HHA will have minimal impact on existing providers within the PSA while significantly improving patient access to care. The analysis below summarizes the expected impacts on volumes, payer mix, access, and costs, along with the assumptions underlying these conclusions.

a. Volumes

The proposed project is designed to address unmet need in the PSA while minimizing the displacement of existing HHA providers. Current providers are unable to meet demand fully, and FHC has a documented list of clients who were referred but could not be served due to a lack of Medicare certification. By targeting this population, FHC expects to capture a portion of the unmet need rather than divert patients from existing agencies. Assumptions about service volumes are based on historical referral patterns, projected demand growth, and FHC's capacity to provide care as a Medicare-certified HHA.

b. Payer Mix

With CON approval, FHC will accept Medicare patients, thereby changing its payer mix. However, the project is not expected to significantly affect the payer mix of other providers in the PSA, as the majority of patients served by FHC would otherwise have limited or no access to home health services. Revenue assumptions reflect standard Medicare and commercial reimbursement rates consistent with regional norms. Payor Mix of the proposed FHC HHA is consistent with that of other providers in the area with Medicaid (both traditional and MCO), adjusted up to at least 2% with Medicare reduced by the same amount. Payor mix data were derived from the MHCC HHA Annual Survey, FY23, Table 19.

c. Access

The proposed project will expand access to home health services in the PSA. By transitioning from an RSA to a Medicare-certified HHA, FHC will serve patients who currently lack access to home-based care, provide timely in-home visits, reduce care delays, and improve continuity of care for post-acute and chronic care management. This improved access is based on documented unmet need, FHC's existing referral sources, and community demand, ensuring that the project addresses service gaps rather than competing for existing patients.

d. Cost of the Healthcare Delivery System

The project is expected to have a neutral to positive effect on overall healthcare system costs. Providing in-home care can prevent unnecessary hospital admissions, reduce avoidable emergency department visits, and support earlier hospital discharge, thereby lowering system-wide costs. Charges for home health services will follow standard Medicare and payer guidelines and align with those of other providers in the region. FHC's operational experience as an RSA ensures efficiency, minimizes overhead, and avoids unnecessary cost escalation. The project expands access without increasing overall costs and enhances equity and efficiency within the local healthcare delivery system.

Summary

In summary, the proposed HHA project addresses substantial unmet need while minimally impacting existing providers' volumes and payer mix. It improves patient access to home health services, maintains cost efficiency, and supports the sustainability of care delivery within the PSA. The assumptions regarding demand, payer mix, and access are grounded in FHC's historical operations, community referrals, and documented unmet need, providing a robust basis for these conclusions.

10.24.01.08G(3)(g) Health Equity.

The Commission shall consider how a proposed project will address health care disparities in availability, accessibility, and quality of care among different populations within the service area. The Commission shall consider how social determinants of health within the service area of the proposed project create disparities in the delivery of health care.

INSTRUCTIONS: In evaluating proposed projects for health equity, the Commission will scrutinize the project's impact on health care disparities and social determinants within the service area. Health equity involves the fair distribution of resources and opportunities, ensuring individuals, regardless of background, have the chance to achieve their highest level of health. It further encompasses addressing disparities and systemic barriers that affect different populations.

With health equity in mind, the applicant shall identify the specific medically underserved area(s)/group(s)[25] within the designated service area and outline how the proposed project will address the unique health needs and quality of care for each identified group.

Applicants are expected to furnish a detailed overview of their organization's expertise and experience in health care access and service delivery. Emphasis should be placed on highlighting any relevant background that underscores the organization's commitment to equitable health care. This encompasses efforts to integrate implicit bias and cultural competency training within the health facility and among current staff members.

Please provide a comprehensive account of how the applicant planned with the community during the preparations for this project and how it will continue to engage with the community. Include a description of any specific initiatives and programs aimed at improving community well-being that are relevant to the proposed project. If applicable, the applicant should acknowledge any unintended barriers caused by the project that may have been identified through community discourse and propose proactive solutions to mitigate and rectify potential issues.

Response: FHC's proposed Medicare-certified HHA is intentionally designed to reduce long-standing disparities in access, timeliness, and continuity of home-based care for medically underserved populations across the PSA. These jurisdictions include large and diverse communities that face disproportionate barriers related to income, transportation, disability, chronic disease burden, and limited provider participation—particularly among Medicaid fee-for-service, Medicaid Managed Care, **and dual-eligible beneficiaries who rely on both programs for coordinated coverage**.

Dual-eligible individuals represent some of the most medically complex and socially vulnerable patients in the PSA; they experience higher hospitalization rates, more frequent care transitions, and greater difficulty accessing Medicare-covered home health services when agencies restrict participation or lack capacity.

[25] According to HRSA, medically underserved populations and areas are identified as those which lack access to primary care services. These groups may face economic, cultural, or language barriers to health care. Some examples include People experiencing homelessness, people who are low-income, people who are eligible for Medicaid, Native Americans and other historically disadvantaged populations of color, migrant farm workers, etc. (https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups)

The PSA is also home to significant racial and ethnic minority populations, including African American and Hispanic residents, who historically experience delayed access to post-acute care, lower rates of referral to home health, and greater challenges navigating fragmented coverage systems.

By expanding Medicare-certified home health capacity, FHC will help address systemic gaps and ensure that low-income seniors, adults with disabilities, and dual-eligible beneficiaries receive timely, coordinated, high-quality care in the home setting.

Declining home health utilization across the PSA does not reflect improved health, but somewhat strained capacity. Industry and Medicare data demonstrate that workforce shortages, agency closures, and reimbursement pressures are limiting access, resulting in delayed or unfulfilled home health referrals. These delays disproportionately affect older adults, low-income families, and publicly insured populations. FHC's proposed expansion directly confronts these gaps by adding new, stable, and comprehensive home-based clinical capacity with seven-day-per-week availability. The proposed agency will ensure that medically and socially complex residents—including individuals with chronic cardiac, pulmonary, neurological, diabetic, musculoskeletal, and psychiatric conditions—receive timely admission and a full continuum of skilled care.

Identification of Medically Underserved Areas and Groups

Based on demographic, socioeconomic, and health-status data for the PSA, the following groups are identified as medically underserved:

- **Older adults**, especially individuals aged seventy-five and older, are a cohort expanding by nearly four percent annually.
- **Low-income residents**, including 7 to 16 percent of the PSA, live below 150 percent of the federal poverty level.
- **Racial and ethnic minority communities**, particularly African American and Hispanic residents, who represent more than half of the PSA population and have higher rates of diabetes, obesity, hypertension, and preventable hospitalizations.
- **Residents with disabilities or limited mobility**, including those who cannot reliably travel to outpatient settings.
- **Individuals with complex chronic conditions**, including COPD, CHF, diabetes, Alzheimer's disease, dementia, and musculoskeletal or neurological disorders.
- **Post-acute patients transitioning from hospital to home**, who face higher risks of readmission without timely skilled services.

FHC's proposed HHA will directly address the needs of these populations by expanding access to skilled nursing, therapy, home health aide services, and multidisciplinary care across the region, with particular emphasis on residents who have historically faced the greatest barriers to healthcare access.

How the Proposed Project Improves Equity for Underserved Populations

1. **Expanded Access to Affordable, Timely Home Health Services:** FHC's program is structured to ensure prompt admission for Medicare, Medicaid, and dual-eligible patients. As an organization with a documented commitment to charity care, FHC will continue to provide financial assistance to low-income patients who otherwise face cost-related barriers. This is particularly important in the PSA, where many households struggle with underinsurance and where home health provides a significantly lower-cost alternative to hospitalization.
2. **Seven-Day-a-Week Availability to Reduce Delays and Readmissions:** FHC will offer nursing, therapy, and aide services seven days per week, supporting the timely initiation of care after hospital discharge—a critical component in reducing preventable readmissions. Evidence shows that even one home health visit per week can reduce the risk of rehospitalization by 82 percent in older adults; FHC's model strengthens this impact through reliable scheduling and multidisciplinary care plans.
3. **Comprehensive Service Scope for Complex Medical and Social Needs:** The proposed HHA will deliver a wide range of disciplines—skilled nursing, PT, OT, ST, MSW, and home health aide services—capable of addressing acute, chronic, postoperative, neurological, pediatric, and geriatric needs. This breadth ensures that high-risk patients, including those with multiple comorbidities, receive coordinated home-based care that is often unavailable or difficult to obtain in the PSA due to capacity constraints.
4. **Targeted Support for Pediatric and Geriatric Populations:** FHC has specialized pediatric nurses and experienced geriatric clinicians trained to communicate effectively with children, older adults, and family caregivers. These populations often experience unique communication, functional, and behavioral needs that require specialized in-home care.

Organizational Background and Experience Supporting Health Equity

FHC currently operates as an experienced home-based care provider with a longstanding commitment to serving Medicaid, waiver, and medically fragile populations. As an RSA, FHC has provided personal care, supportive services, home health aide services, and skilled care coordination to low-income and minority residents for many years. This history has strengthened the organization's familiarity with the social and cultural needs of vulnerable households and its capacity to deliver trauma-informed, culturally sensitive care.

FHC is accredited by the Community Health Accreditation Partner (CHAP) and already maintains robust data-collection processes, including OASIS assessments and patient-satisfaction surveys. These systems will transition and expand seamlessly within the proposed HHA, ensuring compliance with federal and state reporting requirements and supporting continuous monitoring of health equity outcomes.

Staff training at FHC includes cultural humility, implicit bias awareness, communication with persons with disabilities, language support strategies, and trauma-informed care. These training programs will continue and expand under the proposed HHA, reinforcing the organization's commitment to equitable care delivery.

Community Engagement and Planning for the Proposed Project

FHC's preparation for this project has been informed by its longstanding relationships with community referral sources, including hospitals, physician practices, case managers, social service agencies, and managed care organizations that regularly coordinate care for older adults and medically complex residents of the PSA. As a Residential Service Agency, FHC routinely receives referral requests—particularly for Medicare beneficiaries—that it cannot accept due to its current licensure status. These repeated requests have provided direct, ongoing feedback from the community regarding unmet need for skilled home health services. In developing this project, FHC also engaged informally with key referral partners and community-based professionals to better understand barriers to timely home-based care, particularly delays in discharging Medicare patients who require home nursing or therapy services. Letters of support included in Exhibit 14 reflect this outreach and demonstrate strong community endorsement for expanding access through a Medicare-certified HHA.

Going forward, FHC will continue to engage with the community through ongoing discussions with referring providers, collaboration with local hospitals and care coordinators, participation in discharge-planning networks, and continued outreach to social service agencies and community organizations. As part of its commitment to community well-being, FHC will maintain a robust charity care and financial-assistance policy, offer culturally and linguistically responsive care, and ensure seven-day-per-week availability to improve care transitions and reduce avoidable hospital use. No unintended barriers have been identified through community discourse to date; however, FHC is committed to monitoring patient and provider feedback, assessing for access or equity concerns, and implementing proactive solutions—such as targeted outreach, bilingual communication materials, or service expansion—if any issues arise. Through these ongoing practices, FHC will remain responsive to community needs and support equitable access to high-quality home health services across the PSA.

Ongoing Community Engagement

FHC will continue proactive community involvement through:

- Quarterly meetings with referring hospitals, senior centers, federally qualified health centers (FQHCs), and community-based organizations.
- Patient and caregiver feedback surveys.
- Engagement with county aging offices and chronic-disease coalitions.
- Collaboration with organizations addressing food insecurity, transportation, disability services, and home-safety modifications.

FHC will screen all patients for social determinants of health—including food availability, caregiver support, home environment, access to medications, and transportation—ensuring that clinical care is paired with appropriate resource referrals and community partnerships.

Identification and Mitigation of Potential Unintended Barriers

FHC has not identified any unintended access barriers resulting from the proposed project; however, through its community planning process, several potential issues were considered:

- **Language barriers:** FHC employs and will continue to employ multilingual staff and interpreter services. Approximately 85 percent of FHC staff today speak at least one language in addition to English. FHC also contracts with Language Line, a HIPAA-compliant, medical-translation-specific service.
- **Transportation limitations:** While services occur in the home, FHC will coordinate transportation for follow-up medical appointments when appropriate through community partners.
- **Financial barriers:** FHC's charity care program and willingness to serve publicly insured patients without restriction mitigate cost-related inequities.
- **Digital barriers:** Recognizing the limitations of many of its potential clients, FHC will use phone-based communication and in-home visits rather than relying heavily on patient technology.

Should any additional concerns arise, FHC is committed to immediate operational adjustments—including staffing additions, policy changes, and expanded community outreach—to ensure equitable access for all PSA residents.

Conclusion

The PSA faces rapid growth in its older-adult population, elevated chronic-disease burden, widespread socioeconomic barriers, and declining home-health utilization caused by system strain rather than reduced demand. These factors disproportionately affect low-income residents, publicly insured individuals, and communities of color. FHC's proposed Medicare-certified HHA directly addresses these inequities by expanding clinical capacity, strengthening post-acute transitions, and delivering comprehensive, multidisciplinary care seven days per week. With its strong organizational foundation, established commitment to vulnerable populations, and ongoing community engagement strategy, FHC is well-prepared to improve health equity and ensure that all residents—regardless of age, income, race, or insurance type—can access timely, high-quality home health services.

10.24.01.08G(3)(h) Character and Competence.

The Commission shall assess the character and competence of an applicant based upon experience and past performance, including any records of violation in operating a health care service or facility.

INSTRUCTIONS: In evaluating proposed projects for Character/Competence, the Commission will review the information provided in response to Part IIII of the application and look for a detailed narrative response highlighting any past issues and how any issues have now been corrected or addressed. If there have not been any past issues please include in your narrative any history that has been a positive reflection of character/competence. The response should include, at minimum:

- **names/addresses of all owners and individuals responsible for the proposed project and its implementation. This includes any person with 5% or more ownership interest in the real property, bed rights or operations of the facility**
- **for each individual identified disclose any involvement in the ownership, development, or management of another health care facility**
- **for each individual and facility identified disclose if any license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years**
- **for each individual and facility identified disclose inquiries in the last from 10 years from any federal (CMS) or state authority (OHCQ), or other regulatory body regarding possible non-compliance with any state, or federal requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions**
- **disclose if any owners and individuals responsible for the project have identified above have ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities**

REMEMBER TO SUBMIT THE COMPANION TABLE SET FEATURING THE PROJECT BUDGET, STATISTICAL PROJECTIONS, REVENUE AND EXPENSE PROJECTIONS, AND WORKFORCE INFORMATION

Response: Please see the responses to Part III.1-5 for information regarding FHC's Character and Competence. All required tables, including the project budget, statistical projections, revenue and expense projections, and workforce information, are included in Part IV, beginning on page 80.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

Response: First Healthcare Consultants LTD is a **privately held limited company**, **100 percent owned by Ms. Abisola Raimi-Abayomi**. There are no additional individuals or entities with a 5% or greater ownership interest in the applicant.

Abisola Raimi-Abayomi
12906 North Point Lane
Laurel, Maryland 20708
Prince George's County

2. Is the applicant, or any person listed above now involved, or has ever been involved, in the ownership, development, or management of another health care facility or program? If yes, provide a listing of each facility or program, including facility name, address, and dates of involvement.

Response: Neither Ms. Raimi-Abayomi nor FHC has had any involvement in the ownership, development, or management of any other health care facility or program.

3. Has the Maryland license or certification of the applicant home health agency, or any of the facilities or programs listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner, or other person responsible for implementation of the Project was not involved with the facility or program at the time a suspension, revocation, or disciplinary action took place, indicated in the explanation.

Response: Neither Ms. Raimi-Abayomi nor FHC has had their licenses suspended or revoked, nor have they been subject to any disciplinary action (such as a ban on admission) in the last 10 years.

4. **Is any facility or program with which the applicant is involved, or has any facility or program with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility or program. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility or program, and any final disposition reached by the applicable governmental authority.**

Response: Neither Ms. Raimi-Abayomi nor FHC has ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services, which have led to an action to suspend, revoke, or limit the licensure or certification at any facility or program. Furthermore, neither has ever been found non-compliant with any state or federal requirements for the provision of, the quality of, or the payment for health care services, resulting in actions that could lead to penalties, admission bans, probationary status, or other sanctions.

5. **Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or program or any health care facility or program listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).**

Response: Neither Ms. Raimi-Abayomi nor FHC has ever pled guilty to or been convicted of any criminal offense related to the ownership, development, or management of the applicant facility or program.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed home health agency service.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

1/5/2026
Date

Abusolyrorah Abayomi
Signature of Owner or
Authorized Agent of the Applicant

PART IV: HOME HEALTH AGENCY APPLICATION: CHARTS AND TABLES SUPPLEMENT

Table 1 - Project Budget

Table 2a: Statistical Projections – For HHA Services In Maryland

Table 2b: Statistical Projections – For Proposed Jurisdictions

Table 3: Revenues And Expenses - For HHA Services In Maryland

Table 4: Revenues And Expenses - Proposed Project

Table 5: Staffing Information

TABLE 1: PROJECT BUDGET

Instructions: All estimates for 1a- d; 2a- f; and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. Inflation from date of submission of project completion should only be included on the Inflation line 1e. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. USE OF FUNDS	
1. CAPITAL COSTS (if applicable):	
a. New Construction	
1) Building	
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc.)	
a. SUBTOTAL New Construction	
b. Renovations	
1) Building	
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc.)	
b. SUBTOTAL Renovations	
c. Other Capital Costs	
1) Movable Equipment	$20,000
2) Contingency Allowance	
3) Gross Interest During Construction	
4) Other (Specify)	
c. SUBTOTAL Other Capital Cost	*$20,000*
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	**$20,000**
Non-Current Capital Cost	
d. Land Purchase Cost or Value of Donated Land	
e. Inflation (state all assumptions, including time period and rate	
TOTAL PROPOSED CAPITAL COSTS (sum of a - e)	**$20,000**
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	
b. Bond Discount	
c. CON Application Assistance	
c1. Legal Fees	
c2 Other (Specify and add lines as needed)	
d. Non-CON Consulting Fees	
d1. Legal Fees	
d2. Other (Specify and add lines as needed)	
e. Debt Service Reserve Fund	
f. Other (Specify)	

TOTAL (a - e)	
3. WORKING CAPITAL STARTUP COSTS	**$270,587**
TOTAL USES OF FUNDS (sum of 1 - 3)	**$290,587**

B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	$290,587
2. Pledges: Gross _____, less allowance for uncollectable _____= Net	
3. Gifts, bequests	
4. Authorized Bonds	
5. Interest income (gross)	
6. Mortgage	
7. Working capital loans	
8. Grants or Appropriation	
a. Federal	
b. State	
c. Local	
9. Other (Specify)	
TOTAL SOURCES OF FUNDS (sum of 1-9)	**290,587**

ANNUAL LEASE COSTS (if applicable)	
• Land	N/A
• Building	$4,771
• Moveable equipment	N/A
• Other (specify)	N/A

TABLE 2A: STATISTICAL PROJECTIONS – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND

Instructions: Table 2A applies to an applicant that is an existing home health agency and should be completed showing historic and projected utilization *for all home health agency services provided in Maryland*.

Table should report an *unduplicated count of clients* and should indicate whether the reporting period is Calendar Year (CY) or Fiscal Year (FY).

Response: Table 2A is not applicable. FHC is not an existing HHA.

Metric	Two Most Current Actual Years		Projected years – ending with first year at full utilization			
Calendar Year	CY2023	CY2024	CY2027	CY2028	CY2029	CY2030
Client Visits						
Billable						
Non-Billable						
TOTAL						
# of Clients and Visits by Discipline						
Total Clients (Unduplicated Count)						
Skilled Nursing Visits						
Home Health Aide Visits						
Physical Therapy Visits						
Occupational Therapy Visits						
Speech Therapy Visits						
Medical Social Services Visits						
Other Visits (Please Specify)						

TABLE 2B: STATISTICAL PROJECTIONS - PROJECTED HOME HEALTH AGENCY SERVICES IN THE PROPOSED PROJECT

Instructions: All applicants should complete Table 2B for the proposed project, showing projected utilization *only for the jurisdiction(s) which is the subject of the application*. **As in Table 2A above, this table should report an unduplicated count of clients, and should indicate whether the reporting period is Calendar Year (CY) or Fiscal Year (FY).**

Response: The table below shows projected unduplicated HHA clients and client visits for the first three project years.

Metric	Projected years ending with first year at full utilization			
Calendar Year	**CY2027**	**CY2028**	**CY2029**	**CY2030**
Client Visits				
Billable	3,155	4,486	5,818	6,627
Non-Billable	91	129	167	190
TOTAL	**3,245**	**4,615**	**5,985**	**6,817**
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	**199**	**283**	**367**	**418**
Skilled Nursing Visits	1,235	1,757	2,278	2,595
Home Health Aide Visits	133	189	245	279
Physical Therapy Visits	419	596	773	880
Occupational Therapy Visits	1,268	1,803	2,338	2,663
Speech Therapy Visits	79	113	146	167
Medical Social Services Visits	20	29	38	43
Other Visits (Non-Billable)	91	129	167	190

TABLE 3: REVENUES AND EXPENSES – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND (INCLUDING PROPOSED PROJECT)

Instructions: an existing home health agency must complete Table 3, showing historic and projected revenues and expenses for all home health agency services provided *in Maryland.*

Projections should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application.

Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).

Response: FHC is not an existing HHA in Maryland. Table 3 is therefore not applicable.

Metric	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
Calendar Year	CY2023	CY2024	CY2025	CY2027	CY2028	CY2029	CY2030
1. Revenue							
Gross Patient Service Revenue							
Allowance for Bad Debt							
Contractual Allowance							
Charity Care							
Net Patient Services Revenue							
Other Operating Revenues (Specify)							
Net Operating Revenue							
2. Expenses							
Salaries, Wages, and Professional Fees, (including fringe benefits)							
Contractual Services (please specify)							
Interest on Current Debt							
Interest on Project Debt							
Current Depreciation							
Project Depreciation							
Current Amortization							
Project Amortization							
Supplies							
Other Expenses (Specify)							
Total Operating Expenses							
3. Income							
Income from Operation							
Non-Operating Income							

Metric	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
Calendar Year	**CY2023**	**CY2024**	**CY2025**	**CY2027**	**CY2028**	**CY2029**	**CY2030**
Subtotal							
Income Taxes							
Net Income (Loss)							
4A. - Payor Mix as Percent of Total Revenue							
Medicare							
Medicare Advantage							
Medicaid							
Medicaid MCO							
Blue Cross							
Commercial Insurance							
Self-Pay							
Other (Specify)							
TOTAL REVENUE	100%	100%	100%	100%	100%	100%	100%
4B. Payor Mix as a Percent of Total Visits							
Medicare							
Medicare Advantage							
Medicaid							
Medicaid MCO							
Blue Cross							
Other Commercial Insurance							
Self-Pay							
Other (Specify)							
TOTAL VISITS	100%	100%	100%	100%	100%	100%	100%

NOTE: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS.

TABLE 4: REVENUES AND EXPENSES – PROJECTED HOME HEALTH AGENCY SERVICES FOR PROPOSED PROJECT

Instructions: Complete Table 4 for the proposed project, showing projected revenues and expenses *for only the jurisdiction(s) which is the subject of the application*.

Projections should be presented in current dollars. Medicaid revenues for all years should be calculated based on Medicaid rates and ceilings in effect at the time of submission of this application.

Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).

Response: The table below includes projected HHA revenues and expenses for the first three project years ending in 2030.

Metric	Projected Years (ending with first full year at full utilization)			
Calendar Year	**CY2027**	**CY2028**	**CY2029**	**CY2030**
1. Revenue				
Gross Patient Service Revenue	$835,169	$1,189,500	$1,538,680	$1,757,680
Allowance for Bad Debt	$20,879	$29,738	$38,467	$43,942
Contractual Allowance	$83,517	$118,950	$153,868	$175,768
Charity Care	$3,633	$5,174	$6,693	$7,646
Net Patient Services Revenue	$726,597	$1,034,865	$1,338,652	$1,529,182
Other Operating Revenues (Specify)	-	-	-	-
Net Operating Revenue	$726,597	$1,034,865	$1,338,652	$1,529,182
2. Expenses				
Salaries, Wages, and Professional Fees, (including fringe benefits)	$565,036	$817,310	$927,925	$993,611
Contractual Services (please specify)	-	-	-	-
Interest on Current Debt	$634	$1,045	$1,470	$1,802
Interest on Project Debt	-	-	-	-
Current Depreciation	-	-	-	-
Project Depreciation	$2,857	$2,857	$2,857	$2,857
Current Amortization	-	-	-	-
Project Amortization	-	-	-	-
Supplies	$14,401	$20,480	$26,559	$30,249
Other Expenses (See assumptions)	$120,945	$181,819	$233,535	$270,134
Total Operating Expenses	$703,872	$1,023,511	$1,192,346	$1,298,655
3. Income				
Income from Operation	$22,725	$11,355	$146,306	$230,527
Non-Operating Income	$0	$0	$0	$0
Subtotal	$22,725	$11,355	$146,306	$230,527
Income Taxes	$0	$0	$0	$0
Net Income (Loss)	$22,725	$11,355	$146,306	$230,527

Metric	Projected Years (ending with first full year at full utilization)			
Calendar Year	**CY2027**	**CY2028**	**CY2029**	**CY2030**
4A. - Payor Mix as Percent of Total Revenue				
Medicare	72.67%	72.72%	72.83%	72.77%
Medicare Advantage	15.05%	14.95%	14.91%	14.85%
Medicaid	1.47%	1.52%	1.46%	1.58%
Medicaid MCO	1.81%	1.80%	1.80%	1.89%
Blue Cross	0.00%	0.00%	0.00%	0.00%
Commercial Insurance	7.49%	7.46%	7.46%	7.39%
Self-Pay	0.00%	0.04%	0.03%	0.02%
Other (Specify)	1.51%	1.51%	1.51%	1.50%
TOTAL REVENUE	100.00%	100.00%	100.00%	100.00%
4B. Payor Mix as a Percent of Total Visits				
Medicare	65.65%	65.72%	65.84%	65.80%
Medicare Advantage	18.81%	18.67%	18.61%	18.58%
Medicaid	1.94%	2.00%	1.95%	2.01%
Medicaid MCO	2.38%	2.38%	2.38%	2.38%
Blue Cross	0.00%	0.00%	0.00%	0.00%
Other Commercial Insurance	9.31%	9.29%	9.30%	9.30%
Self-Pay	0.00%	0.04%	0.03%	0.03%
Other (Specify)	1.91%	1.89%	1.89%	1.90%
TOTAL VISITS	100.00%	100.00%	100.00%	100.00%

TABLE 5: STAFFING INFORMATION

Instructions: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours. NOTE: PROVIDE A TABLE 5 FOR EACH PROJECTED YEAR.

Response: FHC is not an existing HHA in Maryland. See the assumptions in the following pages for the methodology used to estimate salaries, FTEs, and benefits. Note that payroll taxes are included in Other Expenses.

Year 1: 2027

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	2.50	-	$82,000	-	$205,000	-
Registered Nurse	-	-	1.06	-	$80,000	-	$84,470	-
Licensed Practical Nurse	-	-	0.28	-	$65,000	-	$18,468	-
Physical Therapist	-	-	0.36	-	$75,000	-	$27,000	-
Occupational Therapist	-	-	1.06	-	$75,000	-	$79,500	-
Speech Therapist	-	-	0.08	-	$75,000	-	$6,000	-
Home Health Aide	-	-	0.17	-	$40,000	-	$6,800	-
Medical Social Worker	-	-	0.06	-	$90,000	-	$5,400	-
Other (Please specify.)	-	-	0.25	-	$85,000	-	$21,250	-
						Benefits	$68,083	
						TOTAL	**$521,971**	

***** Indicate method of calculating benefits cost

Year 2: 2028

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	4.00	-	$82,000	-	$328,000	-
Registered Nurse	-	-	1.50	-	$80,000	-	$119,771	-
Licensed Practical Nurse	-	-	0.40	-	$65,000	-	$26,186	-
Physical Therapist	-	-	0.52	-	$75,000	-	$39,000	-
Occupational Therapist	-	-	1.51	-	$75,000	-	$113,250	-
Speech Therapist	-	-	0.12	-	$75,000	-	$9,000	-
Home Health Aide	-	-	0.24	-	$40,000	-	$9,600	-
Medical Social Worker	-	-	0.08	-	$90,000	-	$7,200	-
Other (Please specify.)	-	-	0.25	-	$85,000	-	$21,250	-
						Benefits	$100,989	
						TOTAL	**$774,246**	

***** Indicate method of calculating benefits cost

Year 3: 2029

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	4.00	-	$82,000	-	$328,000	-
Registered Nurse	-	-	1.95	-	$80,000	-	$155,702	-
Licensed Practical Nurse	-	-	0.52	-	$65,000	-	$34,042	-
Physical Therapist	-	-	0.67	-	$75,000	-	$50,250	-
Occupational Therapist	-	-	1.95	-	$75,000	-	$146,250	-
Speech Therapist	-	-	0.15	-	$75,000	-	$11,250	-
Home Health Aide	-	-	0.32	-	$40,000	-	$12,800	-
Medical Social Worker	-	-	0.11	-	$90,000	-	$9,900	-
Other (Please specify.)	-	-	0.25	-	$85,000	-	$21,250	-
						Benefits	$115,417	
						TOTAL	**$884,861**	

***** Indicate method of calculating benefits cost

Year 4: 2030

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	4.00	-	$82,000	-	$328,000	-
Registered Nurse	-	-	2.21	-	$80,000	-	$177,135	-
Licensed Practical Nurse	-	-	0.60	-	$65,000	-	$38,728	-
Physical Therapist	-	-	0.76	-	$75,000	-	$57,000	-
Occupational Therapist	-	-	2.22	-	$75,000	-	$166,500	-
Speech Therapist	-	-	0.17	-	$75,000	-	$12,750	-
Home Health Aide	-	-	0.36	-	$40,000	-	$14,400	-
Medical Social Worker	-	-	0.12	-	$90,000	-	$10,800	-
Other (Please specify.)	-	-	0.25	-	$85,000	-	$21,250	-
						Benefits	$123,984	
						TOTAL	**$950,547**	

***** Indicate method of calculating benefits cost

FINANCIAL ASSUMPTIONS

Project Budget Assumptions (Table 1)

1. Fixed Capital Costs

Movable Equipment: $20,000 for office furniture, computer equipment, and other fixtures required to establish the HHA administrative operations. This includes desks, chairs, filing systems, computers, printers, and other standard office equipment. The equipment will be depreciated over a 7-year useful life using straight-line depreciation ($2,857 annually).

2. Project Timeline And Service Commencement

The HHA is projected to begin operations in January 2027, with Medicare/Medicaid (CMS) certified services commencing in April 2027 following completion of the Medicare certification survey process. This three-month certification period is reflected in the working capital projections, with non-CMS revenue (Medicare Advantage, Insurance, Self-Pay, Other) beginning in January 2027 and CMS revenue (Medicare FFS, Medicaid) starting in June 2027.

Revenue Timing:

Revenue Source	Year 1 Amount	Service Start	Months of Revenue
CMS Revenue	661,227	Apr-27	7 months (Jun-Dec)
Non-CMS Revenue	65,370	Jan-27	12 months (Jan-Dec)
Total Year 1 Net Revenue	726,597		

3. Expense Timing And CMS Visit Ratio

Operating expenses in the monthly cash flow model are adjusted to reflect the delayed start of CMS services. During January-March 2027 (prior to Medicare certification), expenses are scaled to reflect only non-CMS visit volume. Beginning in April 2027, full operating expenses are incurred as CMS services commence. CMS revenue is delayed until June 2027.

Year 1 Visit Distribution:

Billable Visit Type	Visits	% of Total
CMS Visits (Medicare/Medicaid)	2,794	89%
Non-CMS Visits	353	11%
Total Year 1 Visits (Billable)	3,147	

Note: 3,155 versus 3,147 is a rounding difference due to distributing visits by payer and discipline.

