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March 2, 2026

Jeanne-Marie Gawel, Chief Facilities Planning
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Maryland Health Care Commission
Health Care Planning and Development
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Completeness Responses – First Healthcare Consultants LTD, Proposed Medicare-Certified Home Health Agency

Matter Nos.: 26-R4-2487, 26-R4-2488, 26-R4-2489, and 26-R4-2490

Dear Ms. Gawel and Ms. Miles

On behalf of our client, First Healthcare Consultants LTD, PDA, Inc. respectfully submits responses to the questions regarding completeness received on February 9, 2026.

In accordance with Commission instructions, four hard copies of the responses are being submitted via UPS concurrently with this correspondence. All required electronic materials, including digital exhibits and supporting documentation, have also been emailed 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

Completeness Questions for

Medicare-Certified Home Health Agency

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

March 2, 2026

Applicant Responses

Affidavit

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.

26/02/2026

Abisola Raimi-Abayomi
Abisola Raimi-Abayomi (Feb 27, 2026 07:29:02 EST)

Date

Signature of Owner or
Authorized Agent of the Applicant

PART I: PROJECT IDENTIFICATION AND GENERAL INFORMATION

Project Description

1. **In the Plan of Correction located in Exhibit 1, the date is listed as 2018. However, on page 13, the application states that the agency opened in 2022. Please elaborate on this date discrepancy.**

Clarification of Date Discrepancy – Exhibit 1 and Page 13

The Plan of Correction included in Exhibit 1 reflects FHC's initial Maryland Department of Health survey conducted in October 2018. FHC was established in July 2018 and received its initial Residential Service Agency (RSA Level 3) license in October 2018.

The narrative on page 13 of the application incorrectly states that FHC was established in 2022. **This was imprecise wording.** FHC was formally established in July 2018 and has maintained uninterrupted licensure since.

In November 2022, FHC obtained accreditation from Community Health Accreditation Partner (CHAP), a nationally recognized accrediting organization approved by the Centers for Medicare & Medicaid Services. This accreditation reflected FHC's readiness to deliver skilled nursing and therapy services in accordance with nationally recognized quality standards.

Subsequently, in January 2023, the Maryland Department of Health issued an expanded RSA license under the "Other" category, authorizing FHC to provide skilled nursing, physical therapy, and occupational therapy services. This expanded licensure did not represent the formation of a new entity; rather, it reflects the progression and expansion of FHC's clinical scope under continued state oversight.

At initial licensure in 2018, FHC operated under RSA Level 3 authority, which primarily permitted personal care and related services. The 2022 CHAP accreditation and the January 2023 expanded RSA licensure collectively established the regulatory and clinical foundation necessary to support skilled service delivery and ultimately to pursue Medicare-certified home health operations.

The clarified timeline is as follows:

- July 2018 – Organizational establishment
- October 2018 – Initial RSA Level 3 licensure
- November 2022 – CHAP accreditation
- January 2023 – Expanded RSA licensure (skilled nursing and therapy authorization)

FHC has not experienced any lapse in licensure or interruption of operations.

2. On page 20, the application mentions a plan to open a "contact office" in Charles County. Does this refer to Waldorf? Will it be an official branch, and is its financial impact included in the project budget?

Contact Office

The proposed "contact office" referenced on page 20 refers to space in Waldorf, Charles County. Details of the proposed space are in Exhibit 5.

This location will not function as an official branch office under COMAR or Medicare definitions. It will not serve as a separately licensed location, will not independently accept referrals, and will not operate as a distinct administrative or clinical site. The Laurel office will remain the agency's sole main office.

Rather, the Waldorf location will function as a limited "touch office" to support staff serving patients in Southern Maryland. The purpose of the space is to:

- Provide a location for nurses and therapists to check in and complete documentation;
- Store limited clinical supplies;
- Conduct occasional in-person meetings when appropriate; and
- Reduce travel burden across the large Southern Maryland geography.

The financial impact of this contact office is fully incorporated into the project budget:

- Rental expense for the space is included in operating expenses reflected in Table 4 (Revenues and Expenses – Projected Home Health Agency Services for Proposed Project).
- Supplies and related support items are included within the general supplies and operating expense categories and are not treated as a separate capital expenditure.
- No construction, renovation, or separate administrative overhead is associated with the contact office.

Accordingly, the Waldorf contact office is a modest operational support location, not a branch office, and its associated costs are included in the financial projections submitted with the application.

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

Populations and Services

3. How is FHC's proposed home health agency a "lower-cost alternative"?

Lower-Cost Alternative

FHC's proposed Home Health Agency represents a lower-cost alternative to hospital or nursing home care. For the appropriate patient, a home health agency can provide clinically appropriate care in a location that avoids the added cost of overnight institutional care. The cost of care provided in patients' homes involves the direct care providers, supplies, and administrative overhead. There is no brick-and-mortar cost. When appropriately used, post-acute or post-nursing-home-to-home health care can produce system savings. Specifically:

1. Substitution for Higher-Cost Settings

Home health services can prevent or shorten hospital admissions, reduce emergency department utilization, and decrease length of stay in skilled nursing facilities and inpatient rehabilitation facilities. Evidence from a systematic review indicates that home-based care services are generally cost-saving or cost-effective compared with in-hospital care, resulting in lower overall expenditures while achieving similar outcomes outside institutional settings.[1]

2. Prevention of Avoidable Utilization

By adding home health agency capacity and skilled nursing oversight, medication reconciliation, chronic disease management, and therapy services, FHC will reduce preventable readmissions and complications that result in high-cost acute care episodes. FHC regularly encounters patients in its home care service who are confused about medications or who have no one to provide skilled nursing care for surgical and other wounds.

3. Cost Efficiency Through Community-Based Care

By providing care in the home, skilled nurses and therapists can observe and teach patients and families about cultural, dietary, and infection-control practices that support or undermine personal health.

4. Appropriate Utilization Management

FHC's visit projections and staffing model are aligned with demonstrated utilization benchmarks and physician-ordered plans of care, ensuring services are clinically appropriate and not excessive.

[1] Curioni, C., 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. 20, no. 8, 2023.

5. Payer Neutrality and Medicare Compliance

As most home health services are reimbursed under Medicare's prospective payment system, reimbursement is fixed and episode-based, promoting efficiency and cost containment at the system level.

Accordingly, FHC's proposed home health agency will provide a lower-cost alternative to institutional care by shifting the location of care from high-intensity institutional settings to the home. Accreditation-worthy policies and procedures maintain quality, continuity, and regulatory compliance.

4. Revise the Charity Care policy to indicate that the determination of probable eligibility will be made in two business days. Two business days are indicated in the sliding fee scale tables only.

Charity Care Policy

Exhibit 8 has been revised to clarify that FHC will make a probable eligibility determination within two (2) business days of a client's request for charity care or submission of a financial assistance or Medical Assistance application. The policy now distinguishes between probable eligibility (two business days) and the final eligibility determination (within ten business days of receiving documentation), consistent with COMAR 10.24.16.08E.

Please see the revised Exhibit 8 attached to this Completeness Response. Revisions are in red for ease of reading.

Impact Standard

5. **On page 40, the application states that FHC has already identified staff to support the addition of speech therapy and social work services. Does the social work plan include a Social Worker supervised by an MSW, or only an MSW?**

Medical Social Worker

The social work plan includes services provided under the supervision of a Master of Social Work (MSW). FHC will contract with an MSW who meets the Medicare Conditions of Participation to provide the required supervision and oversight. Bachelors-prepared social workers will work under the supervision of the MSW.

By Project Year 4, FHC projects serving 418 unduplicated clients and allocating 0.5 FTE dedicated to medical social work services (pp. 84, 88–92). The MSW will supervise social work activities and ensure compliance with CMS and Maryland regulatory requirements.

This structure is consistent with Medicare requirements, permitting social work services to be provided by a bachelor's-level social worker under MSW supervision.

6. **Commission staff frequently receive concerns from home health providers regarding workforce shortages. On page 41, the application states that the proposed service area has a "strong, diverse pool of licensed nurses and therapists" and that the proposed project will not negatively impact other providers' staffing. Provide the source/basis for the conclusion regarding the labor pool.**

Workforce Shortages

The proposed project will not negatively impact other providers' staffing. As detailed in the application, FHC's Administrator, Abi Raimi-Abyomi, brings extensive experience in home health operations and healthcare workforce recruitment in the region. FHC currently employs or contracts with more than 48 clinical and administrative staff serving these jurisdictions, demonstrating practical access to the regional labor pool. FHC maintains a waiting list of nurses and therapists who want to work for FHC and provide skilled care in patients' homes. However, without access to Medicare and some Commercial patients, FHC does not have enough volume as an RSA to support hiring these staff.

Unlike a new entity starting from scratch that would require large-scale hiring for every position, the proposed FHC HHA represents a measured scope expansion of an existing RSA. Staffing projections reflect incremental growth aligned with the identified unmet need for HHA visits in the service area. FHC is aware of workforce shortages and recruits some staff from outside the state. Given FHC's established recruitment track record, the project is not expected to materially impact staffing availability for other providers.

The conclusion that the PSA has a strong and diverse labor pool is supported by state labor data, workforce development infrastructure, and FHC's demonstrated recruitment experience.

Maryland Department of Labor Local Area Unemployment Statistics ("LAUS") show recent unemployment rates of approximately 3.4 percent in Anne Arundel County, 3.6 percent in Montgomery County, 4.1 percent in Prince George's County, and approximately 3.6 percent in Southern Maryland. These rates reflect active and stable labor markets within the broader Washington–Baltimore metropolitan healthcare corridor. See Exhibit 15.

