Project Information

Submission Date	February 24, 2026
Document Type	**CON Application Completeness Review Response**
Review Schedule	Schedule One
CON Review Service	Home Health Agency (HHA) Services
Proposed Project	Establish a New Medicare-Certified **Home Health Agency**
Proposed Service Area	**Anne Arundel, Montgomery, Prince George's & Southern Region**
Regulatory Justification	COMAR 10.24.16.04

Applicant and Organization Details

Applicant Name	Quality One Care Home Health, Inc. (QOC)
Applicant Status	MD RSA License No. R3057 / Joint Commission Accredited
Headquarters Address	9221 Colesville Road, Silver Spring, MD 20910
Phone / Fax	301.658.7141 / 301.579.4845
Website / Email	www.qualityonecare.com / info@qualityonecare.com

Key Contact for Submission Questions

Name and Title	Amon Chafukira, Program Coordinator
Phone Number	301.658.7141 / 301.355.0121 (Direct)
Email Address	msmatope@gmail.com

Key MHCC Deadlines (Schedule One)

Letter of Intent (LOI) Due	November 7, 2025
Pre-Application Conference	November 19, 2025
Full Application Due	January 9, 2025
Completeness Response Due	February 24, 2026

Submitted To	Certificate of Need Division, Maryland Health Care Commission 4160 Patterson Avenue, Baltimore, MD 21215

TABLE OF CONTENTS

February 24, 2026

VIA EMAIL & FEDERAL EXPRESS MAIL

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 02/09/2026 to Establish a Home Health Agency in Anne Arundel County, Montgomery County, Prince George's County, Calvert County, Charles County and St. Mary's County.
Matter # 26-R4-2479 Anne Arundel County,
Matter # 26-R4-2480 Montgomery County,
Matter # 26R42481 Prince George's County
Matter # 26-R4-2482 Southern Jurisdictions: Calvert County, Charles County, and St. Mary's 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 February 09, 2025, 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,

Amon Chafukira
Program Coordinator
Quality One Care Home Health, Inc

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Part I – Project Identification and General Information

1. **For question 6, please provide separate email addresses and telephone numbers for Amon Chafukira and Mohamed Matope.**

Applicant Response (Q1) – Project Identification

Quality One Care Home Health, Inc. provides the following updated and separate contact information for the individuals identified in Question 6 of the CON application:

Primary Contact	Alternate Contact
Mohamed Matope, Director Quality One Care Home Health, Inc. 9221 Colesville Road Silver Spring, MD 20910 Email: msmatope@gmail.com Telephone: 301-655-0409	Amon Chafukira, Program Coordinator Quality One Care Home Health, Inc. 9221 Colesville Road Silver Spring, MD 20910 Email: chafukay@gmail.com Telephone: 301-355-0121

This information supersedes the contact information provided in the original application.

2. **What capital expenditures will be made? Please provide a breakdown for each CON application of the expenses.**

Applicant Response (Q2) – Capital Expenditures

The proposed project does not involve construction or renovation. Capital expenditures are limited to routine start-up and equipment costs necessary to establish and operate a Medicare-certified home health agency.

The agency will utilize its existing headquarters in Silver Spring, Maryland, and a planned branch office in Waldorf, Maryland.

For purposes of this application, "capital expenditures" are those reflected in Table 1 – Project Budget and include construction costs, renovation or leasehold improvement costs, land acquisition, fixed or capitalized equipment, financing costs, and capitalized working capital requirements.

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As reflected in Table 1, the proposed project does not involve any such capital expenditures. Specifically, the project includes:

- No new construction
- No renovation or leasehold improvements
- No land acquisition
- No fixed or capitalized equipment purchases
- No financing costs
- No capitalized working capital requirement

Accordingly, Total Proposed Capital Costs = $0**,** and Total Uses of Funds = $0, as shown in Table 1 – Project Budget.

The agency will utilize its existing headquarters in Silver Spring, Maryland, and a planned administrative branch office in Waldorf, Maryland. The Waldorf location involves routine operating lease expenses only and does not require construction or leasehold improvements.

Because the proposed Home Health Agency will operate as a single Medicare-certified entity serving multiple jurisdictions, there are no jurisdiction-specific capital expenditures. For clarity, the capital expenditure by CON application is as follows:

- Matter #26-R4-2479 – Anne Arundel County: $0
- Matter #26-R4-2480 – Montgomery County: $0
- Matter #26-R4-2481 – Prince George's County: $0
- Matter #26-R4-2482 – Southern Maryland (Calvert, Charles, and St. Mary's Counties): $0

Information technology systems, supplies, and other start-up costs necessary for operations are treated as operating expenses and are reflected in Table 4 – Revenues and Expenses (Proposed Project**)**, not as capital project costs.

3. The application states the proposed HHA will be a distinct licensed entity from QOC's existing RSA (License R3057). Will this apply to all jurisdictions (each docket number)?

Applicant Response (Q3) – Licensed Entity

Quality One Care currently operates as a licensed Residential Service Agency (RSA) in the State of Maryland. The proposed project involves the establishment of a Medicare-certified Home Health Agency (HHA) under the same corporate entity as the existing RSA. While both divisions will operate under common ownership, they are distinct in licensure category, regulatory oversight, scope of services, and reimbursement structure.

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The RSA operates under Maryland RSA licensure pursuant to COMAR 10.07.10 and provides personal care and related non-Medicare services. The proposed HHA will operate under Maryland home health agency licensure and Medicare certification, providing skilled nursing and therapy services under physician orders in accordance with 42 CFR Part 484.

The proposed HHA will:

- Maintain its own Medicare provider number
- Maintain distinct clinical policies and procedures
- Maintain separate patient records and OASIS reporting systems
- Bill Medicare and other payors independently of RSA operation
- Maintain separate payroll and accounting systems for HHA personnel

Although executive leadership may be shared at the ownership level, staffing dedicated to clinical service delivery for the HHA will be hired and scheduled specifically for HHA operations. RSA staff are not included in the HHA staffing projections reflected in Tables 2B and 5, and HHA personnel are not counted toward RSA staffing levels.

Initially, no clinical staff will routinely provide services for both RSA and HHA patients. In limited or special circumstances, a clinician may be formally reassigned between divisions; however, such reassignment will be documented and staffing allocations adjusted to ensure no duplication of personnel or financial reporting.

Financial projections in Table 4 reflect revenues and expenses attributable solely to the proposed HHA operations within the identified jurisdictions. RSA financial performance is reported separately and is not commingled with HHA operating projections.

The proposed HHA will operate as a single Medicare-certified entity serving the approved jurisdictions under one provider number. The organizational and operational separation described above applies uniformly across all four CON applications (#26-R4-2479, #26-R4-2480, #26-R4-2481, and #26-R4-2482).

3a. Provide an organization chart that shows the relationship between the proposed new HHA, Quality One Care Home Health, Inc., to the existing Quality One Care RSA.

Applicant Response (Q3a) – RSA vs HHA Organization Relationship

A revised organizational chart is attached as Exhibit 1B (Revised), illustrating the relationship between Quality One Care Home Health, Inc.'s existing Residential Service Agency (RSA) division and the proposed Home Health Agency (HHA) division.

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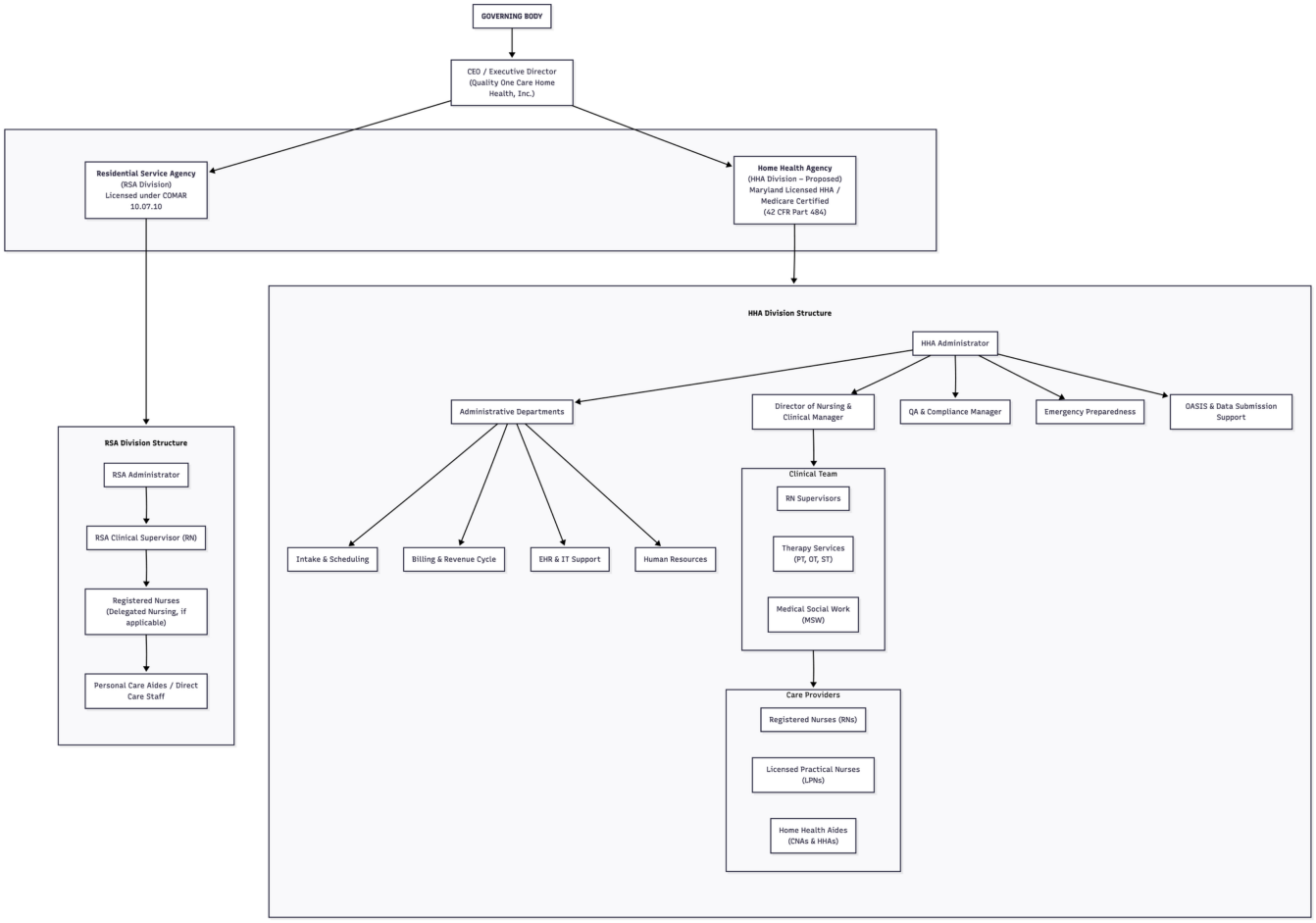
Exhibit 1B – Revised Corporate Organizational Chart



As shown in the revised chart, both the RSA and proposed HHA operate under the same corporate entity and Governing Body. However, they function as separate operational divisions with distinct licensure categories, regulatory oversight, clinical management structures, staffing assignments, and reporting lines. The RSA operates under COMAR 10.07.10, while the proposed HHA will operate under Maryland home health agency licensure and Medicare certification pursuant to 42 CFR Part 484.

The RSA and HHA maintain separate clinical supervision, payroll systems, and financial tracking. No clinical reporting lines cross between divisions, and personnel are not double-counted between RSA and HHA operations.

The internal organizational structure of the proposed HHA remains as previously submitted and applies uniformly across all four CON applications.

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3b. Please explain how the main office is structured, or will be modified, to provide adequate space, staffing oversight, and operational capacity to support both RSA and HHA personnel, including any planned expansions, reconfigurations, or resource allocations to accommodate their separate functional roles.

Applicant Response (Q3b) – Main Office Structure and Operational Capacity

Quality One Care Home Health, Inc. currently operates from its headquarters in Silver Spring, Maryland. The main office is located on approximately 0.72 acres and consists of approximately 5,742 square feet of finished interior space distributed across two levels (main floor and fully renovated lower level with a separate entrance). The main floor is currently utilized for administrative and operational functions. The lower level has already been fully renovated and configured as office-style workspace and is presently unoccupied, providing immediate additional capacity to accommodate projected growth.

The existing facility provides sufficient physical capacity to support both RSA and proposed HHA operations without the need for construction, renovation, or leasehold improvements.

The layout allows for:

- Designated workspace for RSA administrative and clinical oversight staff
- Separate designated workspace for HHA administrative leadership and clinical management
- Shared administrative infrastructure (HR, billing, IT) with role-based system access controls
- Secure electronic record management systems that maintain division-specific compliance and confidentiality requirements. The layout further ensures clinical oversight integrity through private offices for the HHA Director of Nursing and RSA Clinical Supervisor, allowing for confidential clinical review and staff supervision meetings.

Because both RSA and HHA personnel primarily deliver services in patients' homes, the headquarters functions as an administrative, clinical oversight, and coordination hub rather than a centralized service delivery location. The projected staffing growth reflected in Tables 2B and 5 can be accommodated within the existing 5,742 square foot facility due to the field-based service model.

Additionally, a planned administrative suboffice in Waldorf, Maryland will support operations in the Southern Maryland jurisdictions, further distributing administrative oversight responsibilities and reducing capacity strain at the headquarters location.

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Accordingly, the current headquarters facility provides adequate space, supervisory capacity, and operational infrastructure to support both RSA and proposed HHA divisions while maintaining functional separation between their respective roles.

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Part II – Consistency with Review Criteria at COMAR 10.24.01.08G(3)

The "Organizational Structure: RSA vs. HHA Separation Matrix" references positions that are not shown in the organizational chart submitted with the application. Please provide a detailed description of the staffing model for both the RSA and HHA, including (a) positions assigned to each entity, (b) whether staff are dedicated or shared, and (c) how staffing levels will support the distinct services provided by each organization.

Applicant Response PART II – Consistency with Review Criteria at COMAR 10.24.01.08G(3)

The "Organizational Structure: RSA vs. HHA Separation Matrix" was intended to describe regulatory and operational distinctions between the existing Residential Service Agency (RSA) division and the proposed Home Health Agency (HHA) division. For clarity and to ensure full consistency with the organizational chart and Tables 2B and 5 of the application, Quality One Care provides the following detailed clarification of its staffing model.

(a) Positions Assigned to Each Entity

Residential Service Agency (RSA): RSA staffing supports personal care and delegated nursing services pursuant to COMAR 10.07.10 and includes:

- RSA Administrator
- RSA Clinical Supervisor (RN)
- Registered Nurses (delegated nursing, as applicable)
- Direct Care Staff
- RSA Administrative support

RSA personnel are limited to services authorized under RSA licensure. RSA staffing is not included in the HHA staffing projections reflected in Tables 2B and 5.

Proposed Home Health Agency (HHA): HHA staffing supports Medicare-certified skilled home health services pursuant to 42 CFR Part 484 and includes the following categories, as reflected in Tables 2B and 5:

Administrative and Leadership

- HHA Administrator
- Director of Nursing / Clinical Manager
- Intake & Scheduling personnel
- Billing & Revenue Cycle personnel

- EHR / IT support
- Human Resources support (allocated to HHA operations)

Clinical Personnel

- RN Supervisors
- Registered Nurses (RNs)
- Licensed Practical Nurses (LPNs)
- Home Health Aides (CNAs/HHAs)
- Therapy Services (PT, OT, ST)
- Medical Social Work (MSW)

Quality & Compliance Oversight

- QA and compliance admin supporting QAPI, survey readiness, and regulatory reporting

The organizational chart reflects the full leadership and compliance structure required for HHA licensure and Medicare certification.

(b) Dedicated vs. Shared Staff

- **Clinical Staff:** All direct patient-care clinical personnel (RNs, LPNs, HHAs, therapy staff, MSW) are assigned specifically to either RSA or HHA operations. Clinical staff are not routinely shared between divisions. In limited circumstances, a clinician may be formally reassigned; however, such reassignment would be documented and staffing allocations adjusted accordingly to prevent duplication of staffing or financial reporting.
- **Administrative Leadership:** The HHA Administrator and Director of Nursing are dedicated exclusively to HHA operations and are accountable for compliance with the Medicare Conditions of Participation. These roles are not shared with RSA.
- **QA & Compliance Structure:** The HHA will implement a Quality Assurance and Performance Improvement (QAPI) program consistent with 42 CFR Part 484 from the inception of operations. Oversight of quality and compliance functions will be maintained internally under the authority of the HHA Administrator and Director of Nursing.
    - A QA & Compliance lead will be designated within the HHA administrative structure at the commencement of operations.
    - The organizational chart reflects the QA & Compliance structure required for Medicare-certified home health agencies. During early operational phases, the agency may utilize external professional support for technical functions such as policy refinement, mock survey preparation, or regulatory updates; however, quality oversight, compliance monitoring, and performance improvement activities remain under the direct control of HHA leadership.

- As patient census and operational complexity increase, QA responsibilities will continue to be formalized and expanded consistent with projected staffing growth.

- **Corporate-Level Support Functions:** Certain corporate-level services (e.g., HR, IT infrastructure, accounting systems) may provide administrative support to both RSA and HHA divisions. These services operate under separate cost centers, and shared expenses are allocated using documented accounting methodology. Shared corporate services do not involve shared clinical supervision or regulatory accountability.

(c) Staffing Levels and Support of Distinct Services

RSA staffing levels are structured to support personal care and delegated nursing services consistent with RSA licensure requirements.

HHA staffing levels, as reflected in Tables 2B and 5, are phased to align with projected patient census growth and anticipated visit volume. The staffing model supports:

- Skilled nursing visits
- Therapy services (PT/OT/ST)
- Medical social work services
- Home health aide services
- OASIS reporting and regulatory documentation
- Quality assurance and performance improvement activities

Because both RSA and HHA services are primarily delivered in patients' homes, supervisory and administrative staffing is scaled to support field-based care coordination rather than centralized clinical operations.

No personnel are double-counted between RSA and HHA staffing projections. Each division maintains separate payroll systems and financial tracking, ensuring operational integrity and compliance with COMAR 10.24.01.08G(3) and preventing commingling of resources.

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FINANCIAL FEASIBILITY

4. **Please provide a detailed explanation of the basis for the proposed staffing model, including FTE levels for RN, LPN, HHA, PT, OT, ST, MSW, and administrative staff. In your response, address the following:**

Applicant Response (Q4)

Quality One Care's staffing model is derived directly from projected service volume, discipline mix, productivity expectations, and phased operational growth reflected in Tables 2B and 5 of the CON application. All staffing levels correspond to projected visit volume and are scaled conservatively to ensure financial feasibility and operational stability.

- **The assumptions used to determine staffing levels, including patient volume projections, visit frequency, productivity expectations, and travel time by county.**

Applicant Response (Q4a)

Patient Volume & Visit Intensity

Projected unduplicated clients are converted to total annual visits using:

- 15.21 visits per client per year, derived from MHCC FY 2023 utilization data and applied consistently across jurisdictions.

Billable visits are calculated at 98% of total visits to account for non-billable supervisory, orientation, and administrative activities.

Total projected visits are then allocated by discipline using the filed discipline mix:

- Skilled Nursing (SN): 35%
- Home Health Aide (HHA): 40%
- Physical Therapy (PT): 12%
- Occupational Therapy (OT): 6%
- Speech Therapy (ST): 2%
- Medical Social Services (MSW): 5%

This allocation ensures staffing reflects clinical complexity rather than uniform visit distribution.

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RN Productivity & FTE Justification

RN FTE projections in Table 5 are:

- 2026: 1.50 RN FTE
- 2027: 3.00 RN FTE
- 2028: 4.50 RN FTE

Each RN FTE represents 2,080 paid hours annually. Productivity assumptions incorporate:

- Field visit time
- Travel time between visits
- Documentation (including OASIS)
- Case conferencing
- Care coordination
- Supervisory responsibilities

Given service delivery across six counties, travel time varies by jurisdiction. Southern Maryland counties (Calvert, Charles, St. Mary's) require greater travel time per visit compared to Montgomery County. Productivity assumptions therefore incorporate conservative visit-per-day expectations during start-up. RN FTE growth corresponds proportionally to projected increases in skilled nursing visits from 2026 through 2028, ensuring staffing expands in alignment with visit volume.

Therapy & HHA Staffing

Therapy services (PT, OT, ST) and certain MSW services are initially provided through contracted clinicians during ramp-up. This reflects:

- Variable referral patterns
- Discipline-specific demand fluctuations
- Geographic distribution considerations

Home Health Aide staffing grows incrementally as projected aide visits increase.

Administrative staffing levels scale proportionally with intake volume, billing workload, and regulatory reporting requirements.

- **The approach to HHCAHPS and OASIS data collection and coding, including whether these functions will be performed internally or through external vendors.**

Applicant Response (Q4b)

OASIS

- OASIS assessments will be completed by trained RNs.
- Coding and clinical oversight will be performed internally under the Director of Nursing.
- Submission occurs via a CMS-compliant electronic health record system.
- Accuracy monitoring is integrated into the HHA's QAPI program.

HHCAHPS

HHCAHPS survey administration will be conducted through a CMS-approved vendor in accordance with federal requirements. Use of a vendor ensures standardized methodology and regulatory compliance. Oversight of survey performance and performance improvement initiatives remains under HHA leadership.

Quality Assurance and Performance Improvement (QAPI) oversight is internally directed from inception under the authority of the HHA Administrator and Director of Nursing. External professional services, when utilized, provide technical support only and do not substitute for internal compliance accountability.