4. Start-Up Expenses

Start-up expenses represent pre-opening costs incurred prior to service commencement. These costs are incurred in the month before operations begin (December 2026) and include:

- **Salaries, Benefits, and Payroll Taxes:** Two weeks (0.5 months) of Year 1 projected compensation to cover staff orientation, training, and onboarding prior to service commencement.
- **Marketing:** $10,000 initial marketing investment to support referral source development and community outreach prior to launch.
- **Travel, Medical Supplies, IT, Training, Insurance, Rent, Telecom, Payroll Processing, Other Indirect:** One month of Year 1 projected expenses for each category to establish operations.
- **Total Start-up Expenses:** $17,785

5. Working Capital Methodology

Working capital requirements are estimated using a monthly cash flow projection for the first three years of operations. The model calculates monthly cash inflows (receipts) and outflows (operating expenses) to determine cumulative cash flow and the maximum funding requirement. Key assumptions:

- **Cash Receipts:** Assumes 45-day accounts receivable collection period. Cash receipts lag revenue recognition by approximately 1.5 months, with 50% of prior month revenue collected in the current month.
- **Cash Disbursements:** Operating expenses are paid monthly. During January-March 2027 (pre-CMS certification), monthly expenses reflect only non-CMS visit volume (11.2% of full operations). Beginning April 2027, full monthly operating expenses are incurred.
- **Revenue Recognition:** Non-CMS revenue ($5,448/month) begins January 2027. CMS revenue is added in June 2027, bringing total monthly revenue to approximately $99,908/month for the remainder of Year 1.

6. Working Capital Requirement

The working capital requirement is determined by the maximum cumulative cash flow deficit during the projection period. This represents the peak funding needed before the agency achieves positive cumulative cash flow.

Working Capital Summary:

Max Cumulative Cash Flow Deficit (Working Capital) *includes $17,785 of startup expenses*	$270,586.92
Months to Positive Cash Flow	8
Fixed Capital Cost (FF&E)	$20,000.00
Total Project Cost (Capital + Working Capital)	$290,586.92

7. Source Of Funds

The total project cost of $290,587 (fixed capital of $20,000 plus working capital of $270,587) will be funded entirely from FHC's existing cash reserves. No debt financing is required for this project. The agency is projected to achieve positive monthly cash flow by Month 8 (August 2027) of operations.

8. Annual Lease Costs

Annual lease costs are projected.

Lease Category	Annual Cost	Notes
Land	$0	N/A
Building	$4,556	*Equal to HHA rent expense (Year 1)*
Moveable Equipment	$0	None
Other	$0	N/A

Note that the Rent expense is allocated between the HHA and the RSA and increases through the project years as the HHA volume increases relative to the RSA volume. Total rent is $20,253, and the HSA allocation increases from $4,556 to $12,960 from Year 1 to Year 4.

Proposed Revenue Assumptions (Table 4)

1. Payor Mix

Payor mix percentages are derived from the Maryland Health Care Commission (MHCC) Home Health Agency Annual Survey, Fiscal Year 2023, Table 19: Total Number of Home Health Visits by Jurisdiction of Residence, Payment Source and Geographic Region. Jurisdiction-specific data was used for each service area:

Jurisdiction	Medicare	MC Advantage	Medicaid	Medicaid MCO
Anne Arundel	73.2%	12.0%	2.0%	2.0%
Montgomery	67.3%	18.1%	2.0%	2.0%
Prince George's	57.2%	26.3%	2.0%	2.5%
Southern (Calvert, Charles, St. Mary's)	74.3%	8.9%	2.0%	3.4%

Adjustment: Medicaid (traditional and managed care) percentages were adjusted upward (to at least 2%) from the raw MHCC survey data to reflect anticipated market positioning and community need focus. The offsetting adjustments were applied to the Insurance category.

2. Medicare Reimbursement

Medicare reimbursement is calculated using CMS CY 2026 Home Health Prospective Payment System (HH PPS) rates (see following pages for support) with jurisdiction-specific wage index adjustments.

Key Assumptions:

Assumption	Value	Source / Rationale
Average Case-Mix Weight	1.0	Conservative assumption; no acuity adjustment applied
Avg Visits per 30-Day Period	7.41	Based on analysis of comparable HHA Medicare Cost Report data
LUPA Threshold	4	CMS CY 2026 HH PPS Final Rule
LUPA Visits per Period	3	Conservative estimate for LUPA periods
LUPA Percentage	10%	Industry benchmark; ~10% of periods fall below threshold
Inflation Adjustment		None Per MHCC requirements; projections in current dollars

30-Day Period Payment Rates by Jurisdiction:

Jurisdiction	Wage Index	CY 2026 Base Payment	Source
Anne Arundel	0.9508	$1,963.11	CMS HH PPS Wage Index File; CBSA 12580
Montgomery	0.9736	$1,997.92	CMS HH PPS Wage Index File; CBSA 47900
Prince George's	1.0737	$2,150.73	CMS HH PPS Wage Index File; CBSA 47900
Southern	0.9759	$2,001.43	Avg of Calvert, Charles, St. Mary's; CBSA 47900

Rate Calculation Methodology:

The CY 2026 30-day period payment is calculated using the CMS Home Health PPS wage-adjusted methodology:

Step	Calculation	Example (Anne Arundel)
1	National Base Rate × Case-Mix Weight	$2,038.22 × 1.0 = $2,038.22
2	Labor Portion = Step 1 × 74.9%	$2,038.22 × 0.749 = $1,526.63
3	Wage-Adj Labor = Step 2 × Wage Index	$1,526.63 × 0.9508 = $1,451.52
4	Non-Labor Portion = Step 1 × 25.1%	$2,038.22 × 0.251 = $511.59
5	Final Payment = Step 3 + Step 4	$1,451.52 + $511.59 = $1,963.11

Key Parameters:

- National Base Rate: $2,038.22
- Labor Share: 74.9%
- Non-Labor Share: 25.1%

Source: CMS-1828-F, Federal Register Vol. 90, No. 229, December 2, 2025.

3. Lupa & Non-Medicare Per-Visit Rates

LUPA per-visit rates are derived from CMS Table 16 and adjusted for the wage index. These rates are also used for Medicare Advantage, Insurance, Self-Pay, and Other.

LUPA Per-Visit Rates by Jurisdiction:

Discipline	Anne Arundel	Montgomery	Prince George's	Southern
Skilled Nursing	$170.44	$173.46	$186.73	$173.77
Home Health Aide	$77.17	$78.54	$84.54	$78.67
Physical Therapy	$186.29	$189.60	$204.10	$189.93
Occupational Therapy	$187.56	$190.89	$205.49	$191.22
Speech Therapy	$202.50	$206.09	$221.86	$206.45
Medical Social Services	$273.19	$278.03	$299.30	$278.52

Source: CMS Table 16 - Per-Visit Rates, wage-adjusted using the same methodology as 30-day rates above.

4. Medicaid Reimbursement

Medicaid per-visit rates are based on Maryland Medicaid fee schedules effective January 1, 2025 (see following pages for support), which vary by county. For the Southern region (Calvert, Charles, St. Mary's), an average of the three county rates is used.

Medicaid Per-Visit Rates by Jurisdiction:

Discipline	Anne Arundel	Montgomery	Prince George's	Southern (Avg)
Skilled Nursing	$155.27	$170.45	$170.45	$175.56
Home Health Aide	$75.32	$82.70	$82.70	$81.87
Physical Therapy	$167.89	$184.33	$184.33	$186.19
Occupational Therapy	$171.51	$184.33	$184.33	$186.57
Speech Therapy	$168.59	$184.88	$184.88	$188.63
Medical Social Services	N/A	N/A	N/A	N/A

Note: Medicaid Managed Care (MCO) visits are reimbursed at the same rates as Traditional Medicaid.

5. Visit Distribution By Discipline

Visits are distributed by discipline based on the utilization methodology detailed in Step 8, Table P of the Forecast Utilization section (COMAR 10.24.01.08G(3)(b), "Need" Review Criterion). The discipline mix reflects typical home health agency service patterns, with Skilled Nursing and Occupational Therapy comprising the majority of visits:

Representative Discipline Mix:

Discipline	% of Total Visits
Skilled Nursing	39.2%
Home Health Aide	4.2%
Physical Therapy	13.3%
Occupational Therapy	40.2%
Speech Therapy	2.5%
Medical Social Services	0.6%

This discipline distribution is applied consistently across all payer categories within each jurisdiction.

6. Revenue Deductions

Revenue deductions from Gross Patient Service Revenue are calculated as follows:

Deduction	% of Gross Revenue	Basis
Bad Debt Allowance	2.5%	% of Gross Revenue; conservative estimate based on industry experience and analysis of Medicare Cost Reports
Contractual Allowance	10.0%	% of Gross Revenue; conservative estimate based on analysis of Medicare Cost Reports
Charity Care	0.5%	% of Net Revenue. Equivalent to existing agencies in the area per COMAR Section .08E

Note: Some home health agencies set Gross Revenue equal to Net Revenue with minimal contractual allowances. The conservative deductions shown reflect anticipated collection experience while ensuring compliance with charity care obligations equivalent to existing providers in the service area.

7. Revenue Summary By Year

Metric	Year 1 (2027)	Year 2 (2028)	Year 3 (2029)	Year 4 (2030)
Total Patients	199	283	367	418
Total Billable Visits	3,155	4,486	5,818	6,627
Total Visits	3,210	4,565	5,919	6,742
Gross Revenue	$835,169	$1,189,500	$1,538,680	$1,757,680
Net Patient Revenue	$726,597	$1,034,865	$1,338,652	$1,529,182

Revenue projections represent a ramp-up from initial operations (Year 1) to full utilization (Year 4), with visits and patients increasing proportionally across all four service jurisdictions.

Proposed Expense Assumptions (Table 4)

1. Cost Allocation Methodology

The applicant, First Healthcare Consultants Limited (FHC), operates an existing licensed Residential Service Agency (RSA) providing home care services in Maryland. Certain administrative and operational expenses are shared between the existing RSA operations and the proposed Home Health Agency (HHA). These shared expenses are allocated based on the ratio of projected HHA visits to total combined visits (RSA + HHA). As the HHA ramps up and RSA visits decrease, the HHA allocation percentage increases accordingly.

Allocation Calculation:

Metric	Year 1 (2027)	Year 2 (2028)	Year 3 (2029)	Year 4 (2030)
Projected HHA Visits	3,210	4,565	5,919	6,742
Projected RSA Visits	11,060	7,742	5,419	3,794
HHA Allocation Ratio	22.5%	37.1%	52.2%	64.0%

Expenses noted as "allocated" below use this visit-based ratio. Expenses are first scaled from FHC's 2024 actual costs to account for increased patient volume, then allocated to the HHA based on the ratios above.

2. Salaries, Wages, And Professional Fees (Including Fringe Benefits)

- **Salaries:** Based on the detailed staffing model presented in Table 5 - Staffing. Salary rates are derived from market data and FHC's existing compensation structure, with clinical positions (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Services, and Home Health Aides) and administrative positions compensated according to regional benchmarks and organizational pay scales.
- **FTEs:** Clinical full-time equivalents are calculated using a Maryland Statewide Productivity Model derived from the MHCC HHA Annual Survey FY2023 (Tables 9 & 11). For each discipline, projected visits are divided by the statewide visits-per-FTE-per-year benchmark: Skilled Nursing (923 visits/FTE), Physical Therapy (1,156 visits/FTE), Occupational Therapy (1,198 visits/FTE), Speech-Language Pathology (973 visits/FTE), Medical Social Work (352 visits/FTE), and Home Health Aide (773 visits/FTE). The RN/LPN breakdown within Skilled Nursing is allocated proportionally based on FTE distributions derived from analysis of Medicare Cost Reports of comparable agencies. Administrative staffing provides baseline support throughout the projection period.
- **Fringe Benefits:** Calculated at 15% of salaries, based on analysis of Medicare Cost Report data from comparable home health agencies. Benefits include health insurance, retirement contributions, paid time off, and other standard employee benefits.
- **Professional Fees:** Scaled 1.5x from FHC 2024 actual professional fees to account for Medical Director compensation, compliance consulting, and other professional services required for HHA operations. Annual amount of $43,064 applied consistently across all projection years.

3. Contractual Services

No contractual clinical services are projected. All patient care services will be provided by employed staff rather than contract labor.

4. Interest On Current Debt

FHC's existing annual interest expense of $2,817 is held flat and allocated to the HHA based on the visit ratio described above. No new debt is anticipated; the project will be funded from existing cash reserves.

5. Interest On Project Debt

None. The project will be funded entirely from FHC's existing cash reserves without incurring new debt.

6. Current Depreciation / Current Amortization

None. Existing RSA assets are not allocated to the proposed HHA.

7. Project Depreciation / Project Amortization

Based on $20,000 of furniture, fixtures, and equipment (FF&E) for the HHA with a 7-year useful life. Annual depreciation of $2,857 is calculated using straight-line depreciation. No project amortization is applicable.

8. Medical Supplies

Calculated at $4.49 per visit based on the average of Medicare Cost Report data from comparable Maryland home health agencies (Amedisys 2024: $5.48/visit; Interim Healthcare 2024: $3.36/visit; Chesapeake Home Health 2023: $4.62/visit). This rate is applied to total projected visits for each year.

9. Other Expenses

Other Expenses include the following categories:

- **Payroll Taxes:** Calculated at 7.65% of salaries (6.2% Social Security + 1.45% Medicare).
  Marketing: Scaled 1.5x from FHC 2024 actual marketing expense to support the new HHA launch, then allocated to the HHA based on the visit ratio. The increased budget supports referral source development and community outreach for the new service line. Note that $10k of marketing expense is including in the start-up period.
- **Auto/Travel:** Calculated at $5.78 per visit based on the Medicare Cost Report data from comparable Maryland home health agencies (Chesapeake Home Health 2023: $5.61/visit; Amedisys 2024: $3.43/visit). The highest was selected and inflated 3% to reflect FY2023 data. The rate accounts for the geographic spread across four jurisdictions (Anne Arundel, Montgomery, Prince George's, and Southern Maryland). A 3% annual inflation factor is applied to account for fuel and vehicle cost increases, but no inflation through the project years.

- **Information Technology:** Scaled 1.25x from FHC 2024 actual IT expense to support EMR/clinical software requirements for the HHA, then allocated based on the visit ratio. Includes electronic medical records system, point-of-care documentation tools, and OASIS assessment software required for Medicare-certified home health operations.
- **Training:** Scaled 2x from FHC 2024 actual training expense to account for the approximately doubled patient count across RSA and HHA operations. The full amount is assigned to the HHA to support clinical competency requirements, OASIS training, and Medicare compliance education for staff.
- **Insurance:** Scaled 1.75x from FHC 2024 actual insurance expense to account for increased professional liability/malpractice coverage required for skilled nursing and therapy services, then allocated based on the visit ratio.
- **Rent:** FHC's existing annual rent of $20,253 is held flat and allocated to the HHA based on the visit ratio. The HHA will share existing administrative office space with RSA operations.
- **Repairs and Maintenance:** FHC's existing annual repairs expense of $250 is held flat and assigned fully to the HHA as a conservative estimate for minor office equipment and facility maintenance.
- **Taxes (Non-Income):** FHC's existing annual business taxes of $1,035 are held flat and assigned fully to the HHA for business licenses and other non-income tax obligations.
- **Telecommunications:** Scaled 1.5x from FHC 2024 actual telecom expense to support additional phone lines and mobile devices for field staff, then allocated based on the visit ratio.
  Utilities: FHC's existing annual utilities expense of $1,567 is held flat and allocated to the HHA based on the visit ratio for shared office space.
- **Payroll Processing:** Calculated at 0.55% of salaries, based on FHC's 2024 actual payroll processing rate applied to projected HHA salaries.
- **Other Indirect Expenses:** Calculated at 1.97% of net revenue, based on FHC's 2024 actual rate. This category includes miscellaneous administrative expenses such as office supplies, postage, printing, bank fees, and other general operating costs.

10. Expense Summary By Year

Metric	Year 1 (2027)	Year 2 (2028)	Year 3 (2029)	Year 4 (2030)
Total Visits	3,210	4,565	5,919	6,742
Total Operating Expenses	$703,872	$1,023,511	$1,192,346	$1,298,655
Cost per Visit	$219.29	$224.23	$201.43	$192.62
Net Revenue	$726,597	$1,034,865	$1,338,652	$1,529,182
Operating Margin	$22,725	$11,355	$146,306	$230,527

Expense projections demonstrate operational efficiency gains as the HHA scales, with cost per visit decreasing from $219.29 in Year 1 to $192.62 in Year 4 at full utilization. The agency achieves positive operating margins in all projection years, with margins improving significantly as fixed costs are spread across higher visit volumes.

EXHIBITS

The following pages include all supporting documentation as referenced in the Application. For ease of use, Exhibits are independently page numbered beginning at 201.

Exhibit 1

MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality
55 Wade Avenue - Bland Bryant Building
Catonsville, MD 21228
410.402.8040

October 15, 2018

Abisola Raimi-Abayomi, Administrator
First Healthcare Consultants LTD
14000 Jericho Park Drive
Suite 2304
Bowie, MD 20715

RE: NOTICE OF COMPLIANCE WITH HEALTH COMPONENT REQUIREMENTS

Dear Mrs. Raimi-Abayomi:

We have reviewed and accepted the Plan of Correction received on October 5, 2018, as result of an initial survey conducted at your agency on August 9, 2018.

This survey found that your agency is in compliance with the health requirements for COMAR10.07.05 for a **Level Three: Complex Care Provided by RN/LPN and RN Supervision of Aides** Residential Service Agency (RSA). First Healthcare Consultants LTD will be issued the balance of the RSA license.

If you have any questions, please call me at (410) 402-8039.

Sincerely,

Michel Briggs

Michel Briggs, Program Coordinator
Ambulatory Care
Office of Health Care Quality

cc: Dawn Williams
Warren Sraver
File

PRINTED: 09/10/2018
FORM APPROVED

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RS4257	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST HEALTHCARE CONSULTANTS LTD	14000 JERICO PARK DRIVE SUITE 2304 BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Based upon an approved application for a Level Three: Skilled Nursing and Aides; Level of Care: Complex Care provided by Registered Nurses (RN)/Licensed Practical Nurses and RN supervision of Aides, an initial survey was conducted at First Healthcare Consultants LTD, on 08/09/18. The approved application included the agency's policy and procedure manual and submission of a signed affidavit affirming compliance with Code of Maryland Regulations (COMAR), 10.07.05. The survey included a tour of the agency's office, the review of personnel files, the review of patient records, the review of the complaint/incident process, the review of selected policies and procedures and interviews with the Governing Body (GB). A demonstration of complex care (wound dressing) was observed to evaluate the agency's Registered Nurse (RN) skills. The GB was kept informed of the findings as the survey progressed and was given the opportunity to present information relative to the findings during the course of the survey. The administrator was given the DHMH Financial Issue Form and information on how to complete the survey questionnaire using survey monkey. The financial issue form was completed and returned to this surveyor at the exit conference. An exit conference was conducted with the agency's administrator (AD) on 8/09/18. The survey findings were reviewed. The agency's level three license will be approved after an acceptable plan of correction has been received.	A 000	RECEIVED MARYLAND DEPT. OF HEALTH OCT – 5 2018 OFFICE OF HEALTH CARE QUALITY	

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Director of Nursing/CEO 9/30/18

STATE FORM 6599 11VG11 If continuation sheet 1 of 5

Office of Health Care Quality

SURVEY 09/10/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 000	Continued From page 1 The AD was directed to submit a written plan of correction within ten calendar days of receipt of the deficiency statement. The agency staff was informed that failure to submit an acceptable plan of correction could lead to the denial of licensure approval.	A 000		
A1000	.08 (B) (1) (e) .08 Administration. (e) Environment and safety, including: (i) Preparation and storage of enteral formulas, intravenous therapies, other supplies, equipment, and similar items; (ii) Infection control procedures; (iii) Disposal of biomedical waste; (iv) Maintenance of equipment; and (v) Emergency procedures. This Regulation is not met as evidenced by: Based upon direct observation, the agency's skilled nurse failed to practice infection control prevention strategies during a complex care procedure. Failure to ensure use of infection control measures placed agency patients at risk for not receiving safe quality healthcare. Findings included: Standard precautions are the most basic level of infection control and prevention that should be used at all times when providing patient care at any level. The elements of standard precautions includes hand hygiene, use of gloves, barriers (such as eye protection, face shields, gowns and a non- permeable barrier between surface and	A1000	1. Infection Control - a. Infection control training conducted and all staff re-educated on infection control process. Always use a protective barrier. b. Date 0of corrective action: 8/11/018 c. Director of Nursing 8/11/2018 d. Every employee, both current and new will have to go through an infection control training as part of the new employee orientation. With emphasis on the use of a protective barrier.	8/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1000	Continued From page 2 bags) and proper gathering and preparation of patient care equipment and linen. Standard infection control should be applied whenever providing care to protect the patient and caregiver against the spread of germs. During the procedure of cleaning a wound the registered nurse failed to apply any non-permeable barrier(If a membrane is non-permeable, it is respective of the chemical composition of the membrane itself and/or the mechanism of transfer. In other words, it is a barrier for which an object has no means of crossing,except with the aid of a transport mechanism) between the table and the nursing bag of supplies On 8/09/18, during an interview with the governing authority, the importance of practicing good infection control techniques were discussed.	A1000		
A1360	.12 (B)(1) .12 Services Provided B. Provision of Services. (1) A registered nurse shall assess each new client who requires skilled services and assistance with the activities of daily living. This Regulation is not met as evidenced by: Based on the review of patient records and interview with the agency's governing authority (GA), the registered nurse (RN) failed to develop a complete, initial comprehensive assessment (CA) of newly admitted patients. Findings included:	A1360	2. The initial assessment at time of survey was done on form 485 and the forms per approved policy. a. All patient assessments form documentation process has been changed to the approved form only. All staff in-serviced. b. In-service conducted on 8/11/2018. 8/11/18 c. Director of nursing and every RN. d. Chart review process to be implemented as part of the QI process	

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1360	Continued From page 3 Nursing assessment is the gathering of information about a patient's physiological, psychological, sociological, and spiritual status by a licensed RN. Nursing assessment is the first step in the nursing process. Nursing assessment is used to identify current and future patient care needs. It incorporates the recognition of normal versus abnormal body physiology. Prompt recognition of pertinent changes along with the skill of critical thinking allows the nurse to identify and prioritize appropriate interventions. To obtain a baseline of the patient's health status and to ensure safe, quality patient care, every newly admitted patient has to have a CA by the agency's RN. Patients' admitted to the agency for personal care services and complex care had no evidence that the agency's RN had completed a CA (no complete medication profile or past medical diagnosis). On interview, 8/09/18, the GA was unable to provide additional documentation.	A1360	3. One patient chart had discontinued medications listed. a. Staff in-serviced on data gathering and to always ask the patient what medications they are currently taking. Follow up with a phone call to the patient's PCP to verify. b. Date of corrective action: 8/11/2018. 8/11/18 c. Director of Nursing and all RN d. Chart review process to be implemented as part of the QI process.	
A1370	.12 (B)(2)(a) .12 Services Provided. (2) The registered nurse shall also: (a) Participate in developing the client's plan of care and in assigning appropriate personnel; This Regulation is not met as evidenced by: Based on review of patient records and interview with agency staff, there was no evidence that the agency's registered nurse (RN) developed patient care plans (PCP) for the aides prior to providing patient care for patients reviewed. Failure to develop written PCP's placed the patients at risk	A1370	4. Staff in-serviced on data gathering and care plan development for all patients even when there is only a skilled services provider to ensure continuity of care. a. Date of corrective action: 8/11/2018. 8/11/18 b. Director of Nursing and all RN. c. Chart review process to be implemented aspart of the QI proecess	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1370	Continued From page 4 for receiving inadequate care. Findings included: It is the responsibility of the agency's RN to assess each patient and to develop an individualized PCP, which contains the nursing assistant's/aide's work assignment (personal care tasks: bathing, feeding, dressing the patient, medication reminders, and assisting with ambulation/transfer) and other specific information of the patient's condition to ensure safe patient care. The written PCP has to be completed before the assistants/aides provide patient care and has to be available for the staff at the patient's home. Review, on 8/09/18, of patient records found the there was no evidence that a written PCP had been developed by the agency's RN. On interview, on 8/09/18, the Governing Authority was unable to provide additional documentation.	A1370		

STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

7120 SAMUEL MORSE DRIVE
SECOND FLOOR
COLUMBIA, MARYLAND 21046-3422

License No: R5352

Issued to: First Healthcare Consultants LTD
d/b/a Abidaref Regal Healthcare Solutions
12906 North Point Lane
Laurel, MD 20708

Type of Agency: **RESIDENTIAL SERVICE AGENCY**

Date Issued: January 4, 2023

Service(s) Provided: Skilled Nursing, Physical Therapy, Speech Therapy, Occupational Therapy, and Medical Social Services

Population: Adults and Pediatrics

Other: N/A

Authority to operate in this State is granted to the above entity pursuant to the Health-General Article, Section 19-4A et Seq., Annotated Code of Maryland and is subject to any and all statutory provisions including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration: NON-EXPIRING

Patricia Tomaka May MD

Executive Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

CHAP Community Health Accreditation Partner

Certificate of Accreditation

This is to certify that the following organization has met the requirements of the Community Health Accreditation Partner (CHAP) Standards of Excellence, and demonstrated a commitment to providing quality patient care and services.

First Healthcare Consultants Ltd
DBA: Abidaref Regal Healthcare Solution

Laurel, MD

is therefore granted accreditation for the following:

Home Care

Effective: November 29, 2022

Expiration: November 29, 2025

Nathan J. DeGodt
President and CEO, CHAP

COMMUNITY HEALTH ACCREDITATION PARTNER
CHAP
EST. 1965
SEAL OF ACCREDITATION

Cordt Kassner
Chair, CHAP Board of Directors

CHAP is an independent, nonprofit accrediting body for organizations providing home and community-based health care services in accordance with nationally recognized CHAP Standards of Excellence. Additional information regarding CHAP Accreditation and a listing of individual accredited organizations can be obtained by visiting www.CHAPinc.org.

Customer ID: 3006139

23

Exhibit 2

CORPORATE CHARTER APPROVAL SHEET

**** EXPEDITED SERVICE**** **** KEEP WITH DOCUMENT ****

DOCUMENT CODE 02 BUSINESS CODE 03

_____

Close _____ Stock / Nonstock _____

P.A. _____ Religious _____

Merging (Transferor) _____

1000362004075166

ID # D14954200 ACK # 1000362004075166
PAGES: 0002
FIRST HEALTHCARE CONSULTANTS LTD

11/26/2012 AT 03:36 P WO # 0004054791

Surviving (Transferee) _____

New Name _____

FEES REMITTED

	Base Fee:	100
	Org. & Cap. Fee:	20
	Expedite Fee:	~~50~~ 70
	Penalty:	
	State Recordation Tax:	
	State Transfer Tax:	
1	Certified Copies	2.1
	Copy Fee:	
	Certificates	
	Certificate of Status Fee:	
	Personal Property Filings:	
	Mail Processing Fee:	
	Other:	
	TOTAL FEES:	~~210~~ 211

Credit Card _____ Check / Cash ~~X~~

_____ Documents on _____ Checks

Approved By: JB 11/26/13

Keyed By: JB

COMMENT(S): Walk-IN

_____ Change of Name
_____ Change of Principal Office
_____ Change of Resident Agent
_____ Change of Resident Agent Address
_____ Resignation of Resident Agent
_____ Designation of Resident Agent and Resident Agent's Address
_____ Change of Business Code
_____ Adoption of Assumed Name
_____ Other Change(s)

Code _____

Attention: Abisola Laimo - Abayomi

X Mail: Name and Address
12620 Bear Creek Terrace,
Beltsville MD 20705

Stamp Work Order and Customer Number HERE

CUST ID:0002838211
WORK ORDER:0004054791
DATE:11-26-2012 03:36 PM
AMT. PAID:$211.00

ARTICLES OF INCORPORATION FOR A STOCK CORPORATION

FIRST: The undersigned Abisola Raimi-Abayomi and Christina Oliyide

whose address is 12906 North Point Lane Laurel MD/ 12620 Bear Creek Terrace B **, being at least eighteen years of age, do(es) hereby form a corporation under the laws of the State of Maryland.**

SECOND: The name of the corporation is
First Healthcare Consultants Ltd

THIRD: The purposes for which the corporation is formed are as follows:
Provider of Health care quality, risk management, health and safety services and training. Health education and corporate wellness services and programs. Procurement and contracting for medical equipments and Services for health care and health management. General healthcare training and nursing education.

FOURTH: The street address of the principal office of the corporation in Maryland is
12620 Bear Creek Terrace, Beltsville. MD. 20705

FIFTH: The name of the resident agent of the corporation in Maryland is
Abisola Raimi-Abayomi

whose address is 12906 North Point Lane, Laurel, MD. 20708

SIXTH: The corporation has authority to issue 100,000 **shares at $** 1.00 **par value per share.**

SEVENTH: The number of directors of the corporation shall be 2 **which number may be increased or decreased pursuant to the bylaws of the corporation. The name(s) of the director(s) who shall act until the first meeting or until their successors are duly chosen and qualified is/are** ~~Abisola Raimi-Abayomi~~
Christina Oliyide

IN WITNESS WHEREOF, I have signed these articles and acknowledge the same to be my act.

SIGNATURE(S) OF INCORPORATOR(S):

I hereby consent to my designation in this document as resident agent for this corporation.

