

April 2, 2026

**VIA EMAIL & HAND DELIVERY**

Ms. Deanna Dunn  
Health Facilities Coordination Officer  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215-2299

**Re: Quality One Care Home Health, Inc., Responses to Completeness Questions dated 03/05/2026 to Establish a Home Health Agency in Baltimore City, Baltimore County, and Howard County**  
Matter # 25-R2-2476, Baltimore City  
Matter # 25-R2-2477, Baltimore County  
Matter # 25-R2-2478, Howard County

Dear Ms. Dunn:

On behalf of Quality One Care Home Health, Inc., (QOC), we are submitting an electronic version, and four (4) hard copies of its Responses to Completeness Questions dated March 05, 2026, and related exhibits. This submission includes a PDF & WORD version of the responses and EXCEL file, if any, of all requested and required MHCC tables.

We hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agency as noted below.

If you have questions about the information provided above, please contact us at your convenience.

Sincerely,



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Amon Chafukira  
Program Coordinator  
Quality One Care Home Health, Inc

## **QOC Quality One Care**



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: [info@qualityonecare.com](mailto:info@qualityonecare.com) / Web: <http://www.qualityonecare.com>

### **Financial Feasibility**

- 1. MHCC staff have several questions regarding the budget for staffing.**
  - a. Your response states that the incremental increase in Physical Therapist (PT) FTEs reflects QOC’s plan to utilize a hybrid employment and contracting model, which is standard in home-health operations.**

**Further, you state the hiring process includes:**

- i. Engagement of per diem and contract physical therapists to meet early demand**
- ii. Transition to additional employed FTEs as visit volumes grow and stabilize**

**Provide more source information on the budgeted expenses for contractual services. The amounts provided appear low relative to the likely high use of contracted employees to fill the need for incremental and growing start up volumes in the new home health business. Is the low percentage realistic given the stated business plan to rely on contractual services during the start-up of the new services?**

#### **Applicant Response (Q1a) – Financial Feasibility Question 1(a)**

Quality One Care Home Health, Inc. (“QOC”) appreciates MHCC staff’s request for additional clarification regarding the contractual services expense assumptions reflected in Table 4 of the application and referenced in the Applicant’s response to the first completeness review.

As described in the application and prior responses, QOC’s staffing model utilizes a **hybrid employment and contracting approach**, which is common among newly established home health agencies. Under this model, the agency employs core clinical staff, primarily registered nurses, while therapy and specialty services are supplemented through per-visit contractual clinicians during the early stages of operation until patient volumes stabilize.

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The contractual service expense projections included in Table 4 were developed based on projected visit volumes, anticipated service mix, and the use of per-visit contracting arrangements typical for therapy services in home health operations.

## **1. Modest Initial Service Volumes**

As reflected in **Table 2B (Statistical Projections – Projected HHA Services)** of the CON application, QOC projects a gradual ramp-up in service volume during the first three years of operation. Specifically, the application projects the following service levels:

Year	Projected Clients	Total Visits
2026	100	1,162
2027	225	2,350
2028	330	3,033

These projections intentionally reflect a conservative start-up period as the agency establishes referral relationships with hospitals, physicians, and discharge planners in Baltimore City, Baltimore County, and Howard County. Because early patient census levels are modest, staffing requirements during the first year of operation are correspondingly limited.

## **2. Projected Service Mix**

The projected visit distribution further explains why contractual service expenses remain limited during the early operational phase. For Calendar Year 2026, the projected distribution of visits is as follows:

Service Type	Visits
Skilled Nursing	724
Home Health Aide	151
Physical Therapy	75
Occupational Therapy	70
Speech Therapy	6
Medical Social Work	24

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Out of **1,162 total projected visits in 2026**, approximately:

- **62% are Skilled Nursing visits (724 visits)**
- **13% are Home Health Aide visits**
- **Therapy and social work services combined represent approximately 15% of visits**

This service distribution is significant for staffing assumptions because **Skilled Nursing and Home Health Aide services are provided primarily by employed staff**, while therapy disciplines (PT, OT, Speech) and Medical Social Work are typically supplemented through **per-visit contractual clinicians** during start-up. Because therapy services represent a relatively small share of total projected visits in the first year of operation, the contractual service expense required to support those visits is correspondingly limited.