Each PSA jurisdiction is part of a designated Maryland Workforce Development Area, which provides employment tracking, occupational projections, and healthcare workforce training partnerships. A structured workforce infrastructure supports ongoing recruitment and professional training for licensed nurses and therapists.

As discussed on pages 38–39 of the application, the PSA benefits from proximity to major hospital systems, academic medical centers, and community college nursing and allied health programs. Of note, each jurisdiction has an established community college offering clinically appropriate HHA training programs. Together, these programs produce hundreds of new employee candidates annually. See details in the table below.

Table Q: Examples of HHA Appropriate Clinical Training Programs in FHC's PSA

School	County	Relevant Programs	Degree / Certificate Offered
Anne Arundel Community College	Anne Arundel	Nursing (RN), Practical Nursing, Physical Therapist Assistant, Occupational Therapy Assistant	Associate of Science, Certificate
Montgomery College	Montgomery	Nursing (RN), Practical Nursing, Physical Therapist Assistant, Health Sciences	Associate of Applied Science, Certificate
Prince George's Community College	Prince George's	Nursing (RN), Practical Nursing, Health Sciences	Associate of Science, Certificate
College of Southern Maryland	Calvert, Charles, and St. Mary's	Nursing (RN), Practical Nursing, Physical Therapist Assistant	Associate of Science, Certificate

Source: community college websites, accessed February 2026

Page 38 indicates that "… 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**," [emphasis added].

7. Identify for what reason a client would be transferred to another health care facility or program?

Transferring Clients

A client would be transferred to another health care facility or program when the client's clinical needs exceed the scope of services that can be safely and appropriately delivered in the home setting under the Home Health Agency's licensure and Conditions of Participation.

Examples of circumstances that may necessitate transfer include:

- Acute clinical deterioration requiring emergency evaluation or inpatient hospitalization;
- Need for continuous monitoring or services that cannot be provided safely in the home;
- Requirement for a higher level of care, such as skilled nursing facility, inpatient rehabilitation, or long-term acute care hospital services;
- Transition to hospice services when the patient elects a palliative plan of care;
- Patient-initiated relocation outside of the Agency's approved service area; or,
- Patient or family request for transfer to another provider.

In all instances, transfers would be coordinated in accordance with physician orders, patient rights requirements, and federal and state regulations to ensure continuity of care and appropriate discharge planning.

Further details can be found in Exhibit 10, which includes FCH's Discharge Planning Policies, and in the discussion under 10.24.16.08J Discharge Planning, beginning on page 46 of the application.

Data Collection and Submission

8. Current home health agencies report difficulties obtaining responses to patient satisfaction surveys, which can impact CMS star ratings. On page 46, the application states that the RSA currently administers a patient satisfaction survey. Please report your current RSA response rate and describe any strategies used to achieve a high response rate from clients.

RSA Patient Satisfaction Survey Response Rate and Strategies

FHC currently administers two patient feedback tools in its RSA operations:

1. Post-Admission Survey
2. Patient Satisfaction Survey (administered at or near discharge)

Response Rate

Over the most recent 12-month period, FHC collected Post-Admission Surveys from approximately **60 percent of admitted patients**.

Response rates for the Patient Satisfaction Survey have historically mirrored national trends reported by home health agencies, with lower voluntary response rates occurring when paper-based methods were used. In the third quarter of 2025, FHC implemented process improvements designed to increase response rates and reduce barriers to participation.

Strategies Used to Improve Response Rates

FHC has implemented several strategies to promote higher survey participation:

1. **Point-of-Care Distribution:** The Post-Admission Survey is provided at the time of admission with a stamped return envelope. Patients are encouraged to complete and seal the survey during the visit and return it directly to the nurse.
2. **QR Code Implementation (Q3 2025):** Beginning in the third quarter of 2025, FHC transitioned to QR-code-based surveys accessible via text message or staff device. This allows patients or caregivers to complete the survey in under two minutes.
3. **Technology Access Support:** For patients without compatible personal devices, staff provide access to agency-issued devices at the time of visit to facilitate survey completion.
4. **Confidential Submission:** Responses are transmitted directly to a designated agency by email and are not visible to the staff member administering the visit. This reinforces confidentiality and encourages candid feedback.
5. **Caregiver Inclusion:** Surveys may be completed by the primary caregiver when appropriate, improving participation among medically complex or elderly patients.

Relevance to CMS Star Ratings

FHC recognizes that CMS Home Health CAHPS response rates can affect Star Ratings. The transition to QR-based dissemination, point-of-care completion options, and technology-assisted access was specifically implemented to improve response capture and minimize the non-response challenges reported by many agencies.

These operational practices demonstrate FHC's proactive approach to quality measurement and continuous improvement and position the agency to effectively manage CMS CAHPS response requirements upon Medicare certification.

Need

9. Elaborate on how the applicant is uniquely qualified to help address the following identified needs:

a. In the Guidance for the 2025 Home Health Review, Commission staff found a need in Charles, Montgomery, Prince George's, and Anne Arundel Counties due to a lack of quality providers.

b. In the Guidance for the 2025 Home Health Review, Commission staff found a need in Calvert, Charles, and St. Mary's Counties due to high market concentration, meaning one or a small number of agencies dominate the jurisdiction.

Response to MHCC Published Need

The Maryland Health Care Commission's 2025 Review Guidance identifies jurisdictions eligible for a new Home Health Agency based on the presence of published need under COMAR 10.24.16.04. The jurisdictions included in this application—Anne Arundel, Prince George's, Montgomery, Calvert, Charles, and St. Mary's Counties—each qualify under at least one of the Commission's established need categories: **Concentrated Market**, **Insufficient Choice of Quality-Performing HHAs**, or both, see the table below. Exhibit 16 contains an excerpt from the "2025 Home Health Agency Certificate of Need Review: Qualifying Jurisdictions, Types of Applicants, Qualifications for Accepting a CON Application, and Qualifying Maryland Applicants," supporting data in the table.

Table R: Qualifying Jurisdictions by Category, MHCC 2025

County	Highly Concentrated Market	Insufficient Choice of Quality	Consumer Choice
Anne Arundel		X	
Calvert	X		
Charles	X	X	
Montgomery		X	
Prince George's		X	
St. Mary's	X	X	

Source: CHCF Review Guide, p1

Insufficient Choice of Quality-Performing HHAs

COMAR 10.24.16.04A(3) identifies need when sixty percent or more of home health clients are served by agencies that fail to meet the Commission's quality-performance benchmarks. The MHCC quality analysis identifies Anne Arundel, Prince George's, Montgomery, Charles, and St. Mary's Counties as falling into this category. In several of these counties, the majority of patients are served by HHAs with CMS Star Ratings below the benchmark, weaker CHAPS performance, or quality measures that do not meet MHCC's criteria for high-performing agencies.

FHC directly addresses these quality gaps through its established clinical leadership structure, strong care-coordination practices, high documentation standards, and long-standing record of serving medically complex and socially vulnerable patients as an RSA. FHC's experience with structured care plans, interdisciplinary communication, and quality monitoring positions the agency to provide a higher standard of home health services than what is currently available to many residents of these jurisdictions. By enabling FHC and its strong quality systems to become a Medicare-certified provider in these counties, MHCC would increase patient access to an HHA that meets or exceeds MHCC performance expectations.

In addition to its internal quality controls, FHC is accredited by CHAP (Exhibit 1), a nationally recognized accrediting organization approved by CMS. CHAP accreditation requires compliance with nationally recognized standards for patient care, documentation, infection control, quality improvement, and administrative oversight.[2] Continued accreditation reflects ongoing survey review and independent validation of the agency's operational and clinical standards.

FHC is also an enrolled provider with Maryland Medicaid and maintains contracts with Medicaid Managed Care Organizations. Participation in the Maryland Medicaid program requires credentialing review, regulatory compliance, and ongoing adherence to state and federal program requirements.[3] The agency's continued approval to serve Medicaid beneficiaries demonstrates sustained compliance with public payer standards and oversight mechanisms.

Collectively, CHAP accreditation and Medicaid participation provide objective, third-party validation of FHC's quality infrastructure and regulatory compliance, reinforcing the agency's ability to address the quality-related need identified in the Commission's 2025 Home Health Review Guidance.

The same adherence to quality standards will be implemented at the proposed HHA. Please see copies of FHC's proposed quality control policies and procedures in Exhibit 11.

Concentrated Market Need

Under COMAR 10.24.16.04A(2), a jurisdiction qualifies when its HHA market is **highly concentrated**, defined as a Herfindahl-Hirschman Index ("HHI") of 0.25 (or 2,500 after multiplying by 10,000) or higher. According to MHCC's analysis, **Calvert County, Charles County, and St. Mary's County** meet this threshold. In these counties, a small number of dominant providers control most of the market, limiting competition and reducing patient choice. Such concentrated markets can be associated with longer wait times, access barriers for Medicare beneficiaries, and a limited ability for hospitals and physicians to place patients with HHAs who meet specific clinical or geographic needs.

FHC's entry introduces a new, independent Medicare-certified HHA into these concentrated markets, offering additional capacity, seven-day-per-week availability, and strong established care-transition partnerships with regional hospitals. This expansion directly counteracts market concentration by increasing provider choice and reducing the dependence on a small subset of existing HHAs.

[2] Community Health Accreditation Partner (CHAP). *About CHAP Accreditation*. CHAP, https://chapinc.org. Accessed 17 Feb. 2026.