SIGNATURE OF RESIDENT AGENT LISTED IN FIFTH:

Filing Party's Name and Return Address:

CUST ID:0002838211
WORK ORDER:0004054791
DATE:11-26-2012 03:36 PM
AMT. PAID:$211.00

Exhibit 3

First Healthcare Consultants HHA Staffing Structure

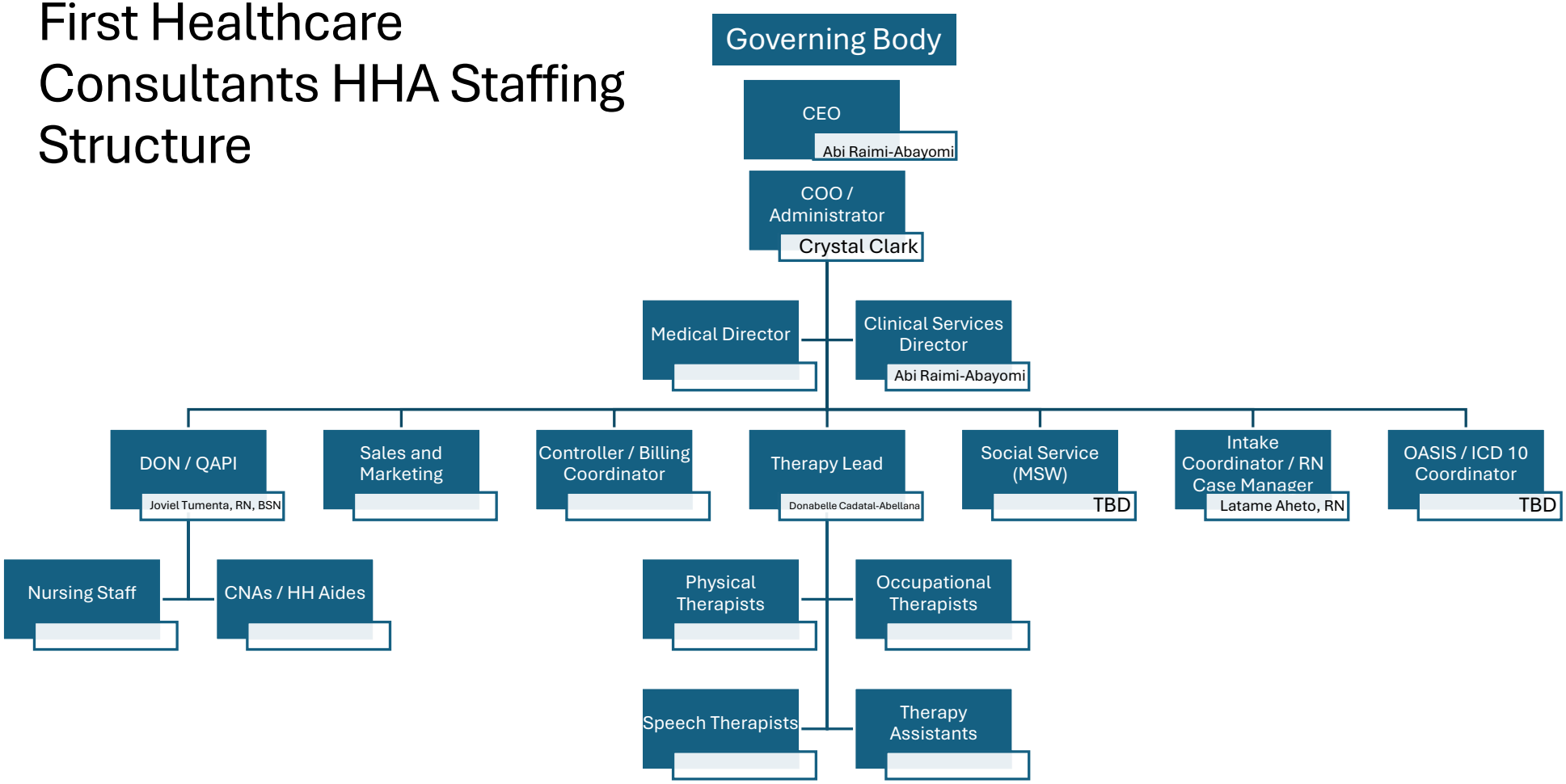


Exhibit 4

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located						FHC Established Link
		Anne Arundel	Mont-gomery	Prince Georges	Calvert	Charles	St. Marys	
Hospitals								
National Institutes of Health Clinical Center	10 Center Dr, Bethesda, MD 20892		x					
Suburban Hospital	8600 Old Georgetown Rd, Bethesda, MD 20814		x					X
Walter Reed National Military Medical Center	8901 Rockville Pike, Bethesda, MD 20889		x					X
Holy Cross Germantown Hospital	19801 Observation Dr, Germantown, MD 20876		x					X
MedStar Montgomery Medical Center	18101 Prince Philip Dr, Olney, MD 20832		x					
Adventist Healthcare Rehabilitation (Rockville)	9909 Medical Center Dr, Rockville, MD 20850		x					X
Adventist Healthcare Shady Grove medical Center	9901 Medical Center Dr, Rockville, MD 20850		x					X
Adventist HealthCare White Oak Medical Center	11890 Healing Way, Silver Spring, MD 20904		x					X
Holy Cross Hospital	1500 Forest Glen Rd, Silver Spring, MD 20910		x					X
Luminis Health Anne Arundel Medical Center	2001 Medical Pkwy, Annapolis, MD 21401	x						X
University of Maryland Baltimore Washington Medical Center	301 Hospital Dr, Glen Burnie, MD 21061	x						X
Gladys Spellman Speciality Hospital & Nursing Center	2900 Mercy Ln, Cheverly, MD 20785			x				X
MedStar Southern Maryland Hospital Center	7503 Surratts Rd, Clinton, MD 20735			x				X
Adventist HealthCare Fort Washington Medical Center	11711 Livingston Rd, Fort Washington, MD 20744			x				X
Luminis Health Doctors Community Medical Center	8118 Good Luck Rd, Lanham, MD 20706			x				X
University of Maryland Laurel Medical Center	901 Harry S Truman Dr N, Largo, MD 20774			x				X
UM Bowie Health Center	7150 Contee Rd, Laurel, MD 20707			x				X
UM Capital Region Medical Center (Largo)	15001 Health Center Dr, Bowie, MD 20716			x				X
Encompass Health Rehab Hospital of Bowie	17351 Melford Blvd, Bowie, MD 20715			x				X
University of Maryland Charles Regional Medical Center	5 Garrett Ave, La Plata, MD 20646					x		X
MedStar St. Mary's Hospital	25500 Point Lookout Rd, Leonardtown, MD 20650						x	X
CalvertHealth Medical Center	100 Hospital Rd, Prince Frederick, MD 20678				x			X
Hospice Programs								
Holy Cross Home Care and Hospice	10720 Columbia Pike, Silver Spring, MD 20901		x					X
Jewish Social Service Agency	6123 Montrose Rd, Rockville, MD		x					X
Montgomery Hospice Inc (Casey House)	6001 Muncaster Mill Rd, Rockville, MD 20855		x					X
Hospice of the Chesapeake	90 Ritchie Hwy, Pasadena, MD 21122	x						
Capital Caring Health	1801 McCormick Dr, Suite 180, Largo, MD 20774		x	x				
Heartland Hospice Services	4 E Rolling Crossroads, Suite 307, Catonsville, MD 21228			x				X
The Community Hospice of Maryland	11785 Beltsville Dr, Suite 1300, Beltsville, MD 20705			x				
Hospice of Charles County	2505 Davis Rd, Waldorf, MD 20603					x		
Hospice of St. Mary's	44724 Hospice Ln, Callaway, MD						x	
Calvert Hospice	4559 Sixes Road, Prince Frederick, MD 20678				x			
AccentCare Hospice & Palliative Care of Maryland (Greater Baltimore)	5457 Twin Knolls Rd, Suite 100, Columbia, MD 21045	x	x	x				
Nursing Homes (SNF)								
Althea Woodland Nursing Home	1000 Daleview Drive, Silver Spring, MD 20901		x					
Autumn Lake Healthcare at Arcola	901 Arcola Avenue, Silver Spring, MD 20902		x					
Bedford Court Healthcare Center	3701 International Drive, Silver Spring, MD 20906		x					
Bel Pre Health & Rehabilitation Center	2601 Bel Pre Road, Silver Spring, MD 20906		x					
Sterling Care Bethesda	5721 Grosvenor Lane, Bethesda, MD 20814		x					
Brighton Garden Tuckerman Lane	5550 Tuckerman Lane, North Bethesda, MD 20852		x					

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located						FHC Established Link
		Anne Arundel	Mont-gomery	Prince Georges	Calvert	Charles	St. Marys	
Brooke Grove Rehab. & Nursing Center	18131 Slade School Road, Sandy Spring, MD 20860		x					
Carriage Hill Bethesda	5215 Cedar Lane, Bethesda, MD		x					
Collingswood Rehabilitation & Healthcare	299 Hurley Avenue, Rockville, MD 20850		x					
Fairland Center	2101 Fairland Road, Silver Spring, MD 20904		x					X
Fox Chase Rehab & Nursing Center	2015 East-West Highway, Silver Spring, MD 20910		x					
Friends Nursing Home	17340 Quaker Lane, Sandy Spring, MD 20860		x					
Hebrew Home of Greater Washington	6121 Montrose Road, Rockville, MD 20852		x					
Kensington Nursing & Rehabilitation Center	3000 McComas Avenue, Kensington, MD 20895		x					
Layhill Center	3227 Bel Pre Road, Silver Spring, MD 20906		x					
Manorcare Health Services - Chevy Chase	8700 Jones Mill Road, Chevy Chase, MD 20815		x					
Manorcare Health Services - Wheaton	11901 Georgia Avenue, Wheaton, MD 20902		x					
Manorcare Health Services - Silver Spring	2501 Musgrove Road, Silver Spring, MD 20904		x					
Manorcare Health Services - Bethesda	6530 Democracy Boulevard, Bethesda, MD 20817		x					
Manorcare Health Services - Potomac	10714 Potomac Tennis Lane, Potomac, MD 20854		x					
Maplewood Park Place	9707 Old Georgetown Road, Bethesda, MD 20814		x					
Montgomery Village Health Care Center	19301 Watkins Mill Road, Gaithersburg, MD 20879		x					
The Village at Rockville	9701 Veirs Drive, Rockville, MD		x					
Cadia Healthcare - Wheaton	4011 Randolph Road, Wheaton, MD 20902		x					
Cadia Healthcare - Springbrook	12325 New Hampshire Avenue, Silver Spring, MD 20904		x					
Autumn Lake Healthcare at Oakview	2700 Barker Street, Silver Spring, MD 20910		x					
Potomac Valley Nursing & Wellness	1235 Potomac Valley Road, Rockville, MD 20850		x					
Rockville Nursing Home	303 Adclare Road, Rockville, MD		x					
Sanctuary at Holy Cross	3415 Greencastle Road, Burtonsville, MD 20866		x					
Shady Grove Center	9701 Medical Center Drive, Rockville, MD 20850		x					
Sligo Creek Center	7525 Carroll Avenue, Takoma Park, MD 20912		x					
Wilson Health Care Center	201 Russell Avenue, Gaithersburg, MD 20877		x					
Regency Care of Silver Spring, LLC	9101 Second Avenue, Silver Spring, MD 20901		x					
Ingleside at King Farm	701 King Farm Boulevard, Rockville, MD 20850		x					
Asbury Methodist Village – Wilson Health	301 Russell Ave, Gaithersburg, MD 20877		x					
Complete Care at Springbrook	12325 New Hampshire Avenue, Silver Spring, MD 20904		x					
Complete Care at Wheaton	4011 Randolph Road, Wheaton, MD 20902		x					
Autumn Lake Oak Manor	3415 Greencastle Road, Burtonsville, MD 20866		x					
Autumn Lake Healthcare at Crofton	2131 Davidsonville Road, Crofton, MD 21114	x						
Fairfield Nursing & Rehabilitation Center	1454 Fairfield Loop Rd, Crownsville, MD 21032	x						
Future Care Chesapeake	305 College Parkway, Arnold, MD	x						
Ginger Cove	4000 River Crescent Drive, Annapolis, MD 21401	x						
Autumn Lake Healthcare at Glen Burnie	7355 East Furnace Branch Road, Glen Burnie, MD 21060	x						
Hammonds Lane Center	613 Hammonds Ln, Brooklyn Park, MD 21225	x						
Marley Neck Health and Rehabilitation Center	7575 East Howard Road, Glen Burnie, MD 21060	x						
North Arundel Health and Rehabilitation Center	313 Hospital Dr, Glen Burnie, MD 21061	x						

Organation Name	Address	Jurisdiction Organization Located						FHC Established Link
		Anne Arundel	Mont-gomery	Prince Georges	Calvert	Charles	St. Marys	
Complete Care at Severna Park	310 Genesis Way, Severna Park, MD 21146	x						
South River Health & Rehabilitation Center	144 Washington Road, Edgewater, MD 21037	x						
Autumn Lake Healthcare at Spa Creek	35 Milkshake Lane, Annapolis, MD 21403	x						
Baywoods of Annapolis	7101 Bay Front Drive, Annapolis, MD 21403	x						
Autumn Lake Healthcare at Waugh Chapel	1221 Waugh Chapel Road, Gambrills, MD 21054	x						
Autumn Lake Healthcare at Baltimore Washington	313 Hospital Drive, Glen Burnie, MD 21061	x						
Complete Care of Annapolis	900 Van Buren Street, Annapolis, MD 21403	x						
Complete Care of Severna Park	310 Genesis Way, Severna Park, MD 21146	x						
Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road, Clinton, MD 20735			x				
Autumn Lake Healthcare at Cherry Lane	9001 Cherry Ln, Laurel, MD 20708			x				
Clinton Nursing & Rehabilitation Center	9211 Stuart Lane, Clinton, MD 20735			x				
Collington Episcopal Life Care	10450 Lottsford Road, Mitchellville, MD 20721			x				
Crescent Cities Center	4409 East West Highway, Riverdale, MD 20737			x				
Doctors Community Rehabilitation and Patient Care	6710 Mallery Drive, Lanham, MD 20706			x				
Forestville Health & Rehabilitation Center	7420 Marlboro Pike, Forestville, MD 20747			x				
Fort Washington Health & Rehabilitation Center	12021 Livingston Road, Fort Washington, MD 20744			x				
Future Care Pineview	9106 Pineview Lane, Clinton, MD			x				
Sterling Care Hillhaven	3210 Powder Mill Road, Adelphi, MD 20783			x				
Larkin Chase Center	15005 Health Center Drive, Bowie, MD 20716			x				
Manor Care Health Services - Hyattsville	6500 Riggs Road, Hyattsville, MD			x				
Manor Care Health Services - Largo	600 Largo Road, Glenarden, MD			x				
Manorcare Health System - Adelphi	1801 Metzerott Road, Adelphi, MD 20783			x				
Patuxent River Health and Rehabilitation Center	14200 Laurel Park Drive, Laurel, MD 20707			x				
Sacred Heart Home, Inc.	5805 Queens Chapel Road, Hyattsville, MD 20782			x				
St. Thomas More Medical Complex	4922 LaSalle Road, Hyattsville, MD 20782			x				
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road, Mitchellville, MD 20721			x				
Riderwood Village	3160 Gracefield Road, Silver Spring, MD 20904			x				
Complete Care at La Plata	1 Magnolia Dr, La Plata, MD 20646					x		
Restore Health Rehabilitation Center	4615 Einstein Place, White Plains, MD 20695					x		
Sagepoint Senior Living Services	10210 La Plata Rd, La Plata, MD					x		
Waldorf Center	4140 Old Washington Highway, Waldorf, MD 20602					x		
Charlotte Hall Veterans Home	29449 Charlotte Hall Rd, Charlotte Hall, MD 20622						x	
Chesapeake Shores	21412 Great Mills Drive, Lexington Park, MD 20653						x	
St. Mary's Nursing Center, Inc.	21585 Peabody St, Leonardtown, MD 20650						x	
Asbury Solomons Island	11100 Asbury Cir, Solomons, MD				x			
Calvert County Nursing Center	85 Hospital Rd, Prince Frederick, MD 20678				x			
Calvert Memorial Hospital Transitional Care Unit	100 Hospital Rd, Prince Frederick, MD 20678				x			
Solomons Nursing Center	13325 Dowell Rd, Solomons, MD				x			
CCRCs								
Asbury Methodist Village (Gaithersburg)	201 Russell Avenue, Gaithersburg, MD 20877		x					
Bedford Court (Silver Spring)	3701 International Drive, Silver Spring, MD 20906		x					
Brooke Grove (Sandy Spring)	18100 Slade School Road, Sandy Spring, MD 20860		x					
Friends House Retirement Community (Sandy Spring)	17340 Quaker Lane, Sandy Spring, MD 20860		x					

Organation Name	Address	Jurisdiction Organization Located						FHC Established Link
		Anne Arundel	Mont-gomery	Prince Georges	Calvert	Charles	St. Marys	
Maplewood Park Place (Bethesda)	9707 Old Georgetown Road, Bethesda, MD 20814		x					
Ingleside at King Farm (Rockville)	701 King Farm Boulevard, Rockville, Maryland 20850		x					
Riderwood Village (Silver Spring)	3150 Gracefield Road, Silver Spring, MD 20904		x					
The Village at Rockville (Rockville)	9701 Veirs Drive, Rockville, MD		x					
BayWoods of Annapolis (Annapolis)	7101 Bay Front Drive, Annapolis, MD 21403	x						
Ginger Cove – Annapolis Life Care (Annapolis)	4000 River Crescent Drive, Annapolis, MD 21401	x						
Collington Episcopal Life Care Community (Mitchellville)	10450 Lottsford Road, Mitchellville, MD 20721			x				
Asbury–Solomons Island (Solomons)	11100 Asbury Circle, Solomons, MD 20688				x			
Adult Evaluation and Review Services								
Montgomery County Dept. of Health & Human Services			x					x
Anne Arundel County Dept. of Aging & Disabilities		x						x
Prince George's County Health Department				x				x
Charles County Health Department						x		
St. Mary's County Health Department							x	
Calvert County Health Department					x			
Adult Day Care Programs								
CCACC Adult Day Healthcare Center			x					
Easterseals	1420 Spring Street, Silver Spring, MD 20910		x	x				
Holy Cross Adult Day Center	9805 Dameron Dr, Forest Glen, MD 20902		x					
Loving Care Adult Medical Day Care	17051 Oakmont Ave A, Gaithersburg, MD 20877		x					
Loving Heart Adult Day Care Center	400 East Gude Drive, Suite 100, Rockville, MD 20850		x					
Montgomery Adult Day Care	9123 Gaither Road, Gaithersburg, MD 20877		x					
Rainbow Center of Montgomery County	8400 Helgerman Court Gaithersburg, MD 20877		x					
Winter Growth Adult Day Program	18110 Prince Philip Drive, Olney, MD 20832		x					
Woods Adult Day Services	8227 Cloverleaf Drive, Suite 300, Millersville, MD 21108	x						
Active Day of Annapolis	2525 Riva Road, Suite 100, Annapolis, MD 21401	x						
Active Day of Pasadena	354 Mountain Road, Suite G, Pasadena, MD 21122	x						
Foundations Adult Medical Day Care	1025 W. Nursery Road, Suite 112, Linthicum, MD 21090	x						
Joseph A. Gilmore Sr Adult Day Care	608 Largo Road, Kettering, MD 20774			x				
Family Service Foundation	5301 76th Avenue, Hyattsville, MD 20784			x				
Helping Hands Adult Day Services	5400 Norfield Road, Capitol Heights, MD 20743			x				
Bella's Reserve Adult Medical Day Care	2120 Industrial Parkway, Silver Spring, MD 20904		x	x				
We Care Adult Services, Inc.	1717 Largo Road, Upper Marlboro, MD 20774			x				
Fenwick Landing Senior Care Community	11665 Doolittle Drive, Waldorf, MD 20602					x		
Sagepoint Senior Living Services (Senior Center Plus)	10200 La Plata Road, La Plata, MD 20646					x		
St. Mary's Adult Medical Day Care	24400 Mervell Dean Road, Hollywood, MD 20636						x	
Adult Day Care of Calvert County	975 SOLOMONS ISLAND ROAD, P.O.BOX 1659 PRINCE FREDERICK Maryland 20678				x			
Friendly Health Services	3720 Solomons Island Rd, Huntingtown, MD 20639				x			
Local Departments of Social Services								
Montgomery	401 Hungerford Drive, 5th Floor, Rockville, Maryland 20850		x					x
Anne Arundel	80 West Street. Annapolis, Maryland 21401	x						x
Prince George's	805 Brightseat Road, Landover, Maryland 20785-4723			x				x

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located						FHC Established Link
		Anne Arundel	Mont-gomery	Prince Georges	Calvert	Charles	St. Marys	
Charles	200 Kent Avenue, LaPlata, Maryland 20646					x		
St. Mary's	23110 Leonard Hall Dr, Leonardtown, MD 20650						x	
Calvert	200 Duke Street, Prince Frederick, Maryland 20678				x			
Home Delivered Meal Programs								
Montgomery County Senior Nutrition Program			x					
Meals on Wheels of Montgomery			x					
Dept. of Aging & Disabilities – Senior Nutrition		x						
Prince George's County Department of Family Services				x				x
Meals on Wheels Prince George's				x				
Meals on Wheels of College Park				x				
Charles County Aging & Senior						x		
Dept. of Aging & Human Services – Home Delivered Meals							x	
Calvert County Office on Aging – Meals Program					x			
Assisted Living Facilities								
Sunrise of Silver Spring	11621 New Hampshire Avenue, Silver Spring, MD 20904		x					
Brighton Gardens of Tuckerman Lane	5550 Tuckerman Lane, North Bethesda, MD 20852		x					
Asbury Methodist Village	201 Russell Avenue, Gaithersburg, MD 20877		x					
Bedford Court	3701 International Drive, Silver Spring, MD 20906		x					
The Village at Rockville	9701 Veirs Drive, Rockville, MD		x					
Brookdale Olney	2611 Olney Sandy Spring Road, Olney, MD 20832		x					
Arden Courts of Kensington	4301 Knowles Avenue, Kensington, MD 20895		x					
Brightview Annapolis	1935 Generals Highway, Annapolis, MD 21401	x						
Sunrise of Annapolis	800 Bestgate Road, Annapolis, MD 21401	x						
Celebration Villa of Manresa (formerly Atria)	85 Manresa Road, Annapolis, MD 21409	x						
Sunrise of Severna Park	43 West McKinsey Road, Severna Park, MD 21146	x						
Brightview South River	8 Lee Airpark Drive, Edgewater, MD 21037	x						
BayWoods of Annapolis	7101 Bay Front Drive, Annapolis, MD 21403	x						
Annapolitan Assisted Living	84 North Old Mill Bottom Road, Annapolis, MD 21409	x						
Tribute at Melford	17300 Melford Boulevard, Bowie, MD 20715			x				
Charter Senior Living of Bowie	7600 Laurel Bowie Road, Bowie, MD 20715			x				
Collington	10450 Lottsford Road, Mitchellville, MD 20721			x				
Morningside House of Laurel	7700 Cherry Lane, Laurel, MD 20707			x				
Birchwood Foundation	6212 Teaberry Way, Clinton, MD		x	x				
Arden Courts of Bowie	12900 Laurel Bowie Road, Bowie, MD 20715			x				
Harmony at Waldorf	11239 Berry Road, Waldorf, MD					x		
The Charleston Senior Community	45 St. Patrick's Drive, Waldorf, MD 20603					x		
Morningside House of St. Charles	70 Village Street, Waldorf, MD 20602					x		
Sagepoint Gardens Assisted Living	123 Morris Drive, La Plata, MD 20646					x		
Fenwick Landing Senior Care Community	11665 Doolittle Drive, Waldorf, MD 20602					x		
Cedar Lane Senior Living Community	22680 Cedar Lane Court, Leonardtown, MD 20650						x	
Discovery Commons at Wildewood	23185 Milestone Way, California, MD 20619						x	
Charlotte Hall Veterans Home	29449 Charlotte Hall Road, Charlotte Hall, MD 20622						x	
The Taylor Farm (Aaron House)	21748 Oscar Hayden Road, Bushwood, MD 20618						x	
Asbury Solomons	11100 Asbury Circle, Solomons, MD 20688				x			

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located						FHC Established Link
		Anne Arundel	Mont-gomery	Prince Georges	Calvert	Charles	St. Marys	
The Hermitage at St. John's Creek	13325 Dowell Road, Solomons, MD 20688				x			
Caribbean Breeze Assisted Living	255 Skinners Turn Road, Owings, MD 20736				x			

Exhibit 5

Kelly Ivey

Subject: FW: Fw: SCO Offices - Suite Available $650/Month - All Inclusive

To: abi.r@fheconsultantsus.com <abi.r@fheconsultantsus.com>
Cc: Sonya Washington <swashington@subercompany.com>; Natasha Suber <natasha.suber@subercompany.com>
Subject: SCO Offices - Suite Available $650/Month - All Inclusive

Good morning, Abi!

I hope all is well! It was a pleasure seeing you today! Below is a breakdown of what is included with our office suites. Also attached is our office rental application in case you decide you would like to submit an application.

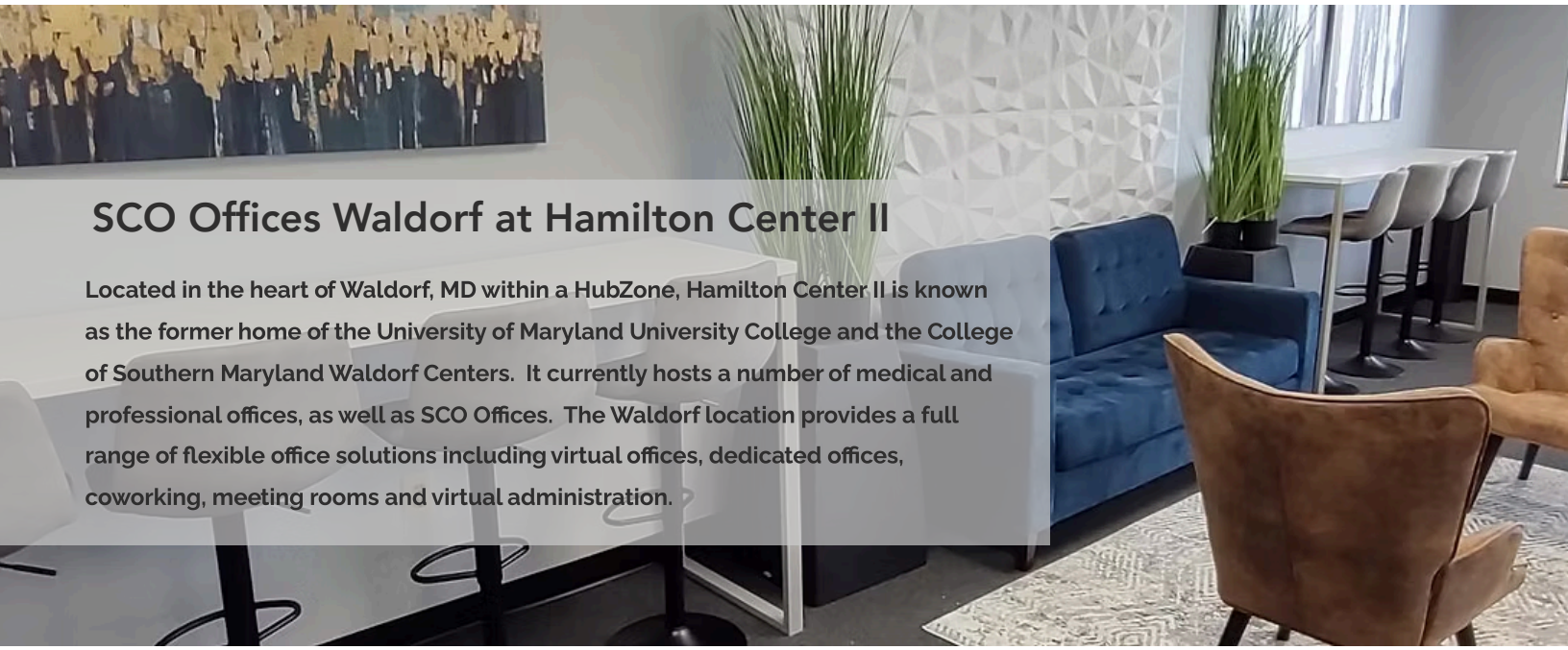
Amenities for All SCO Clients	Executive Suite Plan
• Live Front Desk Reception, Monday-Friday • Evening and Weekend Hours • On-Site Administrative Support • Free WiFi and Access to Printers/Scanners/Copiers • Access to Meeting Rooms, Private Offices, Hot Desks & Coworkspace • Complimentary Beverages and Access to Break Area Kitchenettes • Online Account Management and Room Booking • Opportunities for Networking and Resource Sharing • One of the friendliest and most professional front office teams in the industry!	**Rate: $650/Month** • Includes Business Address with Mail Service • Business Phone Line (Call Routing Available for Existing Phone Numbers) • Includes $160 Hours/Credits a Month of Meeting Room, Private Office and Co-Work Lounge • Includes 100 Prints/Copies a Month • Free WiFi & All Utilities Included • **24/7 Building and Suite Access** • All SCO Amenities

The office will be available January 5th, 2026. There is no security deposit required; however, a $325 nonrefundable office turnover fee applies. Lease terms are month-to-month, with 30 days' written notice required to terminate.

If you have any questions or concerns, please feel free to contact me or Sonya Washington.

Book Time on My Calendar
Book time with Jordyn Hawkins: 15 minutes meeting

**** If you have not done so, please register in the new SCO app, SCO Member Community. If you have any questions, please feel free to contact our team at 240-518-8016 or admin@subercompany.com. Thanks!!!**



SCO Offices Waldorf at Hamilton Center II

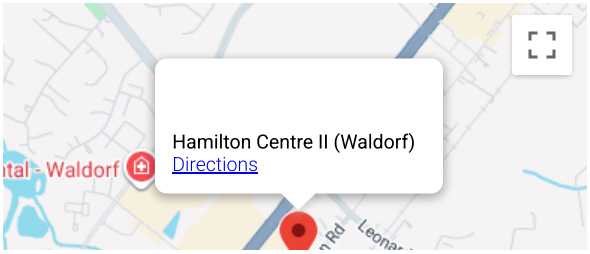
Located in the heart of Waldorf, MD within a HubZone, Hamilton Center II is known as the former home of the University of Maryland University College and the College of Southern Maryland Waldorf Centers. It currently hosts a number of medical and professional offices, as well as SCO Offices. The Waldorf location provides a full range of flexible office solutions including virtual offices, dedicated offices, coworking, meeting rooms and virtual administration.

Suber & Company - SCO Offices

Prime Hub Zone Location in the Heart of Waldorf

SCO members enjoy the following services and amenities at Hamilton Center II in Waldorf, MD.

- Prime HubZone Location
- Broad Range of Virtual Office Plans for Business Address & Mail Service; Phone Lines w/Unlimited Extensions, Conference & Fax; and Office and Meeting Room Hours
- CoWorkspace Plans with Unlimited Access to CoWork Lounge
- Full Service Private Offices, Cubicles and Desks with 24/7 Building Access (Mail Plan, Phone Plan and All Utilities Included)
- On-Site Reception & Administrative Support
- Access to Printers/Scanners/Copiers
- Meeting Room/Private Office Hours Included for all Service Plans
- Ample Free Parking & Free WiFi
- Break Area w/Complimentary Beverages
- On-Site Mailing & Office Supplies
- Online Account Management & Access to Local Resources
- One of the friendliest and most professional front office teams in the industry!



Sign Up Schedule Office Tour

3261 Old Washington Road, Ste 2031

Waldorf, MD 20602

(240) 518-8016

SCO Offices Waldorf Plans

Basic Membership Plan

Includes:

- Access to SCO Member Portal w/Newsfeed, Events, Resources, Training, Member Directory, Room Booking Calendars, & Member Shop.
- 2 CoWorkspace Day Passes each Month at Waldorf, MD Location

$25/Month

JOIN

Corporate Mail Service Plan

Includes:

- Basic Membership Benefits
- Physical Business Address
- Daily Mail Sorting
- Notification of Mail Receipt
- 2 Office/Meeting Room Credits/Hours each Month at Waldorf, MD Location - Credits can be Applied to Meeting Rooms, CoWork Lounge, and Private Offices.

$40/Month

JOIN

Office Hours Plan

Includes:

- Basic Membership Benefits
- 6 Office/Meeting Room Credits/Hours each Month at Waldorf, MD Location - Credits can be Applied to Meeting Rooms, CoWork Lounge, and Private Offices.

$60/Month

JOIN

Corporate Phone Service Plan

Includes:

- Basic Membership Benefits
- Local or Toll Free Number
- Unlimited Extensions
- Go-To Meetings, Fax & Conference Lines
- Call Forwarding & Follow-Me
- Voicemail and Faxes via Email
- 3 Office/Meeting Room Credits/Hours at Waldorf Loction
- Mobile/Desktop App (Additional Cost)

$60/Month

JOIN

Office Hours & Mail Service Plan

Includes:

- Basic Membership Benefits
- Corporate Mail Service Plan Services
- Phone Service Plan
- 8 Office/Meeting Room Credits/Hours - Credits can be Applied to Meeting Rooms, CoWork Lounge, and Private Offices.

$85/Month

JOIN

Business Start-Up Plan

Includes:

- Basic Membership Benefits
- Corporate Mail Plan
- Corporate Phone Service
- 3 Office/Meeting Room Credits/Hours each Month at Waldorf, MD Location - Credits can be Applied to Meeting Rooms, CoWork Lounge, and Private Offices.

$85/Month

JOIN

CoWorkspace Plan

Includes:

- Basic Membership Benefits
- Unlimited Use of the CoWorkspaces (During Reception Hours) at Waldorf, MD Location

$90/Month

JOIN

CoWorkspace with Mail Plan

Includes:

- Basic Membership Benefits
- Corporate Mail Service Plan
- Unlimited Use of the CoWorkspaces (During Reception Hours) at Waldorf, MD Location

$120/Month

JOIN

Hamilton Center II
3261 Old Washington Road, Suite 2031
Waldorf, MD 20602

Office/Fax: 240-518-8016
Email: admin@subercompany.com

Office Hours
Monday thru Tuesday - 9:30AM to 5:30PM
Wednesday thru Friday - 8:30AM to 5:30PM

Room Booking Hours
Monday thru Friday - 8:30AM to 8:30PM
Saturday - 9:00AM to 3:00PM

Contact Us

Locations

Waldorf, MD

More Locations
Coming Soon!