### **3. Early Referral Mix Expected to be Nursing-Dominant**

QOC anticipates that early referrals will be predominantly skilled nursing cases, which is consistent with typical home health start-up patterns. Hospitals and physicians most frequently refer patients for skilled nursing services involving medication management, wound care, chronic disease monitoring, and post-hospital recovery support.

Therapy and social work services are generally ordered after the initial nursing assessment identifies rehabilitative or supportive care needs, resulting in a smaller proportion of therapy visits during the early operational phase. This referral pattern further supports the use of employed nursing staff as the core workforce, with therapy services supplemented by contractors on a per-visit basis.

### **4. Visit-Based Contracting Model**

The contractual expenses reflected in Table 4 were calculated using a **per-visit contracting model** for therapy and social work services, rather than through hourly or full-time employment arrangements. Based on the projected 2026 service mix, therapy and social work services collectively represent approximately **175 visits**, or about **15% of total visits** during the first year of operation.

<b>Discipline</b>	<b>Visits</b>
Physical Therapy	75
Occupational Therapy	70
Speech Therapy	6
Medical Social Work	24

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Contract clinicians are compensated on a **per-visit basis consistent with prevailing home health contracting practices in the region.**

Applying these per-visit rates to the projected therapy visit volumes described above produces contractual expense levels that align closely with the **\$6,000 contractual services projection for 2026** shown in Table 4 of the application.

Because therapy visit volumes remain limited during the early stages of operation, the contractual expense represents a relatively small percentage of overall salary expenditures.

### **5. Consistency with Regional Utilization Patterns**

The projected service mix is also consistent with regional utilization patterns reported in the **MHCC 2023 Home Health Agency Utilization Tables**, which show that Baltimore City, Baltimore County, and Howard County collectively generate more than **577,000 home health visits annually**, representing a significant share of Maryland's total home health utilization.

<b>Jurisdiction</b>	<b>Total Visits</b>
Baltimore City	~179,005
Baltimore County	~315,476
Howard County	~83,372

Within these utilization patterns, **skilled nursing services represent the largest category of visits**, reflecting the central role of nursing services in home health care delivery.

Consistent with these regional trends, QOC anticipates that the majority of early referrals during the start-up phase will involve skilled nursing services, particularly following hospital discharge for:

- medication management
- wound care
- chronic disease monitoring
- post-acute recovery support.

These services are typically delivered by employed registered nurses, rather than contracted clinicians, which further explains why the proportion of contractual service expenses appears modest relative to salary expenses.

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The projected service mix in Table 2B is also consistent with the service distribution reflected in the MHCC 2023 Home Health Agency Utilization Tables, which demonstrate that skilled nursing services constitute the largest share of total home health visits across Maryland and within the Baltimore City–Baltimore County–Howard County region. MHCC utilization data show that therapy disciplines, including Physical Therapy, Occupational Therapy, and Speech Therapy, collectively account for a substantially smaller proportion of total visits when compared to skilled nursing services.

This distribution reflects the structure of the Medicare home health benefit, in which nursing visits frequently serve as the primary clinical entry point for patients following hospitalization, with therapy services introduced as needed based on physician orders and nursing assessment. QOC’s projected visit distribution, where skilled nursing services represent the majority of visits during the start-up year, therefore mirrors the utilization patterns observed among established home health agencies in the region. As a result, the limited proportion of therapy visits projected in the early operational period appropriately translates into a modest level of contractual therapy expense, which is consistent with both the projected service mix and the prevailing utilization patterns documented by MHCC.