- **How staffing levels will scale in relation to projected service volume across counties, including any thresholds or benchmarks used to adjust staffing.**

Applicant Response (Q4c)

Staffing increases are phased and tied directly to projected service growth across counties. Scaling principles include:

- RN FTE additions correspond to increases in skilled nursing visit volume.

- HHA staffing expands as aide visit volume stabilizes.
- Administrative staff increases align with sustained growth in admissions and billing workload.
- Therapy transitions from contract to employed FTE status once visit volume supports consistent full-time workload.

Staffing is not front-loaded; it increases proportionally with projected census growth reflected in Tables 2B and 5. Because services are field based, staffing capacity is evaluated based on active patient census, visit density by county, and travel efficiency.

- **The circumstances under which contracted nurses or therapists will be utilized, including cost, capacity, or operational considerations.**

Applicant Response (Q4d)

Contracted clinicians are utilized under the following circumstances:

1. Start-up volume variability
2. Discipline-specific referral fluctuations
3. Geographic coverage flexibility
4. Temporary census surges
5. Specialized therapy demand

This approach controls fixed salary expense during early ramp-up and prevents underutilized FTE positions.

Contracted staffing costs are fully incorporated into projected expense lines in Table 5.

- **The criteria and triggers for transitioning contracted staff to employed FTE positions, including volume, utilization, or financial thresholds.**

Applicant Response (Q4e)

Transition from contracted to employed positions occurs when:

- Discipline-specific visit volume demonstrates sustained, predictable workload across multiple pay periods
- Projected annualized visits support full-time caseload without financial deficit
- Revenue per visit supports salary and fringe without negative margin impact
- Geographic concentration of visits improves travel efficiency

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As projected service volume increases from 2026 through 2028, Table 5 reflects gradual internalization of certain roles consistent with operational stability.

This phased transition model ensures:

- Financial feasibility
- Controlled expense growth
- Workforce stability
- Regulatory compliance
- Sustainable scaling across jurisdictions

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IMPACT STANDARD

5. How will QOC know that it is capturing new clients rather than displacing clients from exiting HHAs (considering how QOC determined/estimated the share of county visits for the six-county area)?

Applicant Response (Q5) – New Clients vs Displaced Clients

Quality One Care will evaluate whether projected growth reflects incremental service demand rather than displacement of existing home health agencies through structured intake documentation and referral origin monitoring.

Operationally, QOC will utilize its electronic health record platform to document referral source and admission origin for all new patients during the intake process, including hospital discharge, physician referral, community-based referral, or transfer from another home health provider. This information will be maintained within the agency's intake and clinical documentation systems. Management will periodically review referral origin data to evaluate the proportion of admissions originating from hospital discharge, physician referral, community-based referral, or transfer from another HHA. This review allows QOC to assess whether growth reflects incremental service demand or redistribution of existing census.

Projected volumes are derived from MHCC FY 2023 utilization data and the methodology described in Table 2B (Statistical Projections – Assumptions). Unduplicated client estimates were calculated using the standardized 15.21 visits per client factor applied consistently across jurisdictions. The growth model reflects modest and phased implementation over a three-year start-up period, with volume increasing gradually in alignment with staffing ramp-up and operational capacity.

Across all six counties, projected utilization represents a limited proportion of total county-level home health activity, consistent with conservative market entry assumptions reflected in the filed projections.

The Commission has identified that certain Southern Maryland jurisdictions (Calvert, Charles, and St. Mary's Counties) demonstrate higher levels of market concentration. QOC's entry increases provider diversity and adds incremental service capacity within those jurisdictions. In the remaining counties (Anne Arundel, Montgomery, and Prince George's), projected utilization similarly reflects modest market entry relative to overall county-level home health activity. In each jurisdiction, projected volume is structured as phased growth over the three-year start-up period. Accordingly, the proposed HHA is positioned to supplement existing providers across all six counties rather than assume transfer of established census.

QOC's clinical model is structured to support post-acute and medically complex patients consistent with the projected visit intensity of 15.21 visits per client. In addition, QOC's existing community partnerships may expand access among populations seeking additional provider options.

Given the modest scale of projected utilization, the phased growth structure, and the ongoing review of referral origin patterns, QOC's projected volume reflects incremental expansion of service capacity within the six-county area rather than material displacement of established HHAs.

6. How does QOC propose to recruit more Medicaid clients?

Applicant Response (Q6) – Recruitment Process

Quality One Care (QOC) proposes to increase access to Medicare-certified home health services across the six-county service area through targeted referral development, payer enrollment, and community-based partnerships designed to support a balanced payor mix consistent with its projected financial model (Table 4).

QOC's recruitment strategy addresses **Medicare Fee-for-Service, Medicare Advantage, Medicaid (including MCOs), and Commercial insurance populations**, and is structured to expand access without disproportionate impact on any single payor category.

Medicare (Fee-for-Service)

Medicare Fee-for-Service beneficiaries represent a significant portion of the post-acute home health population in the six-county region. QOC will:

- Enroll as a Medicare-certified HHA and maintain compliance with CMS Conditions of Participation.
- Develop referral relationships with hospital discharge planners, case managers, and care transition teams.
- Engage skilled nursing facilities, primary care providers, and specialty practices managing chronic conditions.
- Provide timely response to referrals and rapid start-of-care scheduling to support hospital throughput and readmission reduction initiatives.

QOC's clinical model is aligned with medically complex, post-acute patients who are typically covered under Medicare FFS. Growth in this payor category is expected to occur gradually and in proportion to overall projected census growth.

Medicare Advantage

Medicare Advantage enrollment continues to increase within the service area. QOC will:

- Contract with major Medicare Advantage plans operating in the six counties.

- Participate in plan networks to receive referrals from managed care case managers and utilization review departments.
- Maintain clinical documentation and outcome reporting standards consistent with value-based reimbursement structures.
- Coordinate closely with plan care coordinators to support episode management and avoid unnecessary utilization.

Participation in Medicare Advantage networks diversifies revenue sources and supports projected payer mix assumptions.

Medicaid (including Managed Care Organizations)

QOC will enroll with Maryland Medicaid and applicable Medicaid Managed Care Organizations (MCOs) to ensure participation in network panels serving Medicaid beneficiaries.

Recruitment strategies include:

- Engagement with hospital discharge planners and care coordinators serving Medicaid populations.
- Collaboration with community health clinics, Federally Qualified Health Centers (FQHCs), and social service agencies.
- Structured intake processes to verify eligibility and obtain required authorizations efficiently.
- Leveraging QOC's existing RSA relationships to expand access to Medicare-certified services where clinically appropriate.

Recruitment efforts across all payor categories are designed to increase access while maintaining financial sustainability consistent with Table 4 projections.

Commercial Insurance

Commercially insured patients represent a smaller but important portion of the projected payor mix.

QOC will:

- Contract with commercial carriers operating in the region.
- Establish referral pathways with physician practices and outpatient specialty clinics.
- Engage employer-based and private insurance networks where applicable.
- Maintain flexible scheduling and service responsiveness to meet commercial plan requirements.

Commercial participation enhances payor diversification and supports financial stability.

Market Impact Considerations (COMAR Alignment)

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QOC will accept patients based on clinical appropriateness and operational capacity, not payor type. However, QOC's recruitment strategy is structured to:

- Gradually increase census consistent with conservative ramp-up projections (Table 2B).
- Phase staffing growth proportionally with visit volume (Table 5).
- Maintain a balanced payor mix rather than targeting a single payor class.

Because projected volumes represent a modest market share across a large six-county service area, QOC does not anticipate disproportionate disruption to existing HHAs' caseloads, staffing levels, or payor mix. Growth is expected to occur through incremental referral development and participation in existing network panels rather than aggressive displacement of incumbent providers.

Given the size of the six-county market and the modest projected volumes shown in Table 2B, QOC's entry is not expected to materially alter existing agencies' staffing levels or payer distribution.

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FINANCIAL SOLVENCY

7. Regarding Working Capital & PPEO/APU Risk:

Applicant Response (Q7) – Working Capital & PPEO/APU Risk

Quality One Care (QOC) acknowledges the financial and operational considerations associated with CMS' Provisional Period of Enhanced Oversight (PPEO) and the Annual Payment Update (APU) quality reporting requirements. QOC has structured its funding model and administrative processes to mitigate reimbursement timing variability and maintain operational continuity.

- **Verify that the available cash reserves and contingency plans are sufficient to sustain start-up and early operations under CMS' Provisional Period of Enhanced Oversight (PPEO) (potential pre-payment review holds) and Annual Payment Update (APU) quality reporting requirements.**

  QOC maintains sufficient liquidity to sustain operations during potential pre-payment review periods common to newly certified Medicare providers.

  As of December 31, 2023, QOC reported $1,421,764 in cash and bank balances and total equity of $1,662,613 (audited). The most recent CPA verification letter (October 31, 2025) reflects $630,851 in cash on hand. Both figures demonstrate sufficient liquidity to support the projected $50,000 in start-up costs, ongoing clinical payroll, and reimbursement timing variability associated with Medicare certification and PPEO review. These reserves provide capacity to support projected clinical payroll and operating expenses during periods of reimbursement timing variability.

  The financial model is funded through internal equity and does not include debt service obligations. In the event of extended pre-payment review or reimbursement timing delays, QOC will utilize existing corporate operating reserves to support payroll, administrative expenses, and supply costs until payment cycles normalize.

  Projected growth reflected in Table 2B is phased and conservative, minimizing early fixed cost exposure and reducing financial risk during CMS validation of billing processes.

- **Explain HHQRP readiness to avoid payment reductions, and how QOC will maintain cash flow during delayed Medicare payments.**

  QOC is prepared to comply with Home Health Quality Reporting Program (HHQRP) requirements to avoid the 2% Annual Payment Update (APU) reduction.

• **OASIS Compliance:** QOC will utilize a CMS-compliant electronic health record system with built-in validation functions to support timely and accurate OASIS completion and submission.

• **HHCAHPS Participation:** QOC will contract with a CMS-approved HHCAHPS vendor upon reaching the required patient volume threshold.

• **Billing Oversight:** Dedicated billing and revenue cycle personnel will monitor claim submissions, address Additional Documentation Requests (ADRs) promptly, and reconcile accounts receivable to minimize payment hold durations.

• **Cash Flow Monitoring:** Management and the Governing Body will regularly review cash flow statements and accounts receivable aging to ensure available reserves remain sufficient to support projected operations.

QOC's payer mix includes Medicaid and commercial referral pathways, which provide additional revenue streams during periods of Medicare payment timing variability.

Through these financial controls, liquidity reserves, and compliance safeguards, QOC maintains adequate solvency to sustain start-up and early operations while meeting CMS oversight and reporting requirements.

8. Given RSA financial trend, with the decline in net income reported for RSA operations from 2022–2024, provide a more detailed explanation of resources available to fund the HHA start-up and how the HHA will remain competitive with existing comprehensive HHAs while returning overall operations to profitability.

Applicant Response (Q8) - Resources

Quality One Care acknowledges the decline in RSA net income reported between 2022 and 2024 and provides the following clarification regarding financial capacity and competitive positioning.

Explanation of RSA Financial Trends (2022–2024)

The decline in net income during this period primarily reflects non-recurring capital investments in long-term infrastructure rather than deterioration in core operations.

During this timeframe, QOC:

- Acquired its headquarters property in Silver Spring, Maryland, replacing a recurring lease obligation with an owned asset; and

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- Completed renovations to convert the 5,742 square foot facility into a fully configured administrative and clinical oversight environment capable of supporting expanded service lines.

These investments affected short-term reported net income through transaction-related costs, renovation expenditures, and depreciation, while strengthening the company's balance sheet and eliminating long-term lease exposure. These expenditures were capital in nature and do not reflect ongoing operating losses.

- **Resources Available to Fund HHA Start-Up**

  Despite these capital investments, QOC has maintained positive equity and adequate liquidity. Audited financial statements reflect:

  - $1,421,764 in cash and bank balances as of December 31, 2023
  - Total equity of $1,662,613 as of December 31, 2023

  The October 31, 2025, CPA verification letter reflects $630,851 in cash on hand.

  The proposed HHA start-up requires approximately $50,000 in project set-up costs and is funded entirely through internal equity. No debt financing is associated with this project.

  Accordingly, QOC maintains sufficient working capital to support certification, potential reimbursement timing variability (including PPEO-related review), and early operational ramp-up.

- **Competitive Positioning and Organizational Financial Stability**

  The proposed HHA represents service diversification rather than reliance on RSA margin expansion.

  The RSA provides personal care and delegated nursing services under COMAR 10.07.10. The proposed HHA will provide Medicare-certified skilled services under 42 CFR Part 484, expanding QOC's participation in post-acute and medically complex care markets. The addition of Medicare-certified skilled services broadens revenue sources and reduces reliance on a single service line, supporting longer-term financial balance across operations.

  Ownership of the headquarters facility reduces fixed lease obligations and provides stable administrative capacity for both divisions. The fully renovated lower level provides immediate infrastructure to support expanded operations without additional capital expenditure.

  The HHA is projected to operate with:

- Conservative phased volume growth (Table 2B)
- Staffing aligned with projected visit intensity (15.21 visits per client)
- Dedicated billing oversight to manage Medicare reimbursement timing
- Participation in Medicare, Medicaid, and managed care networks

Projected growth is phased and aligned with staffing ramp-up, minimizing early fixed cost exposure.

Through infrastructure ownership, service diversification, and conservative growth modeling, QOC is positioned to support HHA operations while maintaining overall financial stability across the organization.

Linkages with Other Service Providers

9. What proportion, if any, of the QOCs clients are expected to be children? Many of QOCs current linkages, shown in exhibit 12, are with youth-serving agencies and providers.

Applicant Response (Q9) - Linkages

Quality One Care anticipates that pediatric patients will represent a limited proportion of the projected Home Health Agency (HHA) census across the six-county region.

The statistical projections reflected in Table 2B are based primarily on adult and geriatric home health utilization patterns derived from MHCC FY 2023 data. The projected visit intensity of 15.21 visits per client reflects the regional average for Medicare-certified home health services, which predominantly serve adult and elderly populations. Accordingly, the primary projected service population for the proposed HHA consists of post-acute and medically complex adult patients.

Exhibit 12 reflects QOC's existing community relationships developed through its Residential Service Agency (RSA) operations, including linkages with youth-serving agencies and providers. While QOC may accept pediatric referrals when clinically appropriate and within the scope of HHA licensure, the proposed HHA is not structured as a pediatric-specialty agency, and pediatric services do not form the basis of the utilization projections submitted in this application.

Staffing projections, visit modeling, and financial assumptions underlying the HHA reflect a general skilled home health model serving patients across age groups, with primary alignment to adult and Medicare-eligible populations. Pediatric admissions, if any, are expected to represent a very small percentage of total census and will not materially alter the projected service mix or financial structure of the agency.

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Accordingly, while youth-serving linkages expand referral diversity and community access, pediatric clients are anticipated to comprise only a limited portion of overall HHA admissions within the six-county service area.

Discharge Planning

10. Provide that documentation or the correct exhibit reference for discharge planning. (Exhibit 12 references a different topic- Linkages).

Applicant Response (Q10) – Discharge Planning

Quality One Care acknowledges that Exhibit 12 references provider linkages and referral pathways and was incorrectly cited in connection with discharge planning.

The formal discharge planning process for the proposed HHA is documented in **Exhibit 5 – Admissions & Discharge Policy** (attached). This exhibit includes:

- Integration of discharge planning into the initial assessment and plan of care
- Ongoing reassessment of discharge goals by clinical staff
- Discharge planning procedures and criteria
- Coordination with the ordering physician
- Patient and caregiver education prior to discharge
- Development of a discharge summary and continuity-of-care communication
- Referral to appropriate community resources or follow-up providers
- Compliance with Medicare Notice of Medicare Non-Coverage (NOMNC) requirements, where applicable

Exhibit 5 reflects the agency's policies for safe, orderly discharge and continuity of care consistent with applicable Maryland licensure requirements and 42 CFR Part 484 Conditions of Participation.

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THE NEED CRITERION

11. Please elaborate on how the applicant is uniquely qualified to help address the following identified needs:

Applicant Response (Q11 – Need Criterion)

Quality One Care provides the following explanation of how it is positioned to address the needs identified in the Guidance for the 2025 Home Health Review.

- **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.**

Applicant Response (Q11a) – Lack of Quality Providers

Addressing Identified Need Due to Lack of Quality Providers

The Commission identified a need in these jurisdictions due to a lack of quality providers. QOC is positioned to address this need through structured compliance systems, established clinical infrastructure, and conservative growth modeling.

QOC currently operates as a Maryland-licensed Residential Service Agency and maintains Joint Commission accreditation. This accreditation reflects adherence to nationally recognized quality and safety standards and demonstrates an established compliance framework upon which the proposed HHA will build.

As an established Maryland provider with existing regulatory oversight, administrative infrastructure, and community presence, QOC is positioned to expand services in a controlled and compliant manner rather than entering the market without prior operational foundation.

The proposed HHA is supported by:

- A fully configured administrative and clinical oversight headquarters facility
- Dedicated leadership for Medicare-certified operations
- CMS-compliant electronic health record systems with integrated OASIS validation
- Participation in the Home Health Quality Reporting Program (HHQRP)
- Structured billing oversight to reduce documentation errors and payment delays

QOC's phased implementation model (Table 2B) ensures that staffing growth is aligned with projected volume, reducing operational strain that can negatively impact quality performance. The conservative

ramp-up approach supports stable onboarding of clinical staff and maintenance of appropriate supervision ratios.

In addition, QOC maintains established community linkages within the service area, including relationships with public agencies and healthcare institutions. These existing connections support coordinated referrals and continuity of care, particularly for Medicaid and medically complex populations.

QOC also recruits and retains a culturally competent workforce reflective of the communities served, particularly in Prince George's and Montgomery Counties, supporting effective communication and patient engagement.

Through infrastructure readiness, accreditation-backed compliance systems, and measured growth, QOC is positioned to contribute additional high-quality service capacity within the identified counties.

- **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.**

Applicant Response (Q11b) – High Market Concentration

Addressing Identified Need Due to High Market Concentration

The Commission identified high market concentration in certain Southern Maryland jurisdictions, indicating that a limited number of agencies dominate service delivery.

QOC's entry into these markets increases provider diversity and expands consumer choice without materially displacing existing providers. The agency's projected utilization represents a modest proportion of total county-level home health activity and reflects gradual, phased growth over a three-year period.

QOC's planned administrative presence in Waldorf, Maryland supports localized oversight and coordination in Calvert, Charles, and St. Mary's Counties. This regional infrastructure allows for responsive service delivery and continuity of care. Unlike a de novo entrant without local presence, QOC already maintains community-based relationships in portions of the service area, which supports responsible and incremental market entry. By introducing an additional Medicare-certified provider with conservative volume projections, established infrastructure, accreditation-backed oversight, and localized presence, QOC contributes incremental service capacity and enhances market balance within these jurisdictions.

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FINANCIAL FEASIBILITY

12. Table 1 is not completed. Please provide the proposed budget for this project in the Southern Maryland Counties.

Applicant Response (Q12) – Table 1 for Southern Maryland Counties

Quality One Care acknowledges that Table 1 for the Southern Maryland application was not fully completed. Table 1 reflects capital expenditures associated with the proposed project. The Southern Maryland project does not require any construction, renovation, land acquisition, fixed or capitalized equipment purchases, financing costs, or capitalized working capital.

The proposed administrative presence in Waldorf, Maryland will operate under a standard operating lease arrangement. The lease does not involve construction or leasehold improvements requiring capitalization. Accordingly, the lease expense is treated as an operating expense and is reflected in Table 4 (Revenues and Expenses – Proposed Project), not in Table 1.

Because no capital expenditures are associated with the Southern Maryland application, Table 1 will reflect the following:

- Land Acquisition: $0
- Construction Costs: $0
- Renovation / Leasehold Improvements: $0
- Fixed / Capitalized Equipment: $0
- Financing Costs: $0
- Capitalized Working Capital: $0
- Total Project Cost: $0

Because the Southern Maryland expansion utilizes a lease-based model with no capital development, the "Total Project Cost" is $0. This project is supported by the unified Medicare-certified entity's existing infrastructure, with operating revenues and expenses fully detailed in the originally submitted **Table 4 and Table 5** of the CON application.