[3] Maryland Department of Health. *Maryland Medicaid Provider Participation Requirements*. Maryland Department of Health, https://health.maryland.gov/mmcp. Accessed 17 Feb. 2026.

Alignment of the Project With Published Need

FHC's proposed Medicare-certified Home Health Agency directly aligns with the MHCC's published need determinations and provides solutions to the specific gaps identified by the Commission. In counties with overly consolidated markets, FHC expands competition and provides an additional access point for referring hospitals, physicians, case managers, and families. In counties where the majority of Medicare beneficiaries are currently served by agencies that fail to meet MHCC quality benchmarks, FHC brings a new, high-performing provider with strong quality-assurance systems, improved care transition processes, and tested clinical programs.

By applying a conservative market-share ramp, aligning adoption assumptions with historic utilization patterns, and ensuring service delivery grounded in accessibility, cultural responsiveness, and financial transparency, FHC's project directly combats the lack of high-quality, high-choice home health options identified in the MHCC's need methodology. For these reasons, the proposed project is directly responsive to, and fully consistent with, the Commission's published need findings.

Viability

10. On page 67, the applicant states that there is a documented list of clients who were referred to the agency but could not be served due to lack of Medicare certification. Please specify the timeframe during which this data was collected and the number of clients who were unable to be served, out of the total that were referred.

The documented list referenced on page 67 reflects referral activity collected during Calendar Year 2025 (January 1, 2025, through December 31, 2025).

FHC records indicate that, during CY2025, **almost 16 percent** of its referrals (39 of 244) could not be served because FHC was not Medicare-certified.

FHC maintains internal documentation of referrals declined after intake review. However, electronic referral platforms do not consistently provide complete reporting for cases that are not formally accepted into the system. As a result, referral activity that was not fully processed through intake may not be captured in FHC's internal records. Accordingly, the number of payer-related declines identified above reflects documented internal cases and likely represents a **conservative estimate** of total referrals that could not be served due to Medicare participation requirements.

While precise quantification is limited by the structure of electronic referral reporting, FHC's intake documentation confirms that Medicare certification restrictions have resulted in the inability to serve a measurable number of otherwise appropriate patients during CY2025. Some Medicare Managed Care Advantage plans, such as Humana and United, are starting to require Medicare Certification as a prerequisite for referrals to home care or home health agencies.

Approval of the proposed Home Health Agency would eliminate this payer-based limitation and allow FHC to accept and serve these Medicare and Medicare Advantage beneficiaries.

Impact Criterion

11. On page 70, the applicant states that the impact of this project on the healthcare delivery system will be neutral. Please explain why the outcomes achieved in this project would not result in cost savings for the healthcare delivery system, particularly for hospitals.

Cost of the Healthcare Delivery System

The statement on page 70 describing the impact as "neutral" was intended to reflect that the project does not increase overall system expenditures or create duplicative infrastructure. However, FHC acknowledges that the expansion of home health services is reasonably expected to have a positive cost impact on the healthcare delivery system, particularly for hospitals.

Home health services are delivered in the least intensive, lowest-cost, clinically appropriate setting—the patient's home. By supporting earlier hospital discharge, reducing avoidable readmissions, improving chronic disease management, and decreasing unnecessary emergency department utilization, home health services can lower overall system expenditures.

For hospitals specifically, timely access to home health facilitates:

- Reduced length of stay;
- Improved discharge throughput;
- Lower readmission risk; and,
- More efficient bed utilization.

While reimbursement for home health services follows established Medicare and payer prospective payment methodologies and does not, in itself, guarantee system-wide savings, the substitution of home-based care for higher-cost institutional services is widely recognized as cost-efficient.

Accordingly, the project is expected to have a **neutral to positive impact** on overall healthcare system costs and may result in cost savings, particularly through avoided acute care utilization.

Alternatives to Project

12. Under the "Alternatives" section, explain how the first alternative, "maintain the status quo," differs from the third alternative, "continue as an RSA without Medicare certification."

The first and third alternatives address different perspectives — system-level versus applicant-level impacts.

Alternative 1 – Maintain the Status Quo (System-Level Alternative)

This alternative addresses the service area. It assumes that no new Medicare-certified Home Health Agency will be established in the proposed service area. Under this scenario, existing providers would continue to operate at their current capacity, and the MHCC and State Plan-identified need would remain unmet. Patients would continue to experience limited provider choice and potential access constraints, particularly as demand increases. This alternative evaluates the impact on the broader healthcare delivery system if no additional HHA capacity is introduced.

Alternative 3 – Continue as an RSA Without Medicare Certification (Applicant-Level Alternative)

This alternative evaluates the impact specific to FHC and its referral network. Under this scenario, FHC would continue operating solely as an RSA and would not obtain Medicare certification. While other HHA providers might expand or new agencies could enter the market, FHC itself would remain limited in scope, unable to serve Medicare beneficiaries directly or provide the full range of skilled home health services contemplated under the project. This alternative focuses on the applicant's operational and strategic limitations and the special needs of providers who have historically referred patients to FHC. The referring providers like FHC's quality, and have asked that FHC expand its service scope.

Accordingly, Alternative 1 evaluates the consequences of no additional HHA development in the service area, while Alternative 3 evaluates the consequences of FHC choosing not to pursue Medicare certification, even if other system changes occur.

Health Equity

13. In reference to page 71, provide examples of how the jurisdictions in the PSA face disproportionate barriers. Please include sources of information.

Barriers to Access

The application documents disproportionate barriers to care within the PSA in multiple sections, including the Population Health and Social Determinants discussion on pages 26–29 and in Exhibits 6 and 7.

As described on page 26, PSA jurisdictions have elevated rates of preventable hospitalizations, diabetes prevalence (up to 13 percent), obesity (24–43 percent), and tobacco use (greater than 10 percent in all jurisdictions), according to Robert Wood Johnson County Health Rankings data (Exhibit 6). Preventable hospitalization rates above state and national averages are a recognized indicator of inadequate access to timely primary and community-based care.

Further, as discussed on pages 26–27, the PSA reflects substantial racial and ethnic diversity. In 2025, approximately 37.1 percent of residents identify as White, approximately 34.0 percent as African American, and approximately 16.7 percent as Hispanic or Latino (Exhibit 7; Maryland Department of Planning data). National research from the Centers for Disease Control and Prevention (2023)[4] and the U.S. Department of Health and Human Services Office of Minority Health (2022 CLAS Standards)[5] demonstrates that racially and ethnically diverse communities experience structural barriers, including:

- Gaps in insurance coverage;
- Transportation limitations;
- Language barriers; and,
- Reduced access to culturally competent providers.

The application also notes that approximately 8.0 percent of PSA residents live below the federal poverty level (p. 27; U.S. Census Bureau American Community Survey data, Exhibit 7). Poverty is strongly associated with delayed care, underinsurance, higher chronic disease burden, and reliance on emergency department services (Woolf et al., Urban Institute; HealthyPeople 2030, footnote #17, p. 27).

Additionally, Table C (p. 28) demonstrates declining home health utilization rates in the PSA, despite rapid growth in the 65+ population (Tables A and B, pp. 24–25). Industry and MedPAC findings cited in the application indicate that this decline is linked to workforce shortages and constrained agency capacity rather than reduced need, suggesting access barriers within the PSA (footnote #19, p. 27).

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[4] Centers for Disease Control and Prevention. *Chronic Disease Indicators: Prevalence of Diabetes, Obesity, and Tobacco Use*. Centers for Disease Control and Prevention, 2023, https://www.cdc.gov/chronicdisease/indicators/index.htm.

[5] 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*. U.S. Department of Health and Human Services, 2022, https://thinkculturalhealth.hhs.gov/clas.

Taken together, the PSA jurisdictions face disproportionate barriers, including:

- Higher chronic disease prevalence;
- Elevated preventable hospitalization rates;
- Rapid growth in the 75–84 and 85+ age cohorts;
- Racial and ethnic diversity associated with documented structural access barriers;
- Meaningful poverty rates affecting the affordability of care; and,
- Declining home health utilization despite growing demand.

These factors collectively demonstrate that residents of the PSA experience barriers to timely, culturally competent, and community-based care, supporting the need for expanded home health capacity as proposed in this application.

14. On page 72, the applicant describes declining home health utilization as being influenced by factors beyond access to services, including workforce shortages, agency closures, and low reimbursement rates. Provide the source of these assumptions and explain how FHC will uniquely address these challenges.

Declining Home Health Utilization Rates

The discussion on page 72 regarding workforce shortages, agency closures, and reimbursement pressure is supported by sources cited in the Home Health Use Rates section (pp. 27–28). These include:

- MedPAC reporting documenting post-pandemic declines in home health utilization associated with staffing shortages and operational constraints (footnote #19);
- Trella Health industry analyses identifying reduced admissions and visit volume tied to workforce limitations and reimbursement pressure (footnote #21);
- McKnight's Home Care reporting on agency closures and constrained provider capacity nationwide (footnote #21); and

Recent federal analyses acknowledge that home health agencies nationally have faced workforce pressures and operational constraints that affect service capacity. CMS, through its Home Health Engagement and burden-reduction initiatives, has identified staffing shortages and administrative complexity as factors affecting home health service delivery nationwide.[6]

Similarly, the Health Resources and Services Administration's Bureau of Health Workforce has noted that growth in the direct care workforce has not kept pace with projected demand in many regions, contributing to capacity strain in community-based care settings.[7]

[6] Centers for Medicare & Medicaid Services. *Home Health Engagement*. Centers for Medicare & Medicaid Services, 31 July 2025, https://www.cms.gov/priorities/burden-reduction/overview/customer-engagement/home-health-engagement. Accessed 17 Feb. 2026.
[7] Bureau of Health Workforce, Health Resources and Services Administration. *Addressing the Shortage of Direct Care Workers: Insights from State Initiatives*. The Commonwealth Fund, 19 Mar. 2024,

These sources collectively indicate that recent declines in home health utilization reflect system strain and constrained capacity rather than diminished patient need.