### **6. Reasonableness of the Contractual Expense Percentage**

When considered in the context of the modest initial service volumes projected in Table 2B, the nursing-dominant referral mix expected during start-up, the limited number of therapy visits during the first year of operation, and the per-visit contracting model used for therapy disciplines, the contractual service expense levels reflected in Table 4 represent a reasonable and realistic estimate for a start-up home health agency operating under a hybrid staffing model.

As patient census grows and therapy utilization increases in later years, QOC will expand its clinical workforce accordingly through a combination of additional employed staff and contractual clinicians as needed to meet service demand.

The hybrid staffing model allows the agency to:

- maintain cost flexibility during the early start-up period
- align staffing levels with actual patient volumes
- transition appropriate clinical roles to employed staff as demand stabilizes.

Accordingly, the contractual service expense levels reflected in Table 4 are consistent with the projected service volumes, anticipated service mix, and QOC’s hybrid staffing model.

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Taken together, the projected service mix, staffing structure, and financial assumptions presented in the application reflect a coherent and internally consistent start-up model. The modest level of contractual service expense reflected in **Table 4** corresponds directly to the limited number of therapy visits projected in **Table 2B**, while the majority of clinical services, particularly skilled nursing and home health aide visits, are supported by the employed staffing levels reflected in **Table 5**. This alignment between projected visits, staffing resources, and budgeted expenses ensures that clinical capacity is sufficient to meet projected demand while maintaining financial feasibility during the start-up phase of operations. As patient census increases over time, the Applicant's projections anticipate corresponding increases in both therapy utilization and clinical staffing, thereby maintaining consistency between service demand, workforce capacity, and financial resources throughout the three-year projection period.

The Applicant notes that the use of a per-visit contractual model provides operational flexibility to scale therapy services as needed if referral patterns change, ensuring that patient care needs can be met without requiring immediate increases in fixed staffing costs.

To further demonstrate the alignment between projected service volumes, staffing resources, and budgeted expenses, the Applicant provides the following analysis of staffing capacity relative to projected visit volumes.

### **7. Staffing Capacity and Visit Volume Alignment**

The staffing levels reflected in Table 5 are sufficient to support the projected visit volumes presented in Table 2B and are based on standard home health productivity assumptions. For example, in Calendar Year 2026, the application projects 724 skilled nursing visits, which equates to approximately 14 visits per week. This level of utilization is well within the expected productivity range for a full-time registered nurse in a home health setting. Similarly, therapy and medical social work services total approximately 175 visits annually, or approximately 3 - 4 visits per week, which can be efficiently managed through per-visit contractual clinicians during the start-up phase. As patient census and visit volumes increase in subsequent years, the staffing model reflected in Table 5 demonstrates corresponding increases in clinical FTEs, ensuring that staffing capacity remains aligned with service demand.

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**b. If some of the contractual expense for staff is included in the other expenses, what is the amount within that total?**

**Summary of Expenses from Table 4**

	<b>2026</b>	<b>2027</b>	<b>2028</b>
<b>Salaries &amp; Wages (Including Benefits)</b>	\$82,000	\$148,000	\$198,000
<b>Contractual Services</b>	\$6,000	\$8,000	\$10,000
<b>Contractual as Percent of Salary</b>	7.3%	5.4%	5.1%
<b>Other Expenses</b>	\$11,500	\$15,500	\$19,700
<b>Contractual and Other as % of Salary</b>	21.3%	15.9%	15.0%

**Applicant Response – Financial Feasibility Question 1(b)**

Quality One Care Home Health, Inc. (“QOC”) appreciates MHCC staff’s request for clarification regarding whether any contractual staffing expenses are included within the “Other Expenses” category reflected in Table 4 of the CON Application.