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CONSOLIDATED TABLE 1: PROJECT BUDGET

SOUTHERN MARYLAND (CALVERT, CHARLES, AND ST. MARY'S COUNTIES)

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

A. USE OF FUNDS	
1. CAPITAL COSTS (if applicable):	
a. New Construction	
1) Building	0
2) Fixed Equipment (not included in construction)	0
3) Architect/Engineering Fees	0
4) Permits, (Building, Utilities, Etc.)	0
a. SUBTOTAL New Construction	**$0**
b. Renovations	
1) Building	0
2) Fixed Equipment (not included in construction)	0
3) Architect/Engineering Fees	0
4) Permits, (Building, Utilities, Etc.)	0
b. SUBTOTAL Renovations	**$0**
c. Other Capital Costs	
1) Movable Equipment	0
2) Contingency Allowance	0
3) Gross Interest During Construction	0
4) Other (Specify)	0
c. SUBTOTAL Other Capital Cost	**$0**
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	**$0**
Non-Current Capital Cost	
d. Land Purchase Cost or Value of Donated Land	0
e. Inflation (state all assumptions, including time period and rate	0
TOTAL PROPOSED CAPITAL COSTS (sum of a - e)	**$0**
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	0
b. Bond Discount	0
c. CON Application Assistance	0
c1. Legal Fees	0
c2 Other (Specify and add lines as needed)	0
d. Non-CON Consulting Fees	0
d1. Legal Fees	0
d2. Other (Specify and add lines as needed)	0
e. Debt Service Reserve Fund	0
f. Other (Specify) Licensing	0
TOTAL (a - e)	**$0**
3. WORKING CAPITAL STARTUP COSTS	**$0**
TOTAL USES OF FUNDS (sum of 1 - 3)	**$0**

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B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	
2. Pledges: Gross _____, less allowance for uncollectable _____= Net	
3. Gifts, bequests	
4. Authorized Bonds	
5. Interest income (gross)	
6. Mortgage	
7. Working capital loans	
8. Grants or Appropriation	
a. Federal	
b. State	
c. Local	
9. Other (Specify)	
TOTAL SOURCES OF FUNDS (sum of 1-9)	
ANNUAL LEASE COSTS (if applicable) – Not applicable – Waldorf administrative office lease costs are treated as operating expenses and reflected in Table 4 (Revenues and Expenses). See Note below in regard to operating lease treatment.	
• Land	
• Building	
• Moveable equipment	
• Other (specify)	

Notes:

- Operating revenues and expenses for Southern Maryland are reflected in Table 4 and Table 5 of the CON Application, consistent with the unified Medicare-certified entity structure.
- The proposed HHA will operate as a single Medicare-certified entity across all approved jurisdictions and does not require separate capital development for Southern Maryland.
- All facility-related expenses associated with the Waldorf administrative location are treated as operating lease expenses and reflected in Table 4 (Revenues and Expenses – Proposed Project).
- Tables 1 – 5 of the CON Application have been attached to this response as supporting documents for easy access.

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13. Where in the budget is the estimated lease expense for the proposed branch location in Waldorf? Please explain or modify the budget.

Applicant Response (Q13) – Waldorf Lease

The estimated lease expense for the proposed Waldorf administrative branch location is reflected in the revised and consolidated **Table 4 – Revenues and Expenses (Southern Maryland Counties)** under the expense line item: **"Rent / Facility Lease – Waldorf Administrative Office."**

The projected lease expense is reflected as:

- **$24,000 (CY 2026)**
- **$24,720 (CY 2027)**
- **$25,462 (CY 2028)**

This lease cost is incorporated within **Total Operating Expenses** for each projected year and is treated as an operating lease expense. The project does not involve construction, capital improvements, project debt, depreciation, or amortization related to the Waldorf location.

The consolidated Table 4 has been revised to separately identify the lease expense for clarity and alignment with MHCC reporting requirements. Total Operating Expenses and Net Income remain unchanged from the previously submitted aggregate Southern Maryland projection

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CONSOLIDATED TABLE 4: REVENUES AND EXPENSES

PROJECTED HOME HEALTH AGENCY SERVICES FOR PROPOSED SOUTHERN MARYLAND PROJECT (CALVERT, CHARLES & ST MARY'S COUNTIES)

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

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

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

	Projected Years (ending with first full year at full utilization)		
CY or FY (Circle) - CY	**2026**	**2027**	**2028**
1. Revenue			
Gross Patient Service Revenue	$121,992	$246,397	$366,964
Allowance for Bad Debt	$1,220	$2,465	$3,670
Contractual Allowance	$9,759	$19,711	$29,357
Charity Care	$244	$493	$734
Net Patient Services Revenue	$110,769	$223,728	$333,203
Other Operating Revenues (Specify)	$0	$0	$0
Net Operating Revenue	**$110,769**	**$223,728**	**$333,203**
2. Expenses			
Salaries, Wages, and Professional Fees, (including fringe benefits)	$39,195	$79,395	$118,590
Contractual Services	$18,135	$36,735	$54,870
Interest on Current Debt	0	0	0
Interest on Project Debt	0	0	0
Current Depreciation	0	0	0
Project Depreciation	0	0	0
Current Amortization	0	0	0
Project Amortization	0	0	0
Supplies	$1,755	$3,555	$5,310

Rent / Facility Lease – Waldorf Administrative Office	$24,000	$24,720	$25,462
Other Expenses (Medical Supplies, Mileage, Admin, etc.)	$28,817	$58,993	$78,001
Total Operating Expenses	**$111,902**	**$203,398**	**$282,233**
3. Income			
Income from Operation	($1,132)	$20,330	$50,970
Non-Operating Income	$0	$0	$0
Subtotal	($1,132)	$20,330	$50,970
Income Taxes	$0	$0	$0
Net Income (Loss)	($1,132)	$20,330	$50,969

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**		
CY or FY (Circle) - CY	**2026**	**2027**	**2028**
4A – Payor Mix as Percent of Total Revenue			
Medicare (Traditional)	78.48%	75.53%	72.56%
Medicare Advantage	8.70%	10.68%	12.68%
Medicaid	1.44%	1.45%	1.45%
Commercial Insurance	10.63%	11.59%	12.55%
Other	0.76%	0.76%	0.76%
TOTAL	**100%**	**100%**	**100%**
4B – Payor Mix as Percent of Total Visits			
Medicare (Traditional)	74.30%	71.30%	68.30%
Medicare Advantage	8.90%	10.90%	12.90%
Medicaid	4.20%	4.20%	4.20%
Commercial Insurance	11.50%	12.50%	13.50%
Other	1.10%	1.10%	1.10%
TOTAL	**100%**	**100%**	**100%**

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14. Why is there $0 in current liabilities ending December 2024?

Applicant Response (Q14) – 2024 Dec Liabilities

The December 31, 2024, financial statements included in Exhibit 2 were prepared by the Applicant's independent CPA in accordance with standard accounting practices. As reflected in those statements, Current Liabilities were $0 as of the reporting date.

This presentation reflects that, as of December 31, 2024:

- There were no outstanding short-term borrowings or lines of credit
- All accounts payable, payroll-related liabilities, and accrued expenses had been satisfied prior to year-end
- No project-related debt obligations existed

The absence of current liabilities at year-end reflects the timing of payment of obligations and does not indicate omission of liabilities. The agency continues to incur normal operating expenses, which are recorded and paid in the ordinary course of business.

If requested, the Applicant can provide additional clarification from its CPA regarding year-end liability balances.

15. What is the telehealth business with a Cost of Goods Sold (COGS) of $250K indicated under 2024? This has impacted the Net Operating Revenue. Will this business continue?

Applicant Response (Q15) – Unrecurring Telehealth Business

The CPA-prepared Statements of Revenues and Expenses (Tax Basis) reflect a $250,000 Cost of Goods Sold line item labeled "Business Telehealth" for the period ended October 31, 2024. The corresponding line item for the period ended October 31, 2025, is $0. This reflects that telehealth-related activity occurred during 2024 but did not continue into 2025.

As shown in the same CPA statement, the discontinuation of this line item coincides with the return to positive net income in 2025.

The proposed HHA project is strictly focused on traditional home health modalities (Skilled Nursing, PT, OT, ST, MSW, and Aide services) and does not include continuation of the telehealth activity reflected in 2024. Therefore, the $250,000 expense does not represent an ongoing operating cost and is not projected to affect the financial feasibility of the proposed HHA.

If the Commission requires additional technical clarification regarding the accounting classification of this line item, the Applicant's independent CPA is available to provide further detail.

16. What are the working capital requirements if any. How will the agency pay staff until CMS reimbursements start coming in.

Applicant Response (Q16) – Working Capital Requirements

The proposed HHA project does not require capital construction or project debt. As reflected in the CPA-prepared Statement of Assets, Liabilities and Equity (Tax Basis) as of October 31, 2025, the Applicant reports $630,851 in checking and savings balances and only $96 in current liabilities.

The proposed HHA project encompasses six jurisdictions (Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties). Projected 2026 operating expenses across all jurisdictions are approximately $445,000 annually (approximately $37,000 per month), as reflected in the submitted CON Tables, and represent a modest monthly operating requirement relative to available cash reserves.

Under a conservative assumption of a temporary three- to six-month delay in CMS reimbursement during start-up, existing liquidity is sufficient to cover projected payroll and operating expenses across all six jurisdictions without reliance on borrowing. Available cash reserves substantially exceed projected initial operating exposure.

Accordingly, no additional working capital financing is required. The Applicant will utilize existing cash reserves to support payroll and operational expenses during the CMS enrollment and reimbursement cycle.

If requested, the Applicant's independent CPA can provide additional liquidity analysis demonstrating coverage of projected start-up payroll expenses.

17. Telehealth business is indicated as a one-off expense in December 2024. Will this be a recurring cost? What are the projections for this business line?

Applicant Response (Q17) – Telehealth Business (One-Off Expense)

As stated in the response to Question 15 above, this is not a recurring cost. The CPA-prepared Statements of Revenues and Expenses (Tax Basis) reflect a $250,000 Cost of Goods Sold line item labeled "Business Telehealth" for the period ended October 31, 2024. The corresponding line item for the period ended October 31, 2025, is $0.

This indicates that telehealth-related activity occurred during 2024 but did not continue into 2025. The telehealth expense was therefore limited to that period and is not reflected as an ongoing cost in subsequent operations.

The proposed HHA project does not include continuation of a telehealth business line, and no telehealth-related expenses are included in the HHA financial projections submitted with the CON application.

Accordingly, the $250,000 telehealth expense does not represent a recurring cost and does not impact the projected financial performance of the proposed HHA.

18. The COGS is growing at a significantly higher rate (30% in 2023 and 10% in 2024) than their Gross Revenue (19% in 2023 and 5% in 2024). Is this due to direct wages and subcontractor costs? If the costs for the RSA continue at this rate, and HHA cost are similar, QOC won't be able to increase revenue (the drop in Net Income was -74% in 2023 and -250% in 2024). How does QOC plan to sustain operations of the new costs of the HHA project?

Applicant Response (Q18) - COGS

The increase in Cost of Goods Sold (COGS) relative to revenue growth in 2023 and 2024 is primarily attributable to increases in direct wages and subcontractor expenses, as reflected in the CPA-prepared Statements of Revenues and Expenses (Tax Basis). For the period ended October 31, 2024, COGS included $2,181,160 in Direct Wages and $11,077,903 in Subcontractor costs, as well as a $250,000 Business Telehealth expense.

The telehealth expense did not recur in 2025 (reflected as $0 in the 2025 column), and Net Income returned to positive $89,344 in 2025, reflecting stabilization following transitional costs.

In addition, during 2022–2024 the Applicant undertook significant capital investment in long-term infrastructure, including acquisition of its headquarters property and completion of facility renovations to support expanded service capacity. These investments are reflected on the balance sheet as Leasehold Improvements totaling $445,123. Associated transaction costs, renovation expenditures, and depreciation contributed to short-term margin compression but represent capital investments rather than ongoing structural operating losses.

Accordingly, the decline in reported net income during 2023–2024 reflects a combination of non-recurring telehealth activity and capital infrastructure investment, not deterioration in core RSA operating fundamentals.

With respect to the proposed HHA project, the cost structure differs materially from RSA operations. Table 1 confirms that the HHA project involves no capital construction or project debt. Projected HHA

operating expenses are modest relative to the Applicant's overall revenue base, and the ramp-up is structured to scale staffing in alignment with projected census.

The Applicant maintains substantial liquidity and minimal short-term liabilities. Accordingly, the proposed HHA is financially sustainable and does not depend on continued cost escalation within RSA operations.

19. Please submit a summary table of all jurisdictions for Tables 2A, 2B, 3, and 4 and include the Labor Table 5, distinguishing existing RSA FTEs and changes due to the HHA employees. It is important to see the information per jurisdiction and also the total impact on QOC. Submit tables in Excel.

Applicant Response (Q19) – Tables 2A, 2B, 3, 4 & 5 (Excel Submission)

Summary Tables and Labor Impact (Tables 2A, 2B, 3, 4, and 5)

Pursuant to the completeness review request, the Applicant submits consolidated summary tables in Excel format for all six jurisdictions (Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties) for:

- Table 2A – Projected Clients
- Table 2B – Projected Visits (Billable and Non-Billable)
- Table 3 – Projected Charges and Revenue
- Table 4 – Payor Mix (Percent of Revenue and Percent of Visits)
- Table 5 – Labor Impact

The submitted Excel file includes both jurisdiction-level detail and six-county totals to clearly demonstrate the cumulative impact of the proposed Home Health Agency (HHA) on Quality One Care (QOC) as an organization.

- **Tables 2A and 2B – Clients and Visits:**
    - Tables 2A and 2B summarize projected unduplicated clients and total visits for each jurisdiction and in aggregate. Growth reflects a conservative three-year ramp-up to stabilized operations by 2028.
    - Visit projections are distributed proportionally across jurisdictions based on the service area expansion and align directly with the staffing projections in Table 5. No jurisdiction reflects disproportionate growth relative to total projected volume.

- **Table 3 – Charges and Revenue**
    - Table 3 consolidates projected revenue by jurisdiction and for the six-county total. Revenue projections are derived directly from the visit volumes in Table 2B, and the payor mix assumptions in Table 4.
    - Financial projections reflect a balanced distribution of Medicare Fee-for-Service, Medicare Advantage, Medicaid, Commercial, and other payors, and are consistent with the Applicant's projected payer mix and staffing model.
- **Table 4 – Payor Mix (Revenue and Visits)**
    - Table 4 provides payor mix by jurisdiction and for the six-county total, expressed both as:
        - Percent of total revenue (Table 4A)
        - Percent of total visits (Table 4B)
    - The consolidated six-county weighted payor mix reflects gradual shifts consistent with regional Medicare Advantage enrollment trends and stable Medicaid participation. No single payor category dominates the projected mix.
    - Because payor percentages are applied to jurisdiction-specific visit volumes, the consolidated totals reflect accurate weighted calculations rather than blended or uniform assumptions.
- **Table 5 – Labor Impact**
    - Table 5 distinguishes clearly between: Existing RSA Employee FTEs (2024 baseline), and New HHA FTEs required for the proposed Medicare-certified Home Health Agency.
    - Existing Workforce Baseline
        - Existing RSA employee staffing equals 17.0 FTEs, calculated using full-year 2024 payroll data (total regular hours divided by 2,080 hours per FTE). RSA operations also utilize contracted clinical personnel, reflected separately in subcontractor expenses, but these are not included in the employee FTE baseline.
    - Projected HHA Staffing Additions
        - The HHA program adds staffing incrementally as follows:
            - 2026: 4.8 new FTEs
            - 2027: 9.7 new FTEs
            - 2028: 14.8 new FTEs

- Total QOC employee staffing therefore increases to:
  - 21.8 FTEs in 2026
  - 26.7 FTEs in 2027
  - 31.8 FTEs in 2028
- The net increase in FTEs each year reflects only the additional HHA-related positions. No reduction of RSA staffing is projected.

- Jurisdictional Allocation
  - New HHA FTEs are allocated proportionally based on projected visit volume in each jurisdiction. Counties with higher projected utilization (Montgomery and Prince George's) reflect proportionally greater staffing increases, while Southern Maryland counties reflect moderate increases consistent with projected demand.
  - This proportional allocation ensures that labor expansion corresponds directly to service volume and does not create excess capacity in any single jurisdiction.

Total Organizational Impact

When Tables 2A, 2B, 3, 4, and 5 are viewed collectively:

- Client and visit growth drive staffing increases.
- Staffing increases drive projected revenue growth.
- Payor mix remains balanced across jurisdictions.
- Labor expansion is phased and proportional.
- Existing RSA operations remain intact.

The proposed HHA represents a controlled and gradual expansion of QOC's workforce and service capacity. The cumulative impact results in a net positive employment effect across the six-county region without creating a disproportionate labor or payor concentration in any jurisdiction.

All requested summary tables, including jurisdiction-level detail and six-county totals, are submitted in Excel format as requested.

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20. Explain why with the growth in number of clients and visits, tripling from 2026 to 2028 in Table 2B, that there is no or very limited corresponding increase in staffing (Table 5), for the three years (2026 – 2028).

Applicant Response (Q20) – Staffing Growth Relative to Visit Growth (Tables 2B and 5)

The Applicant acknowledges that projected visits increase from 2,325 in 2026 to 6,945 in 2028 (Table 2B), reflecting a planned three-year ramp-up to stabilized operations. The corresponding staffing increases in Table 5 reflect proportional scaling of clinical FTEs and therefore do not require a one-for-one tripling of staff during the early years of operation.

The apparent difference between visit growth and staffing growth is explained by operational ramp-up efficiencies and baseline capacity assumptions, as detailed below.

- **Please complete the information outlined in the table below for each jurisdiction, and the total for the entire CON application.**

Applicant Response (Q20a) – FTE Position & Change by Jurisdiction

The following tables present the change in FTEs and associated visit growth for each jurisdiction and for the total six-county CON application.

1. **ANNE ARUNDEL COUNTY**

FTE Position	2026 Change in FTE	2026 Visits	2027 Change in FTE	Total 2027 FTEs	2027 Visits	2028 Change in FTE	Total 2028 FTEs	2028 Visits
RN/LPN	0.14	158	0.14	0.28	310	0.14	0.42	462
PT	0.05	54	0.05	0.1	106	0.05	0.15	158
OT	0.03	27	0.03	0.06	53	0.03	0.09	79
ST	0.01	9	0.01	0.02	18	0.01	0.03	26
HHA	0.17	180	0.17	0.34	354	0.17	0.51	529
MSW	0.04	22	0.04	0.08	44	0.04	0.12	66

2. MONTGOMERY COUNTY

FTE Position	2026 Change in FTE	2026 Visits	2027 Change in FTE	Total 2027 FTEs	2027 Visits	2028 Change in FTE	Total 2028 FTEs	2028 Visits
RN/LPN	0.23	257	0.23	0.46	515	0.23	0.69	772
PT	0.08	88	0.08	0.16	176	0.08	0.24	265
OT	0.04	44	0.04	0.08	88	0.04	0.12	132
ST	0.01	15	0.01	0.02	29	0.01	0.03	44
HHA	0.27	294	0.27	0.54	588	0.27	0.81	882
MSW	0.07	37	0.07	0.14	74	0.07	0.21	110

3. PRINCE GEORGE'S COUNTY

FTE Position	2026 Change in FTE	2026 Visits	2027 Change in FTE	Total 2027 FTEs	2027 Visits	2028 Change in FTE	Total 2028 FTEs	2028 Visits
RN/LPN	0.18	194	0.18	0.36	383	0.18	0.54	578
PT	0.06	67	0.06	0.12	131	0.06	0.18	198
OT	0.03	33	0.03	0.06	66	0.03	0.09	99
ST	0.01	11	0.01	0.02	22	0.01	0.03	33
HHA	0.2	222	0.2	0.4	438	0.2	0.6	660
MSW	0.05	28	0.05	0.1	55	0.05	0.15	82

4. CALVERT COUNTY

FTE Position	2026 Change in FTE	2026 Visits	2027 Change in FTE	Total 2027 FTEs	2027 Visits	2028 Change in FTE	Total 2028 FTEs	2028 Visits
RN/LPN	0.05	52	0.05	0.1	105	0.05	0.15	158
PT	0.02	18	0.02	0.04	36	0.02	0.06	54
OT	0.01	9	0.01	0.02	18	0.01	0.03	27
ST	0	3	0.01	0.01	6	0.01	0.02	9
HHA	0.05	60	0.05	0.1	120	0.05	0.15	180
MSW	0.02	8	0.02	0.04	15	0.02	0.06	22

5. CHARLES COUNTY

FTE Position	2026 Change in FTE	2026 Visits	2027 Change in FTE	Total 2027 FTEs	2027 Visits	2028 Change in FTE	Total 2028 FTEs	2028 Visits
RN/LPN	0.08	89	0.08	0.16	184	0.08	0.24	273
PT	0.03	31	0.03	0.06	63	0.03	0.09	94
OT	0.02	15	0.02	0.04	32	0.02	0.06	47
ST	0	5	0.01	0.01	10	0.01	0.02	16
HHA	0.09	102	0.09	0.18	210	0.09	0.27	311
MSW	0.02	13	0.02	0.04	26	0.02	0.06	39

6. ST. MARY'S COUNTY

FTE Position	2026 Change in FTE	2026 Visits	2027 Change in FTE	Total 2027 FTEs	2027 Visits	2028 Change in FTE	Total 2028 FTEs	2028 Visits
RN/LPN	0.06	63	0.06	0.12	126	0.06	0.18	189
PT	0.02	22	0.02	0.04	43	0.02	0.06	65
OT	0.01	11	0.01	0.02	22	0.01	0.03	32
ST	0	4	0.01	0.01	7	0.01	0.02	11
HHA	0.06	71	0.06	0.12	144	0.06	0.18	216
MSW	0.02	9	0.02	0.04	18	0.02	0.06	27

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7. SIX-COUNTY TOTAL (Entire CON Application)

FTE Position	2026 Change in FTE	2026 Visits	2027 Change in FTE	Total 2027 FTEs	2027 Visits	2028 Change in FTE	Total 2028 FTEs	2028 Visits
RN/LPN	0.74	813	0.74	1.48	1,623	0.73	2.21	2,432
PT	0.28	280	0.28	0.56	555	0.27	0.83	834
OT	0.14	139	0.14	0.28	279	0.14	0.42	416
ST	0.05	47	0.05	0.1	92	0.05	0.15	139
HHA	0.77	929	0.78	1.55	1,854	0.77	2.32	2,778
MSW	0.15	117	0.14	0.29	232	0.14	0.43	346
Clinical Subtotal	2.13	2,325	2.13	4.26	4,635	2.10	6.36	6,945
Admin / Supervisor	3.50	—	1.00	4.50	—	1.00	5.50	—
Total New HHA FTEs	4.8	2,325	4.9	9.7	4,635	5.1	14.8	6,945

- **Clarify why there are no projected contractual services in Table 5, if you are proposing to contract for some services during start-up of the HHA.**

Applicant Response (Q20b) – Table 5 Contractual Services Clarification

Table 5 reflects only projected employee FTEs of the proposed Home Health Agency (HHA). It does not include contractual services because Table 5 is structured to report employee staffing levels rather than subcontracted personnel.