FHC's Approach to Addressing These Challenges

FHC is uniquely positioned to mitigate these industry-wide pressures, given its existing operational foundation as a licensed RSA serving the same jurisdictions. Unlike a new entrant with no established service, FHC:

1. Has an Existing Workforce Base.

FHC currently employs or contracts with more than 48 staff and already delivers skilled nursing and therapy services. The proposed HHA expands the scope rather than building from scratch.

2. Leverages Established Infrastructure.

The HHA will operate from FHC's existing office location, avoiding construction costs and new facility overhead, reducing financial risk and operational strain.

3. Implements Geographic Staffing Strategies.

FHC plans to hire staff residing in Southern Maryland to minimize travel burden and improve workforce stability across the PSA. FHC has developed its own hiring outreach mechanism, working directly with training programs in the area and providing internships and mentoring opportunities to enable it to train and select the best among graduates.

4. Maintains Accreditation and Regulatory Readiness.

FHC is accredited by CHAP and intends to pursue Medicare certification through deemed status to support regulatory compliance and operational efficiency.

5. Uses Conservative Volume Forecasting.

Projected volumes align with documented unmet need and phased growth assumptions, reducing the risk of overextension in a constrained labor market.

6. Diversified Payer Experience.

As an existing Medicaid vendor and RSA serving dual-eligible populations, FHC has experience operating within constrained reimbursement environments and managing financial risk.

Accordingly, while workforce shortages and reimbursement pressures are recognized industry challenges, FHC's existing infrastructure, staffing base, accreditation status, and phased implementation strategy position the organization to expand capacity in a measured and sustainable manner.

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https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/addressing-shortage-direct-care-workers-insights-seven-states. Accessed 17 Feb. 2026.

Character and Competence

15. Your response refers to information in Section III of the application. In addition, please provide the Commission with positive examples demonstrating the agency's achievements, character, and competence.

Regulatory Compliance and Accreditation

FHC has maintained uninterrupted licensure as a Maryland Residential Service Agency since its inception, with no enforcement actions, license suspensions, or civil monetary penalties. The agency is accredited by CHAP, with accreditation valid through November 29, 2028 (Exhibit 1). Survey activity has resulted in no Immediate Jeopardy findings, and any standard-level recommendations have been addressed promptly through documented corrective action processes.

This record reflects a sustained commitment to regulatory compliance, internal accountability, and continuous quality improvement.

Quality and Clinical Performance

FHC maintains an active Quality Assessment and Performance Improvement (QAPI) program led by its Director of Nursing. The agency tracks key clinical indicators, including infection control events, incident reporting trends, documentation accuracy, and patient satisfaction. Internal review processes have resulted in measurable improvements in documentation timeliness, care plan accuracy, and service coordination.

FHC administers both post-admission and discharge patient satisfaction surveys. Over the most recent 12-month period, approximately 60 percent of admitted patients completed the post-admission survey, reflecting strong engagement relative to voluntary survey-participation norms. Survey results consistently demonstrate positive feedback regarding responsiveness, professionalism, communication, and culturally competent care. Table ## below provides examples of quality measures tracked and their improvement over time.

Table S: Quality Measures by Measure Type and Performance Level Achieved

Sample Types of Quality Measures*	Measure Type	Performance Level Achieved			
		FY25	FY24	FY23	FY22
Timely Receipt of Plan of Care	Precent of patients that received signed POC from physician within 30 days of admission	82.0%	80.0%	75.0%	55.0%
Medication Profile	Percent of patients who completed medication education, has all meds confirmed with Physician, and then all meds reconciled in home by staff	95.0%	95.0%	95.0%	95.0%
Infections	Percent of patients developed infection during care	0.48%	2.14%	5.88%	0.0%
Falls	Percent of patients who fell during care	0.0%	0.0%	0.65%	0.0%
Clinical Records Review	25% of patients reviewed quarterly and meet internal standards of completeness	95.0%	95.0%	95.0%	95.0%

Source: FHC internal data.

FHC scored well on many patient satisfaction metrics. For example,

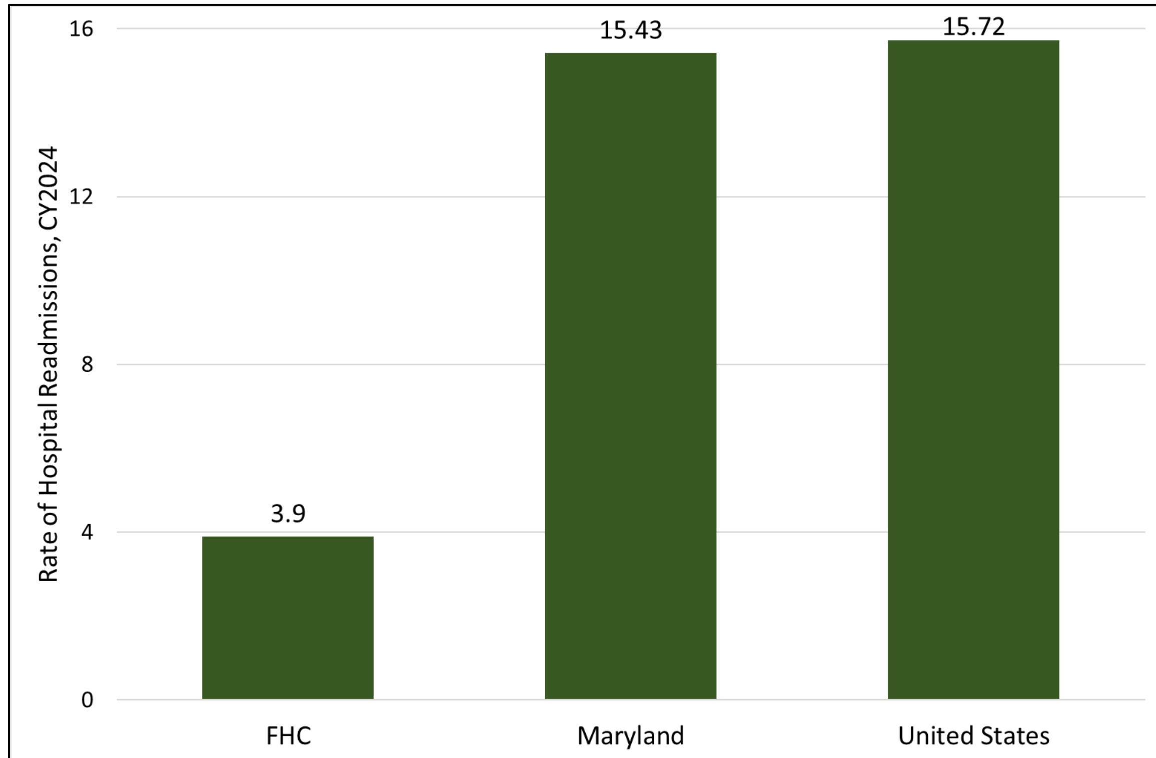
- Teaching of the services provided: 80% yes
- Accessibility to caregiver and office: 80% yes

Operational improvements—including implementation of QR-code survey access and point-of-care completion options—were introduced to further strengthen response capture and transparency.

FHC has demonstrated the ability to stabilize medically complex patients at home, reducing avoidable care escalations and supporting safe transitions after hospital discharge. Notably, **FHC's 2025 client rehospitalization rate was 3.9 percent** – a significant difference from the Maryland average of 15.43 percent as of CY2024.[8]

[8] Maryland Health Services Commission. (2025, April 9). Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2027. https://hscrc.maryland.gov/Documents/Quality_Documents/RRIP/RY%202027/Final%20RRIP%20RY%202027%20recommendation.pdf

Figure C: Maryland and National Medicare FFS Unadjusted Readmission Rates Compared to FHC, CY2024



Source: Maryland Health Services Commission. Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2027; Figure 2; FHC internal data

Workforce Stability and Professional Development

FHC employs or contracts with more than 48 staff across nursing, therapy, aide, and administrative disciplines. Leadership brings decades of combined experience in home health, acute care, regulatory compliance, and healthcare management.

The agency invests in continuing education and professional development, including participation in Maryland-National Capital Homecare Association (MNCHA) leadership training and ongoing clinical education programs. Staffing models emphasize local recruitment within the PSA, reducing travel burden and promoting workforce stability. **Staff retention and professional engagement demonstrate a stable operational foundation.**

Community Engagement and Referral Relationships

FHC is an active Medicaid vendor and contracts with Maryland Medicaid Managed Care Organizations. The agency participates in professional and community organizations, including the Capital Area Healthcare Alliance Business Advisory Council, and maintains referral relationships across the continuum of care.

The agency is regularly approached by patients, families, and providers seeking expanded Medicare-certified services, reflecting established community trust and demand for its care model.