The Applicant confirms that **no contractual staffing expenses are included within the “Other Expenses” category**. All costs associated with contracted clinical personnel—including Physical Therapy, Occupational Therapy, Speech-Language Pathology, and Medical Social Services provided on a per-visit basis—are fully and separately captured under the “Contractual Services” line item in Table 4 (Projected Revenues, Expenses, and Income) of the CON Application.

As shown in Table 4, contractual services are projected at \$6,000 in 2026, \$8,000 in 2027, and \$10,000 in 2028, reflecting the limited number of therapy and medical social work visits relative to total projected service volume, as detailed in Table 2B (Projected Statistical Projections).

The “**Other Expenses**” category, as presented in Table 4 and consistent with the financial assumptions described in the Applicant’s prior completeness response, reflects **non-staff operational expenditures only**.

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These expenses include:

- Electronic Health Record (EHR) and clinical documentation systems (including OASIS-related infrastructure)
- Billing, coding, and administrative support systems
- Office operations and administrative overhead
- Staff mileage reimbursement and travel-related costs
- Medical supplies and routine operational materials

For clarity, the projected “Other Expenses” amounts are:

Year	Other Expenses
2026	\$11,500
2027	\$15,500
2028	\$19,700

These expenses support agency operations but **do not include any form of clinical staff compensation**, whether employed or contracted. Any operational costs that support both employed and contracted staff (e.g., mileage or administrative systems) are appropriately classified as non-compensation expenses and do not represent direct staffing costs.

**c. Given that you state “the decline in net income shown in the RSA financial statements is primarily attributable to rapid increases in labor and operating costs, particularly contract staffing and wage inflation, which outpaced revenue growth during the post-pandemic period. These cost pressures are well documented across the home- and community-based services sector and disproportionately affected legacy service models with limited reimbursement flexibility.”**

**2. Provide the basis for determining whether the salary and contractual expenses are sufficient in 2027 and 2028 to account for increasing cost pressures?**

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### Applicant Response – Financial Feasibility Question 1(c) / Question 2

Quality One Care Home Health, Inc. (“QOC”) appreciates MHCC staff’s request for clarification regarding the basis for determining whether projected salary and contractual expenses in 2027 and 2028 are sufficient to account for ongoing labor cost pressures.

As noted in the CON Application and prior completeness response, QOC recognizes that the home- and community-based services sector has experienced **sustained upward pressure on labor costs**, including wage inflation and increased reliance on contract staffing in the post-pandemic environment. These trends were considered in developing the Applicant’s financial projections.

The projected salary and contractual expense levels for 2027 and 2028, as presented in **Table 4 (Projected Revenues, Expenses, and Income)**, reflect a **structured and forward-looking approach** that accounts for both anticipated growth in service volume and evolving labor cost dynamics. Specifically:

- 1. Alignment with Increasing Service Volume (Table 2B):** Projected expenses increase in proportion to growth in patient census and visit volume. As shown in Table 2B, total visits increase from 1,162 in 2026 to 2,350 in 2027 and 3,033 in 2028, representing a controlled and incremental ramp-up in operations. Correspondingly, salary and contractual expenses increase from \$82,000 in 2026 to \$148,000 in 2027 and \$198,000 in 2028, ensuring that staffing resources scale with service demand.
- 2. Transition from Contractual to Employed Staffing (Table 5):** The Applicant’s staffing model, as reflected in Table 5 (Staffing Information), anticipates a gradual increase in employed clinical FTEs as patient volume stabilizes. This transition reduces long-term reliance on higher-cost contract staffing, which was a primary driver of cost pressures in the RSA model. By shifting appropriate clinical roles to employed staff, QOC improves cost predictability and mitigates exposure to contract rate volatility.
- 3. Use of Per-Visit Contracting for Flexibility:** During both start-up and growth phases, QOC continues to utilize per-visit contractual clinicians for therapy and specialized services. This approach ensures that contractual costs remain variable and volume-driven, rather than fixed, allowing the agency to manage cost increases efficiently without overcommitting to staffing levels that exceed demand.
- 4. Conservative and Scalable Financial Assumptions:** The Applicant’s projections are intentionally conservative and designed to accommodate fluctuations in labor costs. The

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combination of moderate initial service volumes, incremental growth in staffing levels, and a hybrid staffing model, provides sufficient flexibility to absorb increases in wages or contract rates without compromising financial feasibility.