During the initial start-up phase of the HHA (primarily 2026), Quality One Care (QOC) may utilize limited contractual clinical personnel on an as-needed basis to ensure continuity of care while permanent staff are recruited and onboarded. This is a temporary operational strategy typical of new Medicare-certified HHAs.

However:

- Contracted personnel are reflected in financial projections under subcontractor expense lines, not as employee FTEs.
- Contracted staff are not counted toward employee FTE totals because they are not QOC payroll employees.

- The projected employee FTE levels in Table 5 are sufficient to support projected visit volumes based on productivity assumptions.
- As census stabilizes, reliance on contracted personnel decreases and services transition fully to employed staff.

Therefore, the absence of contractual FTEs in Table 5 does not indicate that contractual services will not be used during start-up; rather, it reflects the reporting structure of Table 5, which distinguishes payroll employees from subcontracted services.

QOC will ensure that all contracted clinicians meet Maryland licensure requirements and Medicare Conditions of Participation and will maintain appropriate supervision and oversight consistent with regulatory standards.

- **Review Table 5 totals between years to verify any calculation discrepancies between 2026–2028.**

Applicant Response (Q20b) – Verification of Table 5 Totals (2026 – 2028)

Table 5 has been reviewed for internal consistency across 2026, 2027, and 2028 to verify that all year-over-year totals reconcile and that no calculation discrepancies exist.

The review confirms the following:

1. Year-to-Year FTE Increases Reconcile

The net increase in new HHA FTEs by year is:

- **2026:** 4.8 FTEs
- **2027:** 9.7 FTEs
- **2028:** 14.8 FTEs

The incremental increases are:

- 2027 increase over 2026: **+4.9 FTEs**
- 2028 increase over 2027: **+5.1 FTEs**

These increases correspond directly to projected growth in visit volume as shown in Table 2B and the discipline-specific staffing allocations in Q20(a).

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2. Clinical FTE Totals Reconcile to Visit Volume

Clinical FTE growth is productivity-based and proportionate to visit increases:

- 2026: 2,325 total visits → 2.13 clinical FTEs
- 2027: 4,635 total visits → 4.26 clinical FTEs
- 2028: 6,945 total visits → 6.36 clinical FTEs

These figures scale consistently and reflect stabilized productivity by 2028.

3. Administrative FTE Totals Reconcile

Administrative and supervisory FTEs increase in a phased manner:

- 2026: 3.5 FTEs
- 2027: 4.5 FTEs
- 2028: 5.5 FTEs

Administrative growth reflects scaling of intake, billing, and compliance oversight functions and does not contain calculation discrepancies.

4. Mathematical Consistency Confirmed

All discipline-level FTE subtotals reconcile to:

- Annual clinical totals
- Annual administrative totals
- Annual grand totals

There are no rounding inconsistencies that materially affect totals. Minor decimal rounding reflects standard FTE reporting conventions and does not impact staffing adequacy.

Conclusion

Table 5 totals for 2026 through 2028 have been verified and reconciled accurately across:

- Discipline subtotals
- Clinical and administrative categories
- Net year-over-year increases
- Grand totals

Based on this review, Table 5 totals reconcile consistently across years and categories.

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- **Confirm travel time assumptions are included in FTE calculations.**

Projected visit volumes in Table 2B were developed using MHCC utilization data and six-county historical patterns. Table 5 staffing projections were then derived by applying conservative industry-standard productivity assumptions to those projected visits.

While the MHCC utilization tables report visit volume and client counts (not staffing productivity), the productivity benchmarks used in the FTE model reflect typical Medicare-certified home health agency operations. These benchmarks are intentionally set below theoretical maximum visit capacity and account for non-billable time, including documentation, care coordination, and travel between patient locations.

Travel time was not calculated as a separate line-item variable; rather, it is embedded within the productivity standards used to determine annual visit capacity per FTE.

Accordingly, the staffing model reflects realistic operational capacity across the six-county geographic mix, including both urban and rural service areas.

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Health Equity

21. Under medically underserved populations and communities, several factors were identified. Some of these are:

- **Low-income residents, including individuals who are uninsured or underinsured,**
- **Older adults, particularly those with functional limitations, multiple chronic conditions, or limited caregiver support**
- **Individuals with disabilities, including individuals requiring mobility assistance or home safety supports,**
- **Communities experiencing higher chronic disease burden and reduced access to consistent outpatient care.**

Please provide the source of these assumptions and explain how QOC will uniquely address these challenges.

Applicant Response (Q21) – Source of Medically Underserved Populations Assumptions

1. **Source of Assumptions Identifying Medically Underserved Populations**

The identification of medically underserved populations in QOC's application is grounded in objective utilization data, documented demographic characteristics of the six-county review area, and QOC's existing operational experience.

A. MHCC FY 2023 Home Health Utilization Tables

QOC relied upon the Maryland Health Care Commission ("MHCC") Home Health Agency Utilization Tables for Fiscal Year 2023 including:

- **Table 17** – Total Unduplicated Home Health Clients by Jurisdiction
- **Table 19** – Total Home Health Visits by Jurisdiction
- **Table 20** – Distribution of Visits by Payment Source
- **Table 24** – Clients by Age Group

These tables demonstrate that:

- The six-county region generated **51,258 unduplicated home health clients** (Table 17).
- The region generated **779,489 total home health visits** (Table 19).
- Adults age 65 and older represent the predominant home health population (Table 24).
- Medicare Traditional and Medicare Advantage together account for approximately **92% of statewide home health visits** (Table 20).

This data confirms that the proposed service area is characterized by a predominantly older, medically complex population that relies heavily on Medicare-certified home health services for chronic disease management, post-acute stabilization, and functional recovery.

These sources are objective and consistent with the State Health Plan's emphasis on access to Medicare-certified services and equitable service availability.

B. County-Level Utilization and Geographic Characteristics

County-level data from Tables 17 and 19 demonstrate:

- High utilization volumes in Montgomery and Prince George's Counties; and
- Sustained utilization in Calvert, Charles, and St. Mary's Counties.

The Southern Maryland counties include rural geographic characteristics, longer travel distances, and fewer reporting agencies relative to population size. These factors support identification of access-related challenges within portions of the service area, particularly for homebound individuals and patients with mobility limitations.

C. Existing Operational Experience

QOC currently operates as a Maryland-licensed Residential Service Agency and provides services to:

- Medicaid beneficiaries
- Dual-eligible individuals
- Individuals with functional limitations and disabilities
- Patients requiring home-based chronic disease management

Through this experience, QOC has routinely served individuals with:

- Limited caregiver support
- Mobility impairments
- Financial constraints
- Social determinants of health impacting continuity of care

This operational experience supports the identification of low-income residents, older adults with multiple chronic conditions, individuals with disabilities, and communities experiencing barriers to consistent outpatient access.

Collectively, the MHCC utilization data and QOC's documented service experience form the basis for the medically underserved population descriptions contained in the application.

2. How QOC Will Address Identified Challenges

In consistency with Financial Accessibility (COMAR 10.24.16.08C and .08E), QOC's response to the identified medically underserved populations is structured, policy-based, and operationalized through documented procedures and oversight mechanisms.

A. Low-Income, Uninsured, and Underinsured Residents

QOC will implement the following measures:

- A written **Charity Care and Sliding Fee Scale Policy** (CON Application – Exhibit 4).
- Eligibility for **100% charity care up to 200% of the Federal Poverty Level (FPL).**
- Graduated discounts above 200% FPL.
- A **two-business-day probable eligibility determination process.**
- An interest-free **Time Payment Plan Policy** (CON Application – Exhibit 3).
- Monthly monitoring of charity care performance relative to regional benchmarks.

Services will not be denied or delayed based solely on inability to pay. These measures ensure financial accessibility consistent with the State Health Plan requirements.

B. Older Adults with Chronic Conditions

In response to the documented predominance of the 65+ population (MHCC Table 24), QOC will provide:

- Skilled nursing and interdisciplinary care planning under 42 CFR Part 484.
- Chronic disease management protocols.
- Medication reconciliation and patient education.
- Ongoing reassessment through OASIS-based documentation.
- Coordination with hospital discharge planners to reduce avoidable readmissions.

These structured clinical interventions directly address the needs of medically complex older adults within the service area.

C. Individuals with Disabilities and Functional Limitations

QOC will:

- Conduct home safety and mobility assessments.
- Integrate medical social services into individualized care plans.

- Coordinate with Adult Evaluation and Review Services (AERS), Departments of Social Services, and community-based organizations.
- Provide interdisciplinary planning tailored to functional limitations and caregiver capacity.

These measures build upon QOC's existing service experience and are incorporated into the proposed Medicare-certified HHA model.

D. Communities Experiencing Access Constraints

To address geographic and outpatient access challenges within portions of the six-county region, QOC will:

- Deploy a mobile, field-based clinical workforce across all six counties.
- Maintain centralized administrative oversight from the HQ in the Silver Spring office.
- Establish a Southern Maryland satellite presence to improve operational responsiveness.
- Coordinate with hospitals, assisted living providers, and community-based organizations.
- Conduct structured screening for social determinants of health during intake.

This service model is designed to improve timeliness of care initiation, continuity of care, and Medicare-certified provider capacity within the review area.

Conclusion

The identification of medically underserved populations in the CON application is grounded in:

- Objective MHCC FY 2023 utilization data (Tables 17, 19, 20, and 24).
- County-level geographic characteristics.
- QOC's documented operational experience serving low-income, elderly, and medically complex individuals.

QOC's response to these needs is implemented through written policies, financial accessibility safeguards, interdisciplinary clinical practices, and structured oversight mechanisms incorporated into the proposed HHA operations.

These measures are consistent with COMAR 10.24.16.08B (Populations and Services), COMAR 10.24.16.08C and .08E (Financial Accessibility), and the Commission's need and equity considerations under COMAR 10.24.01.08G(3).

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22. In your own words, describe how QOC will work to overturn denials to secure medically necessary care for these underserved populations.

Applicant Response (Q22) - Process for Addressing and Overturning Coverage Denials

Quality One Care Home Health, Inc. ("QOC") recognizes that coverage denials, whether issued by Medicare, Medicaid, or managed care organizations, can create barriers to timely access to medically necessary home health services, particularly for older adults, low-income residents, and individuals with disabilities. QOC will implement a structured, compliant, and patient-centered approach to addressing such denials.

I. Proactive Measures to Reduce Denials

QOC's priority is to minimize denials through preventive practices, including:

- Verification of eligibility and benefits prior to initiation of care.
- Confirmation that physician orders meet Medicare Conditions of Participation requirements.
- Documentation that supports homebound status and skilled need criteria.
- Accurate and timely completion of OASIS assessments.
- Internal clinical review prior to claim submission.

These measures reduce avoidable technical and documentation-based denials.

II. Structured Response to Coverage Denials

When a denial occurs, QOC will follow a defined review and appeal process.

A. Immediate Internal Review

Upon receipt of a denial:

- Billing and clinical staff will review the denial reason code.
- The Administrator or designee will evaluate whether the denial is:
  - Technical or administrative (e.g., documentation deficiency); or
  - Clinical (e.g., lack of medical necessity determination).

If the denial is documentation-related, QOC will promptly correct and resubmit the claim, where permitted.

B. Clinical Documentation Review and Physician Coordination

If the denial relates to medical necessity:

- QOC's Director of Nursing (or qualified clinical supervisor) will conduct a clinical review of the patient record.
- QOC will coordinate with the ordering physician to obtain additional clinical documentation, updated certifications, or clarifying statements where appropriate.

- Additional documentation supporting skilled need and homebound status will be compiled.

This ensures that appeals are grounded in clear clinical justification.

C. Formal Appeal Submission

Where appropriate and permitted under payer guidelines:

- QOC will submit a formal appeal within required timeframes.
- Appeals will include supporting documentation, physician certification, and relevant clinical records.
- QOC will track appeal status and follow up as necessary.

Appeals will be conducted in accordance with Medicare, Medicaid, or managed care appeal procedures.

III. Support for Underserved Patients During the Appeal Process

Recognizing that underserved populations may be disproportionately affected by denials, QOC will:

- Communicate clearly with patients and caregivers regarding denial reasons and appeal rights.
- Assist patients in understanding payer correspondence.
- Coordinate with social services or case managers when appropriate.
- Apply charity care or sliding fee scale options if needed to prevent interruption of medically necessary services, when permissible under regulatory guidelines.
- Evaluate whether continuation of services is clinically and legally appropriate pending appeal outcome.

QOC's financial accessibility policies ensure that inability to pay does not independently result in denial of medically necessary services.

IV. Compliance and Oversight

QOC will:

- Monitor denial trends through routine administrative review.
- Incorporate denial analysis into QOC's Quality Assurance and Performance Improvement (QAPI) program.
- Provide staff training to reduce recurring denial patterns.
- Maintain documentation consistent with Medicare and State regulatory requirements.

This structured oversight ensures that denial management is systematic, compliant, and focused on protecting patient access.

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Conclusion

QOC's approach to overturning denials is grounded in:

- Proactive compliance with documentation standards.
- Structured internal review and physician coordination.
- Timely and documented appeal submission.
- Patient-centered communication and financial accessibility safeguards.

Through these measures, QOC will work diligently and within applicable regulatory frameworks to secure coverage for medically necessary home health services for underserved populations.

QOC is committed to serving as an active advocate for its patients, particularly those who are elderly, low-income, or medically complex. When medically necessary care is denied, QOC will pursue all appropriate and lawful appeal avenues with diligence and persistence, ensuring that clinical justification is clearly documented and presented. QOC's objective is not merely administrative compliance, but the protection of patient access to necessary care consistent with federal and State requirements.

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Character and Competence

23. Describe QOC's community engagement activities to date and planned on-going engagement that reflect positively on character and competence (e.g., culturally responsive care, SDOH screening and referral, partnerships). Any commendations? Evidence of quality services?

Applicant Response (Q23) - Community Engagement and Evidence of Quality

I. Established Community Engagement and Service Integration

Although the proposed project involves the establishment of a Medicare-certified Home Health Agency, QOC has operated continuously as a Maryland-licensed Residential Service Agency (RSA License No. R3057) and has developed sustained community engagement relationships across Montgomery, Prince George's, Anne Arundel, Charles, Calvert, and St. Mary's Counties.

A. Health System and Referral Integration

QOC maintains structured referral coordination and service relationships with:

- Children's National Hospital (via established referral platforms).
- The Johns Hopkins Hospital (via referral coordination systems).
- The Coordinating Center for REM and Model Waiver.
- Prince George's ARC.
- Multiple county public school systems, including Montgomery, Prince George's, Charles, and Frederick Counties.

These relationships demonstrate QOC's ability to operate within organized referral systems, coordinate transitions of care, and serve medically complex patients in collaboration with major institutions and community-based organizations.

B. Culturally Responsive Service Delivery

QOC serves a demographically diverse population across suburban and rural communities. Its operational practices reflect:

- Recruitment of staff reflective of the communities served
- Delivery of services in languages commonly spoken in the service area, where feasible
- Inclusion of families and caregivers in care planning discussions
- Respectful, culturally sensitive communication standards embedded in agency policy.

Culturally responsive care is operationalized through workforce diversity, patient-centered planning, and responsiveness to socioeconomic and linguistic needs.

C. Structured SDOH Screening and Referral Practices

QOC incorporates assessment of social determinants of health into its intake and care coordination processes. Routine evaluation includes:

- Transportation access.
- Medication affordability.
- Caregiver availability.
- Home safety conditions.
- Financial hardship indicators.

When non-clinical barriers are identified, QOC coordinates referrals to appropriate community resources, including social services agencies, care coordination entities, and community-based organizations. This structured approach to identifying and addressing SDOH-related risks strengthens continuity of care and reflects organizational competence in serving vulnerable populations.

These practices will be formally integrated into the proposed HHA model.

II. Evidence of Organizational Character and Competence

A. Regulatory Compliance and Accreditation

QOC is a Maryland-licensed Residential Service Agency in good standing and is accredited by The Joint Commission which reflects compliance with nationally recognized standards related to:

- Patient safety.
- Clinical documentation integrity.
- Infection control.
- Leadership oversight.
- Performance improvement.
- Protection of patient rights.

This external accreditation provides objective validation of QOC's quality systems and operational discipline.

B. Quality Assurance Infrastructure

QOC maintains an established Quality Assurance and Performance Improvement (QAPI) framework that includes:

- Clinical supervision and chart review
- Incident reporting and corrective action protocols
- Staff competency evaluation and training
- Policy review and compliance monitoring

These systems demonstrate structured governance and operational readiness consistent with Medicare-certified HHA expectations.

C. Operational Stability and Experience

QOC has operated continuously since 2009. Sustained operations across multiple jurisdictions, financial stability (as documented in Exhibit 2), and maintained licensure reflect reliability, organizational maturity, and responsible stewardship of healthcare services.

III. Planned Ongoing Community Engagement

Upon CON approval and HHA licensure, QOC will expand community engagement through:

- Formalized linkages with nursing facilities, assisted living providers, CCRCs, hospice programs, AERS programs, Departments of Social Services, and home-delivered meal programs (consistent with COMAR 10.24.16.08I)
- Continued collaboration with hospital discharge planners across all six counties
- Structured SDOH screening incorporated into HHA intake workflows
- Outreach to community-based organizations serving older adults and individuals with disabilities
- Continued recruitment and development of a culturally responsive workforce

This engagement strategy is designed to strengthen access, improve care transitions, and support equitable service delivery across the six-county service area.

IV. Leadership Ethics and Governance Accountability

QOC's leadership structure reflects a commitment to ethical governance, regulatory compliance, and accountability. The agency operates under defined administrative and clinical oversight roles, maintains separation of operational functions where required, and adheres to documented compliance policies.

Leadership oversight includes:

- Active supervision of clinical and administrative operations
- Ongoing review of quality and safety indicators
- Enforcement of patient rights protections
- Adherence to applicable State and federal regulatory standards
- Maintenance of financial transparency and responsible fiscal management

QOC's governing body and administrative leadership recognize that healthcare delivery carries fiduciary, ethical, and professional obligations. Organizational decisions are guided by patient welfare, regulatory compliance, and long-term service sustainability rather than short-term financial considerations. This governance framework reflects institutional character and reinforces QOC's readiness to operate a Medicare-certified Home Health Agency responsibly.

Conclusion

QOC's sustained licensure, Joint Commission accreditation, structured quality oversight, established referral relationships, culturally responsive service model, SDOH-informed care coordination, and ethical leadership governance collectively demonstrate organizational character and competence.

These attributes support QOC's readiness to expand into Medicare-certified home health services and to serve the six-county region with professionalism, integrity, and regulatory compliance.

QOC respectfully submits that its demonstrated operational history, governance structure, and community engagement activities reflect positively on its character and competence to operate the proposed Home Health Agency.

24. What is Mr. Chafukira role in the project? State his prior involvement in any other health care facilities, if any.

Applicant Response (Q24) – Mr Chafukira's Role in the project.

I. Role in the Proposed Project

Mr. Amon Chafukira serves as the Program Coordinator for Quality One Care and provides operational coordination, regulatory support, and information technology oversight functions that support the Director and Administrator.

For the proposed Medicare-certified Home Health Agency project, Mr. Chafukira's responsibilities have included:

- Coordinating the development and assembly of the Certificate of Need (CON) application
- Working collaboratively with the Administrator, Director of Nursing (DON), clinical leadership, CPA, and legal counsel to gather required documentation
- Ensuring financial, operational, and policy materials were complete and submission-ready
- Supporting regulatory formatting, exhibit organization, and compliance with MHCC submission requirements
- Providing oversight of IT readiness components related to electronic health record (EHR) systems and data compliance infrastructure.
- Assisted in aligning administrative systems and documentation infrastructure with anticipated Medicare Conditions of Participation requirements.

Mr. Chafukira has served in a coordination and project management capacity to ensure that materials submitted to the Maryland Health Care Commission are accurate, organized, and consistent with regulatory requirements. He has also played a very important role in ensuring that multidisciplinary inputs were properly integrated and that the application materials accurately reflect QOC's operational capacity and regulatory readiness.

He does not serve as the clinical lead, Administrator, or Director of Nursing for the proposed HHA. Clinical and operational authority for the proposed HHA will remain with the designated Administrator and Director of Nursing consistent with Medicare Conditions of Participation.

II. Information Technology and Compliance Support

In addition to his program coordination role, Mr. Chafukira provides internal IT support to QOC. His responsibilities include:

- Supporting electronic health record (EHR) systems
- Assisting with HIPAA-related data security measures
- Maintaining system integrity and operational readiness
- Coordinating with vendors regarding software, cybersecurity, and data protection protocols
- Supporting compliance with documentation and recordkeeping requirements

This administrative and technical leadership strengthens QOC's compliance posture, documentation reliability, and operational continuity. As health care delivery increasingly relies on secure data systems and accurate reporting, this role contributes materially to QOC's organizational competence and readiness for Medicare-certified operations.