Financial Stability and Operational Readiness

FHC has demonstrated financial stability through sustained operations as an RSA, sound financial policies (Exhibit 8), and documented funding support (Exhibit 9). **The proposed Home Health Agency leverages existing infrastructure and staffing, minimizing capital risk and supporting measured, sustainable expansion.**

Organizational Character

FHC's operational history reflects a commitment to serving economically vulnerable populations, including Medicaid beneficiaries and medically complex patients. **The agency's financial assistance policy ensures that services are not denied due to an inability to pay, and that eligibility determinations for charity care are made promptly in accordance with COMAR requirements.**

Collectively, FHC's regulatory history, accreditation status, quality oversight structure, workforce investment, financial stability, and community engagement demonstrate the character, competence, and operational capacity necessary to establish and sustain a Medicare-Certified Home Health Agency in the proposed service area.

PART IV: CHARTS AND TABLES SUPPLEMENT

Clarification of Financial Table Revisions and Methodological Corrections

During the production of these completeness responses, the Applicant identified several inconsistencies in the originally submitted pro forma tables and financial assumptions that required correction. The corrections have now been fully incorporated into the revised Tables 1, 2b, 4, and 5.

Corrections

1. Transposition of Physical and Occupational Therapy Visits: Physical Therapy (PT) and Occupational Therapy (OT) visit counts were inadvertently reversed. Because CMS reimbursement rates and average staff compensation for PT and OT differ by less than one percent, the financial impact is minimal. However, the correction was necessary to ensure internal consistency across projected utilization, revenue, and staffing.

2. Administrative FTE Ramp Too Aggressive in PY2: Administrative staffing was originally increased too sharply between PY1 and PY2. The corrected projection phases in administrative FTE growth more gradually, aligning staffing costs with the timing of revenue growth and producing a more accurate net income trajectory.

3. Omission of PTO Factor for Direct Care Staff: Direct care staffing FTEs did not include a Paid Time Off (PTO) adjustment. Applying a 6.1 percent PTO factor (120 hours ÷ 1,960 annual hours) increases staffing costs appropriately to reflect actual full-time labor requirements. This change affects all four project years and more accurately reflects operational reality.

4. Incorrect PY1 HHA-to-RSA Visit Ratio: The allocation of visit-related expenses between HHA and RSA activity was incorrectly weighted in PY1. Applying the corrected ratio increases the share of expenses appropriately allocated to HHA operations in the first projection year. This correction does not alter total operating expenses, but it ensures internal consistency in the distribution methodology.

Impact of Corrections

Collectively, these corrections produce **minor but necessary adjustments** in revenue distribution, staffing costs, and year-over-year operating margins. Importantly:

- The corrected tables show **positive and increasing operating margins** beginning in PY 2.
- The revised working capital requirement is **fully funded from the Applicant's existing cash reserves**, as demonstrated in Exhibit 9 and Table 1.
- None of the corrections materially alter the overall project feasibility, need, or viability analysis; rather, they ensure transparency and methodological accuracy.
- The revised Tables 1, 2b, 4, and 5 included in the following pages supersede the originally filed versions and incorporate all corrections described above. These tables also support the responses to **Questions 16–24**, which follow immediately.

Budget

16. In reference to page 82, explain the source of the $270,587.00 figure included in the budget.

Cash Flow

The $270,587 figure reported on page 82 of the original application represented the maximum cumulative cash flow deficit derived from a monthly cash flow projection model for the first three years of HHA operations, inclusive of $17,785 in pre-opening start-up expenses. Following the corrections described in Questions 18 and 19 below, the revised working capital requirement is $289,584 (inclusive of $19,020 in start-up expenses).

The working capital methodology is described in the Project Budget Assumptions (Section 5, “Working Capital Methodology,” and Section 6, “Working Capital Requirement”) and operates as follows:

- **Cash receipts** are modeled monthly, assuming a 45-day accounts receivable collection period. Non-CMS revenue ($5,437/month) begins in January 2027; CMS revenue is added beginning in June 2027 following the Medicare certification survey process.
- **Cash disbursements** are modeled monthly. During January–March 2027 (pre-CMS certification), monthly operating expenses reflect only non-CMS visit volume (11.2% of full operations). Beginning April 2027, full monthly operating expenses are incurred.
- **The maximum cumulative cash flow deficit** peaks at the end of Month 7 (July 2027) at $289,584, representing the total funding required before the agency achieves positive monthly cash flow in Month 8 (August 2027).

The monthly cash flow model is attached as Exhibit 17.

17. On page 81, no amount is listed for CON application fees. Please provide the amount budgeted for this expense.

CON Fees

The Applicant misunderstood the intent of this line item. Because Maryland has no CON filing fee, line item 2.c of Table 1 (Project Budget) — “CON Application Assistance” — was left blank. The corrected Table 1 now reflects $55,000 under “Other (CON Consultant)” for CON consulting fees associated with the preparation and filing of this application.

The inclusion of the $55,000 CON consultant fee increases Total Financing Costs from $0 to $55,000 and Total Uses of Funds to $347,370, which remains fully funded by the Applicant’s existing cash reserves (see corrected Table 1, Sources of Funds, Line B.1).

Tables

18. On page 84, projected occupational therapy visits are significantly higher than those for other therapy disciplines, particularly compared to physical therapy. Please explain this projection.

Physical Therapy versus Occupational Therapy Visits

The higher projected occupational therapy visits shown on page 84 reflect a labeling error in the table, where occupational and physical therapies were transposed. A corrected Table 2 reflecting the proper allocation of physical therapy and occupational therapy visit projections is provided below.

The corrected projections show that physical therapy visits exceed occupational therapy visits, consistent with historical utilization patterns in home health services and with the clinical distribution assumptions described in the application's methodology section.

This correction did produce minor ripple effects across the financial tables. Because PT and OT staff are compensated at the same average salary ($75,000) and the CMS per-visit reimbursement rates for the two disciplines differ by less than one percent, the overall financial impact is minimal.

Corrected Tables 1, 2b, 4, 5, and all related assumptions are provided at the end of these responses, beginning on page 132.

19. On page 87, the projected income for 2028 is significantly lower than the projected income for the first year (2027). Please confirm whether this is a typographical error.

Projected Income

The lower projected income in PY2 was not a typographical error. However, as described above, administrative staffing in PY2 was too steep, and HHA-to-RSA visit ratios were incorrect. The following table reflects edited values as a result of these corrections, which illustrate a net income increase in each projection year:

Table T: Summary of Edited Revenue and Expenses, 2027-2030

Year	Net Revenue	Total Operating Expenses	Net Income	Operating Margin
2027	$726,296	$738,530	($12,234)	(1.7%)
2028	$1,034,436	$993,566	$40,870	4.0%
2029	$1,338,094	$1,246,753	$91,341	6.8%
2030	$1,528,563	$1,356,373	$172,190	11.3%

Revised administrative staffing ramp. The Year 2 net income dip in the original filing was driven by a step-function increase in administrative staffing from 2.5 FTEs in Year 1 to 4.0 FTEs in Year 2. This significant increase front-loaded $123,000 in additional administrative salary expense into Year 2 before revenue had scaled proportionally.

In the corrected projections, administrative FTEs increase gradually — from 2.5 in Year 1 to 3.25 in Year 2 to 4.0 in Years 3 and 4 — distributing the administrative build-out over two years and aligning the cost ramp more closely with the revenue growth trajectory. As a result, total operating expenses increase 37.1 percent from Year 1 to Year 2, while net revenue increases 42.4 percent, allowing the operating margin to expand in each successive year.

Additional correction — PTO adjustment for direct care staff. Separately, the corrected staffing tables also incorporate a PTO adjustment of 6.1 percent (120 PTO hours ÷ 1,960 annual work hours), applied as a multiplier to each direct care position's base FTE, ensuring staffing levels account for paid leave.

This adjustment increases clinical staffing costs proportionally across all projection years and does not affect the year-over-year trajectory of net income. Its impact is most pronounced in Year 1, when the agency operates on only partial-year CMS revenue (seven months) while bearing the full annualized cost of employee benefits and PTO, resulting in a thinner Year 1 margin.

20. On pages 89–92, total staffing costs (including benefits) are presented across the four projected years. However, these figures differ from—and are lower than—the staffing costs shown in the project revenue table by approximately 4.5%–8.3%. Please confirm which figures are correct and clarify the reason for this variance.

Staffing Cost Variance

The variance between the "Salaries, Wages, and Professional Fees (including fringe benefits)" line on Table 4 and the total compensation reported on Table 5 is reconciled as follows:

Table U: Staffing Cost Variance, Reconciliation, 2027-2030

Year	Table 5 (Staffing)	Table 4 (Salary Line)	Difference
2027	$540,745	$583,809	$43,064
2028	$729,079	$772,143	$43,064
2029	$918,107	$961,171	$43,064
2030	$988,730	$1,031,795	$43,064

The $43,064 difference is consistent across all four projection years and represents Professional Fees, which are included in Table 4 but not in Table 5. This treatment follows the distinct reporting requirements of each table:

- **Table 4** is titled "Salaries, Wages, and Professional Fees (including fringe benefits)" and accordingly includes $43,064 per year in professional fees for Medical Director compensation, compliance consulting, and other professional services required for HHA operations.
- **Table 5** is titled "Staffing Information" and reports only employee compensation (salaries and benefits for agency staff and contract staff). Professional fees for non-employee services are appropriately excluded.

The $43,064 annual professional fees amount is derived by scaling FHC's 2024 actual professional fees by a factor of 1.5x to account for the additional professional services required by a Medicare-certified HHA, as described in the Expense Assumptions (Section 2).