Information

FAQ
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Privacy Policy
Member Portal
Operator Portal
Affiliate Program
Are You An Operator?

Follow Us

** SCO now reports member accounts to Business Experian for business credit reporting.

Exhibit 6

Focus Area	Measure	Description	Weight	Source	Year(s)	Top Performers	US Overall
POPULATION HEALTH AND WELL BEING							
LENGTH OF LIFE							
Life span	Premature Death*	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	50%	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program	2020-2022	6,200	8,400
QUALITY OF LIFE							
Physical health	Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	10%	Behavioral Risk Factor Surveillance System	2022	3.6	3.9
	Low Birth Weight*	Percentage of live births with low birth weight (< 2,500 grams).	20%	National Center for Health Statistics - Natality Files	2017-2023	6%	8%
Mental health	Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	10%	Behavioral Risk Factor Surveillance System	2022	4.9	5.1
Life satisfaction	Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	10%	Behavioral Risk Factor Surveillance System	2022	14%	17%
COMMUNITY CONDITIONS							
HEALTH INFRASTRUCTURE							
Health promotion and harm reduction	Flu Vaccinations*	Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination.	4%	Mapping Medicare Disparities Tool	2022	54%	48%
	Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	4%	ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles	2024, 2022 & 2020	91%	84%
	Food Environment Index+	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	4%	USDA Food Environment Atlas; Map the Meal Gap from Feeding America	2019 & 2022	8.8	7.4
Clinical care	Primary Care Physicians	Ratio of population to primary care physicians.	2%	Area Health Resource File/American Medical Association	2021	1,030:1	1,330:1
	Mental Health Providers	Ratio of population to mental health providers.	1%	CMS, National Provider Identification	2024	220:1	300:1
	Dentists	Ratio of population to dentists.	1%	Area Health Resource File/National Provider Identifier Downloadable File	2022	1,180:1	1,360:1
	Preventable Hospital Stays*	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	4%	Mapping Medicare Disparities Tool	2022	1,596	2,666
	Mammography Screening*	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	1%	Mapping Medicare Disparities Tool	2022	53%	44%
	Uninsured	Percentage of population under age 65 without health insurance.	4%	Small Area Health Insurance Estimates	2022	6%	10%
PHYSICAL ENVIRONMENT							
Housing and transportation	Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	4%	Comprehensive Housing Affordability Strategy (CHAS) data	2017-2021	8%	17%
	Driving Alone to Work*	Percentage of the workforce that drives alone to work.	2%	American Community Survey, five-year estimates	2019-2023	69%	70%
	Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	1%	American Community Survey, five-year estimates	2019-2023	17%	37%
Air, water and land	Air Pollution: Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	8%	Environmental Public Health Tracking Network	2020	5.6	7.3
	Drinking Water Violations+	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	4%	Safe Drinking Water Information System	2023		
Civic and community resources	Broadband Access	Percentage of households with broadband internet connection.	4%	American Community Survey, five-year estimates	2019-2023	92%	90%
	Library Access	Library visits per person living within the library service area per year.	2%	Institute of Museum and Library Services	2022	5	2

SOCIAL AND ECONOMIC FACTORS							
Education	Some College	Percentage of adults ages 25-44 with some post-secondary education.	8%	American Community Survey, five-year estimates	2019-2023	74%	68%
	High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	8%	American Community Survey, five-year estimates	2019-2023	95%	89%
Income, employment and wealth	Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	8%	Bureau of Labor Statistics	2023	2.3%	3.6%
	Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	8%	American Community Survey, five-year estimates	2019-2023	3.7	4.9
	Children in Poverty*	Percentage of people under age 18 in poverty.	8%	Small Area Income and Poverty Estimates; American Community Survey, five-year estimates	2023 & 2019-2023	10%	16%
Safety and social support	Injury Deaths*	Number of deaths due to injury per 100,000 population.	4%	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2018-2022	67	84
	Social Associations	Number of membership associations per 10,000 population.	2%	County Business Patterns	2022	18.0	9.1
	Child Care Cost Burden	Child care costs for a household with two children as a percent of median household income.	4%	The Living Wage Institute; Small Area Income and Poverty Estimates	2024 & 2023	20%	28%

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

State	County	Premature Death		Poor Physical Health Days	Low Birth Weight	Poor Mental Health Days
		Deaths	Years of Potential Life Lost Rate	Average Number of Physically Unhealthy Days	% Low Birth Weight	Average Number of Mentally Unhealthy Days
Maryland		83,019.0	8,091.1	3.4	8.7	4.8
Maryland	Anne Arundel	6,882.0	7,000.6	3.5	7.6	5.0
Maryland	Calvert	1,156.0	6,741.5	3.6	7.0	5.1
Maryland	Charles	2,319.0	8,696.4	3.5	9.8	4.9
Maryland	Montgomery	8,177.0	4,785.3	3.1	7.4	4.6
Maryland	Prince George's	12,813.0	8,436.3	3.6	9.5	5.0
Maryland	St. Mary's	1,569.0	8,104.5	3.7	6.8	5.4

State	County	Poor or Fair Health	Flu Vaccinations	Access to Exercise Opportunities	Food Environment Index	Primary Care Physicians
		% Fair or Poor Health	% Vaccinated	% With Access to Exercise Opportunities	Food Environment Index	# Primary Care Physicians
Maryland		14.6	52.0	92.1	8.7	5,227.0
Maryland	Anne Arundel	12.9	54.0	93.3	8.8	397.0
Maryland	Calvert	12.0	51.0	73.0	8.9	45.0
Maryland	Charles	16.0	42.0	75.8	9.2	64.0
Maryland	Montgomery	11.7	57.0	99.9	8.9	1,421.0
Maryland	Prince George's	17.0	41.0	97.7	9.1	474.0
Maryland	St. Mary's	16.5	44.0	72.8	8.5	42.0

State	County	Primary Care Physicians Rate	Primary Care Physicians Ratio	Mental Health Providers		
				# Mental Health Providers	Mental Health Provider Rate	Mental Health Provider Ratio
Maryland		84.8	1179:1	22,601.0	365.7	273:1
Maryland	Anne Arundel	67.2	1487:1	1,685.0	283.4	353:1
Maryland	Calvert	47.9	2087:1	238.0	251.2	398:1
Maryland	Charles	37.9	2636:1	370.0	215.2	465:1
Maryland	Montgomery	134.7	742:1	4,586.0	433.3	231:1
Maryland	Prince George's	49.6	2015:1	2,245.0	237.0	422:1
Maryland	St. Mary's	36.7	2725:1	175.0	151.8	659:1

State	County	Premature Death: Deaths	Premature Death: Years of Potential Life Lost Rate	Poor Physical Health Days: Average Number of Physically Unhealthy Days	Low Birth Weight: % Low Birth Weight	Poor Mental Health Days: Average Number of Mentally Unhealthy Days
Maryland		4,980.0	80.8	1238:1	2,527.0	45.0
Maryland	Anne Arundel	433.0	73.0	1370:1	2,628.0	45.0
Maryland	Calvert	48.0	50.8	1970:1	2,076.0	45.0
Maryland	Charles	107.0	62.9	1590:1	2,156.0	37.0
Maryland	Montgomery	1,336.0	126.9	788:1	1,495.0	45.0
Maryland	Prince George's	600.0	63.4	1578:1	2,945.0	41.0
Maryland	St. Mary's	59.0	51.4	1947:1	3,177.0	40.0

State	County	Dentists: # Dentists	Dentists: Dentist Rate	Dentists: Dentist Ratio	Preventable Hospital Stays: Preventable Hospitalization Rate	Mammography Screening: % with Annual Mammogram
Maryland		4,980.0	80.8	1238:1	2,527.0	45.0
Maryland	Anne Arundel	433.0	73.0	1370:1	2,628.0	45.0
Maryland	Calvert	48.0	50.8	1970:1	2,076.0	45.0
Maryland	Charles	107.0	62.9	1590:1	2,156.0	37.0
Maryland	Montgomery	1,336.0	126.9	788:1	1,495.0	45.0
Maryland	Prince George's	600.0	63.4	1578:1	2,945.0	41.0
Maryland	St. Mary's	59.0	51.4	1947:1	3,177.0	40.0

State	County	Uninsured: # Uninsured	Uninsured: % Uninsured	Severe Housing Problems: % Severe Housing Problems	Driving Alone to Work: % Drive Alone to Work	Long Commute - Driving Alone: # Workers who Drive Alone
Maryland		340,945.0	6.8	15.6	66.3	3,104,587.0
Maryland	Anne Arundel	25,423.0	5.2	12.1	72.1	309,457.0
Maryland	Calvert	3,455.0	4.4	9.3	74.3	48,555.0
Maryland	Charles	7,065.0	4.9	14.0	72.8	86,201.0
Maryland	Montgomery	66,678.0	7.7	16.8	54.2	549,729.0
Maryland	Prince George's	83,913.0	10.9	19.6	61.2	490,621.0
Maryland	St. Mary's	5,185.0	5.3	13.1	75.0	58,295.0

State	County	Air Pollution: Particulate Matter: Average Daily PM2.5	Drinking Water Violations: Presence of Water Violation	Broadband Access: % Households with Broadband Access	Broadband Access: # Households with Broadband Access	Library Access: Visits per service area population
Maryland		6.3		91.5	2,139,911.0	2.1
Maryland	Anne Arundel	7.1	No	94.9	212,098.0	2.0
Maryland	Calvert	6.2	No	92.9	31,109.0	2.5
Maryland	Charles	7.1	No	92.9	55,906.0	1.0
Maryland	Montgomery	5.9	No	95.3	369,544.0	2.5
Maryland	Prince George's	5.9	No	92.9	319,991.0	1.0
Maryland	St. Mary's	6.3	Yes	90.9	37,957.0	2.4

State	County	Premature Death Deaths	Years of Potential Life Lost Rate	Poor Physical Health Days Average Number of Physically Unhealthy Days	Low Birth Weight % Low Birth Weight	Poor Mental Health Days Average Number of Mentally Unhealthy Days

State	County	Some College # Some College	Population	% Some College
Maryland		1,170,081.0	1,648,124.0	71.0
Maryland	Anne Arundel	126,236.0	165,552.0	76.3
Maryland	Calvert	16,852.0	23,139.0	72.8
Maryland	Charles	31,221.0	44,130.0	70.7
Maryland	Montgomery	215,770.0	275,185.0	78.4
Maryland	Prince George's	167,852.0	263,844.0	63.6
Maryland	St. Mary's	21,508.0	31,513.0	68.3

State	County	High School Completion # Completed High School	Population	% Completed High School
Maryland		3,890,112.0	4,272,813.0	91.0
Maryland	Anne Arundel	385,820.0	411,412.0	93.8
Maryland	Calvert	61,454.0	64,751.0	94.9
Maryland	Charles	107,711.0	114,192.0	94.3
Maryland	Montgomery	668,946.0	733,108.0	91.2
Maryland	Prince George's	569,417.0	656,475.0	86.7
Maryland	St. Mary's	70,924.0	76,783.0	92.4

State	County	Unemployment # Unemployed	Labor Force	% Unemployed
Maryland		67,600.0	3,184,870.0	2.1
Maryland	Anne Arundel	5,790.0	315,180.0	1.8
Maryland	Calvert	930.0	49,497.0	1.9
Maryland	Charles	1,884.0	86,748.0	2.2
Maryland	Montgomery	10,224.0	548,380.0	1.9
Maryland	Prince George's	11,175.0	497,045.0	2.2
Maryland	St. Mary's	1,154.0	58,431.0	2.0

State	County	Premature Death: Deaths	Premature Death: Years of Potential Life Lost Rate	Poor Physical Health Days: Average Number of Physically Unhealthy Days	Low Birth Weight: % Low Birth Weight	Poor Mental Health Days: Average Number of Mentally Unhealthy Days

State	County	Income Inequality: 80th Percentile Income	Income Inequality: 20th Percentile Income	Income Inequality: Income Ratio	Child Care Cost Burden: % Household Income Required for Child Care Expenses
Maryland		195,515.0	42,240.0	4.6	26.1
Maryland	Anne Arundel	214,347.0	57,809.0	3.7	22.5
Maryland	Calvert	223,599.0	64,294.0	3.5	20.9
Maryland	Charles	203,686.0	57,939.0	3.5	24.7
Maryland	Montgomery				30.6
Maryland	Prince George's	182,194.0	45,984.0	4.0	27.1
Maryland	St. Mary's	207,478.0	52,659.0	3.9	19.5

State	County	Children in Poverty: % Children in Poverty	Injury Deaths: # Injury Deaths	Injury Deaths: Injury Death Rate	Social Associations: # Associations	Social Association Rate
Maryland		11.3	28,464.0	93.4	5,449.0	8.8
Maryland	Anne Arundel	6.9	2,573.0	88.1	473.0	8.0
Maryland	Calvert	6.4	371.0	79.6	65.0	6.9
Maryland	Charles	9.0	669.0	80.8	102.0	6.0
Maryland	Montgomery	7.1	2,477.0	47.1	953.0	9.1
Maryland	Prince George's	13.9	3,131.0	67.6	736.0	7.8
Maryland	St. Mary's	10.5	462.0	81.0	74.0	6.4

Focus Area	Measure	Description	Source	Year(s)
POPULATION HEALTH AND WELL BEING				
LENGTH OF LIFE				
Life span	Life Expectancy*	Average number of years people are expected to live.	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program	2020-2022
	Premature Age-Adjusted Mortality*	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program	2020-2022
	Child Mortality*	Number of deaths among residents under age 20 per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2019-2022
	Infant Mortality*	Number of infant deaths (within 1 year) per 1,000 live births.	National Center for Health Statistics - Natality and Mortality Files	2016-2022
QUALITY OF LIFE				
Physical health	Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	Diabetes Prevalence	Percentage of adults aged 18 and above with diagnosed diabetes (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	HIV Prevalence+	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2022
	Adult Obesity	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
Mental health	Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	Suicides*	Number of deaths due to suicide per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2018-2022
Life satisfaction	Feelings of Loneliness+	Percentage of adults reporting that they always, usually or sometimes feel lonely.	Behavioral Risk Factor Surveillance System	2022
COMMUNITY CONDITIONS				
HEALTH INFRASTRUCTURE				
Health promotion and harm reduction	Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	USDA Food Environment Atlas	2019
	Food Insecurity	Percentage of population who lack adequate access to food.	Map the Meal Gap	2022
	Insufficient Sleep	Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	Teen Births*	Number of births per 1,000 female population ages 15-19.	National Center for Health Statistics - Natality Files; Census Population Estimates Program	2017-2023
	Sexually Transmitted Infections+	Number of newly diagnosed chlamydia cases per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2022
	Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	Alcohol-Impaired Driving Deaths	Percentage of driving deaths with alcohol involvement.	Fatality Analysis Reporting System	2018-2022
	Drug Overdose Deaths*	Number of drug poisoning deaths per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2020-2022
	Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	Behavioral Risk Factor Surveillance System	2022

	Physical Inactivity	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
Clinical care	Uninsured Adults	Percentage of adults under age 65 without health insurance.	Small Area Health Insurance Estimates	2022
	Uninsured Children	Percentage of children under age 19 without health insurance.	Small Area Health Insurance Estimates	2022
	Other Primary Care Providers	Ratio of population to primary care providers other than physicians.	CMS, National Provider Identification	2024
PHYSICAL ENVIRONMENT				
Housing and transportation	Traffic Volume	Average traffic volume per meter of major roadways in the county.	EJSCREEN: Environmental Justice Screening and Mapping Tool	2020
	Homeownership	Percentage of owner-occupied housing units.	American Community Survey, five-year estimates	2019-2023
	Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	American Community Survey, five-year estimates	2019-2023
Air, water and land	Access to Parks	Percentage of the population living within a half mile of a park.	ArcGIS Online; US Census TIGER/Line Shapefiles	2024 & 2020
Climate	Adverse Climate Events*	Indicator of thresholds met for the following adverse climate and weather-related event categories: extreme heat (300 or more days above 90F), moderate or greater drought (65 or more weeks), and disaster (2 or more presidential disaster declarations) over the five-year period.	Environmental Public Health Tracking (EPHT) Network; U.S. Drought Monitor (USDM); OPEN FEMA Disaster Declaration Summaries	2019-2023
Civic and community resources	Census Participation	Percentage of all households that self-responded to the 2020 census (by internet, paper questionnaire or telephone).	Census Operational Quality Metrics	2020
	Voter Turnout+	Percentage of citizen population aged 18 or older who voted in the 2020 U.S. Presidential election.	MIT Election Data and Science Lab; American Community Survey, five-year estimates	2020 & 2016-2020
SOCIAL AND ECONOMIC FACTORS				
Education	High School Graduation+	Percentage of ninth-grade cohort that graduates in four years.	EDFacts	2021-2022
	Reading Scores*+	Average grade level performance for 3rd graders on English Language Arts standardized tests.	Stanford Education Data Archive	2019
	Math Scores*+	Average grade level performance for 3rd graders on math standardized tests.	Stanford Education Data Archive	2019
	School Segregation	The extent to which students within different race and ethnicity groups are unevenly distributed across schools when compared with the racial and ethnic composition of the local population. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation.	National Center for Education Statistics	2023-2024
	School Funding Adequacy+	The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district.	School Finance Indicators Database	2022

Income, employment and wealth	Children Eligible for Free or Reduced Price Lunch+	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	National Center for Education Statistics	2022-2023
	Gender Pay Gap	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar."	American Community Survey, five-year estimates	2019-2023
	Median Household Income*	The income where half of households in a county earn more and half of households earn less.	Small Area Income and Poverty Estimates; American Community Survey, five-year estimates	2023 & 2019-2023
	Living Wage	The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children.	The Living Wage Institute	2024
Safety and social support	Child Care Centers	Number of child care centers per 1,000 population under 5 years old.	Homeland Infrastructure Foundation-Level Data (HIFLD)	2010-2022
	Residential Segregation - Black/White	Index of dissimilarity where higher values indicate greater residential segregation between Black and White county residents.	American Community Survey, five-year estimates	2019-2023
	Homicides*	Number of deaths due to homicide per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2016-2022
	Motor Vehicle Crash Deaths*	Number of motor vehicle crash deaths per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2016-2022
	Firearm Fatalities*	Number of deaths due to firearms per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2018-2022
	Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	American Community Survey, five-year estimates	2019-2023
	Lack of Social and Emotional Support+	Percentage of adults reporting that they sometimes, rarely, or never get the social and emotional support they need.	Behavioral Risk Factor Surveillance System	2022
DEMOGRAPHICS				
All	% Below 18 Years of Age	Percentage of population below 18 years of age.	Census Population Estimates Program	2023
	% 65 and Older	Percentage of population ages 65 and older.	Census Population Estimates Program	2023
	% Female	Percentage of population identifying as female.	Census Population Estimates Program	2023
	% American Indian or Alaska Native	Percentage of population identifying as American Indian or Alaska Native.	Census Population Estimates Program	2023
	% Asian	Percentage of population identifying as Asian.	Census Population Estimates Program	2023
	% Hispanic	Percentage of population identifying as Hispanic.	Census Population Estimates Program	2023
	% Native Hawaiian or Other Pacific Islander	Percentage of population identifying as Native Hawaiian or Other Pacific Islander.	Census Population Estimates Program	2023
	% Non-Hispanic Black	Percentage of population identifying as non-Hispanic Black or African American.	Census Population Estimates Program	2023
	% Non-Hispanic White	Percentage of population identifying as non-Hispanic white.	Census Population Estimates Program	2023
	% Disability: Functional Limitations	Percentage of adults reporting any of six specific functional limitations	Behavioral Risk Factor Surveillance System	2022
	% Not Proficient in English	Percentage of population aged 5 and over who reported speaking English less than well.	American Community Survey, five-year estimates	2019-2023
	Children in Single-Parent Households	Percentage of children that live in a household headed by a single parent.	American Community Survey, five-year estimates	2019-2023
	% Rural	Percentage of population living in a census-defined rural area.	Decennial Census Demographic and Housing Characteristics File	2020

	Population	Resident population.	Census Population Estimates Program	2023

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

		Life Expectancy	Premature Age-Adjusted Mortality		Child Mortality		Infant Mortality		Frequent Physical Distress
State	County	Life Expectancy	# Deaths	Age-Adjusted Death Rate	# Deaths	Child Mortality Rate	# Deaths	Infant Mortality Rate	% Frequent Physical Distress
Maryland		77.8	83,019.0	383.2	3,084.0	51.5	3,013.0	6.1	9.8
Maryland	Anne Arundel	78.8	6,882.0	335.4	261.0	45.6	225.0	4.7	9.7
Maryland	Calvert	78.7	1,156.0	336.2	33.0	34.9	32.0	4.9	9.6
Maryland	Charles	76.7	2,319.0	410.3	101.0	57.9	95.0	7.4	11.2
Maryland	Montgomery	83.2	8,177.0	222.5	376.0	35.7	408.0	4.8	8.5
Maryland	Prince George's	77.6	12,813.0	393.5	564.0	61.0	599.0	7.3	10.1
Maryland	St. Mary's	77.0	1,569.0	409.2	62.0	51.2	55.0	5.7	11.4

		Diabetes Prevalence	HIV Prevalence		Adult Obesity	Frequent Mental Distress	Suicides		Feelings of Loneliness
State	County	% Adults with Diabetes	# HIV Cases	HIV Prevalence Rate	% Adults with Obesity	% Frequent Mental Distress	# Deaths	Suicide Rate (Age-Adjusted)	% feeling lonely
Maryland		10.5	33,580.0	643.8	33.5	15.2	3,120.0	9.8	35.9
Maryland	Anne Arundel	8.8	1,455.0	291.3	34.7	15.7	366.0	12.1	34.8
Maryland	Calvert	9.2	140.0	175.4	33.9	15.9	47.0	9.6	34.7
Maryland	Charles	11.7	680.0	477.2	42.9	16.8	90.0	11.2	35.9
Maryland	Montgomery	9.1	4,037.0	455.2	24.2	13.4	437.0	8.0	38.7
Maryland	Prince George's	13.0	8,192.0	1,024.8	36.0	15.2	292.0	6.1	38.6
Maryland	St. Mary's	10.8	160.0	167.0	35.2	16.9	75.0	12.6	33.1

		Limited Access to Healthy Foods		Food Insecurity		Insufficient Sleep	Teen Births	Sexually Transmitted Infections	
State	County	# Limited Access to Healthy Foods	% Limited Access to Healthy Foods	# Food Insecure	% Food Insecure	% Insufficient Sleep	Teen Birth Rate	# Chlamydia Cases	Chlamydia Rate
Maryland		205,285.7	3.6	749,260.0	12.2	38.7	12.6	31,234.0	506.7
Maryland	Anne Arundel	22,243.5	4.1	61,640.0	10.5	38.7	9.7	1,881.0	317.0
Maryland	Calvert	4,640.6	5.2	8,890.0	9.5	36.9	7.4	209.0	221.0
Maryland	Charles	7,597.1	5.2	13,180.0	7.9	40.8	10.7	826.0	485.6
Maryland	Montgomery	17,801.9	1.8	116,990.0	11.1	33.9	8.3	3,536.0	336.0
Maryland	Prince George's	29,867.0	3.5	88,810.0	9.3	43.8	16.3	6,203.0	655.0
Maryland	St. Mary's	4,370.1	4.2	13,410.0	11.8	37.7	10.8	398.0	346.5

State	County	Excessive Drinking	Alcohol-Impaired Driving Deaths			Drug Overdose Deaths		Adult Smoking	Physical Inactivity
		% Excessive Drinking	# Alcohol-Impaired Driving Deaths	# Driving Deaths	% Driving Deaths with Alcohol Involvement	# Drug Overdose Deaths	Drug Overdose Mortality Rate	% Adults Reporting Currently Smoking	% Physically Inactive
Maryland		15.8	801.0	2,714.0	29.5	8,081.0	44.0	9.8	20.5
Maryland	Anne Arundel	21.3	63.0	232.0	27.2	737.0	41.7	11.1	19.7
Maryland	Calvert	20.0	16.0	39.0	41.0	95.0	33.7	10.7	18.1
Maryland	Charles	16.1	42.0	109.0	38.5	180.0	35.8	13.4	23.6
Maryland	Montgomery	15.3	52.0	206.0	25.2	450.0	14.2	8.6	16.2
Maryland	Prince George's	12.3	178.0	559.0	31.8	679.0	24.1	10.5	23.7
Maryland	St. Mary's	19.6	30.0	72.0	41.7	121.0	35.2	13.1	22.4

State	County	Uninsured Adults		Uninsured Children		Other Primary Care Providers		Traffic Volume	Homeowners hip
		# Uninsured Adults	% Uninsured Adults	# Uninsured Children	% Uninsured Children	Other Primary Care Provider Rate	Other Primary Care Provider Ratio	Traffic Volume	# Homeowners
Maryland		292,218.0	7.9	53,199.0	3.8	145.7	686:1	162.6	1,578,702.0
Maryland	Anne Arundel	21,363.0	5.9	4,441.0	3.2	132.5	755:1	122.5	167,618.0
Maryland	Calvert	2,874.0	5.0	643.0	2.8	85.5	1169:1	22.4	29,184.0
Maryland	Charles	5,896.0	5.6	1,315.0	3.2	100.0	1000:1	42.8	48,900.0
Maryland	Montgomery	59,383.0	9.4	8,127.0	3.3	128.8	777:1	218.1	253,448.0
Maryland	Prince George's	73,226.0	12.8	11,507.0	5.6	85.7	1167:1	192.8	214,809.0
Maryland	St. Mary's	4,022.0	5.7	1,243.0	4.4	68.5	1459:1	24.2	30,325.0

State	County		Severe Housing Cost Burden		Access to Parks	Adverse Climate Events			
		% Homeowners	# Households with Severe Cost Burden	% Households with Severe Cost Burden	% with access to parks	Adverse Climate Events	Days above 90F	Weeks in moderate or greater drought	Disaster declarations
Maryland		67.5	328,777.0	14.4	66.2				
Maryland	Anne Arundel	75.0	23,917.0	10.9	57.5	-	33.0	30.0	-
Maryland	Calvert	87.2	3,175.0	9.7	26.3	-	14.0	24.0	1.0
Maryland	Charles	81.2	7,660.0	12.9	25.6	-	139.0	32.0	-

Maryland	Montgomery	65.3	56,362.0	14.8	94.3	-	120.0	41.0	-
Maryland	Prince George's	62.3	57,149.0	16.9	88.0	-	102.0	30.0	-
Maryland	St. Mary's	72.6	4,461.0	10.9	27.5	-	27.0	30.0	1.0

		Census Participation	Voter Turnout	High School Graduation		Reading Scores	Math Scores	School Segregation
State	County	% Census Participation	% Voter Turnout	Cohort Size	High School Graduation Rate	Average Grade Performance	Average Grade Performance	Segregation Index
Maryland			70.4	67,045.0	86.4	3.0	3.0	0.3
Maryland	Anne Arundel	74.6	72.4	5,951.0	89.0	3.2	3.1	0.1
Maryland	Calvert	73.5	70.2	1,246.0	96.0	3.4	3.4	0.0
Maryland	Charles	73.3	75.0	2,211.0	93.0	3.0	2.9	0.1
Maryland	Montgomery	75.4	79.2	12,756.0	90.0	3.3	3.3	0.1
Maryland	Prince George's	67.9	70.7	9,820.0	77.0	2.6	2.5	0.2
Maryland	St. Mary's	68.9	66.9	1,257.0	90.0	3.2	3.1	0.1

		School Funding Adequacy		Children Eligible for Free or Reduced Price Lunch	Gender Pay Gap			Median Household Income
State	County	Spending per Pupil	School Funding Adequacy	% Enrolled in Free or Reduced Lunch	Women's Median Earnings	Men's Median Earnings	Gender Pay Gap	Median Household Income
Maryland		17,752.9	1,542.2	50.7	68,044.0	78,655.0	0.9	98,568.0
Maryland	Anne Arundel	16,620.0	4,835.9	42.3	72,268.0	88,116.0	0.8	116,956.0
Maryland	Calvert	21,252.0	10,680.7	27.5	71,602.0	93,597.0	0.8	124,486.0
Maryland	Charles	16,671.0	(502.7)	47.2	73,592.0	79,370.0	0.9	105,141.0
Maryland	Montgomery	18,101.0	2,401.5	46.1	83,059.0	95,945.0	0.9	125,076.0
Maryland	Prince George's	19,234.0	(3,002.6)	71.5	68,393.0	63,705.0	1.1	97,171.0
Maryland	St. Mary's	16,038.0	5,167.3	40.2	67,296.0	90,694.0	0.7	102,345.0

		Child Care Centers		Residential Segregation - Black/White	Homicides	Motor Vehicle Crash Deaths		Firearm Fatalities	
State	County	# Child Care Centers	Child Care Centers per 1,000 Children	Segregation Index	Homicide Rate	# Motor Vehicle Deaths	Motor Vehicle Mortality Rate	# Firearm Fatalities	Firearm Fatalities Rate
Maryland			6.2	63.0	10.0	4,041.0	9.5	3,995.0	13.1

Maryland	Anne Arundel	166.0	4.7	48.8	4.6	341.0	8.4	242.0	8.3
Maryland	Calvert	40.0	8.4	17.2	1.7	77.0	11.9	35.0	7.5
Maryland	Charles	61.0	6.3	40.7	8.1	181.0	15.8	117.0	14.1
Maryland	Montgomery	351.0	5.5	46.4	2.6	414.0	5.6	254.0	4.8
Maryland	Prince George's	275.0	4.5	48.4	12.8	716.0	11.1	629.0	13.6
Maryland	St. Mary's	20.0	2.8	44.2	3.4	111.0	14.0	61.0	10.7

		Disconnected Youth	Lack of Social and Emotional Support	% Below 18 Years of Age	% 65 and Older	% Female	% American Indian or Alaska Native		% Asian
State	County	% Disconnected Youth	% lacking support	% Below 18 Years of Age	% 65 and Over	% Female	# American Indian or Alaska Native	% American Indian or Alaska Native	# Asian
Maryland		6.1	27.4	22.0	17.3	51.4	47,993.0	0.8	437,702.0
Maryland	Anne Arundel	4.4	27.4	22.5	16.5	50.5	3,525.0	0.6	28,053.0
Maryland	Calvert	5.6	24.6	23.0	16.9	50.3	494.0	0.5	1,977.0
Maryland	Charles	9.8	31.9	23.7	14.2	51.9	1,371.0	0.8	6,095.0
Maryland	Montgomery	4.3	30.8	22.6	17.7	51.3	9,811.0	0.9	170,513.0
Maryland	Prince George's	7.4	35.7	21.8	15.6	51.6	14,756.0	1.6	40,950.0
Maryland	St. Mary's	4.4	27.1	23.9	14.7	49.7	588.0	0.5	3,486.0

			% Hispanic		% Native Hawaiian or Other Pacific Islander		% Non-Hispanic Black	
State	County	% Asian	# Hispanic	% Hispanic	# Native Hawaiian or Other Pacific Islander	% Native Hawaiian or Other Pacific Islander	# Non-Hispanic Black	% Non-Hispanic Black
Maryland		7.1	781,273.0	12.6	8,096.0	0.1	1,865,398.0	30.2
Maryland	Anne Arundel	4.7	63,808.0	10.7	751.0	0.1	114,182.0	19.2
Maryland	Calvert	2.1	5,207.0	5.5	148.0	0.2	13,238.0	14.0
Maryland	Charles	3.5	14,185.0	8.2	258.0	0.2	90,539.0	52.6
Maryland	Montgomery	16.1	223,318.0	21.1	1,078.0	0.1	204,472.0	19.3
Maryland	Prince George's	4.3	215,594.0	22.8	2,193.0	0.2	567,123.0	59.9
Maryland	St. Mary's	3.0	7,232.0	6.3	146.0	0.1	17,905.0	15.5