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III. Prior Involvement in Other Health Care Facilities

In the past, Mr. Chafukira has provided consulting services to several health care facilities in the areas of:

- IT systems implementation and support
- Data security and infrastructure support
- Program coordination and operational workflow organization

His prior consulting work has focused on administrative and technical support rather than clinical operations or ownership roles. He has not served as an owner, governing body member, or licensed operator of other health care facilities.

IV. Ongoing Contribution to QOC

Mr. Chafukira has been involved with QOC since approximately 2010 and has contributed to the agency's administrative development and structured growth. His long-term involvement provides institutional continuity, familiarity with regulatory requirements, and operational alignment across departments.

His role in this project reflects continuity of organizational support and structured coordination across clinical, financial, and legal stakeholders to ensure a complete and compliant CON submission.

His prior consulting experience in health care IT and program coordination, combined with his long-standing involvement with QOC, supports organizational stability and compliance preparedness, while clinical and operational authority for the proposed HHA remains appropriately vested in designated licensed leadership.

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Tables (Staffing & Payer Mix Clarification/Alignment)

25. Ensure salaries, wages, and professional fees (including fringe) align between CPA statements (2023 – 2024) and Table G totals; Table L should reconcile with these statements.

Applicant Response (Q25) – Reconciliation of Salaries, Wages, and Professional Fees

The salaries, wages, and professional fees (including fringe benefits) reported in Table G for CY 2023 and CY 2024 have been reconciled directly to the CPA Statements of Revenues and Expenses for the years ended December 31, 2023, and December 31, 2024.

- For CY 2023, total salaries and wages (including payroll service fees and pension expense) equal **$2,867,151**, which agrees to the CPA statement.
- For CY 2024, total salaries and wages (including payroll service fees and pension expense) equal **$3,159,132**, which agrees to the CPA statement.

Contractual Services in Table G reconcile to "Subcontractors – COS" and "Business Telehealth" as reported in the CPA statements for each respective year.

Table L reflects current staffing levels (CY 2024) and the total personnel cost of **$3,159,132**, which reconciles exactly to the Salaries & Wages (including benefits) line reported in Table G for CY 2024 and to the CPA statement for the year ended December 31, 2024.

Accordingly, Tables G and L are fully aligned with the CPA financial statements for CY 2023 and CY 2024.

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Table G – Revenues & Expenses, Uninflated (SNAPSHOT)

Entire Facility

	Two Most Recent Years (Actual)	
CY	**2023**	**2024**
1. REVENUE		
a. Total Home Health Gross Revenue	$ 16,482,073	$ 17,235,327
b. Outpatient Services	$ -	$ -
Gross Patient Service Revenues	***$ 16,482,073***	***$ 17,235,327***
c. Allowance For Bad Debt	$ -	$ -
d. Contractual Allowance	$ -	$ -
e. Charity Care	$ 5,000	$ -
Net Patient Services Revenue	***$ 16,477,073***	***$ 17,235,327***
f. Other Operating Revenues (Specify/add rows if needed)	$ -	$ -
NET OPERATING REVENUE	***$ 16,477,073***	***$ 17,235,327***
2. EXPENSES		
a. Salaries & Wages (including benefits)	$ 2,867,151	$ 3,159,132
b. Contractual Services	$ 12,437,863	$ 13,629,501
c. Interest on Current Debt	**$ 1,434**	**$ -**
d. Interest on Project Debt	$ -	$ -
e. Current Depreciation	$ 21,603	$ 23,813
f. Project Depreciation	$ -	$ -
g. Current Amortization	***$ -***	***$ -***
h. Project Amortization	$ -	$ -
i. Supplies	$ 64,264	$ 97,594
j. Other Expenses (Specify/add rows if needed)	$ 741,761	$ 866,628
TOTAL OPERATING EXPENSES	***$ 16,134,076***	***$ 17,776,668***
3. INCOME		
a. Income From Operation	**$ 342,997**	**$ (541,341)**
b. Non-Operating Income		$ 52
c. Penalties (Other Expense)		$ (5,490)
SUBTOTAL	***$ 342,997***	***$ (546,779)***
c. Income Taxes		
NET INCOME (LOSS)	***$ 342,997***	***$ (546,779)***

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Table L – Workforce Information (SNAPSHOT)

TABLE L. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and ch ges required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equ one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensu e that the projections in this table are consistent with expenses provided in uninflated rojections in Tables F and G.

		RRENT ENTIRE FACILITY		PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs (2024)**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Officer / Administrator	1.0	$194,220	$194,220.00	0.0	$194,220	$0	0.0		$0	1.0	$194,220
Admin / Support Wages	6.8	$55,001	$373,344.00	0.0	$55,000	$0	0.0		$0	6.8	$373,344
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
Total Administration	7.8		$567,564.00			$0			$0	7.8	$567,564
Direct Care Staff *(List general categories, add rows if needed)*											
Direct Wages	36.3	$70,000	$2,538,061.00	0.0	$70,000	$0	0.0		$0	36.3	$2,538,061
Support Staff	0.0	$60,000	$0.00	0.0	$60,000	$0	0.0		$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
Total Direct Care	36.3		$2,538,061.00			$0			$0	36.3	$2,538,061
Support Staff *(List general categories, add rows if needed)*											
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
Total Support	0.0		$0.00			$0			$0	0.0	$0
REGULAR EMPLOYEES TOTAL	***36.3***		$2,538,061.00			$0			$0	36.3	$2,538,061
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
Total Administration			$0.00			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
Total Direct Care Staff			$0.00			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
			$0.00			$0			$0	0.0	$0
Total Support Staff			$0.00			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0.00			$0			$0	0.0	$0
Benefits / Fringe *(Payroll Service Fees + Pension Expenses)*			**$53,507.00**								**53,507.0**
TOTAL COST	***36.3***		***$3,159,132.00***	***0.0***		***$0***	***0.0***		***$0***		***$3,159,132***

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26. Explain why the Baltimore City and County and Howard County CON application has 27 percent as the benefit ratio, while this application only has a 22 percent benefit ratio.

Applicant Response (Q26) - Benefits Ratio (Baltimore-Howard CON vs This CON Applications)

The difference in benefit ratios between the Baltimore–Howard CON application (27%) and the present Anne Arundel–Montgomery–Prince George's–Southern Region application (22%) is attributable to differences in workforce composition, labor market conditions, and projected compensation structures specific to each service area.

1. Regional Labor Market Differences

The Baltimore City/County and Howard County region reflects a more hospital-centric labor market with higher employer-paid benefit norms, including elevated health insurance premiums, retirement contributions, and employer payroll tax burdens. That application assumed a higher fringe load consistent with prevailing compensation practices and recruitment requirements in that region, resulting in a 27% benefit factor.

By contrast, the six-county region in the present application includes a broader geographic mix, including Southern Maryland counties (Calvert, Charles, and St. Mary's), where wage structures and employer-sponsored benefit cost structures are comparatively lower. As a result, a 22% benefit ratio more accurately reflects the actual projected employer-paid fringe burden for this service area.

2. Workforce Structure and Staffing Model Differences

The Baltimore–Howard application projected a staffing model with:

- A higher proportion of full-time clinical staff
- Greater employer-sponsored health coverage participation
- Higher projected retirement contributions

The current application utilizes:

- A leaner start-up staffing ramp
- Greater flexibility in staffing mix during early years
- Conservative fringe assumptions aligned with current payroll experience

Because benefits are calculated as a percentage of salary expense (and include FICA, FUTA, SUTA, workers' compensation, health insurance, and related fringe), variations in staffing structure directly affect the composite benefit ratio.

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3. Alignment With CPA Financial Statements and Table G

For this application, the 22% benefit ratio:

- Is applied consistently to salary projections in Tables F, G, and L
- Reconciles to the CPA-provided payroll and fringe expense structure for 2023–2024
- Reflects actual employer-paid fringe expense experience rather than a standardized statewide assumption

The Baltimore–Howard submission used a more conservative and regionally elevated fringe assumption based on projected recruitment pressures in that market. The current application uses a benefit ratio calibrated to the Applicant's actual payroll structure and projected staffing model for this specific six-county region.

4. Financial Conservatism and Accuracy

Both benefit ratios are reasonable within Maryland's home health industry range (generally 20%–30% depending on staffing model and insurance elections). The difference does not reflect inconsistency, but rather region-specific financial modeling based on:

- Market wage conditions
- Employer benefit participation assumptions
- Staffing composition
- Historical payroll structure

The 22% ratio in this application is therefore appropriate, supportable, and consistent with the Applicant's projected operations in the Anne Arundel–Montgomery–Prince George's–Southern Maryland region.

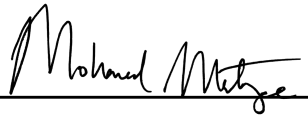
In addition, the benefit ratio variance reflects regional labor market and utilization dynamics. The Baltimore–Howard region is characterized by a higher concentration of hospital systems and large health employers, which exerts upward pressure on total compensation packages, including employer-paid benefits. By contrast, the six-county region in this application includes suburban and rural jurisdictions (including Calvert, Charles, and St. Mary's Counties) with different wage pressures and staffing cost structures. While Montgomery and Prince George's Counties exhibit high Medicare utilization volumes per MHCC Tables 17, 19, and 20, fringe benefit expense is driven primarily by employer compensation structure rather than utilization volume. Accordingly, the 22% benefit ratio reflects the projected staffing model and labor cost environment specific to this region.

Both applications calculated fringe benefits as a percentage of total salary expense using the same methodology (inclusive of FICA, unemployment insurance, workers' compensation, health insurance contributions, and retirement expense). The variation reflects differences in projected staffing composition and regional compensation assumptions rather than a change in methodology.

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.

Date: 02/24/2026



Mohamed Matope
CEO & Director
Quality One Care Home Health, Inc.

EXHIBITS
& SUPPORTIVE DOCUMENTS

Updated Tables (Submitted as Excel)

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Table 1, 2A, 2B, 3, 4 & 5

Table G & L

Updated Exhibit 1B - Organizational Chart

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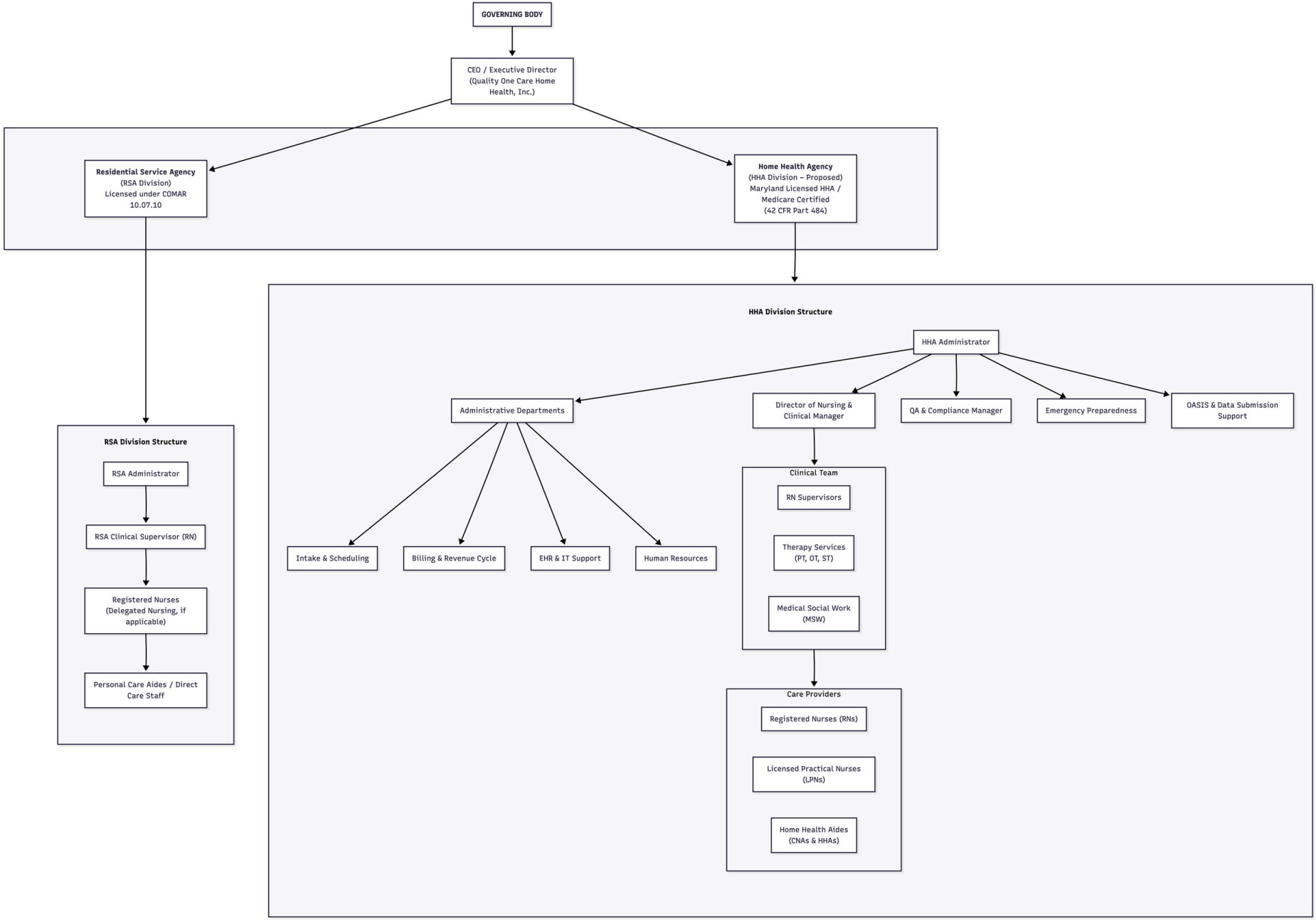
RSA vs HHA Org Chart

QUALITY ONE CARE HOME HEALTH, INC

CORPORATE ORGANIZATIONAL CHART



Updated Exhibit 5 – Admissions and Discharge Policy

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Admissions & Discharge Policy Admission Booklet

QOC Quality One Care
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QOC Admission and Discharge Policy

I. PURPOSE

The purpose of this policy is to ensure that all patients referred to or receiving services from Quality One Care Home Health, Inc. ("QOC") are admitted and discharged in a consistent, patient-centered, clinically appropriate, and legally compliant manner. This policy guides the full continuum of care, from referral to admission through discharge, to ensure:

- Equitable access to care
- High-quality, evidence-based service delivery
- Safe and efficient transitions between care settings
- Protection of patient rights
- Compliance with Medicare Conditions of Participation (42 CFR 484), COMAR 10.24.16.08, COMAR 10.24.01.08G(3), and Joint Commission standards

QOC is committed to serving **adult patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay. QOC may serve pediatric patients as clinically appropriate and based on staffing competencies and program capability.

II. SCOPE

This policy applies to:

- All clinical and administrative staff involved in the referral, intake, admission, care delivery, discharge, documentation, or coordination of services
- All patient populations (adult, pediatric, high-acuity, chronic, post-acute, palliative, etc.)
- All disciplines (RN, LPN, PT, OT, ST, MSW, Home Health Aide)
- All payer types (Medicare, Medicare Advantage, Medicaid, Medicaid Waiver, commercial insurance, workers' compensation, private pay, charity care/discounted care)

III. POLICY STATEMENT

QOC will provide timely, appropriate, and patient-centered admission and discharge processes that:

- Prioritize safety, quality, and continuity of care
- Ensure access to services regardless of ability to pay (see Exhibit 4 – Charity Care and Sliding Fee Scale Policy)
- Actively involve patients, families, and caregivers in all decisions
- Maintain compliance with all regulatory requirements
- Coordinate care with physicians, hospitals, and community providers
- Prevent inappropriate/unsafe discharge or abandonment of patients
- Support the highest possible clinical outcomes and patient satisfaction
- Begin discharge planning at admission and update throughout the episode of care
- Follow CMS and COMAR requirements for documentation and notification

IV. DEFINITIONS

Admission:
The formal acceptance of a patient for home health services based on medical necessity, physician order, eligibility, and agency capacity.

Discharge:
The completion or termination of home health services, either due to goal attainment, transition of care, patient choice, physician order, or specific clinical or safety reasons.

Interdisciplinary Team (IDT):
Registered Nurses, Licensed Practical Nurses, Physical Therapists, Occupational Therapists, Speech Therapists, Medical Social Workers, Home Health Aides, and administrative or clinical leadership collaborating on patient care.

Plan of Care (POC):
Comprehensive treatment plan ordered and approved by a physician in accordance with Medicare requirements (CMS Form 485 or electronic equivalent).

Homebound Status:
CMS criterion for Medicare patients indicating that leaving home requires considerable effort or assistance (not required for pediatric or certain Medicaid populations).

High-Acuity Patient:
A patient requiring complex clinical management (e.g., ventilator, tracheostomy, IV infusion, complex wound care, enteral feeding).

Medically Necessary Services:
Services required to treat illness, injury, or disability, ordered by a physician, and provided by qualified clinicians.

Patient Rights:
The legal and ethical rights afforded to all patients, detailed in QOC's Patient Rights & Responsibilities Policy (provided at admission).

V. ADMISSION PRINCIPLES

QOC admits patients in a manner that ensures:

- Timely access to medically necessary care
- Patient and family involvement in decision-making
- Equitable access regardless of payor, diagnosis, disability, or complexity
- Clinical appropriateness and safety
- Compliance with physician orders and regulatory requirements
- Immediate initiation of discharge planning to ensure continuity of care

QOC will **not** refuse admission based solely on:

- High-acuity or complexity of condition
- Disability or cognitive impairment
- Age (including pediatric or geriatric)
- Ability or inability to pay (see Charity Care Policy)
- Payor type (including Medicaid, Medicare, and uninsured)
- Geographic location within approved service area (Frederick, Carroll, Washington, Allegany, Garrett Counties)

VI. ADMISSION CRITERIA

A patient will be admitted when **all of the following apply**:

1. Clinical Eligibility

- The patient requires **skilled services** (nursing or therapy) as defined by CMS or payor
- The service is **medically necessary** to treat an illness or condition
- The patient's needs can be **safely met at home**
- The patient (or legal guardian) provides **informed consent**

2. Physician Involvement

- A **physician or allowed practitioner** (MD, DO, NP, PA) orders home health services
- The physician agrees to **review and sign the Plan of Care (POC)**
- The physician collaborates with QOC throughout the episode

3. Payor Eligibility

QOC accepts:

- Medicare
- Medicare Advantage
- Medicaid & Medicaid Waiver
- Commercial insurance
- Worker's compensation
- Private pay
- Veterans programs
- Charity care/discounted care (when eligible)

Inability to pay is NEVER a reason to deny admission.

4. Service Area

Patient must reside in one of the following six counties/jurisdiction from Maryland: Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties.

5. Homebound Status (Medicare-specific)

- Medicare patients must meet CMS homebound criteria unless exempt
- Pediatric, Medicaid waiver, or private insurance patients may not need to be homebound

6. Agency Capability

QOC must have the qualified staff, equipment, and resources to meet patient's needs safely and effectively.

VII. SPECIAL POPULATIONS SERVED

A. High-Acuity Patients

QOC accepts medically complex patients requiring:

- Tracheostomy care
- Ventilator support (invasive or non-invasive)
- Enteral or parenteral feeding
- IV infusion therapy
- Complex wound care
- PICC/central line management
- Ostomy care
- Post-operative care
- Chronic disease management (CHF, COPD, diabetes, dementia, oncology, etc.)

B. Pediatric Patients

QOC admits infants, children, and adolescents with:

- Congenital or genetic disorders
- Neuromuscular or neurological impairments
- Tracheostomy or ventilator dependence
- Feeding tube or nutritional support

- Failure to thrive
- Post-NICU/PICU transition
- Technology dependence or ongoing skilled needs

Pediatric admission includes:

- Consent from parent/legal guardian
- Collaboration with pediatric specialists or primary care provider
- Consideration of school or daycare coordination
- Age-appropriate safety and developmental assessment
- Inclusion of family training and education

C. Behavioral and Cognitive Considerations

QOC admits patients with cognitive or behavioral health conditions **when care can be delivered safely**.

QOC may involve social work, behavioral health providers, or caregivers as needed to ensure safety and cooperation.

VIII. REFERRAL & INTAKE PROCESS

QOC receives referrals from:

- Hospitals and discharge planners
- Skilled nursing and rehab facilities
- Physicians and specialists
- Case managers
- Medicaid waiver programs
- Insurance plans/managed care organizations
- Schools or pediatric programs
- Families or self-referrals

Intake Staff Responsibilities:

- Collect clinical information, demographics, and insurance details
- Confirm physician order or request one
- Screen for skilled need and appropriateness
- Verify service area eligibility

- Identify urgency (routine vs. priority vs. same day)
- Communicate with clinical management for high-acuity cases
- Explain services, patient rights, and financial policies
- Initiate benefits verification and authorization

No patient will be denied admission due to incomplete paperwork at referral.
Intake staff will assist patients/families in gathering necessary documentation.

IX. CLINICAL REVIEW & APPROVAL

An RN or Clinical Director reviews every referral to determine:

- Clinical appropriateness
- Required discipline(s)
- Complexity and staffing needs
- Safety considerations
- Need for special equipment or supplies
- Any potential risk factors
- Need for interdisciplinary team collaboration

The **Director of Nursing** and/or **Administrator** must approve any high-acuity or unusual cases to ensure staffing and resource readiness.