21. On page 94, under total startup expenses, please provide additional detail supporting the $17,785 figure.

Startup Expense Clarification

Following the corrections described above, total start-up expenses are $19,020. These represent pre-opening costs incurred in December 2026, the month prior to service commencement, and consist of three components:

1. **Staff compensation** — $2,695. Two weeks (0.5 months) of salaries, benefits, and payroll taxes to cover staff orientation, training, onboarding, and administrative preparation prior to the start of patient services.
2. **Marketing** — $10,000. Initial investment in referral source development and community outreach to support patient intake at launch.
3. **Baseline operating expenses** — $6,325. One month of operating costs is required to establish the agency prior to service commencement, including insurance, IT systems, rent, telecommunications, travel, medical supplies, and other administrative expenses.

A detailed line-by-line breakout of start-up expenses is provided in Exhibit 17.

22. On page 97, the application indicates that Medicare Advantage and insurance reimbursement rates are based on Medicare's LUPA reimbursement rates. Please identify the source of this information.

<u>LUPA Reimbursement Rates</u>

Per-visit reimbursement rates for Medicare Advantage and commercial insurance were estimated using CMS's nationally published per-visit payment rates by discipline, as set forth in the CY 2026 Home Health Prospective Payment System Final Rule.[9] These national rates were adjusted for each jurisdiction using the applicable CMS pre-floor, pre-reclassification hospital wage index, consistent with the methodology CMS uses to adjust home health payments for geographic cost differences. A uniform per-visit rate assumption was applied across both Medicare Advantage and commercial payers. This approach provides a highly defensible, conservative estimate for the following reasons:

- **The LUPA Floor:** Low Utilization Payment Adjustment (LUPA) rates represent the baseline Medicare per-visit payment, stripping away the higher, case-mix-adjusted 30-day episodic payments ("PDGM") utilized in traditional Medicare.
- **Medicare Advantage Proxy:** Unlike traditional Medicare fee-for-service (FFS), Medicare Advantage ("MA") plans predominantly bypass episodic payment models in favor of aggressively managed, negotiated per-visit contracts. Because MA reimbursement yields lower margins than traditional Medicare, using the statutory LUPA per-visit rate serves as an accurate, baseline proxy for MA-contracted rates without overstating episodic upside.[10]
- **Commercial Insurance Upside:** Private insurers customarily negotiate reimbursement at a premium to Medicare payment levels. Pegging commercial revenue to the absolute LUPA floor provides a margin of safety and leaves room for upside in actual collections. Accordingly, using LUPA per-visit rates as the reimbursement assumption for Medicare Advantage and commercial payers provides a conservative floor unlikely to overstate actual revenue.

[9] Calendar Year (CY) 2026 Home Health Prospective Payment System Final Rule (CMS-1828-F); https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-home-health-prospective-payment-system-final-rule-cms-1828-f

[10] Prusynski, Rachel A et al. "Medicare Advantage reimbursement structures impact home health delivery and outcomes." The American journal of managed care vol. 31,11 (2025): 677-685. doi:10.37765/ajmc.2025.89819

23. On page 100, regarding the RN-to-LPN ratio, will the agency use a model in which the initial assessment is conducted by an RN and subsequent nursing visits are conducted by an LPN, or does the agency plan to use an alternative model?

RN-to-LPN Care Delivery Model

FHC will utilize an RN-primary care delivery model consistent with Medicare Conditions of Participation and industry standards.

Under this structure:

- Registered Nurses (RNs) will perform the majority of skilled nursing visits, including initial comprehensive assessments, OASIS data collection as required by 42 CFR § 484.55, periodic reassessments, recertifications, discharge assessments, and clinically complex visits requiring independent clinical judgment.
- The RN will develop and update the plan of care in coordination with the physician and retain overall responsibility for clinical oversight and care coordination.

Licensed Practical Nurses (LPNs) will supplement RN capacity by providing routine, protocol-driven follow-up visits for patients with stable, well-established care plans, under the RN's direction and supervision. These visits may include:

- Routine wound care follow-up;
- Medication management reinforcement;
- Patient education; and,
- Monitoring of stable conditions.

Teaching-intensive cases, IV therapy, complex medication management, and higher-acuity clinical oversight will remain under RN management.

This RN-primary structure reflects the realities of home health care delivery, where clinicians operate independently in patients' homes without immediate on-site support and where independent clinical judgment is frequently required.

The RN/LPN staffing ratio reflected in Table 5 (approximately 79 percent RN and 21 percent LPN within the skilled nursing discipline) is derived from analysis of Medicare Cost Report data from comparable home health agencies operating in the proposed service area and is consistent with industry norms for Medicare-certified HHAs.

The proposed staffing and financial projections align with this care delivery model and do not require modification.

24. On p.94, applicant states that there will be a positive cash flow by month 8 however if there is only enough cash to cover the first three months (p.42) what will occur for months 4-8?

Clarification of Positive Cash Flow and Working Capital

The reference on page 42 to "three months" pertains to the federal capitalization requirement under 42 CFR § 489.28, which requires a new Medicare-certified home health agency to maintain sufficient operating reserves to cover the first three months following the grant of Medicare billing privileges. **This statement does not represent the total amount of cash available to the project.**

As demonstrated in Exhibit 9 and the updated financial documentation included below, FHC has committed total project funding of **$364,584**, consisting of:

- $20,000 in fixed capital
- $55,000 in CON-related consulting costs
- $289,584 in working capital

All funds are sourced from existing cash reserves, and no debt financing is required.

The **$280,427 in working capital** exceeds the three-month CMS minimum requirement and is sufficient to cover the projected cumulative cash flow deficit from project commencement through Month 8 (August 2027), at which point the agency achieves positive monthly cash flow.

The monthly cash flow model in Exhibit 17 details projected inflows, outflows, and cumulative cash position by month and demonstrates that available reserves fully support operations through the pre-positive cash flow period.

Accordingly, while the application acknowledges the CMS three-month capitalization standard, the Applicant's available funding materially exceeds that requirement and supports operations through Month 8 without reliance on external financing.

Revised Supplemental Tables and Assumptions

For clarity, the Applicant has included a revised set of tables and assumptions that correct minor adjustments resulting from the aforementioned corrections and/or clarifications. **Updates from the original submission are highlighted**. All other information is identical to the original submission.

TABLE 1: Project Budget

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 (CON Consultant)	$55,000
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)	**$55,000**
3. WORKING CAPITAL STARTUP COSTS	**$289,584**
TOTAL USES OF FUNDS (sum of 1 - 3)	**$364,584**

B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	$364,584
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)	**$364,584**

ANNUAL LEASE COSTS (if applicable)	
• Land	N/A
• Building	$5,982
• Moveable equipment	N/A
• Other (specify)	N/A

TABLE 2b: Statistical Projections - Projected Home Health Agency Services In The Proposed Project

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	1,268	1,803	2,338	2,663
Occupational Therapy Visits	419	596	773	880
Speech Therapy Visits	79	113	146	167
Medical Social Services Visits	20	29	38	43
Other Visits (Non-Billable)	91	129	167	190

TABLE 4: Revenues And Expenses – Projected Home Health Agency Services For Proposed Project

This entire table is updated as a result of the corrected physical and occupational therapy visits.

Metric	Projected Years (ending with first full year at full utilization)			
Calendar Year	**CY2027**	**CY2028**	**CY2029**	**CY2030**
1. Revenue				
Gross Patient Service Revenue	$834,823	$1,189,007	$1,538,039	$1,756,969
Allowance for Bad Debt	$20,871	$29,725	$38,451	$43,924
Contractual Allowance	$83,482	$118,901	$153,804	$175,697
Charity Care	$3,631	$5,172	$6,690	$7,643
Net Patient Services Revenue	$726,296	$1,034,436	$1,338,094	$1,528,563
Other Operating Revenues (Specify)	-	-	-	-
Net Operating Revenue	$726,296	$1,034,436	$1,338,094	$1,528,563
2. Expenses				
Salaries, Wages, and Professional Fees, (including fringe benefits)	$583,809	$772,143	$961,171	$1,031,795
Contractual Services (please specify)	-	-	-	-
Interest on Current Debt	$832	$1,295	$1,724	$2,027
Interest on Project Debt	-	-	-	-
Current Depreciation	-	-	-	-
Project Depreciation	$2,857	$2,857	$2,857	$2,857
Current Amortization	-	-	-	-
Project Amortization	-	-	-	-
Supplies	$14,561	$20,707	$26,853	$30,585
Other Expenses (See assumptions)	$136,471	$196,563	$254,147	$289,109
Total Operating Expenses	$738,530	$993,566	$1,246,753	$1,356,373
3. Income				
Income from Operation	($12,234)	$40,870	$91,341	$172,190
Non-Operating Income	$0	$0	$0	$0
Subtotal	($12,234)	$40,870	$91,341	$172,190
Income Taxes	$0	$0	$0	$0
Net Income (Loss)	($12,234)	$40,870	$91,341	$172,190
4A. - Payor Mix as Percent of Total Revenue				
Medicare	72.70%	72.75%	72.86%	72.79%
Medicare Advantage	15.04%	14.94%	14.89%	14.83%
Medicaid	1.47%	1.52%	1.46%	1.58%
Medicaid MCO	1.81%	1.80%	1.80%	1.89%
Blue Cross (included in commercial)	0.00%	0.00%	0.00%	0.00%
Commercial Insurance	7.47%	7.45%	7.45%	7.38%
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%

Metric	Projected Years (ending with first full year at full utilization)			
Calendar Year	**CY2027**	**CY2028**	**CY2029**	**CY2030**
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 (included in commercial)	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

Updated figures are highlighted for reference.