State	County	# Non-Hispanic White	% Non-Hispanic White	% with disability	# Not Proficient in English	% Not Proficient in English
Maryland		2,921,370.0	47.3	24.0	210,070.0	3.6
Maryland	Anne Arundel	369,004.0	62.1	22.2	9,941.0	1.8
Maryland	Calvert	70,689.0	74.6	22.1	351.0	0.4
Maryland	Charles	54,099.0	31.5	26.5	1,716.0	1.1
Maryland	Montgomery	430,040.0	40.6	20.1	68,649.0	6.9
Maryland	Prince George's	104,071.0	11.0	25.3	71,853.0	8.0
Maryland	St. Mary's	82,253.0	71.4	26.7	759.0	0.7

State	County	# Children in Single-Parent Households	# Children in Households	% Children in Single-Parent Households	# Rural Residents	% Rural	Population
Maryland		352,458.0	1,374,017.0	25.7	888,464.0	14.4	6,180,253.0
Maryland	Anne Arundel	26,767.0	133,777.0	20.0	44,016.0	7.5	594,582.0
Maryland	Calvert	3,434.0	21,785.0	15.8	57,424.0	61.9	94,728.0
Maryland	Charles	8,846.0	40,469.0	21.9	47,344.0	28.4	171,973.0
Maryland	Montgomery	48,653.0	242,595.0	20.1	28,457.0	2.7	1,058,474.0
Maryland	Prince George's	68,819.0	211,977.0	32.5	23,547.0	2.4	947,430.0
Maryland	St. Mary's	6,130.0	27,487.0	22.3	64,562.0	56.7	115,281.0

Exhibit 7

Demographic Summary of the FHC PSA Counties, 2024

US Census Bureau, American Community Survey, DP02 and DP03

Metric	Maryland	Anne Arundel	Mont-gomery	Prince George's	Calvert	Charles	St. Mary's	Total PSA Percentage	Total PSA Population	Sources
2025 Total Pop	6,244,960	595,005	1,087,289	926,024	96,048	174,221	123,696		3,002,283	Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Percent Distribution		19.8%	36.2%	30.8%	3.2%	5.8%	4.1%	100.0%		
FHC PSA Demographic Data										
Female	51.8%	50.8%	52.3%	51.9%	51.4%	52.8%	50.4%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Male	48.2%	49.2%	47.7%	48.1%	48.6%	47.2%	49.6%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Under 18 Years	24.0%	24.4%	24.6%	24.6%	23.6%	26.2%	26.9%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
18 to 64 Years	57.7%	57.8%	57.8%	59.1%	56.6%	58.1%	57.4%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
65 and Older	18.2%	17.8%	17.6%	16.3%	9.7%	15.7%	15.7%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
Non-Hispanic Other	10.6%	8.4%	20.9%	7.0%	5.0%	8.6%	6.7%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Non-Hispanic Black	30.7%	18.9%	20.3%	60.6%	13.3%	52.2%	15.0%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Non-Hispanic White	47.3%	63.4%	36.3%	12.9%	77.3%	32.5%	72.6%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Hispanic	11.4%	9.2%	22.5%	19.5%	4.4%	6.6%	5.7%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Veterans	6.8%	9.8%	12.0%	12.7%	4.5%	6.4%	13.5%			US Census Burearu American Community Survey 5-Year Estimates Selected Social Characteristics Table DP02
English as a Second Language	21.80%	14.00%	7.80%	8.90%	43.20%	32.00%	7.10%			US Census Burearu American Community Survey 5-Year Estimates Selected Social Characteristics Table DP02
Less then High School Degree	8.60%	6.70%	3.30%	4.90%	8.30%	14.40%	7.20%			US Census Burearu American Community Survey 5-Year Estimates Selected Social Characteristics Table DP02
Disability	12.30%	11.70%	12.30%	12.10%	9.30%	11.00%	12.40%			US Census Burearu American Community Survey 5-Year Estimates Selected Social Characteristics Table DP02
Drove to work (alone + carpool)										US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
Uninsured	6.30%	5.00%	3.40%	3.70%	6.90%	11.50%	3.70%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
Poverty	9.10%	6.40%	7.40%	10.40%	4.80%	6.30%	7.90%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
Household Median Income										US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
<$10,000 - $34,999	16.00%	10.00%	7.50%	12.80%	11.80%	15.70%	15.40%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
$35,000 - $74,999	20.60%	17.50%	15.10%	14.50%	15.10%	22.90%	14.00%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
$75,000 - $149,000	42.90%	41.70%	45.90%	39.50%	35.00%	48.20%	37.90%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
$150,000 - $200,000+	33.30%	42.40%	42.50%	42.10%	47.20%	28.80%	42.00%			US Census Burearu American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024

Demographic Summary of the FHC PSA Counties, 2024

US Census Bureau, American Community Survey, DP02 and DP03

Metric	Maryland	Anne Arundel	Mont-gomery	Prince George's	Calvert	Charles	St. Mary's	Total PSA Percentage	Total PSA Population	Sources
Weighted Average of FHC PSA Demographic Data										
Female		10.1%	18.9%	16.0%	1.6%	3.1%	2.1%	51.8%	1,555,221	
Male		9.8%	17.3%	14.8%	1.6%	2.7%	2.0%	48.2%	1,447,062	
Under 18 Years		4.8%	8.9%	7.6%	0.8%	1.5%	1.1%	24.7%	742,044	
18 to 64 Years		11.5%	20.9%	18.2%	1.8%	3.4%	2.4%	58.2%	1,746,233	
65 and Older		3.5%	6.4%	5.0%	0.3%	0.9%	0.6%	16.8%	504,305	
Non-Hispanic Other		1.7%	7.6%	2.2%	0.2%	0.5%	0.3%	12.3%	370,119	
Non-Hispanic Black		3.7%	7.4%	18.7%	0.4%	3.0%	0.6%	33.9%	1,016,618	
Non-Hispanic White		12.6%	13.1%	4.0%	2.5%	1.9%	3.0%	37.0%	1,112,046	
Hispanic		1.8%	8.1%	6.0%	0.1%	0.4%	0.2%	16.7%	502,731	
Veterans		1.9%	4.3%	3.9%	0.1%	0.4%	0.6%	11.3%	338,561	
English as a Second Language		2.8%	2.8%	2.7%	1.4%	1.9%	0.3%	11.9%	356,551	
Less then High School Degree		1.3%	1.2%	1.5%	0.3%	0.8%	0.3%	5.4%	163,087	
Disability		2.3%	4.5%	3.7%	0.3%	0.6%	0.5%	12.0%	358,836	
Drove to work (alone + carpool)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-	
Uninsured		1.0%	1.2%	1.1%	0.2%	0.7%	0.2%	4.4%	132,220	
Poverty		1.3%	2.7%	3.2%	0.2%	0.4%	0.3%	8.0%	240,204	
Household Median Income										
<$10,000 - $34,999		2.0%	2.7%	3.9%	0.4%	0.9%	0.6%	10.6%	317,314	
$35,000 - $74,999		3.5%	5.5%	4.5%	0.5%	1.3%	0.6%	15.8%	474,297	
$75,000 - $149,000		8.3%	16.6%	12.2%	1.1%	2.8%	1.6%	42.5%	1,277,434	
$150,000 - $200,000+		8.4%	15.4%	13.0%	1.5%	1.7%	1.7%	41.7%	1,251,699	

Estimated Medicare and Medicaid Enrollment in FHC PSA, 2025 Data

Metric	Medicare	Medicaid
a. Total Anne Arundel County Population	595,005	595,005
b. Total Montgomery County Population	1,087,289	1,087,289
c. Total Prince Geroge's County Population	926,024	926,024
d. Total Calvert County Population	96,048	96,048
e. Total Charles County Population	174,221	174,221
f. Total St. Mary's County Population	123,696	123,696
g. Total Population 6-Counties	**3,002,283**	**3,002,283**
h. Total AA Enrollees	107,691	107,200
i. Total Mont Enrollees	194,407	209,161
j. Total PG Enrollees	151,940	260,994
k. Total Cal Enrollees	19,039	14,688
l. Total Char Enrollees	28,724	37,216
m. Total SM Enrollees	19,767	9,386
n. Total FHC PSA Enrollees	**521,568**	**638,645**
o. Percent AA Enrolled	18.1%	18.0%

Demographic Summary of the FHC PSA Counties, 2024

US Census Bureau, American Community Survey, DP02 and DP03

Metric	Maryland	Anne Arundel	Mont-gomery	Prince George's	Calvert	Charles	St. Mary's	Total PSA Percentage	Total PSA Population	Sources
p. Percent Mon Enrolled	17.9%	19.2%								
q. Percent PG Enrolled	16.4%	28.2%								
r. Percent Cal Enrolled	19.8%	15.3%								
s. Percent Char Enrolled	16.5%	21.4%								
t. Percent SM Enrolled	16.0%	7.6%								
u. Percent FHC PSA Enrolled	**17.4%**	**21.3%**								

a - f. Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025

g. Sum of a through f

h-m. Medicare Enrollment Dashboard, September 2025 https://data.cms.gov/tools/medicare-enrollment-dashboard

Mayland Medicaid Enrollment by County, March 2025 https://health.maryland.gov/newsroom/SiteAssets/Pages/Impact-of-Potential-Medicaid-Proposals-to-Maryland-Medicaid/Maryland%20Medicaid%20Fact%20Sheet_05.13.25_232pm.pdf

n. Sum of h through m

o - u. Total enrollees by jurisdiction / total population by jurisdiction

Exhibit 8

Charity Care and Discount Policy

I. PURPOSE

First Healthcare Consultants LTD("FHC") is committed to ensuring that all individuals, regardless of their financial circumstances, have access to medically necessary home health services. The purpose of this policy is to clearly define how FHC provides charity care, discounted services, and interest-free payment plans to eligible patients who are uninsured, underinsured, or otherwise unable to pay.

This policy aligns with FHC's mission of serving underserved and medically complex populations and complies with all applicable federal and state regulations, including **COMAR 10.24.16.08E**, **COMAR 10.24.01.08G(3)(f)**, COMAR 10.24.01.09 and CMS Conditions of Participation as well as all applicable federal and state regulations.

FHC will not deny, delay, or discontinue medically necessary care based on a patient's inability to pay.

II. POLICY STATEMENT

FHC ensures equitable access to care through the following commitments:

1. Provide **charity care (free care)** to patients with household income at or below **100% of the Federal Poverty Level (FPL)**.
2. Provide **discounted care** on a sliding scale to patients with income up to **200% of FPL**, at minimum, and up to 300% FPL based on financial hardship.
3. Offer **interest-free payment plans** to patients who do not qualify for full charity care.
4. Never charge interest, late fees, or use aggressive collection practices.
5. Not refuse, limit, or discontinue services based on inability to pay.
6. Inform all patients of the availability of charity care and discounts, both verbally and in writing, in English and Spanish and other languages as needed.
7. Make this policy publicly available in physical locations and on the agency's website.
8. Report charity care annually to the Maryland Health Care Commission (MHCC) as required.

III. DEFINITIONS

Charity Care:

Medically necessary services provided **at no cost** to eligible patients with income ≤100% FPL or those who demonstrate financial hardship.

Discounted Care:

Reduced charges based on a sliding fee scale for patients with income between 101%–300% FPL.

Financial Hardship:

A situation in which medical expenses, loss of income, or extraordinary circumstances prevent a patient from paying for necessary care, even if income exceeds standard thresholds.

Uninsured Patient:

An individual without any third-party health insurance coverage.

Underinsured Patient:

A patient whose insurance does not cover all medically necessary services or who faces high deductibles, coinsurance, or copayments.

Household Income:

Combined gross income of all household members, as defined by federal guidelines.

Family Size:

As defined by current Federal Poverty Level (FPL) guidelines.

Medically Necessary Services:

Skilled home health services ordered by a physician and delivered under a plan of care.

IV. ELIGIBILITY CRITERIA

A patient may qualify for charity care or discounted services if they meet **any** of the following:

1. Family Size or household income at or below 300% of FPL (with sliding scale applied)
2. High out-of-pocket medical expenses, exceptional medical hardship or extraordinary medical expenses relative to income
3. Significant change in financial circumstances (job loss, divorce, death in family, disability, etc.)
4. Participation in needs-based government assistance programs (e.g., Medicaid, SNAP, SSI)
5. Uninsured/Underinsured status – Status does not automatically disqualify patient

Patients with insurance may still qualify if they have high out-of-pocket responsibility or financial

hardship.

V. SLIDING FEE SCALE (By % of Federal Poverty Level)

FHC uses the current Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services and updates the scale annually.

Household Income (% of FPL)	Patient Responsibility	Discount Applied
0–100%	0%	100% (Full Charity Care – No Charge)
101–150%	25% of charges	75% Discount
151–200%	50% of charges	50% Discount
201–250%	75% of charges	25% Discount
251–300%	Case-by-case (up to 25% discount)	Hardship Discount
>300%	May qualify for hardship discount or payment plan	Determined individually

Note: *The sliding fee scale will be updated annually based on the current Federal Poverty Guidelines published by the U.S. Department of Health and Human Services.*

FHC may provide additional discounts beyond the minimum requirements in cases of verified financial hardship, extraordinary medical expenses or exceptional circumstances.

Application Process

Patients may request charity care or discounted services at any time, including before, during, or after care.

How to Apply:

1. Complete the Financial Assistance Application form
2. Provide proof of income (e.g., tax return, pay stub, W-2, benefits statement)
3. Provide proof of household size
4. Provide documentation of medical expenses or hardship if requested

FHC Responsibilities:

1. Provide the application in English, Spanish, and other languages as needed
2. Assist patients in completing the application
3. Make reasonable efforts to verify information when documents are unavailable
4. Process applications within 10 business days
5. Notify patients in writing of approval or denial

6. Apply approved discounts retroactively **for up to 90 days**

Important: Care will not be denied or delayed while an application is pending.

Failure to provide documentation may result in denial; however, FHC will make reasonable efforts to verify eligibility through alternative means.

Payment Plans

Patients who do not qualify for full charity care may set up an **interest-free payment plan** based on their ability to pay. Monthly payments will not exceed a reasonable percentage of household income.

What to Expect:

1. Affordable monthly payments
2. Flexible terms
3. No interest or late fees
4. May be extended or adjusted for hardship
5. No aggressive collections

Communication Of Policy

FHC will make this policy available:

1. At admission or referral
2. During financial counseling
3. In patient handbooks or welcome packets
4. On the agency website
5. In publicly accessible office areas
6. In English, Spanish, and other languages appropriate to the service area or as needed.

Staff will verbally inform patients of the availability of charity care and assist them in applying. Interpreter services for other languages are available at no cost to the patient.

Non-Discrimination

FHC does not discriminate in the provision of charity care, discounted services, or payment plans based on:

1. Race or ethnicity
2. Color
3. National origin
4. Religion
5. Sex, gender identity, or sexual orientation
6. Age
7. Disability
8. Marital or family status
9. Veteran status
10. Immigration status
11. Insurance status
12. Any other protected characteristic

Eligibility is based solely on financial need and medical necessity.

Confidentiality

All financial and personal information submitted by the patient is:

1. Kept confidential
2. Used only for determining eligibility
3. Protected under HIPAA and other privacy laws
4. Never shared with external entities except as required by law

Reporting And Compliance

FHC will:

- Track all charity care and discount services
- Maintain documentation for auditing purposes
- Report charity care annually to the Maryland Health Care Commission (MHCC) and other agencies as required
- Comply with **COMAR 10.24.16.08E**

Quality And Performance Monitoring

As part of FHC's **Quality Assurance and Performance Improvement (QAPI)** program:

- Utilization of charity care will be reviewed to ensure access
- Barriers to care will be identified and addressed
- Trends in service needs will inform resource planning
- Policy effectiveness will be reviewed annually

Governance And Policy Review

- This policy will be reviewed and updated at least **annually**
- Sliding fee scale will be updated annually according to the latest FPL guidelines
- Significant changes will be approved by senior leadership or governing body
- Staff will receive training on any revisions

No Delay Or Denial Of Service

FHC will **not delay, deny, or discontinue** medically necessary services due to a patient's inability to pay or due to charity/discount application status.

No patient will be referred to collections or incur negative action while an application is pending.

SLIDING FEE SCALE TABLES

Effective Date: 2025

Based on the Federal Poverty Guidelines (FPG)

This Sliding Fee Scale is used to determine the level of financial assistance available to eligible clients of First Healthcare Consultants LTD(FHC). Discount levels are determined by household income and size, as verified through the FHC Financial Assistance Application.

INCOME ELIGIBILITY & DISCOUNT TABLE

All percentages refer to Federal Poverty Guideline (FPG) thresholds.

Household Income as % of FPG	Discount Level	Client Responsibility
0% – 200% of FPG	100% Discount (Full Charity Care)	$0 owed
201% – 300% of FPG	75% Discount	25% of charges
301% – 350% of FPG	50% Discount	50% of charges
351% – 400% of FPG	25% Discount	75% of charges
Above 400% of FPG	Standard Charges Apply – Unless Financial Hardship is documented	May qualify for Time-Payment Plan or Special Hardship Review

HOUSEHOLD INCOME TABLE – 2025 FEDERAL POVERTY GUIDELINES

(Effective January 2025 — official HHS values)

Household Size	100% FPG	200% FPG	300% FPG	400% FPG
1	$15,650	$31,300	$46,950	$62,600
2	$21,150	$42,300	$63,450	$84,600
3	$26,650	$53,300	$79,950	$106,600
4	$32,150	$64,300	$96,450	$128,600
5	$37,650	$75,300	$112,950	$150,600
6	$43,150	$86,300	$129,450	$172,600
7	$48,650	$97,300	$145,950	$194,600
8	$54,150	$108,300	$162,450	$216,600

For households larger than eight (8), add $5,500 for each additional person at the 100% FPG level, then multiply accordingly for higher percentages. larger than 8, add $5,140 per additional person (100% FPG baseline). Values are updated each year when HHS issues new guidelines.

PROGRAM NOTES

- Determinations are based on **gross household income** and documentation submitted.
- Clients with **special financial hardship** may request individualized review.
- Discounts apply only to medically necessary home health services.
- Probable eligibility is determined within **two business days**, as required by Maryland law.

POSTING REQUIREMENT

This chart must be posted:

- In the FHC main office
- On the official website
- In all service intake areas
- Included in client admission packets

*For questions or assistance, call FHC at **301.725.1800** or **info@fheconsultantsus.com***

HEALTH EQUITY & CHARITY CARE COMPLIANCE WORKSHEET

Applicant: First Healthcare Consultants LTD (FHC)

Project Type: Establishment of a Home Health Agency (HHA)

Jurisdictions Served: Anne Arundel, Montgomery, Prince George's, and Southern

Regulatory Reference: COMAR 10.24.16.08E – Charity Care and Sliding Fee Scale: Each applicant for home health agency services shall have **a written policy** for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual's ability to pay and shall provide home health agency services on a charitable basis to qualified indigent and low-income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

COMAR STANDARDS	Quote from the policy	Section citation
1.Determination of Eligibility for Charity Care and Reduced Fees. Within **two business days following a client's initial request for charity care services**, **application for medical assistance, or both, the home health agency shall make a determination of probable eligibility** for medical assistance, charity care, and reduced fees, and **communicate** this probable eligibility determination to the client.	"FHC will make a **probable eligibility determination within two business days** of: (1) A request for charity care, (2) Submission of a financial assistance application, or (3) Submission of a Medical Assistance (Medicaid) application." During the first contact or upon referral, FHC will assess family size, insurance status, household income, and financial resources to determine probable eligibility." "Care will **not be denied or delayed** while an application is pending."	FHC Charity Care Assessment & Financial Assistance Policy — **Section V: Determination of Probable Eligibility** FHC Charity Care & Discount Policy — **Section VI: Application Process**

COMAR STANDARDS	Quote from the policy	Section citation
2.Notice of Charity Care and Sliding Fee Scale Policies. Public notice and information regarding the home health agency's **charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA's service area, and in a format understandable by the service area** population. Notices regarding the HHA's charity care and sliding fee scale policies shall be **posted in the business office of the HHA and on the HHA's website, if such a site is maintained. Prior to the provision of HHA services, a HHA shall address clients' or clients' families concerns with payment for HHA services** and **provide individual notice regarding the HHA's charity care and sliding fee scale policies to the client and family.**	**Public Notice Statement:** "First Healthcare Consultants LTD(FHC) will make home health care available to all adult residents… Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. **Probable eligibility will be determined within two business days**." "FHC will make this policy available: at admission, during financial counseling, in patient packets, on the website, and in publicly accessible office areas, in English, Spanish, and other languages."	FHC Charity Care Public Notice — **Public Notice Statement** FHC Charity Care & Discount Policy — **Section VIII: Communication of Policy** FHC Sliding Fee Scale Tables — **Posting Requirement Section**
3.Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each HHA's charity care policy shall **include provisions for a sliding fee scale and time payment plans for low-income clients who do not qualify for full charity care but are unable to bear the full cost of services.**	**Sliding Fee Scale:** "0–200% FPG — 100% Discount (Full Charity Care) 201–300% FPG — 75% Discount 301–350% FPG — 50% Discount 351–400% FPG — 25% Discount Above 400% FPG — hardship review or time-payment plan." "FHC provides charity care to patients with income at or below 100% FPL and discounted care up to 300% FPL."	FHC Sliding Fee Scale Tables — **Income Eligibility & Discount Table** FHC Charity Care & Discount Policy — **Section V: Sliding Fee Scale** FHC Time Payment Plan Policy — **Payment Plan Terms**

COMAR STANDARDS	Quote from the policy	Section citation
4. Policy Provisions. An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, **provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve** during the most recent year for which data is available. The applicant shall demonstrate that: **Its track record** in the provision of charity care services, if any, supports the credibility of its commitment; and **It has a specific plan** for achieving the level of charity care to which it is committed.	"FHC will **not deny, delay, or discontinue** medically necessary care based on inability to pay." "FHC does not discriminate in the provision of charity care… based on race, ethnicity, national origin, gender, age, disability, immigration status, insurance status, or any protected characteristic." "FHC provides charity care (free care) to patients ≤100% FPL and discounted care up to 300% FPL." "Probable eligibility will be determined within two business days… Discounts may be applied retroactively for up to 90 days." "Utilization of charity care will be reviewed to ensure access… Policy effectiveness will be reviewed annually."	FHC Charity Care & Discount Policy — **Sections II, IX & XII** FHC Charity Care Assessment & Financial Assistance Policy — **Section V**

Charity Care Assessment & Financial Assistance Policy

I. PURPOSE

First Healthcare Consultants LTD("FHC") or "FHC") is committed to ensuring that all individuals, regardless of their financial circumstances, have access to medically necessary home health services.

The purpose of this policy is to establish clear, compliant, and equitable policies for assessing and providing financial assistance, including charity care, sliding fee scale discounts, and time-payment arrangements, to eligible clients of FHC.

This policy aligns with FHC's mission of serving underserved and medically complex populations and complies with all applicable federal and state regulations, including **COMAR 10.24.16.08E**, **COMAR 10.24.01.08G(3)(f)**, COMAR 10.24.01.09 and CMS Conditions of Participation as well as all applicable federal and state regulations.

FHC will not deny, delay, or discontinue medically necessary care based on a patient's inability to pay.

II. POLICY STATEMENT

First Healthcare Consultants LTD(FHC) is committed to ensuring access to high-quality home health services for all adult residents of its licensed service area, including individuals who are uninsured, underinsured, or experiencing financial hardship. FHC does not discriminate based on race, color, creed, gender, age, sexual orientation, gender identity, national origin, disability, or financial status.

Clients who lack adequate insurance coverage and demonstrate inability to pay may qualify for:

- Charity care (free or reduced-cost services)
- Sliding fee scale discounts based on Federal Poverty Guidelines
- Time-payment plans allowing extended, affordable repayment options

FHC will make timely determinations of probable eligibility in accordance with MHCC regulations.

III. PUBLIC NOTIFICATION

In compliance with Maryland regulations, FHC will publicly communicate its Charity Care and Financial Assistance policies through:

- Notices posted prominently in FHC business offices,
- Information published on FHC's official website,
- Annual newspaper publication within the service region.

Required Notice Language:

"First Healthcare Consultants LTD will make home health care available to all adult residents of its service area regardless of race, creed, gender, age, sexual orientation, national origin, or financial status. If insurance coverage is not available for reimbursement, patients or guarantors are responsible for payment. Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. Probable eligibility will be determined within two business days of a request for assistance or an application for Medical Assistance. Assistance amounts are based on Federal Income Poverty Guidelines. For information or applications, call 301.725.1800."

IV. PAYMENT EXPECTATIONS & TIME-PAYMENT PLANS

Clients who do not qualify for Medicaid, insurance reimbursement, or charity care are responsible for payment of services rendered. FHC will:

- Issue billing statements over a three-month cycle,
- Provide follow-up communication after the second billing notice,
- Offer time-payment plans with minimum monthly payments as low as $10,
- Allow repayment periods up to 18 months based on financial circumstances.

V. DETERMINATION OF PROBABLE ELIGIBILITY

FHC will make a **probable eligibility determination within two business days** of:

- A request for charity care,
- Submission of a financial assistance application,
- Submission of a Medical Assistance (Medicaid) application.

During the first contact or upon referral, FHC will assess:

- Family size,
- Insurance status,
- Household income and available financial resources.

Probable Eligibility Guidance:

1. If the client has applied for Medicaid, FHC will treat the client as Medicaid-pending unless a denial occurs.
2. If the client:
    a. Lacks insurance,
    b. Is not eligible for Medicaid, and
    c. Demonstrates insufficient income or resources, the client will be considered probably eligible for charity care or sliding-scale discounts.

Clients will receive written communication of probable eligibility determination.

VI. FINAL ELIGIBILITY DETERMINATION

1. Final charity care eligibility must be determined by FHC. A client's self-declaration of inability to pay is not considered adequate proof.
2. Clients who have applied for Community Medicaid and completed required documentation may be accepted as "Medicaid Pending." In these cases, no FHC charity form is required, but FHC will monitor Medicaid application progress.
3. FHC will assess total financial resources, including disposable income, assets, and ordinary living expenses.
4. FHC must confirm that no other party is legally responsible for the patient's medical expenses.

VII. SLIDING FEE SCALE

FHC will apply sliding-scale discounts based on the most current **Federal Poverty Level (FPL)** guidelines (See Exhibit on Federal and State FPL Guidelines). Eligibility and discount tiers will be published annually and included in the client information packet.

VIII. DOCUMENTATION REQUIREMENTS

Clients applying for charity care, sliding-scale discounts, or time-payment arrangements may be required to provide:

- Proof of income (pay stubs, tax return, benefits statements),
- Household size verification,
- Medicaid denial letter (if applicable),
- Documentation of financial hardship or catastrophic events.

FHC will maintain confidentiality and handle all documentation in compliance with HIPAA and state privacy laws.

IX. STAFF RESPONSIBILITIES & TRAINING

FHC staff responsible for intake, billing, and financial assistance review shall be trained annually in:

- Eligibility determination procedures,
- Federal and state regulatory requirements,
- Communication of patient rights and available financial options.

X. RECORDKEEPING & COMPLIANCE

FHC will maintain records of:

- All applications received,
- Probable and final eligibility determinations,
- Correspondence with clients regarding financial assistance,
- Annual publication notices.

Records will be retained in accordance with MHCC, Medicare Conditions of Participation, and state recordkeeping requirements.

XI. POLICY REVIEW

This policy will be reviewed annually and updated to reflect FHC operational updates, regulatory changes, and changes to Federal Poverty Guidelines.

XII. REGULATORY AUTHORITY

This policy is established in accordance with the following Maryland laws and regulations:

- **COMAR 10.24.16** – Home Health Agency Regulations
- **COMAR 10.24.10** – Certificate of Need Procedures
- **COMAR 10.24.01.08G** – Charity Care Standards
- **Maryland Health–General §19-214.1** – Billing & Financial Assistance Notice Requirements

XIII. DEFINITIONS

Charity Care: Free or discounted services provided to eligible clients based on financial hardship.
Sliding Fee Scale: A structured discount schedule tied to Federal Poverty Level (FPL) income brackets.

Probable Eligibility: A preliminary determination made within two business days based on available information.

Financial Hardship: A circumstance in which a client lacks sufficient income or assets to pay for medically necessary care.

Medicaid Pending: Status given to a client who has applied for Medical Assistance but has not yet received a determination.

XIV. SLIDING FEE SCALE

FHC applies a transparent, annually updated sliding fee scale based on Federal Poverty Guidelines:

- **0–200% FPL:** 100% discount (free care)
- **200–300% FPL:** 75% discount
- **300–350% FPL:** 50% discount
- **350–400% FPL:** 25% discount
- **Above 400% FPL:** May be eligible for time-payment plans or special hardship review.

A full version of the Sliding Fee Schedule will be included in the FHC client information packet and posted publicly.

XV. PATIENT RIGHTS

All clients receiving services from FHC have the right to:

- Apply for charity care, sliding-scale discounts, or time-payment arrangements.
- Receive a probable eligibility determination within two business days.
- Receive written notification of approval, denial, or need for additional documentation.
- Appeal any denial of financial assistance.
- Receive medically necessary services without discrimination, delay, or retaliation.

Applying for financial assistance **will not** affect the quality, timeliness, or availability of services.

XVI. APPEALS AND RECONSIDERATION

Clients may request reconsideration of any denial within **15 days** of notification. Appeals must be submitted in writing and may include new or updated financial information.
FHC will review and respond to appeals within **10 business days** of receipt.

XVII. DOCUMENTATION & RETENTION REQUIREMENTS

FHC will retain all charity care applications, probable eligibility determinations, final eligibility decisions, appeals and associated outcomes, and all financial documentation used in determining eligibility for a minimum of seven (7) years. These records will be securely maintained in compliance with HIPAA requirements and all applicable Maryland state privacy regulations.

XVIII. ANNUAL REVIEW & APPROVAL AUTHORITY

This policy will be reviewed annually, and all revisions must be approved by the FHC Administrator and the FHC Compliance Officer. Updates will reflect regulatory changes, MHCC CON requirements, and modifications to operational practices.

XIX. NON-RETALIATION ASSURANCE

FHC strictly prohibits retaliation or any adverse action against clients who request financial assistance, apply for charity care or sliding-scale discounts, or appeal a financial determination. Medical services will not be delayed or denied while a charity care application is being processed.

FHC Charity Care Public Notice

First Healthcare Consultants LTD(FHC) will make home health care available to all adult residents of its service area regardless of race, creed, gender, age, sexual orientation, national origin, or financial status. If insurance coverage is not available for reimbursement, patients or guarantors are responsible for payment. Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. Probable eligibility will be determined within two business days of a request for assistance or an application for Medical Assistance. Assistance amounts are based on Federal Income Poverty Guidelines. For information or applications, call 301.725.1800.

Please complete the attached application. Once completed submit the application and all required supporting documentation to:

First Healthcare Consultants LTD
RE: Client Financial Services Department
Address: 12906 North Point Lane, Unit A, Laurel, MD 20708
Phone: 301.725.1800
Fax: 1.800.275.0157
Email: info@fheconsultantsus.com

CHARITY CARE & FINANCIAL ASSISTANCE APPLICATION FORM

This application is used to determine eligibility for Charity Care, Sliding-Scale Discounts, or Time-Payment Arrangements under the First Healthcare Consultants LTD(FHC) Charity Care and Financial Assistance Program.

Applicants must complete all sections and provide required documentation. Incomplete applications may delay processing.