X. RAPID ADMISSION & HOSPITAL COORDINATION

To support hospital throughput and reduce readmissions:

- Standard admission begins **within 48 hours** of referral
- **Same-day or next-day** start of care for urgent or high-priority patients
- QOC may conduct **hospital or facility pre-discharge visits**
- QOC collaborates directly with hospital case managers or physicians
- QOC accepts referrals **7 days/week**
- QOC maintains an **on-call nurse** for urgent clinical coordination

This rapid, flexible admission model supports MHCC goals for timely post-acute transitions.

XI. INITIAL ASSESSMENT

A **comprehensive, in-home assessment** is performed by an RN or qualified therapist and includes:

- Physical exam and clinical status
- Functional, cognitive, and psychosocial assessment
- Medication reconciliation
- Pain and symptom management
- Fall risk evaluation
- Home safety and environmental review
- Social determinants of health (transportation, support, financial)
- Patient and caregiver education needs
- Cultural or language needs
- Emergency and contingency plans

For Medicare patients: OASIS assessment is completed as required.

XII. PLAN OF CARE (POC)

Following assessment, the clinician develops a patient-centered Plan of Care that includes:

- Diagnoses and clinical goals
- Types and frequency of services
- Interventions and treatment plan
- Equipment, supplies, or technology needs
- Safety measures and caregiver training
- Discharge planning considerations
- Interdisciplinary coordination

The POC is:

- Reviewed, approved, and signed by the physician (CMS Form 485 or EHR equivalent)
- Reviewed every 60 days or sooner if the condition changes
- Updated based on patient progress and/or new orders

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DISCHARGE POLICY

I. Discharge Planning

- Discharge planning starts **at admission** and is updated at every IDT review.
- The clinician discusses likely discharge goals, criteria, and needs with the **patient/caregiver and physician**; updates the plan of care as the condition evolves.
- Planning prioritizes **safety**, **continuity**, **patient goals/preferences**, and **timely transition** to the appropriate level of care.

II. Discharge Criteria

A patient may be discharged when one or more apply:

1. **Goals achieved / no further skilled need**
    - Wound closed; medication stabilized; therapy goals met.
2. **Maximum practical benefit reached**
    - Plateau despite appropriate interventions; transition to maintenance/outpatient.
3. **Patient choice / refusal / transfer**
    - Patient elects to stop services or move to another HHA/SNF/assisted living/hospice.
4. **Physician order to discontinue home health**
    - Document order and clinical rationale.
5. **Hospitalization or death**
    - If no return expected, complete discharge; if return expected, place on hold per payor rules.
6. **Unsafe environment / staff safety risk** *(last resort)*
    - After reasonable mitigation (family conference, MSW involvement, care plan adjustments), physician notified; safe alternative arranged.
7. **Nonadherence that makes care unsafe or ineffective** *(last resort)*
    - After documented education, problem-solving, and MD involvement, determine if alternate setting/provider is safer.

Important: QOC **does not discharge** simply because care is complex, costly, time-consuming, or because reimbursement is low/denied.

III. Discharge Protections & Patient Rights

- Patients are informed of rights at admission (see **Patient Rights & Responsibilities Policy**).
- QOC ensures **no abandonment**: a **safe alternative** (another provider or level of care) is offered/arranged whenever possible.
- Language/communication needs are accommodated; teach-back used to confirm understanding of discharge instructions.

IV. Medicare Requirements (NOMNC & Appeals)

For Medicare/MA patients:

- Provide the **Notice of Medicare Non-Coverage (NOMNC)** within required timeframes prior to planned discharge.
- Inform patients of their **right to appeal** through the QIO; continue services as required pending decision.
- Document timing, delivery, and patient understanding of NOMNC and any appeals.
- Coordinate with the plan/QIO and physician during appeal; maintain safe care until determination.

V. Discharge Notification & Orders

- **Planned discharges:**
  - Notify patient/family **verbally and in writing**; document consent/understanding.
  - Notify and obtain **physician order** prior to discharge (unless patient refuses services).
  - Give **advance notice** (generally ≥48 hours) when feasible.
- **Urgent discharges (safety/behavioral risk):**
  - Notify physician **immediately**; document risks and mitigation; ensure safe transition where possible.

VI. Transfer to Another Agency/Level of Care

- With patient consent, QOC coordinates transfer to another HHA, SNF, IRF, LTACH, outpatient clinic, hospice, or community program.
- QOC provides a **warm handoff**: direct clinician-to-clinician communication whenever possible, and timely transmission of the discharge/transfer summary and relevant records.

VII. Discharge Summary

Complete within 48 hours of discharge (matches your prior policy). Summary includes:

- Reason for discharge and type (planned, transfer, refusal, hospitalization, death)
- Patient condition/status at discharge (clinical, functional, psychosocial)
- Services provided and **goals achieved/not achieved** with rationale
- **Medications** at discharge; outstanding orders/monitoring needs
- Education provided; caregiver competence/teach-back confirmed
- **Equipment/supplies** in home; vendor contacts
- Referrals made (e.g., outpatient PT, wound clinic, MSW, community resources)
- **Follow-up appointments** (PCP/specialist) and who scheduled them
- Physician notification and final orders
- NOMNC/appeal information (when applicable)
- Contact information for questions post-discharge

VIII. Continuity of Care & Post-Discharge Follow-up

- Provide written discharge instructions (plain language; patient's preferred language).
- Send discharge summary and key documents to the **physician/next provider** promptly.
- **Follow-up calls**:
  - **Day 3** to confirm safety, meds, wound/therapy plan, equipment in place.
  - **Day 7** to reassess status, barriers, and address problems—helps reduce readmissions.
- For high-risk patients (e.g., CHF, COPD, complex wounds), consider an extra check-in within **24–48 hours**.

IX. Documentation Standards

- Document all notifications, patient/caregiver education, physician communications, NOMNC/appeal steps, and handoffs.
- File the discharge summary and related artifacts in the **EHR within 48 hours**.
- Use standardized checklists to ensure completeness and consistency.

X. Roles & Responsibilities

- **Primary Clinician (RN or lead therapist):** coordinates discharge plan; completes summary; educates patient/caregiver.
- **Physician/Allowed Practitioner:** reviews progress; issues discharge/transfer orders; collaborates on plan.

- **Therapists (PT/OT/ST):** update functional status, equipment needs, and outpatient plans.
- **Medical Social Worker:** addresses psychosocial barriers; links to community resources; assists with safe disposition.
- **Home Health Aide:** provides input on daily function/self-care; reinforces education.
- **Intake/Scheduling/Billing:** finalize logistics, benefits, and notify payor as needed.

XI. Quality & Compliance Integration

- Admission timeliness, unplanned discharges, appeals, readmissions within 30 days, and post-discharge call completion are tracked in **QAPI**.
- **Case reviews** are performed on discharges related to safety/nonadherence to ensure appropriate mitigation steps were taken and no abandonment occurred.
- Trends inform staff education, process improvement, and resource allocation.

XII. Policy Governance

- Reviewed at least **annually**; updated to maintain compliance with **CMS Conditions of Participation (42 CFR 484.50 & 484.58)**, **COMAR 10.24.16.08 A/B/G/I/K**, and **Joint Commission** standards.
- Staff receive training on any changes; compliance is monitored via chart audits and QAPI metrics.

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

APPEALS, DOCUMENTATION, QUALITY, GOVERNANCE

I. Patient Appeals & Grievances

Patients have the right to voice concerns without fear of retaliation.
QOC maintains a **formal grievance and appeal process** consistent with Medicare Conditions of Participation and QOC's **Patient Rights & Responsibilities Policy.**

Patients may appeal:

- Denial of admission
- Proposed discharge or reduction in services
- Quality concerns
- Staff behavior or communication
- Any aspect of their care

Appeal process:

1. Patient/family may submit verbally or in writing.
2. QOC leadership reviews within **5 business days.**
3. A written response is provided with findings and resolution.
4. Unresolved issues may be escalated to **external agencies** (e.g., MDH, MHCC, CMS, Joint Commission).

For **Medicare beneficiaries:**

- QOC will provide the **Notice of Medicare Non-Coverage (NOMNC)** before discharge.
- Patients have the right to a **fast appeal** through the **Quality Improvement Organization (QIO)**.
- QOC will comply with all QIO determinations and continue care as required during appeals.

II. Documentation Requirements

QOC maintains complete and accurate records for all admissions and discharges in accordance with CMS, COMAR, and Joint Commission requirements. Documentation includes:

- Referral and intake data
- Initial and comprehensive assessments
- Home safety and environmental evaluations
- Plan of Care (physician-signed and updated)
- Interdisciplinary notes and communications
- Discharge planning activities
- Physician notifications and orders
- NOMNC and appeal documentation (if applicable)
- Final discharge summary (completed within **48 hours**)
- Referrals and handoff documentation
- Patient education and follow-up contact

All documentation is securely maintained in the Electronic Health Record (EHR).

III. Quality Assurance & Performance Improvement (QAPI) Integration

QOC uses admission and discharge data to monitor and improve performance.
The following indicators are reviewed regularly:

Admission-related Metrics:

- Time from referral to admission (48-hour target / same-day options)
- Admission delays and root causes
- High-acuity and pediatric admissions

Discharge-related Metrics:

- Discharge reasons by category (goals met, patient refusal, transfer, safety)
- Unplanned discharges
- 30-day hospital readmission rates
- Discharge documentation timeliness (<48 hours)
- Post-discharge follow-up completion (Day 3 and Day 7)
- Medicare appeals and outcomes

Quality & Patient Experience:

- Patient/caregiver satisfaction
- Continuity of care outcomes

- Identified barriers to care
- Staff competency and training needs
- Opportunities for improvement

Actions from QAPI may include:

- Staff education or re-training
- Process changes
- Policy updates
- Resource allocation
- Collaboration with referral partners

IV. Staff Training & Competencies

All staff involved in referral, admission, service delivery, and discharge are trained on:

- This Admission & Discharge Policy
- Patient Rights & Responsibilities
- CMS Conditions of Participation
- COMAR 10.24.16 standards
- Documentation requirements
- Communication protocols
- Cultural competence and health equity
- Pediatric and high-acuity care processes (as applicable)

Training is provided:

- During orientation
- Annually
- As needed based on QAPI findings or regulatory changes

Competency is validated through:

- Skills checklists
- Direct observation

- Chart audits
- Performance reviews

V. Policy Review & Governance

This policy is reviewed **annually** by:

- Director of Nursing / Clinical Director
- Administrator / Executive Leadership
- QAPI Committee
- Compliance Officer (if applicable)

QUALITY ONE CARE HOME HEALTH, INC

~ We Care with Golden Hands ~

Quality One Care
HOME HEALTH, INC

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Phone: +1 (301) 658-7141 / Email: info@qualityonecare.com

Web: https://www.qualityonecare.com

TABLE OF CONTENTS

WELCOME TO QUALITY ONE CARE

Dear Patient and Family Members,

Welcome, and thank you for choosing Quality One Care Home Health, Inc (QOC). We are honored to have you as a client and appreciate the opportunity to provide care within the comfort of your home. QOC is dedicated to offering a comprehensive range of home health services aimed at promoting, maintaining, and restoring health, while also minimizing the impact of illness and disability.

Our commitment is to deliver high-quality care through our compassionate and dedicated staff, which includes nurses, home health aides, and other professionals who empathize with your concerns during times of illness and the need for home care.

This booklet is designed to furnish you with essential information regarding your home care services. We encourage you to carefully review all the contents within this booklet. Should you have any concerns or questions about our services, please do not hesitate to reach out to any member of our management team. You can find their contact information, along with other important phone numbers, in this booklet and on your home care chart.

Wishing you a swift recovery!

Mohamed Matope, RN
Director

HOURS OF OPERATION

Hours of Operation:

Quality One Care Home Health Inc (QOC) office hours are Monday through Friday, from 9:00 am to 5:00 pm, except during company holidays.

For All Life-Threatening Emergencies:

In the event of a life-threatening emergency, please dial 911 immediately, then notify Quality One Care Home Health Inc. at 301-658-7141.

After Hours Coverage:

We offer 24-hour on-call service, seven days a week, ensuring you receive necessary home care services. In a medical emergency, proceed to the nearest hospital emergency room or dial Emergency Medical Services (911). Please refer to the On-Call Guidelines on Page 5 for further information.

Weather Conditions:

During seasons of inclement weather, such as snow, ice, or floods, we strive to maintain home care visits. However, the safety of our staff is paramount. If road conditions pose hazards, our staff will attempt to contact you by phone to inform you of any visit cancellations or schedule changes.

Emergency Preparedness Plan:

In cases of environmental or natural disasters (e.g., earthquake, blizzard, flood), or emergencies, we have an emergency plan in place to ensure continuity of patient services. Every effort will be made to meet your medical needs during such events.

All patients are assigned a priority level Code that is updated as needed. The code assignment determines the agency's response priority in case of a disaster or emergency. These codes are maintained in the agency's office, along with information that may be helpful to Emergency Management Services in case of an area disaster or emergency.

On-Call Guidelines:

A licensed nurse is always on call at our agency and is available after regular office hours. If you experience a change in your condition, please try to contact the office during regular office hours so that we can assess whether a visit is necessary and communicate with your physician if needed. However, we are available after regular office hours for urgent conditions only. Please note that we do not carry medications with us and cannot administer anything unless it has been ordered by your physician. Below is a list of some reasons for which you may need to contact our agency after regular hours:

- **Chest Pain:** Chest pain usually requires that you be seen by your physician either in the office or emergency room for diagnostic studies.
- **Fever:** Elevations in temperatures above 100°F should be called in, and instructions may be given over the telephone. A home visit may be necessary.
- **Respiratory Distress:** Severe respiratory distress usually requires evaluation by your physician. You may be instructed in ways to ease shortness of breath, proper use of respiratory aids, or oxygen if these are ordered by your physician.
- **Catheters:** Catheters are not an emergency unless you are unable to urinate. Usually, someone can wait 6-8 hours at night without a catheter if they are not taking in liquids. If the catheter does not drain or comes out and you are unable to urinate, you may need to call. You will be taught to either irrigate or remove the catheter if it becomes stopped up. If it is leaking or comes out, pad yourself well with absorbent cloths and call early in the morning so someone can be scheduled to visit.
- **GJ Tubes:** If the GJ-Tube dislodges (comes out) place lower size G-Tube to keep stoma open. Do not use it. Send the patient to the emergency room.

Calls or Injuries:

Notify the on-call nurse or call 911. Routine supplies or equipment cannot be delivered after regular hours. Any questions you may have concerning these guidelines can be answered by your nurse or by calling the office during regular office hours.

CUSTOMER SATISFACTION

Your satisfaction is of utmost importance to us. If there is anything unclear about our services, the care you receive, or if you feel you are not receiving the care you require, please do not hesitate to ask questions. Periodically, our agency conducts a Patient Satisfaction Survey to gather feedback. Your responses are invaluable in helping us enhance our services and ensure that we consistently meet your needs and expectations. If you have any concerns or suggestions, we encourage you to share them with us. Your input helps us continuously improve and provide the best possible care.

PLAN OF CARE, TREATMENTS & SERVICES

We actively engage you, your caregiver, or designated representative, along with key professionals and staff members, in developing your personalized plan of care, treatment, and services. This plan is crafted based on identified problems, needs, and goals, as well as physician orders for medications, care, treatment, and services. It considers timeframes, your environment, and your personal preferences whenever possible. The overarching goal of this plan is to enhance your ability to care for yourself effectively. Moreover, effective pain management is recognized as a crucial component of your treatment.

Moreover, effective pain management is recognized as a crucial component of your treatment. We are committed to ensuring that your pain is addressed and managed appropriately throughout your care journey.

The plan may encompass various interventions and goals tailored to meet your specific needs, including but not limited to:

- Nursing care
- Medication management
- Personal care assistance
- Discharge planning and coordination.

Each of these interventions and goals will be customized to address your individual requirements, enhance your well-being, and facilitate your recovery and overall health. Our team is dedicated to working collaboratively with you and your caregivers to ensure that the plan is comprehensive, effective, and aligned with your preferences and objectives.

The plan is subject to regular review and updates as necessary, to ensure it remains responsive to your evolving needs. We actively encourage your participation in this process and are committed to providing any pertinent medical information to support you effectively.

It's important to acknowledge that you have the right to refuse any medication or treatment procedure. However, in such instances, we may request a written statement releasing the agency from any liability arising from such actions. We will, however, urge you to engage in discussions with your physician for advice and guidance regarding your decision.

Furthermore, please promptly inform the agency if you choose to enroll in Medicaid/Medicare, a private Health Maintenance Organization (HMO), or Hospice. It's worth noting that Medicaid/Medicare coverage for the services we provide may be affected if you are enrolled in an HMO or Hospice. Therefore, timely notification ensures appropriate adjustments can be made to your care plan and billing arrangements.

If Medicaid/Medicare home health services are denied, you will not be held liable for charges unless you have received notification from QOC stating that we understand certain services are no longer covered by Medicaid/Medicare. It's important to note that Medicaid/Medicare does not cover part-time or full private daily nursing or aides at home, prescribed or over-the-counter medications, or home-maker services or meals delivered at home. We will communicate any changes in coverage or services provided by Medicaid/Medicare to ensure transparency and clarity regarding your financial responsibilities.

If you are receiving Medicaid/Medicare benefits, you may receive a Medicaid/Medicare Summary Notice (MSN) after we have submitted a final claim for services. The MSN will detail the services provided, charges billed to Medicaid/Medicare on your behalf, and the amount Medicaid/Medicare paid. It's important to note that the MSN is not a bill; rather, it serves as a summary of the services rendered and the associated Medicaid/Medicare payments.

Should any changes occur in this policy regarding services or charges, you or your responsible party will be promptly notified. If you have any questions or concerns regarding charges or insurance billing, please don't hesitate to contact our office. We're here to provide clarification and assistance whenever needed.

GUIDELINES FOR INSURANCE BENEFITS IN HOME CARE

Insurance pays 100% for home care services if the following criteria is met:

1. **Homebound Status:** You are considered homebound if, due to illness or injury, it requires considerable effort for you to leave home, and your absences are infrequent or of relatively short duration. Exceptions include attending religious services, receiving healthcare treatment, or attending unique and infrequent special events such as family reunions, funerals, or graduations.

2. **Eligible Insurance Beneficiary:** You are an eligible insurance beneficiary under the care of a doctor who has ordered treatment. This care must be deemed reasonable and medically necessary by your healthcare provider.

3. **Skilled Care Requirement:** You require skilled care that can only be provided by licensed health professionals. These professionals may include nurses, physical and occupational therapists, speech-language pathologists, and medical social workers. You may also be eligible for a home health aide.

4. **Intermittent Care Need:** You need care on an intermittent basis, meaning that professional staff will visit your home to provide assessments, treatment, and teaching as ordered by your doctor. Insurance does not typically cover extended periods of time for healthcare staff to remain with you at home. The duration of the visit is determined by the specific treatment ordered by your doctor.

It's essential to verify your insurance coverage and consult with your healthcare provider to ensure that the services you require meet the eligibility criteria outlined by your insurance plan.

Insurance will send you an Explanation of Benefits (EOB). An EOB is not a bill; rather, it serves to detail the charges for your home care services and the payment made by your insurance to Quality One Care Home Health.

It's important to note that Quality One Care Home Health may bill you for any copayment or deductible portion not covered by your insurance payment.

Recognizing that insurance information is subject to change, we kindly request that you promptly notify us if you acquire any other insurance coverage or opt for a managed care insurance plan. This ensures that our records remain accurate and up to date.

If you have any questions regarding your insurance or need to update your information, please don't hesitate to call us at +1 (301) 658-7141. We're here to assist you with any inquiries you may have.

SCOPE OF SERVICES

Skilled Nursing Care encompasses a range of specialized services, including:

- Colostomy Care
- Diabetic Management and Education
- Medication Management
- Medical Management
- Pain Management
- Post-Surgical Care
- Wound Care
- Clinical Monitoring and Case Management
- Patient Education and Support
- IV Therapy Administration and Teaching, including Central Venous Catheter Care and Management
- Nutritional Support, including Enteral Nutrition and Total Parenteral Nutrition (TPN)

These skilled nursing interventions are designed to address various healthcare needs and promote your overall well-being under the guidance of trained and licensed nursing professionals.

Physical Therapy Services are tailored to assist individuals dealing with acute nerve, orthopedic, or muscle disorders. Your therapist will develop a customized program that includes light exercise or stretching activities aimed at improving movement and mobility. This routine is designed to address your specific condition and help you regain functionality, reduce pain, and enhance your overall quality of life.

The benefits of therapy may include improvement in your strength, joint mobility, pain management, cardiopulmonary status, skin integrity, endurance, energy management, wound healing, adaptation to environment, equipment management, secretion elimination, safety awareness, and posture. Physical therapy may also increase your functional ability, muscle relaxation, motor control, balance, and coordination. Therapy may decrease or eliminate pain, minimize impairment, and remove necrotic tissue.