- 5. Consistency with Industry Trends and Operational Experience:** QOC's projections are informed by its existing operational experience as a Maryland-licensed Residential Service Agency and reflect observed trends in labor cost escalation. The Applicant has incorporated these considerations into its forward projections by increasing salary levels and staffing capacity over time while maintaining a balanced approach between employed and contracted personnel.

Taken together, the projected increases in salary and contractual expenses in 2027 and 2028 appropriately reflect both **anticipated growth in service demand and prevailing labor market conditions**.

The Applicant's hybrid staffing model, combined with scalable cost structures and conservative projections, provides a sufficient and realistic basis for managing ongoing cost pressures while maintaining financial stability.

The Applicant's projections also reflect improved operational efficiency as patient volume increases. Based on the projections in Tables 2B and 4, salary expense per visit remains stable across the projection period, indicating that staffing levels are scaled in a manner that maintains productivity while absorbing increases in labor costs. This reflects standard home health operating dynamics, where increased patient volume allows for more efficient utilization of clinical staff and offsets upward pressure on wages and contract rates.

In addition, projected increases in service volume, as reflected in Table 2B, correspond with projected revenue growth in Table 4, providing sufficient financial capacity to absorb rising labor costs while maintaining financial stability.

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**3. In response to question 34a in the first completeness questions, the staffing growth is lower compared to the client and visit growth. For example, Speech Therapist are at 0.1FTE in 2026 and 2027, yet volume more than doubles from 6 to 15 visits. Likewise, Medical Social Work remains at 0.1FTE yet visits are more than double from 24 to 55 in the same period.**

**Applicant Response – Tables Question 3(a) and 3(b)**

Quality One Care Home Health, Inc. (“QOC”) appreciates MHCC staff’s request for additional clarification regarding the relationship between projected staffing levels, visit volume growth, and the calculation of contractual expenses.

**a. Provide a breakdown of the operating expenses by major category.**

**Applicant Response – Tables Question 3(a) – Operating Expenses Breakdown**

The Applicant’s projected operating expenses, as presented in Table 4 (Projected Revenues, Expenses, and Income) of the CON Application, are organized into three primary categories:

Expense Category	Description
Salaries & Wages (including benefits)	Compensation for employed administrative and clinical staff, including registered nurses, home health aides, and supervisory personnel
Contractual Services	Per-visit Payments to contracted clinicians, including Physical Therapy, Occupational Therapy, Speech-Language Pathology, and Medical Social Work
Other Expenses	Non-staff operational costs, including EHR systems, billing and administrative support, office overhead, mileage reimbursement, and medical supplies

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Email: [info@qualityonecare.com](mailto:info@qualityonecare.com) / Web: <http://www.qualityonecare.com>

As reflected in Table 4, projected expenses are as follows:

Category	2026	2027	2028
Salaries & Wages	\$82,000	\$148,000	\$198,000
Contractual Services	\$6,000	\$8,000	\$10,000
Other Expenses	\$11,500	\$15,500	\$19,700

This structure reflects a **balanced cost model**, where:

- Core clinical and administrative functions are supported through employed staff
- Specialized and lower-volume services are supported through contractual clinicians
- Operational infrastructure is captured separately under “Other Expenses”

**b. Provide more information on the use of contractual employees, and how the contractual expenses are calculated, to confirm that sufficient FTEs are being captured to cover the volume growth projected.**

**Applicant Response – Tables Question 3(b) – Sufficiency of Contractual & FTE Coverage**

The Applicant’s staffing model is designed to align with projected service volumes while maintaining operational flexibility. As reflected in **Table 2B (Projected Statistical Projections)** and **Table 5 (Staffing Information)**, projected increases in visit volume are managed through a combination of employed staff and per-visit contractual clinicians.