SECTION 1. APPLICANT INFORMATION

Name

Date of Birth / /

Social Security Number - -

Address

City **State** **ZIP**

Phone **Email**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

U.S. Citizen: ☐ Yes ☐ No

Permanent Resident: ☐ Yes ☐ No

Employer

Employer Address

City **State** **ZIP**

SECTION 2. HOUSEHOLD MEMBERS

List all members of your household, including yourself.

Name	Age	Relationship	Monthly Income

SECTION 3. MEDICAL ASSISTANCE / INSURANCE STATUS

Have you applied for Medicaid/Medical Assistance? ☐ Yes ☐ No

If YES, Date Applied" **/** **/**

Status: ☐ Pending ☐ Approved ☐ Denied

Do you receive any state or county assistance? ☐ Yes ☐ No

If Yes, Describe:

SECTION 4. MONTHLY INCOME

List gross monthly income for all sources. Attach documentation for each applicable item.

Income Source	Monthly Amount
Employment	
Retirement / Pension	
Social Security	
Disability	
Public Assistance	
Unemployment	
Veterans Benefits	
Alimony	
Rental Income	
Self-Employment	
Other:	
TOTAL	

SECTION 5. ASSETS

LIQUID ASSETS

Asset Type	Current Balance
Checking Account	
Savings Account	
CD/Bonds/Money Market	
Other	
TOTAL	

OTHER ASSETS

Asset Type	Make / Year	Approximate Value / Loan Balance
Home		
Primary Vehicle		
Other		
TOTAL		

SECTION 6. MONTHLY EXPENSES

Expense Type	Monthly Amount
Rent / Mortgage	
Utilities	
Car Payment(s)	
Credit Card(s)	
Insurance (Car)	
Insurance (Health)	
Medical Expenses	
Food	
Other:	
TOTAL	

Do you have unpaid medical bills? ☐ Yes ☐ No
If yes, for what service(s)?

If you already have a payment plan, **monthly payment amount:** _____

SECTION 7. DOCUMENTATION CHECKLIST

Please attach copies (not originals) of the following, when applicable:

- ☐ Last 3 months of pay stubs
- ☐ Employer income verification letter
- ☐ Last year's tax return (if self-employed)
- ☐ 3 months of bank statements
- ☐ Social Security / pension award letters
- ☐ Public assistance or benefit letters
- ☐ Letter of support (if another person provides housing/food)
- ☐ Medicaid denial or approval letter (if applicable)

SECTION 8. CERTIFICATION & SIGNATURE

I certify that the information provided in this application is accurate and complete. I understand that First Healthcare Consultants LTD may request additional information to determine eligibility. I agree to notify FHC of any changes to my financial situation within 10 days.

Applicant Signature

Date: **Relationship to Patient:**

Exhibit 9

December 26, 2025

Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215

Re: First Healthcare Consultants Ltd Funds Availability

Dear Commissioners and Staff:

Please accept this letter as our acknowledgement that, as of the date of this letter, First Healthcare Consultants Ltd has cash available in excess of $400,000 to fund its proposed home health agency project. These funds are unrestricted in nature and are immediately available for use for the start-up of a new business.

This letter is issued solely for the benefit of First Healthcare Consultants Ltd, and Atlantic Union Bank assumes no liability whatsoever in connection with this letter.

Please contact me directly with any questions.

Sincerely,

Cynthia Long
Assistant Vice President | Branch Manager
Laurel Main Branch | 319 Main Street | Laurel, MD 20707
(240) 264-5422 | cindy.long@atlanticunionbank.com

Exhibit 10

2.17 DISCHARGE/TRANSFER POLICY

1. The Agency will maintain a process for the ongoing assessment of each patient/client's continuing care and discharge planning needs. This is required to ensure that patient/client discharges are adequately planned to terminate services when the patient/client no longer has a need or desire for care, and to ensure that the patient/client's continuing care needs are met and that the patient/client participates in the discharge planning process. The reason for discharge is discussed and charted.

2. Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, care, all physicians issuing orders for the agency plan of care, and the patient's primary care practitioner or other healthcare professional who will be responsible for providing care and services to the patient after discharge for the agency (if any).

3. Patients/clients may be discharged for various reasons including the patient expires, the client/patient's condition improves and therefore the client/patient no longer needs the care provided, the physician discontinues the order for home care services, the patient moves out the Agency geographic service area or the client/patient refuses the care and requests discontinuation of services.

4. Discharge planning shall begin at the time of admission with patients/clients included in the process and being advised as to the expected duration of treatment. Re-evaluation by the RN and additional planning with the patient/client shall occur throughout the course of care and shall include documentation of specific plans and the expected date of discharge.

5. Discharge plans will be coordinated with other care/service providers, as applicable.

6. All discharged patients will have required documentation to ensure appropriate communication is provided to the physician, as requested.

7. Patients may require transfer from the Agency. Reasons for transfer include the patient moves out of the Agency geographic area, the patient requires care/service not provided by the Agency or the Agency is not a preferred provided by the patient's insurance company.

8. All transferred patients will have required documentation to ensure appropriate communication is provided to the receiving agency.

Discharge/Transfer Procedure:

1. The Agency will develop and implement an effective transfer and discharge planning process for patients who are transferred to another agency or who are discharged to a Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), or Long Term Care Hospital (LTCH).

2. The Agency will assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The Agency must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

3. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.

4. This broad, flexible requirement allows home health agencies to tailor the exchange of information to the exact circumstances and needs of the care transition in order to support the patient's post-discharge goals.

5. Continue to send Discharge summary to post-discharge provider.

6. Agencies will be required to provide data to the patient and caregiver on quality and resource use measures that are relevant to the patient's goals of care and treatment preferences. This applies for patients discharged to a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF) or long-term care hospital (LTCH). **Transfers to hospitals are not included in the requirement for home health agencies.**

    a. Instead of a specified list, the Agency will send necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences to the receiving facility of health care practitioner to ensure the safe and effective transition of care.

    b. The Agency is required to comply with requests for additional necessary clinical information made by the receiving facility or health care practitioner,

which may include items such as a copy of the patient's current plan of care or latest physicians' orders.

c. Information you have to share outcomes with:

    a. Home Health Agencies

    b. Skilled Nursing Facilities

    c. Inpatient Rehabilitation Facilities

    d. Long Term Acute Care Hospital

7. Quality measures and data on resource-use measures relevant to patient goals and treatment preferences; see below:
    a. https://www.medicare.gov/homehealthcompare/search.html

    b. https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

    c. https://www.medicare.gov/nursinghomecompare/search.html

    d. https://www.medicare.gov/longtermcarehospitalcompare/

8. The patient will be transferred or discharged when:
    a. It is necessary for the patient's welfare because the agency and the physician agree the agency can no longer meet the patient's needs.
    b. The patient or payor will no longer pay for services.
    c. The goals of the patient have been met.
    d. Patient choice.
    e. Patient dies.
    f. The agency ceases to operate.

9. At least 2 days before the discharge (final) visit, the Medicare beneficiary patient will receive the notice to discharge with instructions on the purpose of the form. The patient will be required to sign the Notice of Medicare Non-Coverage (NOMNC). Included on the NOMNC form will be the name and phone number of the local QIO for the patient to contact in the effect the patient wishes to appeal the discharge. If any of the following reasons are present the Notice of Non-Coverage form should not be used:

    a. because the Medicare benefit is exhausted;
    b. for denial of Medicare admission;
    c. for denial of non-Medicare covered services; or
    d. due to a reduction or termination of Medicare services that do not end the skilled Medicare services.

In these cases, the patient will receive the CMS form 1003-Notice of Denial of Medical Coverage (NDMC).

10. When the patient/client is transferred to another organization or facility, the patient/client is informed in a timely manner of the need for transfer and/or level of care and of the alternatives. The patient/client and family have input into these decisions. They are notified of any financial benefit to the referring home care. Relevant information regarding the patient/client's condition and care requirements will be provided verbally and in writing to the facility with the Agency becoming aware of the transfer.

11. A transfer does not need to be completed for patients who are temporarily at a facility for the purposes of observation and diagnostic testing if it is expected that home care will be resumed following the non-admission stay. However, an Agency representative will communicate with hospital personnel regarding the patient's care. The patient's clinical record will reflect the need for facility care with a communication note. Missed visit paperwork will be completed accordingly, if applicable.

12. All patients/clients will receive discharge instructions regarding his/her ongoing care needs prior to the final visit.

13. Prior to discharging the patient, the attending physician shall be notified. A written discharge summary will be sent to the physician within 5 business days of discharge with a copy maintained in the clinical record. The discharge summary will include:
    a. Patient identifying information
    b. Patient's physician and phone number
    c. The reason for discharge
    d. The date of discharge
    e. The patient's physical and psychosocial status at the time of discharge
    f. The patient's diagnosis
    g. A summary of the care and services provided
    h. Patient progress toward desired goals
    i. Instructions and referrals provided to the patient

14. Agency staff will be responsible for assisting the patient /family to identify and provide for anticipated care needs after discharge from the Agency.

15. Patient/family will be informed of the discharge, orally and in writing, at least five (5) days prior to discharge. The following will be discussed:

a. The date of the discharge
b. The reason for the discharge
c. Contact information for the receiving facility if the patient is to be transferred.
d. Expectation that they will participate in their discharge planning process.

16. OASIS data sets are completed when a patient is transferred or discharged.

17. Patients are discharged from the Agency for cause in the following situations:

a. The treatment goals are attained or are no longer attainable
b. A change in the patient/client's condition requires care or services other than those that can be safely provided by the Agency
c. Another person (i.e., family member) is able and willing to provide the required service
d. The patient refuses to obtain needed medical supervision
e. The patient and/or family consistently refuse to cooperate in attaining treatment goals
f. The home setting is not suitable
g. The patient moves from the geographic area served by the Agency
h. The patient is receiving the same services from another Agency
i. The physician consistently fails to sign the plan of treatment in the required time period or does not renew the Plan of Care at the 60-day interval or gives orders that are not consistent with the stated diagnosis
j. The Agency is closing out a particular service or all of its services; in such instances appropriate referral will be made
k. The patient is institutionalized
l. The patient expires
m. The patient, family, or physician requests discharge
n. Payment sources are exhausted, and the Agency is fiscally unable to provide free or reduced-fee care. In such instance appropriate referral will be made with the patient's participation in the discharge/transfer process
o. Behavior of patient or caregiver interferes with the agency's ability to provide care. The patient is non-compliant or continuously abusive to staff and all interventions have failed; appropriate referral will be made
p. The situation is unsafe for the staff
q. The patient requires continuous care in the home, over and above the intermittent care provided by the Agency

r. The patient is no longer homebound by Medicare definition (when applicable).

Discharge of Patients in Unsafe Situations

The safety of field staff is of primary importance. If in any way this safety would be compromised, the case (after all efforts to resolve the issues have been exhausted) will be closed and the patient and/or responsible caregivers will be notified.

1. In any situation where a field staff person feels immediate danger and/or a threat to safety, the home or area should be left at once and the supervisor notified.

2. If there are ongoing unsafe situations in the home or area, which the field staff observes, this should be brought to the attention of the supervisor as soon as possible. Examples of unsafe situations include:

    a. Drug dealing

    b. Firearms which are visible and available

    c. Persons in the home or proximity who exhibit violent or agitated, threatening behavior

    d. Environmental issues, e.g., vermin, open flames near oxygen cylinders, animal droppings, etc.

    e. Animals that are not locked away. If injury occurs involving an animal attacking a patient/client or employee, the following procedure will be implemented:

        i. The employee will alert his/her supervisor immediately regarding the injury

        ii. Report the incident to the county animal control office

        iii. Notify the patient's physician (if the patient is injured) and carry out orders, if any

        iv. Document the incident in the patient/client's clinical record (if patient is injured)

        v. Complete an Incident/Accident Report form and submit it to the Administrator

        vi. If the employee is injured, the employee is sent to the emergency room of the hospital of choice for treatment.

3. A patient care conference, with the participation of all appropriate disciplines will be held to discuss the situation and any appropriate actions which could be taken.

4. Documentation will include a description of the situation, any discussions and communications with the patient, caregiver, organizational staff, community resources, etc., and any actions to be taken.

5. If the decision is made to discharge the patient/client, the following steps will be taken:
    a. The patient/client or representative will be notified by administration of the decision to discharge, the reason and the date of the last visit by certified mail. Whenever possible, the patient/client will be given time to secure other modes of care or placement.

    b. The agency will provide the patient or representative with contact information of other agencies that may be able to provide care.

    c. The physician involved and any appropriate referral source or community resources will also be informed by telephone and certified mail.

    d. A summary of the situation, attempts to resolve it, and the action taken, will be documented and placed in the chart.

Completion of Discharged Records

In order to verify closure of inactive records, all clinical records will be completed and audited within thirty days of discharge as follows:

1. The clinical record of a discharged patient/client is fully completed, including a discharge summary that is sent to the physician within five (5) business days of the discharge.

2. Each clinical record is audited within ten working days and returned to the secretary for filing.

Interruption of Services

When an interruption of services occurs during a patient/client's certification period, a form is to be completed and placed in the clinical record with previous progress notes to clarify why visits have not occurred. This will apply to instances in which the patient/client has been admitted to the hospital or to any other situation that creates the need for a brief, temporary hold on Agency services. It does not apply to a one-time missed visit occurrence.

1. When an interruption of services occurs, the following procedure should be followed:

a. Complete the Interruption of Services/Transfer Summary form which includes an explanation as to why services must be temporarily halted and anticipated length of hold, if known.

    i. The Interruption of Services/ Transfer Summary must include:

        1. Date
        2. Patient identifying information and emergency contact
        3. Destination of patient transferred
        4. Contact person receiving report and date and time report given
        5. Patient's physician and phone number
        6. Diagnosis related to the transfer
        7. Significant health history
        8. Transfer orders and instructions
        9. A brief description of services/care provided and ongoing needs that cannot be met
        10. Patient progress toward desired goals
        11. Instructions and referrals provided to the patient
        12. Status of patient at the time of transfer

    The transfer form is required for patients who are temporarily admitted to the hospital for exacerbation of illnesses if it is expected that a home care will be resumed after hospitalization.

b. The Transfer Summary is sent within 2 business days of planned transfer or 2 business days of becoming aware of unplanned transfer if patient is still receiving healthcare services.

c. The Agency will maintain a log of hospitalized patients/clients.

d. Request notification of patient/client discharge from the hospital in order to resume home care if appropriate.

2. Once the patient/client has been released from the hospital and home health services have resumed, the form is completed, and an interim nursing assessment is performed by an RN to determine whether or not there has been a significant change in the patient/client’s needs.

3. If the patient/client is in the hospital at the time of recertification, the patient/client will be discharged from home health services and then readmitted to home health when discharged from the hospital in order to continue home care services.

4. If the patient/client expires while in the hospital, the discharge will be completed to reflect this occurrence and the clinical record will be closed.

Notice Delivery to Representatives

CMS requires that notification of changes in coverage for a beneficiary who is not competent be made to a representative acting on behalf of the beneficiary. Notification to the representative may be problematic because he or she may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary is incapable or incompetent, and the provider cannot obtain the signature of the beneficiary's representative through direct personal contact.

1. If the provider is unable to personally deliver a notice of non-coverage to a person legally acting on behalf of a beneficiary, then the provider should telephone the representative to advise him or her when the beneficiary's services are no longer covered.

2. The beneficiary's appeal rights will be explained to the representative, and the name and telephone number of the appropriate quality improvement organization (QIO) should be provided.

The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date.

1. Place a dated copy of the notice in the beneficiary's medical file and document the telephone contact to include name of person initiating the contact, name of the representative contacted, date and time of the contact and the telephone number called.

2. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested.

3. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt.

4. When notices are returned by the post office, with no indication of a refusal date, then the beneficiary's liability starts on the second working day after the provider's mailing date.

Exhibit 11

Quality Assurance and Performance Improvement (QAPI) Program & Policy

I. PURPOSE

The purpose of the Quality Assurance & Performance Improvement ("QAPI") Program is to ensure that First Healthcare Consultants LTD ("FHC") consistently delivers safe, effective, patient-centered, high-quality home health services and continuously improves clinical outcomes, patient experience, and operational performance across all service areas and patient populations.

This QAPI Program is designed to:

- Fully comply with CMS Conditions of Participation (42 CFR §484.65)
- Meet the Maryland State Health Plan standards (COMAR 10.24.16.08 – Quality)
- Satisfy COMAR 10.24.01.08G(3)(f) – Quality Review Criteria
- Align with Joint Commission Home Care Accreditation Standards
- Support FHC's mission to provide evidence-based, high-performing, equitable care

FHC is committed to serving **adult and pediatric patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay.

II. POLICY STATEMENT

FHC maintains an agency-wide, data-driven QAPI Program that is:

- Ongoing and proactive
- Led by administrative and clinical leadership
- Supported by all staff and disciplines
- Focused on measurable quality indicators and patient outcomes
- Linked to strategic goals, regulatory standards, and patient needs
- Driven by data, patient feedback, staff input, and regulatory requirements
- Designed to continuously improve performance, prevent problems and sustain excellence

III. SCOPE

This QAPI Program applies to:

- All departments and disciplines
- All clinical programs (skilled nursing, therapy, high-acuity care, pediatric care, chronic

disease programs, etc.)

- All service lines and locations (existing and new)
- All payor types (Medicare, Medicaid, commercial, private pay, etc.)
- All patient populations (adult, pediatric, medically complex, underserved)
- All aspects of operations that impact care quality and patient experience

IV. GOVERNANCE & RESPONSIBILITY

Governing Body

The Governing Body (or Administrator/Executive Leadership) holds ultimate responsibility for:

- QAPI design, implementation, and results
- Allocating adequate resources (staff, time, data systems, training)
- Approving QAPI goals and Performance Improvement Projects (PIPs)
- Reviewing QAPI quarterly and annual reports
- Holding leadership accountable for outcomes
- Ensuring QAPI aligns with strategic priorities and regulatory obligations

QAPI Committee

The QAPI Committee meets **at least quarterly** and includes:

- Administrator / Executive Director
- Director of Nursing / Clinical Director
- Therapy Supervisor(s)
- Quality Improvement Coordinator / QAPI Nurse
- Medical Director or physician advisor (as needed)
- Representatives from nursing, therapy, MSW, and home health aides
- Representatives from intake/scheduling/billing as appropriate

Responsibilities:

- Analyze quality data and trends
- Review patient outcomes and satisfaction
- Evaluate compliance with clinical standards and regulatory measures
- Identify opportunities for improvement
- Select and monitor PIPs
- Develop and track corrective action plans

- Report findings to the Governing Body

Management & Supervisors

Department leaders are responsible for:

- Monitoring discipline-specific quality indicators
- Educating and supervising staff
- Ensuring protocol compliance
- Implementing corrective actions
- Reporting issues to the QAPI Committee

All Staff Members

All employees participate in QAPI by:

- Delivering high-quality care
- Reporting incidents, near misses, and concerns
- Following policies and best practices
- Participating in training and improvement projects
- Supporting a culture of safety, accountability, and excellence

QAPI is embedded in daily operations — not a separate function.

V. QAPI PROGRAM STRUCTURE

FHC's QAPI Program includes four required components as defined by CMS:

Performance Measurement

Systematic collection and analysis of data in:

- Clinical outcomes
- Patient safety events
- Operational efficiency
- Patient experience & satisfaction
- Staff competency and retention
- Regulatory compliance

Performance Improvement Activities

When opportunities or problems are identified, FHC:

- Conducts root cause analysis (RCA)
- Develops and implements corrective actions
- Re-measures performance
- Ensures sustained improvement

Performance Improvement Projects (PIPs)

Data-driven, interdisciplinary projects that focus on:

- High-risk, high-volume, or problem-prone processes
- Critical quality concerns or strategic priorities
- Patient safety, access, or outcome improvements

Continuous Feedback & Integration

QAPI activities lead to:

- Policy and procedure updates
- Staff training
- Operational changes
- Technology enhancements
- Resource allocation
- Long-term strategic planning

VI. QUALITY INDICATORS & DATA SOURCES

FHC collects both quantitative and qualitative data, including:

Clinical Outcomes (examples):

- Wound healing rates
- Improvement in functional ability
- Pain management effectiveness
- Medication reconciliation accuracy
- CHF/COPD/diabetes outcomes
- OASIS outcome measures
- High-acuity case success metrics (vent/trach/IV)

Patient Safety:

- Falls and fall-related injuries

- Infection rates (wound, line sepsis, etc.)
- Adverse events or medical errors
- Hospitalizations and ED visits (especially 30-day readmissions)
- Timeliness of interventions and follow-up

Operational Performance:

- Time from referral to admission (48-hour standard)
- Same-day or next-day start of care rate
- Visit frequency compliance
- Missed or canceled visits
- Staff productivity and caseload
- Scheduling efficiency

Patient Experience:

- Patient satisfaction surveys (98% historical performance)
- Family/caregiver feedback
- Complaint/grievance tracking
- Net promoter scores (if used)

Staff & Workforce:

- Staff retention and turnover
- Competency validation results
- Training completion rates
- Staff satisfaction and culture assessments

Regulatory Compliance:

- CMS process measures (e.g., timely initiation of care)
- State requirements (COMAR)
- Joint Commission standards
- Documentation audit results

VII. HEALTH EQUITY & ACCESS MONITORING

FHC actively monitors access and outcomes to ensure care is **equitable and effective** across:

- Geographic areas

- Age groups (including pediatric vs adult)
- Disability or functional status
- Socioeconomic status / payor type
- Race / ethnicity / language
- Medically underserved or rural populations

When disparities are identified, FHC implements targeted interventions (e.g., outreach, staff education, telehealth expansion, partnerships with local providers).

VIII. USE OF TECHNOLOGY & DATA ANALYTICS

FHC leverages technology to enhance quality:

- **Electronic Health Record (EHR)** with integrated clinical alerts, documentation audits, and outcomes tracking
- **Clinical dashboards** to monitor real-time performance
- **Telehealth and remote monitoring** to support high-acuity, rural, and chronic care populations
- **Data analytics tools** to identify trends, predict risks, and support early intervention
- **Secure communication platforms** to coordinate interdisciplinary care and reduce delays Technology supports **faster decisions, better coordination, and improved patient safety.**

IX. PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

Purpose of PIPs

Performance Improvement Projects are **targeted, data-driven initiatives** aimed at improving specific aspects of care with the greatest impact on:

- Patient outcomes
- Safety
- Access
- Satisfaction
- Regulatory compliance
- Strategic goals

Criteria for Selecting PIPs

PIPs are initiated when:

- Quality data reveals below-target performance

- A process is high-risk or high-volume
- A problem is persistent or trending negatively
- Regulatory requirements indicate focus
- Staff, patient, or caregiver feedback identifies issues
- Strategic priorities or innovation opportunities arise

Examples of PIPs FHC May Conduct:

- Reduce 30-day hospital readmission rates (CHF, COPD, wound infections)
- Improve admission timeliness (48-hour or same-day starts)
- Strengthen medication reconciliation accuracy
- Improve caregiver education and competency in high-acuity cases
- Increase wound healing rates
- Decrease missed or canceled visits
- Enhance pediatric tracheostomy or ventilator care outcomes
- Improve documentation completeness and timeliness
- Increase patient satisfaction scores beyond 98%

PIP Methodology

Each PIP follows a structured improvement model:

- Define the problem with data
- Establish measurable goals/outcomes
- Form an interdisciplinary PIP team
- Conduct root cause analysis (e.g., fishbone, 5 Whys)
- Develop and implement interventions
- Measure progress regularly
- Modify interventions as needed
- Sustain successful improvements
- Report to QAPI Committee and Governing Body

Minimum Requirement

At least **one PIP at all times**, as required by CMS. FHC typically conducts **multiple PIPs simultaneously** to drive improvement across key areas.

X. USE OF QAPI TO DRIVE RESOURCES & STAFFING

FHC uses QAPI findings to inform:

- Staffing levels and caseload distribution
- Specialized clinical training needs
- Recruitment of high-acuity and pediatric specialists
- Investment in telehealth, remote monitoring, and data systems
- Scheduling and workflow optimization
- Budget allocation for quality initiatives
- Development or expansion of specialty programs

Quality drives operational decision-making at FHC.

XI. VALUE-BASED CARE & INNOVATION

FHC aligns QAPI with Home Health Value-Based Purchasing (HHVBP) measures, including:

- Improvement in ambulation
- Improvement in self-care
- Medication management
- Hospital readmission reduction
- Patient experience (satisfaction and communication)
- Timely initiation of care
- Adopt evidence-based best practices
- Pilot new care models (e.g., advanced chronic care programs)
- Scale successful initiatives across all service areas
- Drive efficiency without sacrificing care quality

XII. PATIENT SAFETY & RISK MANAGEMENT

FHC uses a comprehensive safety program that includes:

- Incident and near-miss reporting (non-punitive culture)
- Investigation and root cause analysis (RCA)
- Corrective action implementation
- Regular safety rounds (field observations, case reviews)
- Fall and injury prevention strategies
- Medication safety protocols

- Infection surveillance and control
- Emergency preparedness drills
- Staff safety training and reporting mechanisms

High-risk events are reported to the Governing Body and monitored for trends.

XIII. STAFF EDUCATION & COMPETENCY

QAPI findings directly inform staff training, including:

- Orientation and annual competencies
- High-acuity skills (vent/trach, wound, IV, pediatric)
- Documentation accuracy
- Cultural competence and health equity
- Emergency preparedness
- Ethics and patient rights
- Regulatory changes and best practices

FHC ensures:

- Competency checklists are validated
- Staff receive ongoing education
- Performance issues lead to targeted retraining or coaching
- High performers are recognized and used as preceptors/mentors

XIV. DOCUMENTATION & REPORTING

FHC maintains comprehensive records of:

- QAPI Committee meetings
- Quarterly performance dashboards
- Data trend reports and analysis
- Identified issues and improvement actions
- PIP charters, interventions, and outcomes
- RCA findings and action plans
- Staff training related to QAPI
- Annual QAPI Program evaluation

Documentation is maintained in a secure, organized manner and is available to CMS, state surveyors, and accrediting bodies.

XV. ANNUAL QAPI PROGRAM EVALUATION

Every year, FHC conducts a formal QAPI Program Evaluation that includes:

- Review of quality indicators and trends
- Summary of PIPs conducted and outcomes
- Analysis of goals met and unmet
- Identification of emerging risks or gaps
- Assessment of resource sufficiency
- Staff competency and training needs
- New priorities for the next year
- Recommendations for policy or operational changes
- Approval by Governing Body

XVI. CULTURE OF QUALITY & CONTINUOUS IMPROVEMENT

FHC promotes a culture where:

- Quality is everyone's responsibility
- Data drives decisions
- Patient safety is non-negotiable
- Transparency is expected
- Improvement is continuous
- Success is celebrated
- Innovation is encouraged
- Patients, families, and staff are heard

FHC strives to be a leader in clinical excellence, patient satisfaction, and operational performance.

XVII. POLICY REVIEW & APPROVAL

This QAPI Program and Policy is reviewed at least annually and updated to ensure continued alignment with:

- CMS Conditions of Participation (42 CFR 484.65)
- COMAR 10.24.16.08 Quality standards & Best practices in home health care
- Community Health Accreditation Partner (CHAPs)

Hand Hygiene Technique Compliance

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

Instructions: This survey is designed to evaluate the understanding and application of proper hand hygiene practices among clients and their family members. Please complete each item by checking the appropriate box. Your participation helps us improve the quality of care provided.

1. Education & Understanding

- ☐ I received verbal and/or written instruction on proper handwashing techniques.
- ☐ I understand when handwashing is required (e.g., before/after care, meals, restroom use).
- ☐ I was educated on the differences between handwashing with soap and using hand sanitizer.
- ☐ I understand how hand hygiene helps prevent infections and protects my loved one.

2. Skill Demonstration (To Be Completed with Staff Observation)

- ☐ I demonstrated how to wash hands using soap and water, covering all hand surfaces for at least 20 seconds.
- ☐ I demonstrated how to use alcohol-based hand sanitizer appropriately when soap and water are not available.
- ☐ I performed hand hygiene before and after participating in patient care activities during the observation.
- ☐ Observed and Verified by Staff

3. Application and Compliance

- ☐ I am able to demonstrate proper hand washing technique.
- ☐ I have access to clean water, soap, and paper towels at home.
- ☐ I use hand hygiene consistently during daily routines and caregiving.
- ☐ I encourage other caregivers/family members to follow hand hygiene protocols.

4. Feedback

- ☐ I feel confident in my ability to maintain good hand hygiene.
- ☐ I would benefit from additional training or materials on hand hygiene.

☐ I am satisfied with the training provided by the agency.

5. Additional Comments (Optional)

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
This survey is confidential and used solely to evaluate and improve our educational services. Your feedback helps us ensure safety and compliance.

Tracheostomy Suctioning Techniques

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

Instructions: Please review the following items with the client or family caregiver. Check each box that applies. This form should be completed during initial training and reviewed annually or as needed.

1. Understanding of Suctioning Equipment Use

- ☐ Able to identify suction machine and its parts
- ☐ Can assemble suction equipment correctly
- ☐ Demonstrates knowledge of appropriate suction pressure settings
- ☐ Understands when and how often to suction

2. Demonstration of Proper Technique

- ☐ Performs hand hygiene before and after suctioning
- ☐ Uses appropriate Personal Protective Equipment (PPE)
- ☐ Measures catheter insertion depth accurately
- ☐ Suctions tracheostomy tube correctly (using circular motion, ≤ 10 seconds per pass)
- ☐ Allows sufficient recovery time between suction passes

3. Safety and Emergency Readiness

- ☐ Recognizes signs of respiratory distress
- ☐ Knows when to stop suctioning and call for medical help
- ☐ Keeps spare tracheostomy supplies readily available
- ☐ Able to describe steps for accidental decannulation

4. Post-Suctioning Care

- ☐ Cleans suction catheter or uses disposable appropriately
- ☐ Properly discards waste and used supplies
- ☐ Ensures tracheostomy ties are secure
- ☐ Monitors for secretions, bleeding, or skin breakdown around the stoma

5. Client/Family Confidence

- ☐ Verbalizes understanding of procedure
- ☐ Demonstrates confidence in performing suctioning independently
- ☐ Agrees to contact nurse if unsure or if changes are noticed

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Medication Management Education

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

1. Medication Education

a. Were you educated on how to take your medications safely?

☐ Yes ☐ No ☐ Not Sure

b. Do you understand the purpose of each medication you are currently taking?

☐ Yes, completely ☐ Somewhat ☐ No

c. Were written instructions (e.g., medication list or schedule) provided to you?

☐ Yes ☐ No ☐ Not Sure

d. Were you informed about potential side effects of your medications?

☐ Yes ☐ No ☐ Not Applicable

e. Do you know what to do or who to contact if you experience side effects?

☐ Yes ☐ No ☐ Not Sure

2. Medication Management Support

a. Do you use a pill organizer or reminder system (e.g., phone alert, caregiver)?

☐ Yes ☐ No ☐ Not Applicable

b. Did someone assist you with medication setup (sorting pills, creating schedule, etc.)?

☐ Yes ☐ No ☐ Not Applicable

c. Have your nurses or caregivers reviewed your medication list with you regularly?

☐ Yes, every visit ☐ Sometimes ☐ No

d. Do you feel confident managing your medications independently or with help?

☐ Yes ☐ No ☐ I need more training

e. How satisfied are you with the medication education provided?

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied

f. Would you like additional support or follow-up regarding your medications?

☐ Yes ☐ No

3. Feedback and Suggestions

How would you rate the clarity and usefulness of the medication management education you received?

- ☐ Very clear and helpful
- ☐ Somewhat helpful
- ☐ Not helpful
- ☐ I did not receive education

Do you have any suggestions on how we can improve our medication management education and support?

_____

_____

_____

_____

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Home Oxygen Safety

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

1. Oxygen Safety Training Completion

a. Did you (or your caregiver) receive education from a nurse or respiratory therapist on how to safely use and store oxygen at home?

☐ Yes ☐ No ☐ Not Sure

b. Was this training provided at the start of care or during your first oxygen setup visit?