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	-	-	1.17	-	$75,000	-	$87,551	-
Occupational Therapist	-	-	0.37	-	$75,000	-	$27,857	-
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	$70,532	
						TOTAL	**$540,745**	

***** 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	-	-	3.25	-	$82,000	-	$266,500	-
Registered Nurse	-	-	1.50	-	$80,000	-	$119,771	-
Licensed Practical Nurse	-	-	0.40	-	$65,000	-	$26,186	-
Physical Therapist	-	-	1.66	-	$75,000	-	$124,163	-
Occupational Therapist	-	-	0.53	-	$75,000	-	$39,796	-
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	$95,097	
						TOTAL	**$729,079**	

* 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	-	-	2.14	-	$75,000	-	$160,776	-
Occupational Therapist	-	-	0.68	-	$75,000	-	$50,939	-
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	$119,753	
						TOTAL	**$918,107**	

***** 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	-	-	2.44	-	$75,000	-	$183,061	-
Occupational Therapist	-	-	0.77	-	$75,000	-	$58,102	-
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	$128,965	
						TOTAL	$988,730	

* Indicate method of calculating benefits cost

Financial Assumptions

Figures and the narrative, updated from the original submission, are highlighted for ease of review.

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	661,050	Apr-27	7 months (Jun-Dec)
Non-CMS Revenue	65,245	Jan-27	12 months (Jan-Dec)
Total Year 1 Net Revenue	726,296		

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:** $19,020

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 ($5,437/month) begins January 2027. CMS revenue is added in June 2027, bringing total monthly revenue to approximately $99,873/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 $19,020 of startup expenses*	$289,583.96
Months to Positive Cash Flow	8
Fixed Capital Cost (FF&E)	$20,000.00
Other Cash Requirements (CON Consultant)	$55,000.00
Total Project Cost (Capital + Working Capital)	$364,583.96

7. Source Of Funds

The total project cost of $364,584 (fixed capital of $20,000 plus working capital of $289,584) 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	$5,982	*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 $5,982 to $14,575 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	40.2%
Occupational Therapy	13.3%
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	3,245	4,615	5,985	6,817
Gross Revenue	$834,823	$1,189,007	$1,538,039	$1,756,969
Net Patient Revenue	$726,296	$1,034,436	$1,338,094	$1,528,563

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	3,245	4,615	5,985	6,817
Projected RSA Visits	7,742	5,419	3,794	2,656
HHA Allocation Ratio	29.5%	46.0%	61.2%	72.0%

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. A PTO adjustment of 6.1% is applied as a multiplier to each direct care position's base FTE (120 PTO hours divided by 1,960 annual work hours), ensuring the uplift scales proportionally with each discipline's staffing level.
- **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 included 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	3,245	4,615	5,985	6,817
Total Operating Expenses	$738,530	$993,566	$1,246,753	$1,356,373
Cost per Visit	$227.57	$215.28	$208.31	$198.98
Net Revenue	$726,296	$1,034,436	$1,338,094	$1,528,563
Operating Margin	($12,234)	$40,870	$91,341	$172,190

Expense projections demonstrate operational efficiency gains as the HHA scales, with cost per visit decreasing from $227.57 in Year 1 to $198.98 in Year 4 at full utilization. The agency achieves positive operating margins in project years 2 through 4, with margins improving significantly as fixed costs are spread across higher visit volumes.

Exhibits

8. First Health Care Consultants LTD Financial Policies REVISED 248
15. Local Area Unemployment Statistics, Anne Arundel, Montgomery, Prince George's, and Southern Jurisdictions 352
16. CHCF Review Guidance, Excerpt 358
17. Monthly Cashflow Model 360

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~~ Make a probable eligibility determination within two (2) business days of a client's request

5. Final eligibility determination completed within ten (10) business days
6. Notify patients in writing of approval or denial
7. Apply approved discounts retroactively **for up to 90 days**

Important: Care will not be denied or delayed while an application is pending. No medically necessary services will be denied, delayed, or discontinued while a probable eligibility determination or final financial assistance review 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
<u>**2.Notice of Charity Care and Sliding Fee Scale Policies.**</u> 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 15

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- Re-entry
- Business Services

Local Area Unemployment Statistics (LAUS) - Workforce Information & Performance

The statistics in this section are gathered from the LAUS Program. This program provides estimates of labor force (employment and unemployment) and the unemployment rate, by place of residence.
For more information read our LAUS Program Information Sheet and go to the Bureau of Labor Statistics' website.

Maryland Seasonally Adjusted LAUS Data

LAUS Maryland - Seasonally Adjusted	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Unemployment Rate	3.4%	3.6%	3.8%	0.0%	4.2%	4.2%
Unemployment	110,419	115,704	122,282	0.0	135,323	136,376
Employment	3,127,217	3,123,146	3,116,011	0.0	3,104,314	3,096,065
Labor Force	3,237,636	3,238,850	3,238,293	0.0	3,239,637	3,232,441
Labor Force Participation Rate	64.7%	64.7%	64.7%	NA	64.6%	64.5%

Due to the Federal Shutdown, Oct 2025 data is not avaliable

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Maryland Not Seasonally Adjusted LAUS Data

LAUS Maryland - Not Seasonally Adjusted	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Unemployment Rate	3.8%	4.3%	4.3%	0.0%	4.8%	3.7%
Unemployment	125,298	138,656	140,236	0.0	153,138	118,108
Employment	3,162,141	3,104,064	3,091,896	0.0	3,064,036	3,075,005
Labor Force	3,287,439	3,242,720	3,232,132	0.0	3,217,174	3,193,113
Labor Force Participation Rate	65.7%	64.8%	64.6%	NA	64.2%	63.7%

Due to the Federal Shutdown, Oct 2025 data is not avaliable

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County Unemployment Rate

Unemployment Rate by County	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Maryland	3.8%	4.3%	4.3%	0.0%	4.8%	3.7%
Allegany County	5.3%	5.6%	5.6%	0.0%	6.1%	5.0%
Anne Arundel County	3.4%	3.7%	3.8%	0.0%	4.1%	3.1%
Baltimore city	4.9%	5.6%	5.5%	0.0%	6.1%	4.9%
Baltimore County	3.8%	4.3%	4.4%	0.0%	4.7%	3.6%
Calvert County	3.5%	3.8%	3.8%	0.0%	4.0%	3.0%
Caroline County	3.6%	3.9%	4.2%	0.0%	4.3%	3.3%
Carroll County	3.1%	3.4%	3.4%	0.0%	3.5%	2.7%
Cecil County	4.1%	4.6%	4.5%	0.0%	4.7%	3.6%
Charles County	4.0%	4.7%	4.6%	0.0%	5.3%	4.1%
Dorchester County	3.9%	4.4%	4.7%	0.0%	5.2%	4.2%
Frederick County	3.3%	3.6%	3.8%	0.0%	4.1%	3.1%
Garrett County	3.8%	4.2%	4.3%	0.0%	4.4%	4.0%
Harford County	3.6%	4.0%	3.9%	0.0%	4.1%	3.1%
Howard County	3.4%	3.8%	3.9%	0.0%	4.1%	3.1%
Kent County	3.9%	4.3%	4.6%	0.0%	4.6%	3.9%
Montgomery County	3.6%	4.0%	4.2%	0.0%	4.5%	3.5%
Prince George's County	4.2%	4.8%	4.8%	0.0%	5.5%	4.3%
Queen Anne's County	3.0%	3.2%	3.5%	0.0%	3.7%	2.9%
Somerset County	4.5%	5.0%	4.9%	0.0%	5.0%	3.9%
St. Mary's County	3.5%	3.9%	3.8%	0.0%	4.0%	3.0%
Talbot County	3.7%	4.0%	4.3%	0.0%	4.6%	3.6%
Washington County	4.2%	4.7%	4.8%	0.0%	5.0%	4.0%
Wicomico County	3.8%	4.3%	4.4%	0.0%	4.8%	3.9%

To access historical data, scroll down to the bottom of the table and click (download), specify Date Range "From, To" then choose whether you want to Preview/Print or download in a specific format (e.g., XLS, Text).

