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

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

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.

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):

Address:

Street City Zip State County

Telephone:

Name of Owner/Chief Executive:

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.

3. **FACILITY**

Name of HHA provider:

Address:

Street City Zip County

Name of Owner (if differs from applicant):

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

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 ☐

Partnership ☐ Date and State of Incorporation

C. General

Limited ☐

Limited Liability Partnership ☐

Limited Liability Limited Partnership ☐

Other (Specify): ☐

Limited Liability Company

D. Other (Specify): ☐

E.

To be formed:

Existing: ☐

☐

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

A. Lead or primary contact:

Name and Title:
Mailing Address:

Street City Zip State

Telephone:
E-mail Address (required):
Fax:

B. Additional or alternate contact:

Mailing Address:

Street City Zip State

Telephone:
E-mail Address (required):
Fax:

B. Additional or alternate contact:

Name and Title: _____

Company Name _____
Mailing Address:

Street City Zip State

Telephone:

E-mail Address (required):
Fax:

If company name is different than applicant briefly describe the relationship _____

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
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		
Home Health Aide		
Occupational Therapy		
Speech, Language Therapy		
Physical Therapy		
Medical Social Services		

* 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.)

	Street	City	County	State	Zip Code	Telephone
Existing Main Office						
Existing Branch Offices						
Locations of Proposed HHA Main Office						
Locations of Proposed Branch Office						

10. Project Implementation Schedule for an HHA

An application for a CON or other Commission approval shall propose a schedule for implementation of the project in accordance with COMAR 10.24.01.12A(1) that specifies the estimated time for, at a minimum, the following project implementation steps: Obligation of Capital Expenditure, Beginning Construction, Complete Construction and Full Operation.

In developing the schedule, please note that COMAR 10.24.01.12C requires a holder to obligate at least 51 percent of the approved capital expenditure for a project involving building construction, renovation, or both, as documented by a binding construction contract or equipment purchase order, within the following specified time periods:

(a) An approved new hospital has up to 36 months

(b) A project involving an approved new non-hospital health care facility or involving a building addition or replacement of building space of a health care facility has up to 24 months

(c) A project limited to renovation of existing building space of a health care facility has up to 18 months

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

In a multiphase plan of construction with more than one construction contract approved for an existing health care facility, a holder has:

(a) Up to 12 months after approval to obligate 51 percent of the capital expenditure for the first phase of construction

(b) Up to 12 months after completion of the immediately preceding phase of construction to obligate 51 percent of the capital expenditure for any subsequent approved phase

For Home Health projects, please also provide:

A. Licensure: _____months from CON approval date.
B. Medicare Certification _____months from CON approval date.

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.

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

(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.

10.24.16.08B. Populations and Services.
An applicant shall describe the population to be served and the specific services it will provide.

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.

10.24.16.08D. Fees and Time Payment Plan.
An applicant shall make its fees known to prospective clients and their families at 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.

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.

(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.

(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.

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

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;

(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

(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.

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.

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.

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.

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.

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).

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.

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.

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.

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).**

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.

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.

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)[2] 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.

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

[2] 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)

- 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

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.

_____
_____
_____
_____
_____

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.

_____
_____
_____
_____

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.

_____
_____
_____
_____

1. 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.

_____
_____
_____
_____

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).

_____
_____
_____

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 healthy 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.

_____	_____
Date	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 JURSIDICTIONS

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	**$**
c. Other Capital Costs	
1) Movable Equipment	
2) Contingency Allowance	
3) Gross Interest During Construction	
4) Other (Specify)	
c. SUBTOTAL Other Capital Cost	**$**
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	**$**
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)	**$**
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)	**$**
3. WORKING CAPITAL STARTUP COSTS	**$**
TOTAL USES OF FUNDS (sum of 1 - 3)	**$**
B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	
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)	**$**
ANNUAL LEASE COSTS (if applicable)	
• Land	
• Building	
• Moveable equipment	
• Other (specify)	

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).

	Two Most Current Actual Years		**Projected years – ending with first year at full utilization**			
CY or FY (circle)			20__	20__	20__	20__
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).**

	Projected years – ending with first year at full utilization			
CY or FY (circle)	20__	20__	20__	20__
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 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).

	Two Most Recent Years -- Actual		**Current Year Projected**	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
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							
Subtotal							
Income Taxes							
Net Income (Loss)							
Table 3 Cont.	**Two Most Actual Ended Recent Years**		**Current Year Projected**	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
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 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 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).

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
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				
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				

Subtotal				
Income Taxes				
Net Income (Loss)				

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	20___	20___	20___	20___
4A. - Payor Mix as Percent of Total Revenue				
Medicare				
Medicare Advantage				
Medicaid				
Medicaid MCO				
Blue Cross				
Other Commercial Insurance				
Other (Specify)				
TOTAL	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits				
Medicare				
Medicare Advantage				
Medicaid				
Medicaid MCO				
Blue Cross				
Other Commercial Insurance				
Self-Pay				
Other (Specify)				
TOTAL	100%	100%	100%	100%

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.**

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								
Registered Nurse								
Licensed Practical Nurse								
Physical Therapist								
Occupational Therapist								
Speech Therapist								
Home Health Aide								
Medical Social Worker								
Other (Please specify.)								
Benefits								
TOTAL								

***** Indicate method of calculating benefits cost

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