☐ Yes ☐ No ☐ Don't Remember

c. Were written materials (handouts, checklists, or posters) provided to you on oxygen safety?

☐ Yes ☐ No ☐ Not Sure

d. Were you educated on the importance of avoiding smoking or open flames near oxygen?

☐ Yes ☐ No ☐ Don't Remember

e. Did the staff check where and how the oxygen tanks were stored in your home?

☐ Yes ☐ No ☐ Not Applicable

2. Confidence and Knowledge Retention

a. On a scale of 1 to 5, how confident do you feel about safely using and storing oxygen in your home?

☐ 1 – Not Confident

☐ 2 – Somewhat Confident

☐ 3 – Neutral

☐ 4 – Confident

☐ 5 – Very confident

b. Do you know what to do in case of an oxygen-related emergency or equipment failure?

☐ Yes ☐ No ☐ Not Sure

c. Do you know how to clean and maintain your oxygen equipment (if applicable)?

☐ Yes ☐ No ☐ Not Applicable (Maintenance handled by provider)

3. Feedback and Suggestions

Do you believe the training you received was:

- ☐ Easy to understand
- ☐ Too basic
- ☐ Too complicated
- ☐ Not applicable to your situation

Do you have any suggestions for improving how we provide oxygen safety training?

_____

_____

_____

_____

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Fall Prevention

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

1. Fall Prevention Education Completion

a. Did you receive education from a nurse or therapist on how to prevent falls at home?

☐ Yes ☐ No ☐ Not Sure

b. Was this training provided during your admission or within the first few days of service?

☐ Yes ☐ No ☐ Don't Remember

c. Were you given written materials (handouts or visual aids) on fall prevention?

☐ Yes ☐ No ☐ Not Sure

d. Did the staff discuss common household hazards that increase fall risk (e.g., loose rugs, poor lighting, uneven surfaces)?

☐ Yes ☐ No ☐ Not Sure

e. Did the nurse or staff make recommendations for home modifications (e.g., grab bars, non-slip mats, clutter removal)?

☐ Yes ☐ No ☐ Not Applicable

2. Confidence and Fall History

a. Have you or your caregiver made changes to your home environment to reduce fall risks?

☐ Yes ☐ No ☐ Not Applicable ☐ In Progress

b. On a scale of 1 to 5, how confident do you feel about avoiding falls in your home?

☐ 1 – Not Confident

☐ 2 – Somewhat Confident

☐ 3 – Neutral

☐ 4 – Confident

☐ 5 – Very confident

c. Since beginning care with our agency, have you experienced any falls?

☐ No falls ☐ One fall ☐ More than one fall ☐ Prefer not to say

3. Feedback and Suggestions

How would you rate the clarity and usefulness of the fall prevention education you received?

- ☐ Very clear and helpful
- ☐ Somewhat helpful
- ☐ Not helpful
- ☐ I did not receive education

Do you have any suggestions on how we can improve our fall prevention education and support?

_____

_____

_____

_____

_____ _____

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Feeding Tube Insertion Demonstration

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

Instructions: This survey is designed to assess your understanding and ability to demonstrate safe and accurate feeding tube insertion. Please complete the checklist below. Your feedback helps us maintain and improve our quality of care.

1. Feeding Tube Insertion Demonstration

Please check the box for each step that you or your caregiver feel confident in performing correctly after receiving education/training:

- ☐ Washed hands thoroughly before the procedure
- ☐ Verified the correct placement of the tube before use
- ☐ Flushed the tube with the appropriate solution prior to feeding
- ☐ Administered the correct formula and volume as directed
- ☐ Maintained proper positioning during and after the feeding
- ☐ Recognized signs of tube displacement or complications
- ☐ Cleaned the insertion site and equipment properly
- ☐ Documented feedings or reported to the nurse as instructed
- ☐ Felt comfortable asking questions or requesting help
- ☐ Understood the emergency steps in case of aspiration or blockage

2. Overall Understanding and Confidence

Please check the box that best represents your experience:

- ☐ I feel very confident performing this task independently
- ☐ I feel somewhat confident but may need occasional help
- ☐ I do not feel confident and need additional training

3. Additional Comments (Optional)

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
This survey is confidential and used solely to evaluate and improve our educational services. Your feedback helps us ensure safety and compliance.

Home Equipment Maintenance/Cleaning Compliance

Client Name: _____ Date: _____

Staff Completing Audit: _____

Instructions: This form should be completed by field staff conducting home visits. Please review each applicable equipment item for maintenance, cleanliness, and functionality. Select all that apply. Signature required at the end.

1. Equipment Inventory (Check all present in the home)

- ☐ Oxygen Concentrator
- ☐ Nebulizer
- ☐ Suction Machine
- ☐ Feeding Pump
- ☐ Pulse Oximeter
- ☐ Wheelchair / Walker
- ☐ Bed Rails / Hospital Bed
- ☐ Other (Specify): _____

2. Maintenance Compliance (Check all that apply)

- ☐ All equipment is clean and free of visible dust, mold, or residue.
- ☐ Equipment is stored in a safe, accessible location.
- ☐ Power cords and tubing are free from damage or frays.
- ☐ Disposable parts (filters, masks, tubes) have been replaced on schedule.
- ☐ Manufacturer's guidelines for cleaning/maintenance are being followed.
- ☐ No foul odors, rust, or leakage detected.
- ☐ Client/family was reminded about routine equipment checks.

3. Corrective Actions (if applicable)

- ☐ Client/family was educated on cleaning schedule
- ☐ Malfunctioning equipment was reported to agency or DME vendor
- ☐ Maintenance issue resolved during visit
- ☐ Follow-up visit scheduled
- ☐ Not applicable

4. Comments / Observations

Staff Auditor Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
This survey is confidential and used solely to evaluate and improve our educational services. Your feedback helps us ensure safety and compliance.

Hazard Vulnerability Assessment Completion

Client Name: _____ Date: _____

Staff Completing Audit: _____

1. Hazard Identification (Check all that apply in the client's home environment)

- ☐ Fire hazards (e.g., faulty wiring, unattended candles, overloaded outlets)
- ☐ Slip/trip hazards (e.g., loose rugs, cluttered walkways, wet floors)
- ☐ Inadequate lighting (especially near stairways or bathrooms)
- ☐ Unsecured medical equipment or tubing
- ☐ Poor ventilation or exposure to smoke/allergens
- ☐ Hazardous chemicals or substances accessible to children/vulnerable adults
- ☐ Pets that may pose fall risks or cause allergic reactions
- ☐ Lack of functioning smoke or carbon monoxide detectors
- ☐ Unsafe storage of medication or sharp objects
- ☐ Unclear emergency exits or blocked paths
- ☐ Other (Specify): _____

2. Client Education Topics Reviewed (Check all completed)

- ☐ Emergency preparedness (fire, medical, evacuation plan)
- ☐ Proper use and storage of medical equipment
- ☐ Fall prevention strategies
- ☐ Safe medication handling and disposal
- ☐ Environmental safety and cleanliness
- ☐ When and how to call emergency services
- ☐ Infection control measures (e.g., hand hygiene, disinfection)
- ☐ Other (Specify): _____

3. Client/Family Understanding

- ☐ Client/family understood hazard risks
- ☐ Client/family verbalized understanding of mitigation strategies
- ☐ Client/family demonstrated safe practices

4. Recommendations Made

Staff Auditor Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Client Satisfaction

Client Name: _____ Date _____

Staff Name: _____

Survey Completed by: ☐ Client ☐ Family Member ☐ Other (Specify) _____

Instructions: Please review each statement below and circle the number that best reflects your level of satisfaction. Your feedback is confidential and helps us improve our services.

How do you feel?	Very Satisfied	Satisfied	Neutral	Dis-satisfied	Very Dis-satisfied
Staff are respectful and professional	1	2	3	4	5
Staff arrive on time for scheduled visits	1	2	3	4	5
Communication with the agency is easy and responsive	1	2	3	4	5
My care plan is explained clearly and updated as needed	1	2	3	4	5
I feel safe and cared for by the staff	1	2	3	4	5
My needs are met in a timely and respectful manner	1	2	3	4	5
I am informed about my medications and treatments	1	2	3	4	5
The agency addresses my complaints or concerns promptly	1	2	3	4	5
Agency and staff are knowledgeable and professional	1	2	3	4	5
I am satisfied with the overall quality of services received	1	2	3	4	5

1. What do you like most about our services?

_____

_____

_____

_____

2. What could we do to improve our care services?

3. Additional comments or suggestions

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
This survey is confidential and used solely to evaluate and improve our educational services. Your feedback helps us ensure safety and compliance.

HAND HYGIENE / GLOVE USE

Staff Name / Title: _____ Location: ☐ Home ☐ Lab ☐ Office

MONTH	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Number of Nurses Observed												
Hand Hygiene (use of alcohol foam hand rub or washing hands with soap and water for at least 15 seconds)												
Before touching a patient	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Before clean and aseptic procedures, including medication suction, G-tube care, tracheostomy care, personal care, wound care,etc.	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
After touching the patient	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Before and after contacting equipment	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
After removing gloves or other personal protective equipment (PPE)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Proper donning and removing glove	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
After equipment contact upon exiting patient's room**	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Glove Use												
Whenever potential for hand contact with blood/body substance	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y N	☐ Y ☐ N	☐ Y ☐ N
Gloves removed right after use	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Total Score (total count of "Y")												
Compliance Score (total score / 9 * 100)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**

Annual Average Compliance Score: % National Average: % State Average: % Agency Goal: %

OXYGEN CYLINDER STORAGE COMPLIANCE

Staff Name / Title: _____ Location: ☐ Home ☐ Lab ☐ Office

MONTH	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Staff Position Observed	RN / LPN	HHA / CNA / PCA	RN / LPN	HHA / CNA / PCA	RN / LPN	HHA / CNA / PCA	RN / LPN	HHA / CNA / PCA
Cylinder stored in well-ventilated area	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Cylinder placed in the stander	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Cylinder stored in a manner to prevent hazard by tipping, falling or rolling.	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Cylinder stored upright	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Cylinders are 20 feet away from combustible or flammable substance	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Total Score (total count of "Y")								
Compliance Score (total score / 5 * 100)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**

Annual Average Compliance Score: **%** **National Average:** **%** **State Average:** **%** **Agency Goal:** **%**

OXYGEN SAFETY

Client Name: _____ Date of Birth: _____

Staff Name: _____ Training Date: _____

O2 Related Diagnosis: _____ Code Status: _____

Allergies: _____

1. Training Type:

- ☐ Initial Teaching
- ☐ Reassessment

2. Oxygen Type (used at home):

- ☐ Compressed oxygen cylinders, or "green tanks
- ☐ Oxygen concentrators
- ☐ Liquid oxygen systems

3. Means of Delivery:

- ☐ Nasal cannula
- ☐ Ventilator
- ☐ Mask
- ☐ Trach collar

4. Training Provided:

- ☐ Placing “No Smoking Oxygen in Use” signs
- ☐ Handling and storage of oxygen cylinders
- ☐ Hazards of smoking with oxygen in use
- ☐ Importance of securing electric devices to prevent short-circuit sparks.
- ☐ Danger of using volatile, flammable materials near the patient using oxygen

5. Trainees:

- ☐ Patient
- ☐ Mother
- ☐ Father
- ☐ Other:_____

6. Type of Training:

- ☐ Instructed
- ☐ Supervised
- ☐ Independent
- ☐ Return demonstration

7. Training Tools:

- ☐ Verbal
- ☐ Video
- ☐ Demonstration
- ☐ Printed material
- ☐ Other: _____

8. Response to Training:

☐ Good ☐ Fair ☐ Poor ☐ Anxious ☐ Unable to Cope

☐ Clear indication of understanding ☐ Needs further instruction

Plan for next training:

Equipment Cleaning Log

Client Name: _____ DOB: _____

EQUIPMENT TO CLEAN /CHANGE	HOW OFTEN	DATE CLEANED	PROPER CLEANSER USED	EQUIPMENT CHECKED	EQUIPMENT FUNCTIONS WELL	INITIALS
Suction machine	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Suction canister	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Suction Tubing	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Ventilator	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Ventilator Tubing	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Vent. Water Chamber	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
CPAP/BIPAP	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	

EQUIPMENT TO CLEAN /CHANGE	HOW OFTEN	DATE CLEANED	PROPER CLEANSER USED	EQUIPMENT CHECKED	EQUIPMENT FUNCTIONS WELL	INITIALS
CPAP/BIPAP tubing	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Monitors	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Nebulizer	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Aerosol Tubing	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Oxygen Tank	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Oxygen Tubing	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Oxygen Concentrator	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Tracheostomy Tube	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	

EQUIPMENT TO CLEAN /CHANGE	HOW OFTEN	DATE CLEANED	PROPER CLEANSER USED	EQUIPMENT CHECKED	EQUIPMENT FUNCTIONS WELL	INITIALS
Feeding Pump	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
IV infusion pump	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Wheelchair	Monthly		□Y □N	□Y □N	□Y □N	
Patient bed &furniture	Monthly		□Y □N	□Y □N	□Y □N	
Hoyer lift	Monthly		□Y □N	□Y □N	□Y □N	
Refrigerator	Monthly		□Y □N	□Y □N	□Y □N	
Medication cart	Monthly		□Y □N	□Y □N	□Y □N	
Toys	Monthly		□Y □N	□Y □N	□Y □N	

Staff Name (Print)	Initials

FALL REDUCTION PROGRAM EVALUATION

Reducing the risk of patient harm from falls is one of the National Patient Safety Goals established by the Joint Commission. FHC has implemented a fall-reduction program that provides guidelines for staff caring for patients at the agency. The program not only reduces the number of falls but also minimizes fall-related injuries.

Key components include:

- Fall Risk Assessment for each patient
- Environmental Assessment
- Staff education and training
- Education for patient & family
- Review of patient medications
- Individualized patient care plan
- Post-Fall Assessments
- Evaluation

FHC will measure the effectiveness of the program quarterly

The agency's comprehensive fall reduction program includes restraint-free tools to:

- Identify high fall risk patients
- Alert caregivers of a potential fall
- Hip protectors and floor cushions to reduce the risk of fall-related injuries
- Patient Safety tools to reduce the hazards within the patient's environment

Fall Risk Assessment Evaluation

Staff Name: _____ Date: _____

RISK CONTROL MEASURES	YES / NO	CORRECTIVE ACTION
Risk Assessment Process		
1. Is every client evaluated for risk of falling, utilizing a fall-assessment tool that considers the following factors, among others: a. Previous fall history and associated injuries? b. Gait and balance disturbances? c. Foot and leg problems? d. Reduced vision? e. Medical conditions and disabilities? f. Cognitive impairment? g. Bowel and bladder dysfunction? h. Special toileting requirements? i. Use of multiple prescription and over-the-counter medications? j. Need for mechanical and/or human assistance? k. Environmental hazards?		
2. Are higher-risk clients identified, including those who experience recurrent falls or have multiple risk factors?		
3. Are higher-risk clients referred to their physician for a more thorough assessment?		
4. Is a home safety check conducted before the commencement of services?		
5. If safety problems are detected in the home, are corrective actions recommended to the client as part of the service agreement?		
6. Are direct care staff members involved in the initial client assessment and ongoing reassessment?		
7. Are services regularly assessed and modified in response to changes in the client's condition?		
8. Are clients and families informed of key risk factors and basic safety strategies?		
9. Are all assessment findings documented and incorporated into the client's plan of care?		

RISK CONTROL MEASURES	YES / NO	CORRECTIVE ACTION
Staff Education		
1. Are educational in-service programs offered to direct care staff on a regular basis, and are attendance records kept?		
2. Do staff educational programs focus on skills training, such as how to use gait belts and assist with transfers?		
3. Do educational offerings examine the root causes of falls, as well as their prevention?		
4. Are staff members instructed to assess and document the client's condition at each visit, and also to: a. Report any changes to the supervisor and family in a clear and timely manner? b. Perform frequent home safety checks? c. Reinforce fall-reduction tactics with clients and family? d. Encourage clients to ask for assistance with risky tasks? e. Keep accurate, detailed records of client encounters		
Post Fall Analysis		
1. Are all clients fall reviewed for quality assurance purposes, including analysis of root causes and tracking of trends?		
2. Does the post-fall analysis require caregivers to describe the circumstances of the fall, and also to: a. Identify major causal factors, both personal and environmental? b. Indicate the client's functional status before and after the fall? c. Suggest interventions to prevent or mitigate future falls?		
3. Is the post-fall analysis thoroughly documented, and are findings incorporated into quality assurance and/or incident reporting programs		

FALL RISK ASSESSMENT

The fall risk assessment serves as the basis for care planning. The agency will conduct the fall risk assessment on each patient at the start of care, when there is a change in the patient's condition, and at re-certification.

The Morse Fall Risk Assessment is an official fall-risk assessment scale used by FHC. It is made up of six subscales: History of falls, secondary diagnosis, ambulatory aid, iv or heparin lock, gait, and mental status.

I. EDUCATION:

In order to promote patient and family participation in the fall reduction and safety plan, the Fall Risk and Prevention procedure is introduced upon admission. Using the Morse Fall Scoring system. Besides admission, patients are reassessed based on a change of status, transfer, or after a fall occurs.

The identified fall risk factors and interventions are reviewed with the patient and family. This is to help them understand why they are at risk for falls and increase their compliance with key interventions.
The goal of the agency is to assess and improve patients' knowledge of risks for falls, and how to prevent falls. The agency will use different teaching methods and tools that are appropriate to the patient/family level of understanding.

The education is documented and revised as patient status changes Education Topics include the following:

- Impaired balance and gait
- Vision
- Medications
- Environment
- Chronic conditions

II. ENVIRONMENTAL ASSESSMENT

FHC understands that environmental assessment is effective in falls reduction. On initial assessment, the agency examines the physical environment to determine whether the home is safe for the patients. The agency will educate its nursing staff the importance of maintaining a safe environment for all its patients; assist with identifying patients who are high risk for fall; provide the tools to educate patient/families of the potential risk for falls and outline strategies to develop individualized plan of care to reduce fall. Often, some modifications are necessary to accommodate the functional abilities of the patients.

All patients are considered at risk of falling and simple prevention strategies have been put in place to ensure the risk of fall is minimized. A safe environment will be maintained for all patients. Standard safety measures have been put place for all patients regardless of identified

risk, these include:

- Patients are nursed in an appropriate bed
- Orientate all patients and parents to room
- Keep beds with brakes on
- Side rails are raised for appropriate age and patient groups
- Appropriate non slip footwear for ambulating patients
- Maintain adequate lighting in child's room; low level lighting at night.
- Keep floors clear of clutter including equipment and toys
- Secure and supervise all children with a safety belt or harness in wheelchairs, highchairs, strollers, infant seats and any specialist seating)
- Bathroom assist unsteady patients with ambulation
- Place necessary items a patient may need within reach (drinking water, phone, etc)
- Ensure equipment is well maintained and serviced appropriately (such as wheelchairs and commodes)

POST-FALL ASSESSMENT

A post-fall assessment is a structured way to collect information after a fall. The patient will be carefully and systematically assessed for injuries. All findings will be documented in the nursing record, and an incident report will be filled.

The post-fall assessment focuses on immediate risk of injury or complications and will begins as soon as possible after the fall. It includes:

- General information about the fall
- Patient Assessment---vital signs; visible signs of injury (type & pain scores); Glucometer (if diabetic); Glasgow Scale (if suspected brain injury and Morse Falls scale
- Interventions based on Morse Falls scale
- Notification of RN supervisor
- Activation of EMS response team for emergency situation

The desired outcome of the post-fall assessment is to:

- Specify root cause Specify type of fall
- Identify actions to prevent reoccurrence Change plan of care
- Involve patient/family in learning about the fall occurrence Prevent repeat fall

I. PLAN OF CARE

POLICY

An individualized plan of care tailored to the client's risk factors will be developed by FHC. This is done after completion of the fall risk assessment and will be based on the assessment of the client's needs, strengths, limitations and goals.

PROCEDURE

The plan of care will match the identified client's risk factors such as mobility challenges, medication, mental status, and continence needs.

The plan of care identifies particular kinds of risks specific to a client and interventions to mitigate those risks.

The plan of care guides staff on how to reduce falls. Fall reduction care planning is a process by which the client's risk assessment information is translated into an action plan to address the client's needs. It is an active document that ensures continuity of care and changes as the client's condition changes.

The DON/RN (Director of Nursing, Registered Nurse) develops a Plan of Care for each client following completion of the risk assessment.

The individualized plan of care is developed for patients with any of the following:

- Patient has risk factors for falling (found on the risk assessment form)
- Patient has fallen since admission
- Patient or family are anxious about falls

Based on the results and the provisions of the Plan of Care, the DON will select the appropriate staff that meet the skills and experience qualification needed to provide the specific needs of the client. To maintain full compliance with the requirements of this policy, the following is addressed as applicable to each client:

1. The client's plan of care is based on assessments of the client's health, function, and psychosocial condition.
2. The assessment of a client is provided:
    a. Before the client receives services from the agency
    b. When there is a change in client's condition
    c. At recertification
3. The agency shall ensure that the care plan developed for the client at a minimum addresses:
    a. The services to be provided to the client, which are based on the
    b. assessment of the client
    c. When and how often the services are to be provided
    d. How and by whom the services are to be provided
    e. Long-range and short-range goals for the client
    f. Physical needs, including safety measures to protect against fall and injuries
4. The client's plan of Care shall be reviewed by a registered nurse.

REVIEW OF MEDICATION

The agency reviews and evaluates medication-related fall risk on admission and at regular intervals. FHC has identified common ways medications contribute to falls. Such as:

- Sedation
- Impaired balance/coordination/reaction time
- Orthostatic hypotension
- Parkinsonism
- Cognitive changes

SCREENING MEDICATION FALL RISK

The agency has developed a screening tool to help identify the reactions of medication, and a medication related risk factors for falls

Drug	Reaction
Ant diabetic agents	Hypoglycemia
Cardiovascular agents	Orthostatic hypotension, dizziness, syncope, bradycardia
Psychotropic agents	Psychomotor impairment, sedation, orthostatic hypotension, confusion
Analgesics	Sedation, Confusion
Metoclopramide	Psychomotor impairment, sedation
Anticonvulsants	Sedation, psychomotor impairment, confusion
Antihistamines	Sedation, confusion, blurred vision

MEDICATION FALL RISK SCORE

The agency has also developed a Medication Fall Risk Scoring to determine if a patient is at risk for falls and plan care accordingly.

Point Value (Risk Level)	Class Of Medication	Reaction
3 (High)	Analgesics, antipsychotics, anticonvulsants, benzodiazepines	Sedation, dizziness, postural disturbances, altered gait and balance, impaired cognition
2 (Medium)	Antihypertensive, cardiac drugs, antiarrhythmic, antidepressant,	Induced orthostatic, impaired Cerebral perfusion, poor health status
1 (Low)	Diuretics	Increased ambulation, induced orthostatic
Scores >/= 6		Higher risk for fall; evaluate patient

To calculate the score, the staff member completing the assessment will sum the point values (risk levels) for each medication the patient is taking. If the patient is taking more than one medication in a particular risk category, the score should be calculated by (risk level score) x (number of medications in that risk level category). For a patient at risk, the agency will use evaluation tools to determine whether medications may be tapered, discontinued, or replaced with a safer alternative.

FALL REDUCTION PROGRAM EVALUATION

On evaluation, the interventions on the plan of care are noted to be effective and accurate. The agency licensed staff are providing adequate supervision and are committed to the reducing falls. Staff training on reduction of falls and identifying patients that are high risk for falls was noted to be effective. Standard safety measures have been maintained.

The program appears to have had a protective effect. No fall or injury has been reported. Patient and patient family appears to be knowledgeable about the risk for fall and the prevention of falls.

STAFF TRAINING AND EDUCATION

The agency staff will be trained and educated on fall reduction and fall-related injuries**.** Reducing falls requires leadership commitment and a systematic approach.

The training/education will entail the following:

- Informing staff of the need to reduce falls/fall-related injuries by: Communicating safety information to staff Incorporating fall/safety precaution into the patient care
- Training staff on the standardized, validated tool used by the agency to identify risk factors for falls. (Morse Fall Scale is used by the agency)
- Training is provided to staff on using the tool to ensure inter-rater reliability.
- Informing staff of the interventions in the individualized plan of care based on identified fall and injury risks.
- Training on implementation of the interventions
- Training on assessment and continued reassessment of the patient
- Training on environmental safety
- Training on post-fall assessment and how to accurately fill the post-fall form

Fall Risk Assessment Tool

Client Name: _____ Date of Birth: _____

Staff Name: _____ Date: _____

1. Background

Patient Fall risk factors (check all that apply):

- ☐ Impaired mobility
- ☐ Impaired mentation
- ☐ Impaired / altered elimination patterns (nocturia, urgency, frequency, diarrhea, incontinence, laxative, bowel prep)
- ☐ Impaired communication / sensory (vision, hearing, neuropathy)
- ☐ Impaired vital signs (fever, slow or fast heart rate, low blood pressure)
- ☐ Prior fall history
- ☐ Medication NOTE: If pertinent, attach copy of MAR for previous 12-hours
  - ☐ Anticonvulsant
  - ☐ Anti-anxiety agent
  - ☐ Psychotropic
  - ☐ Hypnotic/Sleep aid
  - ☐ Pain Medication
  - ☐ Diuretic
  - ☐ Notable medication change within the past 2 days
  - ☐ Other _____
- ☐ Diagnosis-related
  - ☐ Hypotension
  - ☐ Hypoglycemia
  - ☐ TIA/Syncope
  - ☐ Parkinson's
  - ☐ History of CVA or paralysis
  - ☐ Orthopedic condition
  - ☐ Other _____

2. Assessment

Vital Signs: T: P: R: B/P: O2:

Neurochecks if evidence / suspicion of head injury:

If diabetic, Glucometer result: Pain Level (1-10)

Describe any NEW onset pain:

Injury (describe findings):

- ☐ None
- ☐ Minor
- ☐ Major
- ☐ Death

3. Recommendation

What can we do to prevent this from happening again? Care plan recommendations:

- ☐ High-Fall Risk Precautions
- ☐ Clear path to Bathroom
- ☐ Frequent monitoring
- ☐ Remove clutter
- ☐ Every 2hrsToileting
- ☐ Non-slip footwear
- ☐ Oxygen/IV tubing mgmt
- ☐ Hip protectors
- ☐ Patient/family education
- ☐ PT Evaluation
- ☐ Improved positioning
- ☐ Review of meds
- ☐ Other: _____

Additional Notes

4. Post Fall Checklist

- ☐ Notify physician
- ☐ Notify RN supervisor
- ☐ Assess patient for injury and document assessment findings in the nursing record
- ☐ Revise plan of care to include reduction strategies
- ☐ Fill out incident report

First Healthcare Consultants Patient Satisfaction Survey

We were privileged to participate in the care of the above patient. We are interested in rendering quality care to our patients and would appreciate your input by answering the following questions. Your evaluation will allow us to be more responsive to future patient/family needs.

* Indicates required question

- ◯ Option 1

What service(s) did you receive from the agency? (select all that apply) *

- ☐ Nursing
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Home health aide
- ☐ Home making/chore service
- ☐ Medical social worker

Were you satisfied with the care you received? *

- ◯ Yes
- ◯ No

If you answered no to the above question, please explain why not.