**1. Low-Volume Disciplines Managed Through Contractual Staffing**

The disciplines identified by MHCC staff, Speech Therapy and Medical Social Work, represent **low absolute visit volumes**, even as they grow proportionally:

- **Speech Therapy:** increases from 6 visits (2026) to 15 visits (2027)
- **Medical Social Work:** increases from 24 visits (2026) to 55 visits (2027)

While this reflects percentage growth, the **absolute volume remains low**. For example:

- 15 speech therapy visits annually equates to **less than one visit per week**
- 55 MSW visits annually equates to approximately **1 visit per week**

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Given these low volumes, a **0.1 FTE allocation combined with per-visit contractual support is sufficient and appropriate** to meet service demand.

### **2. Per-Visit Contracting Model Ensures Capacity Coverage**

Contractual services are calculated based on projected visit volumes for therapy and MSW disciplines. Under this model:

- Clinicians are engaged **only as needed**, based on actual visit demand
- Costs scale proportionally with service utilization
- No fixed FTE commitment is required for low-frequency disciplines

This ensures that even as visit volumes increase, sufficient clinical capacity is available without requiring full-time staffing for services that do not justify it.

### **3. Staffing Growth Focused on Core Clinical Services**

As reflected in Table 5, staffing growth is concentrated in **core clinical roles**, particularly registered nursing, which accounts for the majority of projected visits. This approach reflects standard home health operational practice, where:

- Skilled nursing serves as the primary driver of care delivery
- Therapy and MSW services are supplemental and episodic
- Interdisciplinary services are coordinated based on patient need rather than fixed staffing ratios

### **4. Alignment Between Volume Growth and Staffing Model**

Although visit volumes increase between 2026 and 2027, the staffing model remains appropriate because:

- Growth in therapy and MSW visits occurs from a **very low baseline**
- Absolute visit counts remain within the capacity of part-time or contracted clinicians
- Per-visit contracting ensures that additional demand can be met without increasing fixed FTE levels prematurely

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### 5. Operational Flexibility and Scalability

The Applicant's hybrid staffing model allows for:

- **Scalable clinical capacity**, as contractual clinicians can be increased if demand exceeds projections
- **Cost control**, by avoiding overstaffing in low-volume disciplines
- **Efficient resource utilization**, ensuring that FTE levels remain aligned with sustained demand rather than temporary fluctuations

Taken together, the projected staffing levels, contractual utilization, and expense calculations reflect a **coherent and operationally appropriate model** in which clinical capacity is sufficient to meet projected service demand. The use of per-visit contractual clinicians for low-volume disciplines ensures that increases in visit volume are fully supported without requiring disproportionate increases in FTE staffing.

The Applicant notes that, should actual referral volume for therapy or medical social work services exceed projections, additional contractual clinicians can be engaged on a per-visit basis to ensure adequate clinical coverage without delay.

### 4. **Table I has 110 clients listed for 2026, yet the response to question 11 of the previous response is 100 in 2026. Please provide the correct response, and verify the budget submitted reflects the current client and visit totals.**

#### **Applicant Response – Tables Question 4 (Client Volume Reconciliation and Budget Consistency)**

Quality One Care Home Health, Inc. (“QOC”) appreciates MHCC staff’s identification of the discrepancy between Table I and the response to Question 11 in the prior completeness submission regarding projected client volume for 2026.

The Applicant confirms that the correct projected number of unduplicated clients for the proposed Home Health Agency is **100 clients in 2026**.