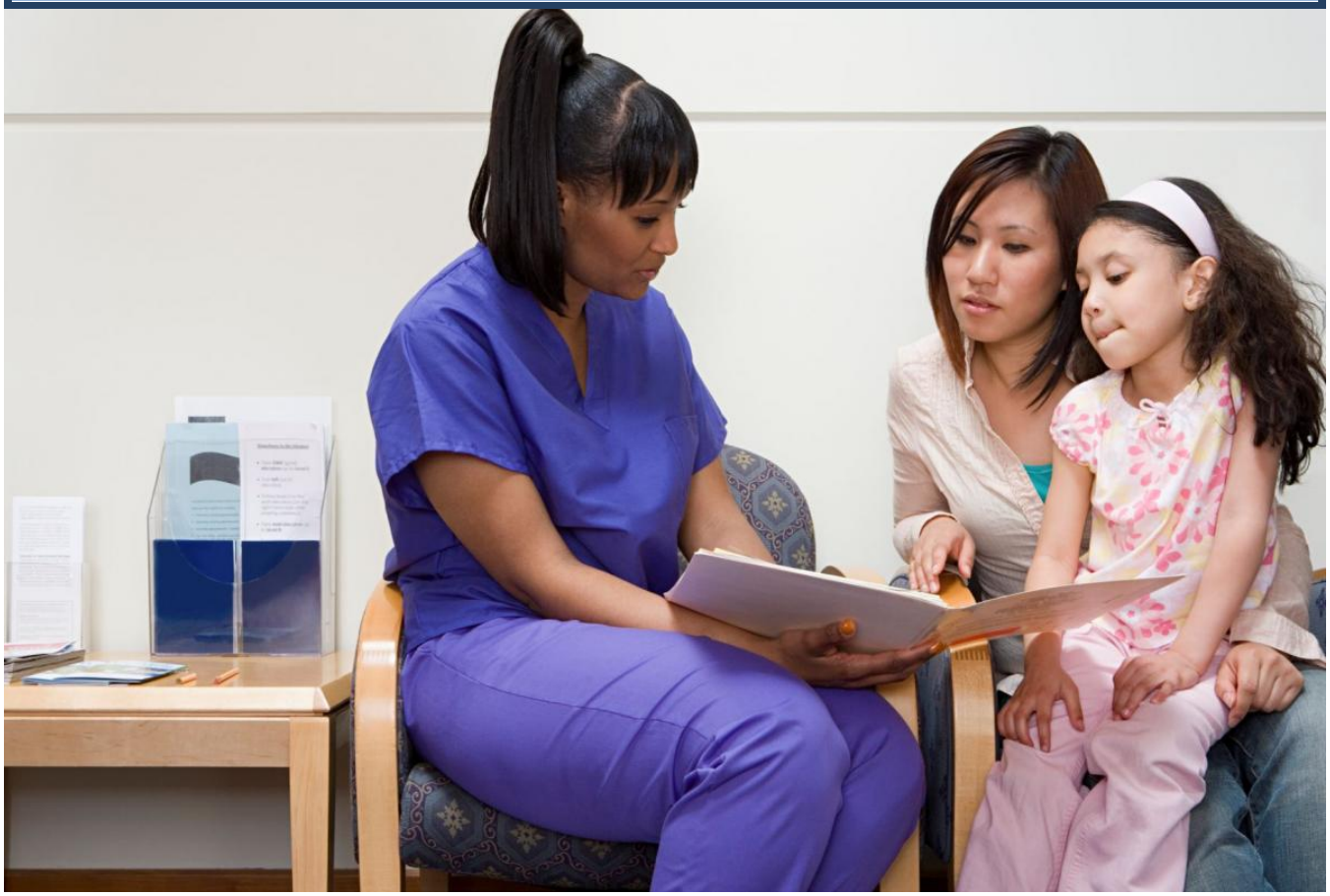
The risks associated with physical therapy may include muscle soreness, strain, or sprain; skin breakdown, redness, irritation, or burns; increase in pain; fatigue, edema, bleeding at the debridement site, fainting, increased tingling in your upper or lower extremities, shortness of breath, deterioration in your diagnosis, and if you have cancer, increased growth of cancer.

Occupational Therapy Services focus on assisting individuals in regaining fine motor coordination and enhancing activities of daily living (ADLs) such as dressing and feeding. These services are specifically tailored to address your unique needs and challenges, aiming to improve your independence and quality of life. Through targeted interventions and personalized strategies, occupational therapists work with you to enhance your ability to perform everyday tasks and achieve greater autonomy in daily living.

Speech Therapy Services aim to enhance communication skills for individuals experiencing impaired language and speech, cognitive function issues, or difficulties with chewing or swallowing. Through personalized interventions and exercises, speech therapists work with patients to address specific challenges and improve overall communication abilities. Whether it's enhancing language comprehension, articulation, cognitive abilities, or addressing swallowing difficulties, speech therapy is tailored to meet the unique needs of everyone, ultimately striving to improve their quality of life and functional independence.

Home Health Aide Services are recommended to support activities of daily living (ADLs) and assist individuals in regaining fine motor coordination and improving their ability to perform tasks such as dressing and feeding, among others. These services are designed to provide personalized assistance and support to individuals who may require help with various ADLs due to illness, injury, or other health conditions. Home health aides work closely with patients to promote independence and enhance their overall quality of life by helping with tasks essential for daily functioning.

KNOW YOUR RIGHTS



As our patient, you and your family or caregivers have the right to be actively involved in your care. We respect your autonomy and strive to ensure that your preferences and concerns are taken into consideration.

1. **You have the right to be treated with consideration, respect, and dignity, and to receive appropriate and quality service in a timely manner without discrimination based on age, race, sex, handicap status, national origin, or sexual preference.** Both patients and caregivers are entitled to mutual respect and dignity. Our staff is strictly prohibited from accepting gifts or borrowing from you. This ensures a professional and ethical relationship between our staff and those under our care.

2. **You have the right to receive information in a manner that is understandable to you.** We are committed to providing clear and concise communication regarding your care, treatment, and services, ensuring that you have the information necessary to make informed decisions about your health and well-being. If you have any questions or concerns about the information provided, please don't hesitate to ask, and we will do our best to clarify and address them.
3. **You have the right to participate in the planning or changes in your plan of care, treatment, and services whenever possible and to the extent that you are competent to do so.** Additionally, **you have the right to be informed of any changes in the care, treatment, and services provided by the home health agency.** Your input and involvement are valuable in ensuring that your care plan aligns with your preferences, needs, and goals. We are committed to keeping you fully informed and involving you in decisions about your care.
4. **You have the right to be instructed in appropriate care techniques.** Our team provides you with the necessary knowledge and skills to manage your care effectively. Whether it involves wound care, medication management, mobility assistance, or any other aspect of your care, we will ensure that you receive clear and thorough instructions tailored to your specific needs. Our goal is to empower you with the knowledge and confidence to participate actively in your own care and promote your overall well-being.
5. **You have the right to make informed treatment decisions and retain the autonomy to refuse any portion of planned care, treatment, or services without relinquishing other portions of the treatment plan, except when there are medical contraindications to partial treatment.** We respect your right to actively participate in decisions about your health and well-being. Our team will provide you with comprehensive information about your treatment options, including the risks, benefits, and alternatives, to support you in making decisions that align with your preferences and values. Your choices will be respected, and we will work with you to ensure that your care plan reflects your individual needs and goals.
6. **You have the right to be educated about your pain management options, as well as the role your family can play in managing pain when appropriate.** Our team is committed to providing you with comprehensive information about the potential limitations and side effects of pain treatments, empowering you and your family to make informed decisions about your care. We will work closely with you to develop a personalized pain management plan that addresses your individual needs and preferences while minimizing any potential risks. Your comfort and

well-being are our top priorities, and we are here to support you every step of the way in managing your pain effectively.

7. **You have the right to receive care without discrimination based on whether an advance directive has been executed.** Regardless of your decisions regarding advance directives, you will be treated with dignity, respect, and the same high standard of care. Our commitment to providing quality care is unwavering, and we will ensure that your wishes and preferences are honored to the best of our ability, in accordance with ethical and legal guidelines. You can trust that you will receive compassionate and equitable care from our team, regardless of your advance directive status.
8. **You have the right to expect privacy and confidentiality regarding your written, verbal, and electronic information, including your clinical record, medical care program, and social and financial circumstances related to your care.** We are committed to maintaining the confidentiality of your personal and health information in accordance with applicable laws and regulations. Our Notice of Privacy Practices provides detailed information about your rights regarding privacy and confidentiality. Your trust is important to us, and we take all necessary measures to safeguard your information and ensure that it is only shared when appropriate and authorized.
9. **You have the right to receive assistance in coping with the eventuality of death.** Our team is here to provide support and guidance to you and your loved ones during this difficult time. We understand that facing the end of life can be challenging, and we are committed to offering compassionate care and resources to help you navigate this journey with dignity and peace of mind. Whether it involves emotional support, spiritual guidance, or practical assistance with end-of-life planning, we are here to support you every step of the way. You are not alone, and we will do everything we can to ensure that you and your loved ones feel supported and cared for during this time of transition.
10. **You have the right to receive reasonable continuity of service.** We provide consistent and reliable care to meet your ongoing needs. Our goal is to ensure that you receive the necessary support and assistance on a regular basis, maintaining continuity in your care plan to promote your health and well-being. We strive to minimize disruptions and ensure that you can rely on our team for the care and assistance you require, fostering trust and confidence in our services. If there are any changes or disruptions to your care, we will communicate with you promptly and

work to address any concerns to the best of our ability. Your continuity of care is important to us, and we are committed to providing the support you need to live your best life.

11. **You have the right to receive, upon request, information concerning the identity and responsibilities of the individuals responsible for your health care.** We are committed to transparency and will provide you with information about the members of our team who are involved in your care, including their roles and responsibilities. If you have any questions or concerns about your care providers, please don't hesitate to ask, and we will ensure that you have the information you need to feel informed and confident in the care you receive. Your comfort and peace of mind are important to us, and we are here to support you every step of the way.
12. **You have the right to have your property, personal privacy, and security treated with respect during home care visits.** We are committed to ensuring that your home environment is respected and that your privacy and security are always maintained. You have the right to unlimited contact with visitors or others, and we will facilitate private communication with these individuals as needed. Your home is your sanctuary, and we will take all necessary precautions to ensure that you feel comfortable and secure while receiving care. If you have any concerns about privacy or security during home care visits, please let us know, and we will address them promptly to ensure your peace of mind.
13. **You have the right to be informed of the various health care disciplines providing care or services and the frequency of proposed visits.** We are committed to transparency and will provide you with clear information about the different healthcare professionals involved in your care, as well as their roles and responsibilities. Additionally, we will communicate the frequency of proposed visits, ensuring that you are informed about the schedule and timing of appointments.

    Our goal is to keep you fully informed and involved in your care plan, empowering you to make informed decisions about your health and well-being. If you have any questions or concerns about the disciplines providing care or the frequency of visits, please don't hesitate to ask, and we will be happy to provide clarification and address any concerns you may have.

14. **You have the right to be fully informed, verbally and in writing, of the following:**
    - All items and services furnished by the home health agency for which payment may be made under Medicaid/Medicare.
    - The coverage available for items and services under Medicare, Medicaid, and any other federally funded program for which the home health agency is responsible.
    - Any charges for items and services not covered under Medicare, Medicaid, and/or private insurance, including the approximate maximum dollar amount that the individual may have to pay for items and services furnished by the home health agency.
    - Any changes in the charges for items and services for which the individual may be liable within thirty (30) calendar days of the changes, to the extent that the home health agency is aware.

    We are committed to providing clear and transparent information about your coverage and any associated costs, ensuring that you have a complete understanding of your financial responsibilities. If you have any questions or concerns about billing or charges, please do not hesitate to reach out, and we will be happy to provide clarification and assistance. Your peace of mind is important to us, and we are here to support you every step of the way.
15. **You have the right to receive, upon request, a fully itemized billing statement, including the date of service and unit charge for each item or service provided.** We are committed to transparency and accountability in our billing practices, and we will provide you with detailed information about the charges associated with your care. If you have any questions or concerns about your billing statement, please don't hesitate to reach out, and we will be happy to provide clarification and assistance. Your satisfaction and understanding are important to us, and we are here to ensure that you have the information you need regarding your financial responsibilities.
16. **You have the right to receive, upon request, the Agency's policy on uncompensated care.** We are committed to providing transparency regarding our policies and procedures, including those related to uncompensated care. If you would like to learn more about our approach to uncompensated care or have any questions about our policies, please feel free to reach out, and we will be happy to provide you with the information you need.

    Your understanding and peace of mind are important to us, and we are here to support you every step of the way.

17. **You have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation.** We are committed to providing a safe and supportive environment for all individuals under our care, and we strictly prohibit any form of abuse or neglect. Our team is trained to recognize and prevent instances of abuse or exploitation, and we take all necessary measures to ensure the safety and well-being of our clients.

    If you ever feel that your rights are being violated or that you are experiencing any form of mistreatment, please don't hesitate to reach out to us immediately. Your safety and dignity are our top priorities, and we are here to support you and address any concerns you may have.
18. **You have the right to file a written complaint with the agency, with the assurance that said complaint will be duly investigated by our agency and that a copy of a written summary report will be offered to you.** We take all complaints seriously and are committed to addressing any concerns you may have in a prompt and thorough manner. You have the right to voice your grievances without fear of coercion, discrimination, or reprisal, and we will ensure that your care, treatment, or services are not unreasonably interrupted for voicing grievances. Your feedback is important to us, and we are dedicated to continuously improving our services based on your input. If you have any concerns or complaints, please don't hesitate to reach out, and we will do everything we can to address them and ensure your satisfaction.
19. **You have the right to voice a complaint, including concerns about advance directives implementation, or to ask questions about home health care without fear of discrimination or reprisal, please call any of our clinical supervisors at (301) 658-7141 between 9:00 am and 5:00 pm, Monday through Friday.** Your feedback is valuable to us, and we are committed to addressing any concerns you may have promptly and effectively.

    If you feel that Quality One Care was not able to resolve your complaint satisfactorily, you can contact the Department of Health and Mental Hygiene (DHMH) as a last resort. Your right to voice complaints and seek resolution is important to us, and we encourage you to reach out if you have any concerns about your care or services. We are here to support you and ensure that your needs are met to the best of our ability.

20. **You have the right to have your cultural, psychosocial, spiritual, personal values, beliefs, and preferences respected.** At Quality One Care, we are committed to providing culturally sensitive and inclusive care that honors your individuality and uniqueness. We do not discriminate based on social status, political belief, sexual preference, race, color, religion, national origin, age, sex, or handicap status. Your dignity and autonomy are paramount, and we strive to create an environment where you feel valued, understood, and respected. If you have specific cultural or personal preferences that you would like us to consider in your care, please let us know, and we will do our best to accommodate your needs. Your well-being is our priority, and we are here to support you in living a fulfilling and meaningful life according to your own values and beliefs.
21. **You have the right to have your family involved in decision-making as appropriate concerning your care, treatment, and services, when approved by you or your surrogate decision-maker and when allowed by law.** At Quality One Care, we recognize the importance of family involvement in the healthcare decision-making process. Your family members can provide valuable support and insight into your preferences and needs, and we welcome their input when it comes to planning your care.

    However, we also respect your autonomy and recognize that you may have specific wishes regarding who is involved in your care decisions. If you prefer to have family members involved, we will work closely with you to ensure that their participation is aligned with your preferences and best interests. Additionally, we will always adhere to relevant legal requirements regarding decision-making and confidentiality.

    Your comfort and well-being are our top priorities, and we are committed to working collaboratively with you and your family to develop a care plan that meets your unique needs and preferences. If you have any questions or concerns about family involvement in your care, please don't hesitate to discuss them with us. We are here to support you every step of the way.

22. **You have the right to access, request changes to, and receive an account of disclosures regarding your own health information as permitted by law.** At Quality One Care, we are committed to protecting your privacy and confidentiality, and we adhere to all applicable laws and regulations regarding the handling of your health information.

    If you would like to access your health information, request changes to it, or receive an account of disclosures, please contact us, and we will provide you with the necessary forms and guidance to facilitate these requests. We understand the importance of maintaining control over your health information and will work closely with you to ensure that your rights are respected and upheld.

    Your privacy and confidentiality are of the utmost importance to us, and we provide you with the information and support you need to make informed decisions about your care. If you have any questions or concerns about accessing or managing your health information, please don't hesitate to reach out to us. We are here to assist you every step of the way.

These rights are intended to empower you and ensure that your healthcare experience is centered around your needs, preferences, and goals.

KNOW YOUR RESPONSIBILITIES

As our patient, you have the responsibility to:

- Remain under a physician's care while receiving the Agency services and inform the Agency whenever you change physicians.
- Provide the Agency with a complete and accurate health history to plan and carry out care.
- Inform Agency staff about any changes in your health status, condition, treatment, medication, including re-hospitalizations, doctor's appointments, as well as the need for home care visit schedule changes.
- Provide the Agency with all requested insurance and financial information/records.
- Sign or have your legal representative sign the required consents and releases for insurance billing.
- Participate in your plan of care by following the mutually agreed-upon home care treatment plan so that you can fully benefit from home care services.
- Inform the Agency if you do not understand or are unable to take part in your own care.
- Arrange for a family member or friend who is willing, available, and capable of providing your care if you are unable to care for yourself.
- Recognize the responsibility of the Agency to reduce services as your condition improves and discontinue services once the goals of care have been met.
- Be available to the Agency staff for home visits at reasonable times.
- Notify the Agency if you are going to be unavailable for a visit.
- Treat the Agency personnel with respect and dignity without discrimination as to color, religion, sex, or national or ethnic origin.
- Notify the Agency of any problems or dissatisfaction with your care.
- Accept the consequences for any refusal of treatment or choice of noncompliance.
- Provide the Agency personnel with a safe home environment in which your care can be provided.
- Inform the Agency if you are no longer homebound and, therefore, no longer entitled to home care services.

By fulfilling these responsibilities, you contribute to the effectiveness and success of your care plan and help ensure the best possible outcomes for your health and well-being. If you have any questions or concerns about your responsibilities as a patient, please don't hesitate to discuss them with us. We are here to support you in your journey to better health.

While the Agency is providing you with home health services, it is important that you focus on your care. Therefore, we want to ensure that you understand your financial responsibility and address any questions you may have before the start of care. You will then be required to sign a Service Agreement/Patient Responsibility form. This gives the Agency the authority to complete the necessary paperwork and bill you or your health insurer directly for your care. We will bill you or your insurer weekly or at an agreed-upon interval, and payments are due upon receipt. Other accrediting bodies, licensing, or certifying agencies may also review the Service Agreement.

During the admission visit, the admitting clinician will ask you to provide your insurance information. Even if you have already provided this information, we will need to see it again to ensure that the information we have is correct. Information you may be asked to provide includes, but is not limited to, the following:

- Complete insurance identification numbers.
- Names and addresses of all insurance policies you and your spouse have.
- Names of policyholders.

Most health insurance companies or third-party payers, such as Medicare, Medicaid, Blue Cross, and managed care companies, offer home health coverage. The amount of coverage varies, but it can be as high as 80% to 100%, leaving you with a small to no co-payment. Most of these payers cover most of the services we offer, such as nursing, therapy, and medical social work.

In cases where the services you require are not covered by your insurance, you have the option of paying for these services if you decide to accept the uncovered services. Most third-party payers allow for direct billing by the Agency. In the cases of those who do not, you will be billed directly by the Agency and responsible for the charges. Check with your insurance company to determine if they will send payment to the Agency directly or reimburse you for what you pay to the Agency directly.

If you anticipate having difficulty paying for services for which you are responsible, let us know. The agency will work with you to develop a payment plan based on your income and expenses. If you have no resources, we can advise you on how to apply for medical assistance. If you are ineligible for medical assistance, please ask if the Agency has any charitable funds available for which you may apply. If you have any questions about the agency bill, please give us a call. We will be happy to assist you.

YOUR DOCTOR'S RESPONSIBILITIES

Your doctor's signature is legally required on the treatment plan for home care services to be provided. The treatment plan, which includes specific medical orders, is sent to your doctor to sign, and return to the Agency.

SCHEDULING AND CANCELING VISITS

Your Scheduled Visits: Your primary nurse will discuss with you the number and frequency of visits you will need as part of your home care plan. The names of your home care staff and the telephone number for the home care office will be provided for your convenience.

Canceling Visits: In today's healthcare environment, we must be very conscious of using our staff's time wisely. We understand that sometimes you may need to cancel a visit, especially when you have a doctor's appointment. When this is necessary, we require that you call the Agency to inform the supervisor or scheduler about the schedule change. Please provide your name, address, and the name of the nurse, therapist, or home health aide, who needs to know about the cancellation. This will prevent staff from coming to your home to deliver service when you are not there. We are here to work with you and your doctor to help you meet the goals of your care. This becomes challenging if there are frequent cancellations. Please be aware that after three (3) cancellations for reasons other than a doctor's appointment, or if we visit you three (3) times and you are not home, we may discontinue services after notifying you and your doctor. This notification will be provided in writing, along with the names of three other agencies that you may contact to receive home care services.

MAKING DECISIONS ABOUT YOUR MEDICAL CARE

The law recognizes three ways of making healthcare decisions for the future, including decisions about treatments needed to sustain life. These three ways are an advance directive, a power of attorney for healthcare, and a documented discussion with your physician.

- **Advance Directive (also known as Living Will or Healthcare Instructions):** This is a written document that outlines a person's preferences for medical treatment if they become unable to communicate their wishes due to illness or incapacity.
- **Durable Power of Attorney for Healthcare (also known as Appointment of Healthcare Agent):** This is a legal document that designates a healthcare agent to make medical decisions on behalf of a person if they become incapacitated and are unable to make decisions for themselves.
- **Documented Discussion with Physician:** This refers to a recorded conversation or note in your medical record where you discuss and make decisions regarding the use of life-sustaining treatment during a consultation with your physician. This documentation is legally valid in the state of Maryland.