Your answer

Did you participate in your plan of care? *

- Yes
- No

Did you receive and understand your “Bill of Rights” including the toll-free “hotline”number that you could call if any problems were not resolved by the agency or if you were dissatisfied with the services provided? *

- Yes
- No

Did the staff visit as frequently as they stated they would? *

- Yes
- No

Did you feel comfortable asking staff questions regarding your health? *

- Yes
- No

Did the staff person visit at a mutually agreeable time? *

- Yes
- No

If you had therapy, were exercise instructions given to you in a clear, written manner that you could easily understand? *

- Yes
- No
- Not Applicable

Did you feel that you were discharged appropriately? *

- ◯ Yes
- ◯ No

Would you use the services of the agency in the future? *

- ◯ Yes
- ◯ No

Please provide any suggestions for improvement

Your answer

Patient Name *

Your answer

Date *

Your answer

Submit Clear form

Exhibit 12

Estimated Annual HHA Use Rates by Resident Age Group and County / Jurisdiction, FY19-FY23

Anne Arundel

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR CY20-CY25
0 to 4	35,962	36,066	36,170	36,275	36,379	36,485	36,590	36,822	37,056	37,291	37,528	37,766	0.3%
5 to 14	72,209	72,284	72,359	72,435	72,510	72,585	72,661	72,900	73,140	73,380	73,622	73,864	0.1%
15 to 24	71,172	71,093	71,014	70,934	70,855	70,776	70,697	71,165	71,637	72,111	72,589	73,070	-0.1%
25 to 44	155,362	156,317	157,272	158,233	159,199	160,172	161,150	160,928	160,707	160,486	160,265	160,045	0.6%
45 to 64	156,944	155,436	153,928	152,434	150,955	149,490	148,039	147,405	146,773	146,144	145,518	144,894	-1.0%
65 to 74	54,890	55,926	56,962	58,017	59,092	60,186	61,301	62,388	63,495	64,621	65,767	66,934	1.9%
75 to 84	24,736	26,142	27,548	29,029	30,589	32,234	33,967	34,969	36,000	37,062	38,155	39,280	5.4%
85+	9,428	9,617	9,806	9,999	10,195	10,396	10,600	11,064	11,549	12,054	12,582	13,133	2.0%
Total	580,704	582,881	585,058	587,354	589,775	592,323	595,005	597,642	600,356	603,150	606,026	608,986	0.4%

TABLE 15

Unduplicated Clients **ACTUAL** | ***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR FY19-FY23
0 to 4	170	169	150	158	141	159	159	160	162	163	164	165	-4.6%
5 to 14	26	27	39	34	33	32	32	32	32	32	32	32	6.1%
15 to 24	50	39	51	59	42	48	48	48	49	49	49	50	-4.3%
25 to 44	225	258	294	264	183	249	251	251	250	250	250	249	-5.0%
45 to 64	1,706	1,672	1,722	1,532	1,261	1,531	1,516	1,510	1,503	1,497	1,491	1,484	-7.3%
65 to 74	2,151	2,366	2,599	2,537	2,446	2,555	2,602	2,648	2,695	2,743	2,792	2,841	3.3%
75 to 84	2,693	3,310	3,720	3,825	4,029	4,087	4,307	4,434	4,565	4,699	4,838	4,981	10.6%
85+	2,641	3,272	3,299	3,426	3,635	3,443	3,511	3,664	3,825	3,992	4,167	4,350	8.3%
Total	9,662	11,113	11,874	11,835	11,770	12,105	12,427	12,748	13,081	13,425	13,782	14,152	5.1%
unknown			*3*	*1*									

Estimated Use Rate per 1,000 ***population***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	Average FY19-FY23
0 to 4	4.7	4.7	4.1	4.4	3.9								4.4
5 to 14	0.4	0.4	0.5	0.5	0.5								0.4
15 to 24	0.7	0.5	0.7	0.8	0.6								0.7
25 to 44	1.4	1.7	1.9	1.7	1.1								1.6
45 to 64	10.9	10.8	11.2	10.1	8.4								10.2
65 to 74	39.2	42.3	45.6	43.7	41.4								42.4
75 to 84	108.9	126.6	135.0	131.8	131.7								126.8
85+	280.1	340.2	336.4	342.6	356.5								331.2
Total	16.6	19.1	20.3	20.1	20.0	20.4	20.9	21.3	21.8	22.3	22.7	23.2	19.2

Estimated Annual HHA Use Rates by Resident Age Group and County / Jursidiction, FY19-FY23

Montgomery

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR CY20-CY25
0 to 4	65,391	66,157	66,923	67,698	68,482	69,275	70,077	70,444	70,813	71,184	71,556	71,931	1.2%
5 to 14	131,373	132,046	132,719	133,396	134,077	134,761	135,448	136,261	137,078	137,900	138,728	139,560	0.5%
15 to 24	115,371	115,972	116,573	117,177	117,784	118,395	119,008	119,834	120,666	121,503	122,347	123,196	0.5%
25 to 44	290,931	291,954	292,977	294,003	295,033	296,066	297,103	296,852	296,602	296,352	296,102	295,852	0.4%
45 to 64	280,614	279,534	278,454	277,378	276,306	275,239	274,175	274,873	275,572	276,274	276,977	277,682	-0.4%
65 to 74	94,368	96,176	97,984	99,826	101,703	103,615	105,563	107,206	108,874	110,569	112,289	114,037	1.9%
75 to 84	45,018	47,393	49,768	52,262	54,881	57,632	60,520	62,655	64,865	67,152	69,521	71,973	5.0%
85+	22,253	22,758	23,263	23,778	24,305	24,844	25,395	26,353	27,347	28,379	29,449	30,560	2.2%
Total	1,045,319	1,051,990	1,058,661	1,065,519	1,072,571	1,079,826	1,087,289	1,094,477	1,101,817	1,109,313	1,116,969	1,124,791	0.7%

TABLE 15

Unduplicated Clients **ACTUAL** | ***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR FY19-FY23
0 to 4	857	886	761	1,047	221	784	793	797	801	805	809	814	-28.7%
5 to 14	33	33	62	22	33	37	37	38	38	38	38	38	0.0%
15 to 24	84	86	87	78	87	86	86	87	87	88	89	89	0.9%
25 to 44	591	517	589	460	375	512	514	513	513	513	512	512	-10.7%
45 to 64	3,268	2,990	2,802	2,389	2,123	2,681	2,671	2,677	2,684	2,691	2,698	2,705	-10.2%
65 to 74	4,315	3,988	4,516	4,026	4,076	4,428	4,512	4,582	4,653	4,725	4,799	4,874	-1.4%
75 to 84	5,112	4,955	5,579	5,608	6,331	6,373	6,692	6,928	7,172	7,425	7,687	7,958	5.5%
85+	5,668	5,684	5,865	5,624	6,240	6,210	6,348	6,587	6,836	7,094	7,361	7,639	2.4%
Total	19,928	19,139	20,261	19,254	19,486	21,111	21,652	22,209	22,785	23,379	23,994	24,629	-0.6%
unknown			*1*	*2*	*89*								

Estimated Use Rate per 1,000 ***population***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	Average FY19-FY23
0 to 4	13.1	13.4	11.4	15.5	3.2								11.3
5 to 14	0.3	0.2	0.5	0.2	0.2								0.3
15 to 24	0.7	0.7	0.7	0.7	0.7								0.7
25 to 44	2.0	1.8	2.0	1.6	1.3								1.7
45 to 64	11.6	10.7	10.1	8.6	7.7								9.7
65 to 74	45.7	41.5	46.1	40.3	40.1								42.7
75 to 84	113.6	104.6	112.1	107.3	115.4								110.6
85+	254.7	249.8	252.1	236.5	256.7								250.0
Total	19.1	18.2	19.1	18.1	18.2	19.6	19.9	20.3	20.7	21.1	21.5	21.9	18.5

Estimated Annual HHA Use Rates by Resident Age Group and County / Jursidiction, FY19-FY23

Prince George's

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR CY20-CY25
0 to 4	56,614	56,680	56,746	56,813	56,879	56,945	57,012	56,919	56,827	56,734	56,642	56,550	0.1%
5 to 14	111,886	111,654	111,422	111,190	110,959	110,728	110,498	109,848	109,201	108,558	107,919	107,284	-0.2%
15 to 24	122,629	122,466	122,303	122,139	121,976	121,814	121,651	122,611	123,578	124,552	125,535	126,525	-0.1%
25 to 44	261,443	260,863	260,283	259,704	259,126	258,549	257,974	256,605	255,242	253,887	252,540	251,199	-0.2%
45 to 64	234,449	233,385	232,321	231,261	230,206	229,156	228,111	227,435	226,761	226,088	225,418	224,750	-0.5%
65 to 74	76,634	78,533	80,432	82,376	84,368	86,408	88,497	89,795	91,112	92,449	93,805	95,181	2.4%
75 to 84	32,697	34,686	36,675	38,778	41,002	43,353	45,839	47,761	49,763	51,849	54,023	56,288	5.7%
85+	12,226	12,872	13,518	14,196	14,908	15,656	16,442	17,611	18,864	20,206	21,643	23,182	5.0%
Total	908,580	911,139	913,698	916,457	919,424	922,610	926,024	928,584	931,348	934,325	937,525	940,959	0.3%

TABLE 15

Unduplicated Clients **ACTUAL** | ***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR FY19-FY23
0 to 4	425	533	452	533	153	421	421	421	420	419	419	418	-22.5%
5 to 14	25	18	30	23	23	24	24	23	23	23	23	23	-2.1%
15 to 24	92	73	180	58	54	91	91	92	92	93	94	95	-12.5%
25 to 44	609	572	722	492	405	556	555	552	549	546	543	540	-9.7%
45 to 64	3,377	3,354	2,329	2,523	2,425	2,761	2,748	2,740	2,732	2,724	2,716	2,708	-7.9%
65 to 74	3,893	4,135	4,336	4,095	3,954	4,388	4,495	4,560	4,627	4,695	4,764	4,834	0.4%
75 to 84	3,990	4,048	4,282	4,298	4,592	5,014	5,302	5,524	5,756	5,997	6,249	6,510	3.6%
85+	2,875	2,716	2,602	2,825	2,994	3,252	3,415	3,658	3,918	4,197	4,495	4,815	1.0%
Total	15,286	15,449	14,933	14,847	14,600	16,507	17,050	17,570	18,118	18,695	19,302	19,943	-1.1%
unknown				*1*	*16*								

Estimated Use Rate per 1,000 ***population***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	Average FY19-FY23
0 to 4	7.5	9.4	8.0	9.4	2.7								7.4
5 to 14	0.2	0.2	0.3	0.2	0.2								0.2
15 to 24	0.8	0.6	1.5	0.5	0.4								0.7
25 to 44	2.3	2.2	2.8	1.9	1.6								2.2
45 to 64	14.4	14.4	10.0	10.9	10.5								12.0
65 to 74	50.8	52.7	53.9	49.7	46.9								50.8
75 to 84	122.0	116.7	116.8	110.8	112.0								115.7
85+	235.2	211.0	192.5	199.0	200.8								207.7
Total	16.8	17.0	16.3	16.2	15.9	17.9	18.4	18.9	19.5	20.0	20.6	21.2	16.4

Estimated Annual HHA Use Rates by Resident Age Group and County / Jurisdiction, FY19-FY23

Calvert

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR CY20-CY25
0 to 4	4,910	4,987	5,064	5,142	5,221	5,301	5,383	5,390	5,396	5,403	5,409	5,416	1.5%
5 to 14	11,600	11,581	11,562	11,542	11,523	11,503	11,484	11,612	11,741	11,872	12,004	12,138	-0.2%
15 to 24	11,760	11,602	11,444	11,288	11,134	10,982	10,832	10,623	10,417	10,216	10,019	9,825	-1.4%
25 to 44	21,406	21,826	22,246	22,674	23,111	23,556	24,009	24,206	24,405	24,605	24,807	25,010	1.9%
45 to 64	28,596	28,042	27,488	26,945	26,413	25,891	25,380	24,813	24,259	23,717	23,188	22,670	-2.0%
65 to 74	8,933	9,282	9,631	9,993	10,369	10,759	11,164	11,529	11,905	12,294	12,695	13,110	3.8%
75 to 84	4,002	4,265	4,528	4,808	5,105	5,420	5,755	6,005	6,265	6,537	6,821	7,117	6.2%
85+	1,664	1,723	1,782	1,844	1,907	1,973	2,041	2,145	2,253	2,368	2,488	2,614	3.4%
Total	92,871	93,308	93,745	94,236	94,783	95,386	96,048	96,321	96,642	97,012	97,431	97,900	0.6%

TABLE 15

Unduplicated Clients **ACTUAL** | ***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR FY19-FY23
0 to 4	18	22	14	12	12	16	17	17	17	17	17	17	-9.6%
5 to 14	2	-	4	5	8	4	4	4	4	4	4	4	41.4%
15 to 24	6	8	6	7	4	6	6	6	6	6	5	5	-9.6%
25 to 44	64	59	47	38	28	50	51	52	52	53	53	53	-18.7%
45 to 64	298	280	290	276	222	257	252	246	241	235	230	225	-7.1%
65 to 74	357	336	363	402	344	403	418	432	446	460	475	491	-0.9%
75 to 84	482	405	444	447	402	526	558	583	608	634	662	691	-4.4%
85+	380	302	309	388	335	380	393	413	434	456	479	504	-3.1%
Total	1,607	1,412	1,477	1,575	1,355	1,642	1,699	1,752	1,807	1,865	1,926	1,990	-4.2%

unknown

Estimated Use Rate per 1,000 ***population***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	Average FY19-FY23
0 to 4	3.7	4.4	2.8	2.3	2.3								3.1
5 to 14	0.2	-	0.3	0.4	0.7								0.3
15 to 24	0.5	0.7	0.5	0.6	0.4								0.5
25 to 44	3.0	2.7	2.1	1.7	1.2								2.1
45 to 64	10.4	10.0	10.6	10.2	8.4								9.9
65 to 74	40.0	36.2	37.7	40.2	33.2								37.5
75 to 84	120.5	95.0	98.0	93.0	78.7								97.0
85+	228.4	175.3	173.4	210.4	175.6								192.6
Total	17.3	15.1	15.8	16.7	14.3	17.2	17.7	18.2	18.7	19.2	19.8	20.3	15.8

Estimated Annual HHA Use Rates by Resident Age Group and County / Jursidiction, FY19-FY23

Charles

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR CY20-CY25
0 to 4	10,004	10,179	10,354	10,533	10,714	10,898	11,086	11,239	11,394	11,551	11,710	11,871	1.7%
5 to 14	21,589	21,763	21,937	22,113	22,290	22,469	22,649	22,988	23,332	23,681	24,035	24,395	0.8%
15 to 24	22,120	22,077	22,034	21,991	21,948	21,905	21,862	21,919	21,975	22,032	22,089	22,146	-0.2%
25 to 44	39,302	39,981	40,660	41,351	42,054	42,768	43,495	44,104	44,721	45,346	45,981	46,624	1.7%
45 to 64	48,890	48,709	48,528	48,347	48,167	47,988	47,809	47,298	46,792	46,292	45,797	45,307	-0.4%
65 to 74	13,136	13,708	14,280	14,876	15,497	16,143	16,817	17,601	18,421	19,279	20,178	21,118	4.2%
75 to 84	5,852	6,207	6,562	6,937	7,333	7,752	8,195	8,529	8,877	9,239	9,616	10,008	5.7%
85+	1,841	1,914	1,987	2,063	2,142	2,223	2,308	2,432	2,563	2,700	2,845	2,998	3.8%
Total	162,734	164,538	166,342	168,210	170,144	172,147	174,221	176,108	178,074	180,120	182,250	184,467	1.2%

TABLE 15

Unduplicated Clients **ACTUAL** | ***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR FY19-FY23
0 to 4	36	22	8	22	19	23	23	23	24	24	24	25	-14.8%
5 to 14	1	3	3	3	5	3	3	3	3	3	3	3	49.5%
15 to 24	16	15	15	19	17	16	16	16	16	16	16	16	1.5%
25 to 44	100	113	132	95	66	107	109	110	112	113	115	116	-9.9%
45 to 64	718	622	715	620	425	613	610	604	597	591	585	578	-12.3%
65 to 74	709	666	646	621	567	730	761	796	833	872	913	955	-5.4%
75 to 84	709	684	736	782	717	859	908	945	984	1,024	1,065	1,109	0.3%
85+	423	381	405	440	506	481	500	526	555	584	616	649	4.6%
Total	2,712	2,506	2,660	2,602	2,322	2,832	2,930	3,024	3,124	3,228	3,337	3,452	-3.8%

unknown

Estimated Use Rate per 1,000 ***population***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	Average FY19-FY23
0 to 4	3.6	2.2	0.8	2.1	1.8								2.1
5 to 14	0.0	0.1	0.1	0.1	0.2								0.1
15 to 24	0.7	0.7	0.7	0.9	0.8								0.7
25 to 44	2.5	2.8	3.2	2.3	1.6								2.5
45 to 64	14.7	12.8	14.7	12.8	8.8								12.8
65 to 74	54.0	48.6	45.2	41.7	36.6								45.2
75 to 84	121.1	110.2	112.2	112.7	97.8								110.8
85+	229.8	199.1	203.8	213.3	236.3								216.4
Total	16.7	15.2	16.0	15.5	13.6	16.4	16.8	17.2	17.5	17.9	18.3	18.7	15.4

Estimated Annual HHA Use Rates by Resident Age Group and County / Jurisdiction, FY19-FY23

St. Mary's

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR CY20-CY25
0 to 4	7,245	7,386	7,527	7,671	7,817	7,967	8,119	8,240	8,363	8,488	8,614	8,743	1.9%
5 to 14	16,078	16,113	16,148	16,183	16,218	16,254	16,289	16,455	16,622	16,791	16,962	17,134	0.2%
15 to 24	14,741	15,047	15,353	15,665	15,983	16,308	16,639	16,711	16,784	16,857	16,930	17,004	2.0%
25 to 44	29,083	29,566	30,049	30,540	31,039	31,546	32,062	32,410	32,761	33,117	33,476	33,839	1.6%
45 to 64	31,482	31,432	31,382	31,331	31,281	31,231	31,181	31,133	31,086	31,038	30,990	30,943	-0.2%
65 to 74	9,024	9,388	9,752	10,130	10,522	10,930	11,353	11,803	12,272	12,759	13,265	13,791	3.9%
75 to 84	4,366	4,622	4,878	5,147	5,432	5,732	6,049	6,272	6,503	6,743	6,991	7,249	5.5%
85+	1,524	1,598	1,672	1,749	1,830	1,915	2,004	2,104	2,208	2,318	2,433	2,554	4.6%
Total	113,544	115,152	116,760	118,416	120,123	121,883	123,696	125,128	126,599	128,110	129,662	131,257	1.4%

TABLE 15

Unduplicated Clients **ACTUAL** | ***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR FY19-FY23
0 to 4	18	16	19	15	7	16	16	17	17	17	17	18	-21.0%
5 to 14	4	2	3	4	5	4	4	4	4	4	4	4	5.7%
15 to 24	12	15	10	15	7	13	13	13	13	13	13	13	-12.6%
25 to 44	69	70	77	70	72	75	76	77	78	79	80	81	1.1%
45 to 64	438	392	389	398	299	381	381	380	379	379	378	378	-9.1%
65 to 74	440	368	360	414	414	448	466	484	503	523	544	566	-1.5%
75 to 84	472	392	406	489	472	525	554	575	596	618	640	664	0.0%
85+	315	275	252	341	344	349	366	384	403	423	444	466	2.2%
Total	1,768	1,530	1,516	1,746	1,620	1,812	1,875	1,933	1,993	2,056	2,121	2,189	-2.2%

unknown

Estimated Use Rate per 1,000 ***population***

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	Average FY19-FY23
0 to 4	2.5	2.2	2.5	2.0	0.9								2.0
5 to 14	0.2	0.1	0.2	0.2	0.3								0.2
15 to 24	0.8	1.0	0.7	1.0	0.4								0.8
25 to 44	2.4	2.4	2.6	2.3	2.3								2.4
45 to 64	13.9	12.5	12.4	12.7	9.6								12.2
65 to 74	48.8	39.2	36.9	40.9	39.3								41.0
75 to 84	108.1	84.8	83.2	95.0	86.9								91.6
85+	206.7	172.1	150.7	194.9	187.9								182.5
Total	15.6	13.3	13.0	14.7	13.5	14.9	15.2	15.4	15.7	16.0	16.4	16.7	14.0

Estimated Annual HHA Use Rates by Resident Age Group and County / Jursidiction, FY19-FY23

Southern

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR CY20-CY25
0 to 4	22,159	22,552	22,945	23,345	23,752	24,167	24,588	24,870	25,155	25,443	25,735	26,030	1.7%
5 to 14	49,265	49,457	49,649	49,841	50,034	50,228	50,422	51,055	51,696	52,345	53,002	53,667	0.4%
15 to 24	48,605	48,726	48,847	48,968	49,089	49,211	49,333	49,261	49,189	49,118	49,046	48,975	0.2%
25 to 44	89,790	91,373	92,956	94,566	96,204	97,871	99,566	100,720	101,888	103,069	104,264	105,473	1.7%
45 to 64	108,957	108,183	107,409	106,641	105,879	105,122	104,370	103,256	102,155	101,065	99,987	98,920	-0.7%
65 to 74	31,093	32,378	33,663	34,999	36,388	37,832	39,334	40,935	42,602	44,336	46,141	48,019	4.0%
75 to 84	14,220	15,094	15,968	16,892	17,870	18,905	19,999	20,806	21,646	22,520	23,428	24,374	5.8%
85+	5,028	5,235	5,442	5,656	5,880	6,112	6,353	6,680	7,024	7,386	7,766	8,166	3.9%
Total	369,118	372,998	376,878	380,909	385,096	389,446	393,965	397,584	401,355	405,281	409,369	413,624	1.1%

Unduplicated Clients	**ACTUAL**					***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***							CAGR
Age Group	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**	**CY24**	**CY25**	**CY26**	**CY27**	**CY28**	**CY29**	**CY30**	**FY19-FY23**
0 to 4	72	60	41	49	38	55	56	57	57	58	59	59	-14.8%
5 to 14	7	5	10	12	18	10	11	11	11	11	11	11	26.6%
15 to 24	34	38	31	41	28	35	35	35	35	35	35	34	-4.7%
25 to 44	233	242	256	203	166	232	236	239	242	245	248	250	-8.1%
45 to 64	1,454	1,294	1,394	1,294	946	1,248	1,239	1,226	1,213	1,200	1,187	1,174	-10.2%
65 to 74	1,506	1,370	1,369	1,437	1,325	1,581	1,643	1,710	1,780	1,852	1,928	2,006	-3.2%
75 to 84	1,663	1,481	1,586	1,718	1,591	1,910	2,020	2,102	2,187	2,275	2,367	2,462	-1.1%
85+	1,118	958	966	1,169	1,185	1,211	1,259	1,324	1,392	1,464	1,539	1,619	1.5%
Total	6,087	5,448	5,653	5,923	5,297	6,282	6,500	6,703	6,916	7,139	7,373	7,617	-3.4%

unknown

Estimated Use Rate per	1,000	***population***											Average
Age Group	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**	**CY24**	**CY25**	**CY26**	**CY27**	**CY28**	**CY29**	**CY30**	**FY19-FY23**
0 to 4	3.2	2.7	1.8	2.1	1.6								2.3
5 to 14	0.1	0.1	0.2	0.2	0.4								0.2
15 to 24	0.7	0.8	0.6	0.8	0.6								0.7
25 to 44	2.6	2.6	2.8	2.1	1.7								2.4
45 to 64	13.3	12.0	13.0	12.1	8.9								11.9
65 to 74	48.4	42.3	40.7	41.1	36.4								41.8
75 to 84	116.9	98.1	99.3	101.7	89.0								101.0
85+	222.3	183.0	177.5	206.7	201.5								198.2
Total	16.5	14.6	15.0	15.5	13.8	16.1	16.5	16.9	17.2	17.6	18.0	18.4	15.1

Estimated Annual HHA Use Rates by Resident Age Group and County / Jurisdiction, FY19-FY23

6-County Service Area

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CAGR CY20-CY25
0 to 4	180,113	181,455	182,797	184,150	185,512	186,884	188,267	189,062	189,861	190,663	191,468	192,277	0.7%
5 to 14	364,726	365,441	366,156	366,872	367,590	368,309	369,029	370,092	371,158	372,227	373,300	374,375	0.2%
15 to 24	357,772	358,257	358,742	359,228	359,714	360,201	360,689	362,878	365,080	367,295	369,524	371,766	0.1%
25 to 44	797,473	800,507	803,541	806,587	809,644	812,713	815,793	815,147	814,502	813,857	813,213	812,569	0.4%
45 to 64	780,957	776,538	772,119	767,726	763,357	759,014	754,695	752,998	751,304	749,614	747,928	746,246	-0.6%
65 to 74	256,962	263,013	269,064	275,255	281,588	288,067	294,695	300,368	306,149	312,042	318,049	324,171	2.3%
75 to 84	116,669	123,315	129,961	136,965	144,347	152,126	160,325	166,197	172,284	178,594	185,135	191,915	5.4%
85+	48,920	50,482	52,044	53,654	55,314	57,026	58,790	61,731	64,819	68,061	71,466	75,041	3.1%
Total	2,903,591	2,919,008	2,934,425	2,950,437	2,967,066	2,984,340	3,002,283	3,018,472	3,035,156	3,052,354	3,070,082	3,088,360	0.6%
	422,551	436,810	451,069	465,874	481,249	497,219	513,810	528,295	543,252	558,697	574,649	591,127	
	14.6%	15.0%	15.4%	15.8%	16.2%	16.7%	17.1%	17.5%	17.9%	18.3%	18.7%	19.1%	

Unduplicated Clients	**ACTUAL**					***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***							CAGR
Age Group	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**	**CY24**	**CY25**	**CY26**	**CY27**	**CY28**	**CY29**	**CY30**	**FY19-FY23**
0 to 4	1,524	1,648	1,404	1,787	553	1,417	1,427	1,433	1,439	1,446	1,452	1,458	-22.4%
5 to 14	91	83	141	91	107	103	103	104	104	104	105	105	4.1%
15 to 24	260	236	349	236	211	259	260	261	263	265	266	268	-5.1%
25 to 44	1,658	1,589	1,861	1,419	1,129	1,550	1,556	1,554	1,553	1,552	1,551	1,549	-9.2%
45 to 64	9,805	9,310	8,247	7,738	6,755	8,221	8,174	8,155	8,137	8,119	8,101	8,082	-8.9%
65 to 74	11,865	11,859	12,820	12,095	11,801	12,949	13,247	13,502	13,762	14,027	14,297	14,572	-0.1%
75 to 84	13,458	13,794	15,167	15,449	16,543	17,382	18,319	18,990	19,686	20,407	21,154	21,929	5.3%
85+	12,302	12,630	12,732	13,044	14,054	14,182	14,621	15,352	16,120	16,927	17,773	18,663	3.4%
Total	50,963	51,149	52,721	51,859	51,153	56,064	57,707	59,353	61,065	62,845	64,698	66,626	0.1%
unknown	*0*	*0*	*4*	*4*	*105*								

Estimated Use Rate per	1,000	***population***											Average
Age Group	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**	**CY24**	**CY25**	**CY26**	**CY27**	**CY28**	**CY29**	**CY30**	**FY19-FY23**
0 to 4	8.5	9.1	7.7	9.7	3.0								7.58
5 to 14	0.2	0.2	0.4	0.2	0.3								0.28
15 to 24	0.7	0.7	1.0	0.7	0.6								0.72
25 to 44	2.1	2.0	2.3	1.8	1.4								1.91
45 to 64	12.6	12.0	10.7	10.1	8.8								10.83
65 to 74	46.2	45.1	47.6	43.9	41.9								44.95
75 to 84	115.4	111.9	116.7	112.8	114.6								114.26
85+	251.5	250.2	244.6	243.1	254.1								248.70
Total	17.6	17.5	18.0	17.6	17.2	18.8	19.2	19.7	20.1	20.6	21.1	21.6	

Exhibit 13

MD Historical HHA Service in FHC Jurisdictions

Total Number of Unduplicated Clients by Client Residence County / Jurisdiction, 2019-2023 (TABLE 13)

County / Jurisdiction	FY19	FY20	FY21	FY22	FY23	5 Yr CAGR	3Yr CAGR
Anne Arundel	9,662	11,113	11,874	11,835	11,770	4.0%	-0.3%
Montgomery	19,928	19,139	20,261	19,254	19,486	-0.4%	-1.3%
Prince George's	15,286	15,449	14,933	14,847	14,600	-0.9%	-0.7%
Calvert	1,607	1,412	1,477	1,575	1,355	-3.4%	-2.8%
Charles	2,712	2,506	2,660	2,602	2,322	-3.1%	-4.4%
St. Marys	1,768	1,530	1,516	1,746	1,620	-1.7%	2.2%
Total SA	50,963	51,149	52,721	51,859	51,153	0.1%	-1.0%

Total Number of Visits Based on Unduplicated Client County by Client Residence County / Jurisdiction, 2019-2023 (TABLE 14)

County / Jurisdiction	FY19	FY20	FY21	FY22	FY23	5Yr AGR	3Yr CAGR
Anne Arundel	183,802	171,300	183,336	177,026	175,627	-0.9%	-1.4%
Montgomery	317,724	284,299	292,281	277,677	270,550	-3.2%	-2.5%
Prince George's	300,771	285,644	284,722	265,614	260,690	-2.8%	-2.9%
Calvert	32,341	23,460	24,264	21,303	17,358	-11.7%	-10.6%
Charles	50,080	41,325	43,627	36,749	29,238	-10.2%	-12.5%
St. Marys	31,718	24,660	26,212	28,011	26,026	-3.9%	-0.2%
Total SA	916,436	830,688	854,442	806,380	779,489	-3.2%	-3.0%

Estimated Visits per Unduplicated Client, 2019-2023

County / Jurisdiction	FY19	FY20	FY21	FY22	FY23
Anne Arundel	19.0	15.4	15.4	15.0	14.9
Montgomery	15.9	14.9	14.4	14.4	13.9
Prince George's	19.7	18.5	19.1	17.9	17.9
Calvert	20.1	16.6	16.4	13.5	12.8
Charles	18.5	16.5	16.4	14.1	12.6
St. Marys	17.9	16.1	17.3	16.0	16.1
Total SA	18.0	16.2	16.2	15.5	15.2

Maryland Estimated Visits by Non / Billable and Discipline, 2019-2023 (TABLES 6 & 9)

***not available at jurisdiction level*

Metric	FY19	FY20	FY21	FY22	FY23	5Yr Average
Billable	2,225,550	2,046,969	2,018,232	1,887,847	1,892,291	10,070,889
Non Billable	55,788	70,191	53,525	63,477	49,279	292,260
Total Visits	2,281,338	2,117,160	2,071,757	1,951,324	1,941,570	10,363,149
Skilled Nursing	903,651	859,620	783,877	735,934	704,925	3,988,007
Home Health Aide	109,652	89,073	92,046	74,331	63,991	429,093
OT	306,781	255,720	259,476	257,480	272,966	1,352,423
PT	883,479	786,197	833,790	770,820	819,666	4,093,952
SLT	56,662	50,044	52,750	50,545	46,448	256,449
Med Soc Work	18,568	13,483	11,403	12,342	10,011	65,807
Total Visits	2,278,793	2,054,137	2,033,342	1,901,452	1,918,007	10,185,731

Estimated Visits per Unduplicated Client by Non / Billable and Discipline, 2019-2023

Metric	FY19	FY20	FY21	FY22	FY23	5Yr Avgerage
*Total MD Unduplicated Clients**Table 13*	*123,033*	*125,769*	*129,774*	*134,194*	*129,733*	642,503
Billable	18.1	16.3	15.6	14.1	14.6	15.7
Non Billable	0.5	0.6	0.4	0.5	0.4	0.5
Total	18.5	16.8	16.0	14.5	15.0	16.1
Skilled Nursing	7.3	6.8	6.0	5.5	5.4	6.2
Home Health Aide	0.9	0.7	0.7	0.6	0.5	0.7
OT	2.5	2.0	2.0	1.9	2.1	2.1
PT	7.2	6.3	6.4	5.7	6.3	6.4
SLT	0.5	0.4	0.4	0.4	0.4	0.4
Med Soc Work	0.2	0.1	0.1	0.1	0.1	0.1

Exhibit 14

Date: 12.24.25

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Letter of Support for First Healthcare Consultants' Proposed Medicare-Certified Home Health Agency

Ms. Shaw-Taylor,

I am pleased to submit this letter in support of First Healthcare Consultants' ("FHC") application to establish a Medicare-certified home health agency in Anne Arundel, Montgomery, Calvert, Charles, Prince George's, and St. Mary's Counties.

In my professional role, I am familiar with the growing need for reliable, high-quality home health services across the region. Population aging, chronic disease prevalence, and barriers to access make home-based care an increasingly important component of the healthcare system. The proposed project by FHC directly addresses these challenges by expanding service capacity and improving access to care in the home.

FHC has demonstrated strong operational performance and a commitment to quality through its work as a Residential Service Agency. The organization's transition to a Medicare-certified home health agency will allow it to extend those same standards of care to a broader population, particularly Medicare beneficiaries who require skilled services but prefer to remain at home.

I believe FHC is well positioned to operate a home health agency that is responsive to community needs, aligned with care coordination efforts, and supportive of overall system efficiency. I respectfully encourage approval of this application.

Sincerely,

Signature: Jocelyn Williams Bolar
Name: Jocelyn Williams Bolar Title: SHA/CNA Patient's Family
Organization:
Address: 534 Chalet Dr. W. Millersville, MD 21108
Phone 443 255.3454 Email choc4moi@yahoo.com

Date: December 26, 2025

Ewurama Shaw-Taylor, Chief
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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

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Sincerely,

Signature: 

Name: Fachecia Fort Title: DNP, CRNP

Organization: Golden Oasis Healthcare Services, LLC

Address: 14625 Baltimore Ave. Ste,805, Laurel, MD 20707

Phone 336-259-2865 Email Fachecia@yahoo.com

Date: 12.29.2025

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Letter of Support for First Healthcare Consultants' Proposed Medicare-Certified Home Health Agency

Ms. Shaw-Taylor,

I am writing to express my support for First Healthcare Consultants' ("FHC") proposal to establish a Medicare-certified home health agency in our community. My family and/or I have firsthand experience with the care provided by FHC through its current in-home services.

The staff at FHC have consistently demonstrated professionalism, compassion, and respect, and they have played an important role in helping us manage health needs in the comfort of our home. Their services have allowed greater independence, reduced stress for caregivers, and improved overall quality of life.

The ability for FHC to offer Medicare-certified home health services is especially important for families like ours. Access to Medicare-covered home health care will make it easier for patients to receive skilled services without unnecessary delays, financial strain, or hospital visits.

Based on our positive experience with FHC as a Residential Service Agency, I am confident that the same level of quality and dedication will carry over to its home health agency. I strongly support approval of this application and believe it will benefit patients and families throughout the service area.

Sincerely, VITA CAIN

Signature: Vita J Cain

Name: VITA J CAIN

Address: 15350 Christy Lane
WALDORF MD 20601

Phone 301-830-7088 Email

I am familiar with FHC's services through: *(e.g., former patient, **family caregiver**, etc.)*

Date: 12/29/2025

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

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Sincerely,

Signature: Alicia M Fiallo
Name: Alicia M. Fiallo
Address: 7856 Bastille Place, Severn MD 21144
Phone 443-683-6420 Email chelafiallo@live.com

I am familiar with FHC's services through: *(e.g., former patient,* ***family caregiver****, etc.)*

Date: 12/29/2025

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

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Sincerely,

Signature: Vicki L. Johnson

Name: Vicki L. Johnson for Wilson Privitera

Address: 8620 Portsmouth Dr. Laurel, MD 20708

Phone 240-994-1648 Email Vjohnson9@hotmail.com

I am familiar with FHC's services through: *(e.g., former patient, family caregiver, etc.)*

Date: 12-22-2025

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Letter of Support for First Healthcare Consultants' Proposed Medicare-Certified Home Health Agency

Ms. Shaw-Taylor,

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Sincerely,

Signature: Curtis J Washington Jr

Name: Curtis James Washington Jr.

Address: 3535 Chickahuxen Rd PO Box 237 Marbury MD 20658

Phone 202-316-0219 Email

I am familiar with FHC's services through: *(e.g., former patient, family caregiver, etc.)*