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Year	Unduplicated Clients	Total Visits
2026	100	1,162
2027	225	2,350
2028	330	3,033

These figures represent the **controlling projections** used throughout the CON Application and prior completeness responses and are reflected in **Table 2B (Projected Statistical Projections)**, which serves as the basis for all utilization, staffing, and financial modeling.

The figures shown in **Table I (110 clients in 2026 and 230 clients in 2027)** reflect earlier draft values that were not carried forward consistently into the final statistical projections and narrative responses. The Applicant regrets this inconsistency.

The Applicant further confirms that the **budget and related projections were developed using the corrected client and visit totals of 100 / 225 / 330**, together with the associated projected total visits of **1,162 in 2026, 2,350 in 2027, and 3,033 in 2028**. These are the utilization assumptions that underlie the staffing and financial analyses submitted with the application and prior completeness response.

Accordingly, the Applicant confirms that the **submitted budget and all supporting tables accurately reflect the corrected client and visit totals**, and requests that MHCC rely on the Table 2B projections as the correct and controlling values. Additionally, the Applicant will revise and resubmit **Table I** as an exhibit to this response to align with these figures to ensure full consistency across the CON table package. The Applicant confirms that no revisions to the financial projections were required, as the budget was originally developed using the corrected client and visit totals reflected in Table 2B.

**5. Benefits are calculated at 27 percent in this application. In the Southern Maryland CON application, QOC used 22 percent, and in the Western Maryland CON application, QOC uses 20 percent for benefit expenses.**

**Applicant Response – Financial Feasibility Question 5(a) and 5(b)**

Quality One Care Home Health, Inc. (“QOC”) appreciates MHCC staff’s request for clarification regarding the variation in benefit expense assumptions across different CON applications and the impact on workforce recruitment and retention.



**a. Why is QOC allotting a different percentage in different regions? Are different benefits being provided in the different reasons?**

**Applicant Response – Financial Feasibility Q5(a) - Variation in Regional Benefit Percentage**

The variation in benefit percentages across QOC’s CON applications reflects **regional labor market conditions, workforce composition, and operational assumptions**, rather than differences in the types of benefits offered.

QOC provides a **consistent core benefits framework** across all regions, which includes standard offerings such as employer-paid payroll taxes, workers’ compensation, unemployment insurance, and applicable employee benefits. The variation in percentage assumptions - **27% in the Baltimore/Howard region, 22% in Southern Maryland, and 20% in Western Maryland** - is driven by the following factors:

- **Labor Market Competitiveness:** The Baltimore City, Baltimore County, and Howard County region represents a **more competitive healthcare labor market**, with higher wage expectations and greater competition for licensed clinical staff. The higher benefit percentage reflects a more robust compensation structure necessary to attract and retain qualified personnel in this environment.
- **Staffing Mix and Employment Model:** The projected mix of employed versus contractual staff varies by region. The Baltimore-area model anticipates a **greater proportion of employed clinical staff earlier in the ramp-up period**, which increases the relative share of benefit-related expenses compared to regions where contractual staffing may represent a larger portion of service delivery.
- **Cost of Employment Factors:** Employer-side costs, including payroll taxes, insurance, and other employment-related expenses, are modeled conservatively in the Baltimore-region application to reflect **higher utilization and staffing intensity**, as well as anticipated wage pressure in urban and suburban markets. The higher percentage also reflects a greater proportion of employer-supported benefits such as health insurance contributions and workforce retention incentives in the Baltimore-region labor market.

Accordingly, the variation in benefit percentages reflects **market-responsive financial modeling**, not differences in the underlying benefit offerings.