More Data:

- Counties
- Cities
- Metropolitan Statistical Area (MSA)
- Annual Data

Press Release Schedule

Data are estimates relating to the week of the 12th of the month. The count is of persons by place of residence.
**Data prepared in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics.*

Maryland Department of Labor
Division of Workforce Development and Adult Learning
Office of Workforce Information and Performance
100 S. Charles Street, Tower 1
Baltimore, Maryland 21201
410-767-2250
DLWDALLMI-LABOR@maryland.gov

Maryland Department of Labor

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Area Explorer - Anne Arundel County Workforce Development Area - Workforce Information & Performance

Local Area Unemployment Statistics (LAUS)

Anne Arundel Workforce Development Area	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Unemployment Rate	3.4%	3.7%	3.8%	0.0%	4.1%	3.1%
Unemployment	10,835	11,892	12,100	0.0	12,832	9,791
Employment	310,317	305,885	304,549	0.0	302,943	304,183
Labor Force	321,152	317,777	316,649	0.0	315,775	313,974

Note: Data Not Seasonally Adjusted (Due to the Federal Shutdown, Oct 2025 data is not avaliable)

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- Quarterly Census of Employment and Wages
- Maryland Fact Finder
- Occupational and Wage Data
- Occupational Projections
- Commuting Patterns
- Labor Force, Demographic and Jobs Overview
- Growth Industry Tool
- Major Employers

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WDAL Services

- Información en español
- Find an American Job Center (AJC) Near You
- Overview
- Job Fairs and Recruitments
- Job Seeker Services
- Dislocated Worker Information
- Reemployment Services and Eligibility Assessment Program
- Rapid Response Supplemental Funding
- Veterans Services
- Eligible Training Provider List - WIOA
- Information for Individuals with Disabilities
- Agricultural Employers and Workers
- Youth Workforce Programs and Services
- Re-entry
- Business Services

Area Explorer - Montgomery County Workforce Development Area - Workforce Information & Performance

Local Area Unemployment Statistics (LAUS)

Montgomery Workforce Development Area	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Unemployment Rate	3.6%	4.0%	4.2%	0.0%	4.5%	3.5%
Unemployment	20,637	22,615	23,553	0.0	25,322	19,219
Employment	554,361	544,119	542,348	0.0	534,897	534,197
Labor Force	574,998	566,734	565,901	0.0	560,219	553,416

Note: Data Not Seasonally Adjusted (Due to the Federal Shutdown, Oct 2025 data is not avaliable)

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- Quarterly Census of Employment and Wages
- Maryland Fact Finder
- Occupational and Wage Data
- Occupational Projections
- Commuting Patterns
- Labor Force, Demographic and Jobs Overview
- Growth Industry Tool
- Major Employers

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Quick Links

- Home
- Monthly Labor Review
- Employment Situation
- Local Area Unemployment Statistics (LAUS)
- Current Employment Statistics (CES)
- Press Release Schedule
- Area Explorer
- Growth Industry Tool
- Occupational Employment and Wage Statistics
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Area Explorer - Prince George's County Workforce Development Area - Workforce Information & Performance

Local Area Unemployment Statistics (LAUS)

Prince George Workforce Development Area	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Unemployment Rate	4.2%	4.8%	4.8%	0.0%	5.5%	4.3%
Unemployment	21,681	24,298	24,468	0.0	28,013	21,502
Employment	497,324	483,564	484,206	0.0	476,898	477,940
Labor Force	519,005	507,862	508,674	0.0	504,911	499,442

Note: Data Not Seasonally Adjusted (Due to the Federal Shutdown, Oct 2025 data is not avaliable)

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Area Explorer - Southern Maryland Workforce Development Area - Workforce Information & Performance

Local Area Unemployment Statistics (LAUS)

Southern Maryland Workforce Development Area	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Unemployment Rate	3.8%	4.2%	4.1%	NA	4.6%	3.5%
Unemployment	7,571	8,373	8,178	NA	8,962	6,754
Employment	194,257	189,596	189,134	NA	186,304	186,996
Labor Force	201,828	197,969	197,312	NA	195,266	193,750

Note: Data Not Seasonally Adjusted (Due to the Federal Shutdown, Oct 2025 data is not avaliable)

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- Quarterly Census of Employment and Wages
  - Calvert County
  - Charles County
  - St. Mary's County
- Maryland Fact Finder
  - Calvert County
  - Charles County
  - St. Mary's County
- Occupational and Wage Data
- Occupational Projections
- Commuting Patterns
- Labor Force, Demographic and Jobs Overview
- Growth Industry Tool
- Major Employers
  - Calvert County
  - Charles County
  - St. Mary's County

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Exhibit 16

**2025 Home Health Agency Certificate of Need (CON) Review:
Qualifying Jurisdictions, Types of Applicants, Qualifications for Accepting a CON Application, and Qualifying Maryland Applicants**

Qualifying Jurisdictions

Consistent with the Home Health Agency (HHA) Chapter of the State Health Plan (COMAR 10.24.16.04), multiple jurisdictions qualify as having a need for additional HHA services. The qualifying counties under a highly concentrated market are Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico and Worchester. The qualifying counties under insufficient choice of quality performing home health agencies are Anne Arundel, Baltimore, Carroll, Charles, Frederick, Garrett, Harford, Howard, Montgomery, Prince George's, St. Mary's, Wicomico and Baltimore City. There was no need identified for consumer choice.

Types of Applicants

Pursuant to the HHA Chapter of the State Health Plan (COMAR 10.24.16.06B), only the following types of entities are eligible to apply for a CON to provide HHA services:

- Existing Medicare-certified HHAs licensed in Maryland and proposing to add one or more jurisdictions to its authorized service area;
- Existing Medicare-certified HHAs licensed in another state and proposing to establish a new HHA in Maryland; or
- Non-HHA service providers currently licensed and accredited, in good standing, as a hospital, a nursing home or a Maryland residential service agency (RSA) providing skilled nursing services and proposing to establish a new HHA in Maryland.

Qualifications for All Applicants

The Commission will only accept a CON application submitted by an applicant that provides documentation that it qualifies as an applicant, in conformance with COMAR 10.24.16.06C.

Performance-Related Qualifications by Type of Applicant

Consistent with COMAR 10.24.16.06D and COMAR 10.24.16.07, quality measures and performance levels were approved by the Commission at its June 12, 2025 meeting to be used for the 2025 CON review schedule of proposed HHA projects. Performance-related qualifications necessary for accepting an application will vary by type of applicant as described in COMAR 10.24.16.07B-D. An applicant's performance will be determined based on the data publicly reported on the applicable CMS Care Compare websites. Performance- related qualifications by type of applicant are summarized below.

Exhibit 17

FHC MD HHA Batch 1 Startup and Working Capital		1	2	3	4	5	6	7	8
	Startup Period	**Jan-27**	**Feb-27**	**Mar-27**	**Apr-27**	**May-27**	**Jun-27**	**Jul-27**	**Aug-27**
Net Revenue		$ 5,437	$ 5,437	$ 5,437	$ 5,437	$ 5,437	$ 99,873	$ 99,873	$ 99,873
Non-CMS revenue spread over 12 months									
CMS revenue spread ofver six months (June-Dec)									
	Startup Period	**Jan-27**	**Feb-27**	**Mar-27**	**Apr-27**	**May-27**	**Jun-27**	**Jul-27**	**Aug-27**
Cash Inflow/Receipts		-	2,719	5,437	5,437	5,437	5,437	52,655	99,873
Assuming 45 days in A/R									
Operating Costs	**Startup Period**	**Jan-27**	**Feb-27**	**Mar-27**	**Apr-27**	**May-27**	**Jun-27**	**Jul-27**	**Aug-27**
These variable expenses are ramped with visits									
Salaries	$ 2,198	$ 4,395	$ 4,395	$ 4,395	$ 50,781	$ 50,781	$ 50,781	$ 50,781	$ 50,781
Benefits	$ 330	$ 659	$ 659	$ 659	$ 7,617	$ 7,617	$ 7,617	$ 7,617	$ 7,617
Payroll Taxes	$ 168	$ 336	$ 336	$ 336	$ 3,885	$ 3,885	$ 3,885	$ 3,885	$ 3,885
Marketing	$ 10,000	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183
Travel	$ 175	$ 175	$ 175	$ 175	$ 2,025	$ 2,025	$ 2,025	$ 2,025	$ 2,025
Medical Supplies	$ 136	$ 136	$ 136	$ 136	$ 1,572	$ 1,572	$ 1,572	$ 1,572	$ 1,572
Bad Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
IT	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734
Training	$ 46	$ 46	$ 46	$ 46	$ 531	$ 531	$ 531	$ 531	$ 531
Contractor	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117
Interest	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69
Professional Fees	$ -	$ 403	$ 403	$ 403	$ 4,651	$ 4,651	$ 4,651	$ 4,651	$ 4,651
Rent	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499
Repairs	$ -	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21
Taxes	$ -	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86
Telecom	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318
Utilities	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39
Payroll Processing		$ 24	$ 24	$ 24	$ 278	$ 278	$ 278	$ 278	$ 278
Other Indirect	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192
Cash Outflows by Month	**$ 19,020**	**$ 12,432**	**$ 12,432**	**$ 12,432**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 77,597**
Total Cash Inflows		$ -	$ 2,719	$ 5,437	$ 5,437	$ 5,437	$ 5,437	$ 52,655	$ 99,873
Total Cash Outflows	$ (19,020)	$ (12,432)	$ (12,432)	$ (12,432)	$ (77,597)	$ (77,597)	$ (77,597)	$ (77,597)	$ (77,597)
Principal Payment Outflow									
Net Cash Flow before WC interest	$ (19,020)	$ (12,432)	$ (9,714)	$ (6,995)	$ (72,160)	$ (72,160)	$ (72,160)	$ (24,942)	$ 22,275
Monthly Interest on WC Outflow	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Net Monthly Cash Flow	$ (19,020)	$ (12,432)	$ (9,714)	$ (6,995)	$ (72,160)	$ (72,160)	$ (72,160)	$ (24,942)	$ 22,275
Cumulative Cash Flow	$ (19,020)	$ (31,452)	$ (41,166)	$ (48,161)	$ (120,321)	$ (192,481)	$ (264,642)	$ (289,584)	$ (267,308)
		1	2	3	4	5	6	7	8

Start up Costs & Pre-opening	**$ 19,020**	
Total Working Capital	**$ 289,584**	Maximum amount borrowed (max cumulative cash flow deficit)
Fixed Capital Cost (from Table 1)	**$ 20,000**	
Financing Cost & Other Cash Requirements	**$ 55,000**	
Total Capital Cost and Working Capital	**$ 364,584**	
Max Money Available		
Months to positive cash flow	8	