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9221 Colesville Road, Silver Spring, MD 20910

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Email: [info@qualityonecare.com](mailto:info@qualityonecare.com) / Web: <http://www.qualityonecare.com>

### **b. What impact will this have on how competitive QOC will be in recruiting and retaining required HHA staff?**

#### **Applicant Response – Financial Feasibility Question 5(b) - Impact on Recruitment and Retention**

The higher benefit allocation in the Baltimore/Howard region is expected to **enhance QOC's competitiveness in recruiting and retaining qualified home health staff**, particularly in a market characterized by strong demand for nurses and clinical professionals. Specifically:

- **Competitive Total Compensation:** By incorporating a higher benefit load into the financial projections, QOC ensures that total compensation packages - including wages and employer-supported benefits - remain competitive with other home health agencies and healthcare providers in the region.
- **Workforce Stability:** A stronger benefits structure supports **employee retention**, reduces turnover, and promotes continuity of care, which is particularly important in-home health settings where patient relationships and care consistency are critical.
- **Recruitment Flexibility:** The Applicant's hybrid staffing model allows QOC to balance employed staff with contractual clinicians. The enhanced benefits allocation strengthens the agency's ability to recruit and transition appropriate roles to employed staff over time, reducing reliance on higher-cost contract labor.
- **Operational Feasibility:** The benefit assumptions have been incorporated into the overall financial projections and remain consistent with projected revenues and service volumes. As such, the higher percentage does not adversely impact financial feasibility but instead reflects a **realistic and sustainable approach to workforce development** in a competitive labor market.

In summary, the variation in benefit percentages across regions reflects **intentional, market-based adjustments** rather than inconsistencies in benefit offerings. The higher allocation in the Baltimore/Howard region strengthens QOC's ability to recruit and retain qualified staff in a competitive labor market, while remaining fully aligned with the projected service volumes, staffing model, and financial assumptions presented in the CON Application. These benefit assumptions are incorporated within a conservative, volume-driven financial framework and do not adversely impact the overall feasibility or sustainability of the proposed project.

**QOC Quality One Care**



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**Screenshot of Revised TABLE I**

Quality One Care Home Health, Inc. – Home Health Agency  
Reporting Period: Calendar Year (CY)

**TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE**

*INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify*

CY	Projected Years (ending at least two years after project completion and full occupancy) Includ			
	2026	2027	2028	
<b>1. DISCHARGES</b>				
a. Total Home Health Clients Served (Unduplicated)	100	225	330	
b. ICU/CCU	0	0	0	
<b>Total MSGA</b>	<b>100</b>	<b>225</b>	<b>330</b>	
c. Pediatric	0	0	0	
d. Obstetric	0	0	0	
e. Acute Psychiatric	0	0	0	
<b>Total Acute</b>	<b>100</b>	<b>225</b>	<b>330</b>	
f. Rehabilitation	0	0	0	
g. Comprehensive Care	0	0	0	
h. Other (Specify/add rows of needed)	0	0	0	
<b>TOTAL DISCHARGES</b>	<b>100</b>	<b>225</b>	<b>330</b>	
<b>2. PATIENT DAYS</b>				
a. General Medical/Surgical*	0	0	0	
b. ICU/CCU	0	0	0	
<b>Total MSGA</b>	<b>0</b>	<b>0</b>	<b>0</b>	
c. Pediatric	0	0	0	
d. Obstetric	0	0	0	
e. Acute Psychiatric	0	0	0	
<b>Total Acute</b>	<b>0</b>	<b>0</b>	<b>0</b>	
f. Rehabilitation	0	0	0	
g. Comprehensive Care	0	0	0	
h. Other (Specify/add rows of needed)	0	0	0	
<b>TOTAL PATIENT DAYS</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>3. AVERAGE LENGTH OF STAY</b>				
a. General Medical/Surgical*	0.0	0.0	0.0	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>Total MSGA</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>#DIV/0!</b>
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>Total Acute</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>#DIV/0!</b>

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**AFFIRMATION**

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.

\_\_\_\_\_  
Mohamed Matope, Director  
Quality One Care Home Health, Inc.

04/01/2026

\_\_\_\_\_  
Date

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**EXHIBIT**

1. Table I – Statistical Projections (Submitted via email as Excel Document)