We encourage you to exercise your legal rights to healthcare decision-making. We will honor your wishes and offer support during the time that we are providing you with care.

- Social workers can help you fully understand Advance Directives and assist you in clarifying your healthcare wishes and decisions.
- If you already have an Advance Directive, we strongly suggest that a copy be kept in this handbook for accurate reference by all our clinicians in case of an emergency.

You can obtain the Advance Directive and Power of Attorney forms provided by Maryland from the following sources:

- Maryland Department of Health
- Local hospitals or healthcare facilities
- Legal services or attorney offices specializing in healthcare directives.
- Online resources such as the Maryland state government website or legal document websites

Additionally, you may contact your healthcare provider or social worker for guidance on obtaining these forms.

OBTAINING A COPY OF YOUR MEDICAL RECORD

Agency employees are responsible for maintaining the confidentiality of your medical records. You have the right to request the release of information from your medical records.

Access to individual patient's medical and financial information shall be limited to the patient, their designated representatives, legal guardian, or legal representative, except as required by law or third-party payment contracts, accrediting bodies, licensing, or certifying agencies.

The Following Guidelines May Be Used to Request the Release of Your Medical Records:

Call the Agency and request a patient authorization to release information form. Forward the form, signed by the patient (or designee with power of attorney), or a court subpoena to the Administrator, supervisor, or designee, or write a letter to the Administrator, supervisor, or designee. Include the following information:

- Your full name and date of birth
- Date of treatment
- Name and address of the person or facility to which disclosure is to be provided.
- The specific kind and amount of information to be disclosed, such as laboratory results or clinical notes on your chart.
- The purpose of the request, for example, "continuing care" or "insurance"
- Your signature and date

COMPLAINTS AND GRIEVANCE PROCEDURES

The information provided below outlines the grievance process for you or your representative to follow if you wish to file a grievance.

- The client or client representative shall be provided with a copy of the complaint process at the time of admission to the agency. This process specifies that complaints are to be filed with the agency's administrator without fear of retaliation or disruption of services.

- The agency shall provide each client or client's representative with the name, mailing address, and telephone numbers of the following:

Quality One Care Home Health Agency (QOC)
9221 Colesville Road,
Silver Spring, MD 20910
Phone: 301-658-7141

The Office of Health Care Quality (OHCQ)
7120 Samuel Morse Drive, 2nd Floor.
Columbia, MD 21046
Phone: 410-402-8094
Hotline Number: 800-492-6005

Maryland Department of Health
201 Preston Street
Baltimore, MD 21201
Phone: 410-767-6500
Toll-free: 1-877-463-3464

Office of Quality and Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace,
Illinois, 60181

- Complaints and grievances can be made verbally or in writing.

- QOC's Administrator will log the complaint or grievance in the designated logbook and immediately acknowledge the receipt of the complaint either in writing or verbally, reassuring the complainant that action is being taken to investigate the matter.

- The Administrator will investigate the complaint or grievance.

- The administrator will develop a written report that recounts all pertinent issues involved in the complaint or grievance investigation, as well as the recommendations, within ten (10) days of receipt of the complaint or grievance.

- A written decision or remedy will be sent to the person who lodged the complaint, and a copy of the decision will be filed and recorded.

- If a patient or family member indicates dissatisfaction with the agency's response, either verbally or in writing after resolution is made, they shall be informed that they have the right to initiate an appeal in writing within 10 business days of the response or forward the complaint to the Department of Health.

HOME INFUSION SAFETY GUIDELINES

Ambulatory Pump or IV Pole Pump:

The electrical safety requirements for ambulatory pumps or IV pole pumps are crucial to ensure the safe and effective administration of medications or fluids. Here are some key points regarding electrical safety:

1. **Continuous Power Supply:**
    a. The pump should be always plugged in to maintain the battery charge. This ensures that the pump remains operational and can deliver medications or fluids consistently.
    b. The battery charge should only be utilized when the length of the power cord is inadequate or during a power failure. Relying on battery power should be minimized to ensure uninterrupted therapy whenever possible.
2. **Avoiding Water Exposure:**
    a. Patients should never take a bath or shower while using the pump. Water exposure can damage the pump and pose electrical hazards, leading to malfunctions or shocks.
    b. It's essential to keep the pump away from sources of water and moisture to prevent damage and ensure patient safety.
3. **Preventing Spills:**
    a. Patients should avoid spilling liquids, including solutions, on the pump. Liquid spills can cause electrical shorts or damage components, compromising the pump's functionality and safety.
    b. Care should be taken during handling and administration to prevent accidental spills near the pump.
4. **Proper Outlet Usage:**
    a. If a grounded electrical outlet is not available, a three-prong adapter must be used to ensure proper grounding. Grounding helps dissipate electrical charges safely and reduces the risk of electrical shocks or fires.

5. **Proper Voltage and Amperage:**
    a. Ensure that the electrical outlet provides the correct voltage and amperage for the pump. Using an outlet with insufficient voltage or amperage may result in the pump not functioning correctly or overheating.
6. **Accessibility:**
    a. Place the pump near an electrical outlet that is easily accessible. Avoid using extension cords or power strips unless necessary, as they can increase the risk of electrical hazards if not used properly.
7. **Avoid Overloading Circuits:**
    a. Do not overload electrical circuits by plugging in too many devices simultaneously. Overloading circuits can cause overheating and electrical fires. If other devices are connected to the same circuit, ensure that the total power draw does not exceed the circuit's capacity.
8. **Regular Inspection:**
    a. Periodically inspect the electrical outlet and plug for any signs of damage or wear. Cracked outlets, frayed cords, or loose connections should be addressed immediately to prevent electrical hazards.
9. **Prohibition of Extension Cords:**
    a. Extension cords should not be used with ambulatory pumps or IV pole pumps. Extension cords can pose tripping hazards and increase the risk of electrical hazards if not used properly. Always use a nearby electrical outlet that is easily accessible.
10. **Familiarity with Alarm System:**
    a. Be familiar with the pump's alarm system and understand what each alarm signifies. This ensures that you can respond appropriately in case of an alarm activation, which may indicate issues such as occlusion, low battery, or pump malfunction.
11. **Proper Storage:**
    a. When not in use, ambulatory pumps should be stored in the pouch provided to prevent tugging or damage to your catheter or the pump itself. Proper storage helps maintain the integrity of the equipment and reduces the risk of accidental damage.

Adhering to these electrical safety requirements helps mitigate the risks associated with using ambulatory pumps or IV pole pumps, promoting patient safety and treatment efficacy. Regular maintenance and inspection of the equipment are also essential to identify and address any potential electrical hazards promptly. It's crucial to be prepared for various emergency situations when using infusion therapy at home. Here are some safety precautions and guidelines to follow:

In Case of Fire:

- Immediately detach yourself from the IV pole or pump.
- Ensure that your ventral venous catheter is clamped.
- Leave the area and call for help.

Environmental Safety Precautions:

- Avoid using stairs while the pump or pole is in use.
- Remove any loose rugs or objects that could cause you to fall.
- Administer medication in an area with bathroom accessibility if possible.
- Secure excess tubing to avoid tangling.

For Any Infusion Therapy:

- Wear disposable gloves when exposure to blood or body fluids is possible.
- Dispose of all needles and contaminated syringes in the provided receptacle without recapping them.
- Seal the receptacle securely when it is two-thirds full and call the pharmacy or your home health agency for disposal instructions.

For Chemotherapy:

- Wear disposable gloves when handling liquid chemotherapy.
- Use a spill kit if there is a spill.
- Dispose of contaminated needles, syringes, and supplies in closed, leak-proof, puncture-proof containers without overfilling them.
- Place all other contaminated materials in provided chemotherapy bags and seal them.

For Narcotic Infusion:

- Safeguard all medication cassettes containing narcotics due to their potency and danger.
- Dispose of remaining contents of old medication cassettes into a toilet following a change.

For Natural and Unforeseen Disasters:

- Contact your home infusion company or healthcare provider for instructions if phone service is available.
- Proceed to the nearest emergency room if phone service is not available.
- Determine the closest hospital and alternative routes in case of emergency.
- Coordinate with family and friends regarding transportation to the nearest emergency room if necessary.
- Inform local authorities of your medical needs in case of a disaster.
- Obtain the phone number of the National Guard in your area.

By following these guidelines and safety precautions, you can ensure your well-being and effectively manage infusion therapy at home, even during emergencies or unforeseen events.

INFECTION CONTROL

It's crucial for both patients and caregivers to grasp infection prevention and control measures. This is essential in thwarting the transmission of severe illnesses like AIDS, hepatitis, tuberculosis, and infections in open wounds. Despite the omnipresence of germs and viruses, effective strategies can be employed to manage them.

Hand Washing & Hygiene:

- Wash your hands before eating, cooking, or handling wounds, bandages, or IV supplies.
- Also wash after using the bathroom, changing soiled bedding, or clothing, or handling bodily fluids.
- Use plenty of soap and warm water, rubbing your hands together for at least 30 seconds, especially before and after handling food, after using the bathroom, and after coughing or sneezing.
- Be sure to wash between your fingers.
- Dry your hands with paper towels or a clean towel.
- Our staff will use additional precautions when handling certain types of care involving bodily fluids, such as gloves, masks, goggles, gowns, or aprons.
- Use hand sanitizer with at least 60% alcohol if soap and water are not available.

Disposal of Hazardous Materials:

- Before disposing of soiled bandages, gloves, or other disposable items in public trash areas, wet them with a disinfectant solution like bleach.
- Then, place these items in two plastic bags and tightly seal them with tape or a tie.
- After handling waste, wash your hands thoroughly.

Sharp Objects Disposable Guidelines:

All needles, lancets, syringes, and other sharp objects should be placed in a rigid, leak-proof, puncture-resistant container with a tight-fitting lid. Suitable containers include detergent bottles, 2-liter pop bottles, plastic juice containers, coffee cans, or a purchased "sharps" container.

Avoid using glass containers, as they may break, or plastic milk jugs, as the plastic is too thin.

Remember to:

- Label all sides of the container with the word "sharps" in big letters.
- Keep all containers out of the reach of children.
- Do not use a container intended for recycling.

When the container is ¾ full, screw on the lid tightly and reinforce it with heavy-duty tape.
Return the securely closed container to your local pharmacy, doctor's office, hospital, clinics, outpatient laboratory, or hand it to your home care nurse for disposal.

Needles and Syringes:

- Needle and syringes must be disposed of in a hard, puncture-proof container with a tight lid. Your nurse will demonstrate proper disposal procedures and provide additional information.

Storage of Supplies:

- Store all patient care supplies in a clean, dry place. Avoid placing these items on the floor.
- Keep storage and disposal areas inaccessible to children and pets.
- Medications requiring refrigeration must be stored at the appropriate temperature in the refrigerator.

Soiled Linens:

- Sheets, towels, washcloths, pajamas, or other clothing soiled with blood, urine, or feces should be washed separately in hot, soapy water with half a cup of bleach added to the washing machine or wash tub.

Wound Care:

- Keep wounds clean and covered with sterile bandages to prevent bacteria from entering.
- Change dressings as instructed by healthcare providers.
- Follow proper techniques for wound cleaning and dressing changes.

Environmental Cleaning:

- Regularly clean and disinfect frequently touched surfaces such as doorknobs, light switches, and countertops.
- Use EPA-approved disinfectants and follow instructions for proper use.
- Launder linens, towels, and clothing regularly in hot water.

Food Safety:

- Wash fruits and vegetables thoroughly before eating.
- Cook foods to the appropriate temperatures to kill harmful bacteria.
- Store perishable foods in the refrigerator promptly.

Personal Protective Equipment (PPE):

- Wear gloves, masks, and PPE as instructed when providing care to individuals with infections.
- Dispose of PPE properly after use and wash hands immediately.

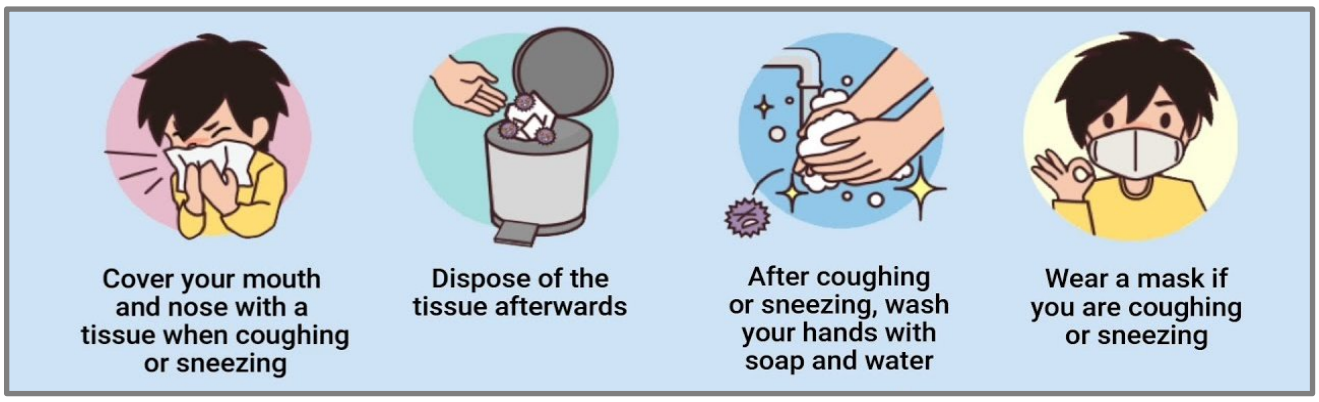
Vaccinations:

- Stay up to date on vaccinations, including flu shots and other recommended vaccines.
- Encourage household members and caregivers to receive vaccinations as appropriate.

Educate and Communicate:

- Educate patients, caregivers, and household members about infection prevention strategies.
- Communicate openly with healthcare providers about any signs or symptoms of infection.

Respiratory Hygiene/Cough Etiquette:



All individuals exhibiting signs and symptoms of a respiratory infection are advised to implement the following measures to contain respiratory secretions.

- Cover your mouth and nose with a tissue or your elbow when coughing or sneezing.
- Dispose of used tissues promptly in a waste receptacle.
- Wash your hands thoroughly with soap and water after coughing, sneezing, or disposing of tissues.
- Avoid close contact with individuals who are coughing or sneezing.
- If you don't have a tissue, cough, or sneeze into your elbow rather than your hands to prevent the spread of respiratory droplets.

Precautions to Prevent Infection:

- In some cases, certain bacteria can develop resistance to multiple antibiotics, leading to infections that are difficult to treat. To minimize the risk of spreading infection at home, caregivers should follow these precautions:
- Wash hands thoroughly with soap and water for at least 20 seconds after physical contact with an infected or colonized individual, before leaving the home.
- Handwashing is the most effective measure for controlling the spread of infection.
- Use towels for drying hands only once; consider using disposable paper towels.
- Wear disposable gloves if there is expected contact with body fluids & wash hands after removing gloves.
- Change and launder linens if they become soiled and do so at least once a week.
- Routinely clean the patient's environment, especially if it becomes soiled with body fluids.
- Double-bag soiled dressings and dispose of them in the trash.
- Launder clothes that come into contact with wound drainage.
- Avoid sharing personal hygiene items and eating utensils.

By following these guidelines and incorporating infection prevention practices into daily routines, individuals can minimize the risk of infections and promote better health outcomes.

HOME SAFETY GUIDELINES

Ensuring patient safety is paramount, especially considering that home accidents are a leading cause of injury and mortality, particularly among individuals aged 60 and above.

With age, agility diminishes, and bones become more prone to fractures. Consequently, even a minor fall can lead to severe injury or disability.

The Keys to Safe and Sensible Home Care Include:

1. Being aware of your home surroundings.
2. Making necessary changes to eliminate the risk of accidents.
3. Creating an emergency plan.
4. Ensuring that only authorized healthcare personnel with proof of employment at Quality One Care Home Health, Inc. (such as a name tag or ID card) are allowed into your home.

Electrical Safety:

- Ensure that electrical appliances and cords are clean, in good condition, and not exposed to liquids.
- Check that electrical equipment bears the Underwriters Labs (UL) label.
- Make sure there are an adequate number of outlets in each room without the use of "octopus" outlets.
- Verify that electrical outlets are grounded.
- Ensure adequate lighting throughout the house, especially in stove and sink areas.
- Keep curtains away from stove and other open flame areas.
- Install an exhaust hood with filters in the kitchen and ensure the exhaust system discharges directly outside.
- Maintain clean and uncluttered counter space and avoid storing heavy items above easy reach.
- Turn pan handles away from burners and keep hot pan holders near the stove.

- Operate microwave oven only when food is inside.
- Avoid cooking on high heat with oils and fat.
- Do not wear clothing with loose sleeves while cooking.
- Use refrigeration and proper storage to avoid food poisoning, keeping perishable foods refrigerated and periodically checking for freshness.
- Turn off kitchen appliances when not in use.

Disposable Items and Equipment:

- Disposable items include paper cups, tissues, dressings, soiled bandages, plastic equipment, urinary/suction catheters, disposable diapers, Chux, plastic tubing, and medical gloves.
- Store medical supplies in a clean and dry area.
- Dispose of used items in waterproof (plastic) bags.
- Fasten the bags securely and dispose of them in the trash.

Medical Equipment/Oxygen Safety:

- Follow manufacturer's instructions for proper use and maintenance of specialized medical equipment, keeping them nearby for reference.
- Perform routine and preventive maintenance as per manufacturer's instructions.
- Keep contact information for equipment service readily available in case of problems or failure.
- Ensure backup equipment is available when necessary.
- Provide adequate electrical power for medical equipment like ventilators and oxygen concentrators.
- Regularly check equipment batteries by a qualified service person.
- Install bedside rails properly and use only when necessary; do not use them as substitutes for physical restraints.
- Ensure mattresses fit the bed to prevent patients from getting trapped between the mattress and rails.
- Use protective barriers with bedside rails to reduce gaps where patients could be trapped.

- Keep all oxygen equipment away from open flames and ensure there is no smoking around oxygen.
- Prevent oxygen from freezing or overheating.
- If using electrically powered equipment like oxygen or ventilators, ensure registration with the local utility company.

Fire Safety Precautions:

- Ensure all family members and caregivers are familiar with emergency 911 procedures.
- Notify the fire department if a disabled person is present in the home.
- Prohibit smoking in bed or when oxygen equipment is in use.
- Regularly check and clean the heating system by qualified maintenance personnel.
- Maintain and use space heaters according to manufacturer's specifications.
- Ensure there are exits from all areas of the house and know fire escape routes for easy exit plans.
- Familiarize yourself with exit stair locations if living in an apartment building.
- Keep hallways clean and clear.
- Do not use elevators during a fire emergency.
- Prepare a fire drill/safety plan and practice escape routes from each room in the home.
- Display the fire department number prominently for easy access.
- Check fire extinguishers frequently for stability.
- Install smoke detectors in hallways and near sleeping areas.
- Regularly check and replace smoke alarm batteries when changing clocks for daylight savings time.
- In case your fire escape route is blocked, remain calm, close the door, seal cracks to prevent smoke entry, and signal for help at the window.

Bedbound Patient:

In the event of a fire, if a bedbound patient needs to be evacuated to a safe area, they can be placed on a sturdy blanket and carefully pulled or dragged out of the home. However, prioritize life safety above all else. If the fire is small and contained, you may consider using a fire extinguisher until the fire department arrives.

To Prevent Falls, Ensure the Following Safety Measures Are in Place:

- Maintain well-lit stairways and hallways.
- Use night-lights in bathrooms, halls, and passageways.
- Keep a flashlight or lamp within easy reach of the bed.
- Remove throw rugs or use ones with nonskid backing.
- Arrange electrical and telephone cords along walls and away from traffic areas.
- Use step stools with high handrails if necessary.
- Install secure handrails on stairs.
- Place grab bars near the shower, tub, or toilet.
- Attach shower stools or non-skid strips to the bottom of the tub.
- Consider using elevated toilet seats or stools.
- Clean up spills immediately.
- Keep outside walks clear of snow and ice.
- Be aware of medications that may cause dizziness.
- Limit alcoholic beverages.
- Rise slowly from seated or lying positions.
- Use a cane for extra stability if needed.
- Ensure steps are in good condition and free from objects.
- Use non-skid strips on steps or securely fastened carpeting.
- Install light switches at the top and bottom of stairways and in long halls.
- Ensure doors do not swing out over stairs or steps.
- Provide adequate headroom clearance in stairways.

To Ensure Bathroom Safety, Implement the Following Precautions:

- Use a non-skid mat or strips in the standing area of the bathtub or shower.
- Ensure bathtub or shower doors are made of safety glass or plastic.
- Install grab bars on the walls near the bathtub or toilet.
- Avoid using towel bars or soap dishes in the shower as grab bars.
- Keep electrical appliances away from the bathtub or shower area.
- Set the water heater thermostat below 120°F to prevent scalding accidents.
- Use night lights to illuminate the path to the bathroom at night.

To Manage Hazardous Items and Poisons Safely, Adhere to These Guidelines:

- Store hazardous items only in their original containers, exercising caution.
- Familiarize yourself with how to contact your local poison control team.
- Refrain from mixing products containing chlorine or bleach with other chemicals.
- Exercise caution with insecticides, purchasing only what is immediately needed and disposing of excess properly.
- Keep hazardous items, cleaners, and chemicals out of reach of children and individuals who may be confused or impaired.
- Dispose of household trash in a covered waste receptacle located outside the home.

To Ensure Medication Safety, Follow These Guidelines:

- Request snap caps from your pharmacist if child-proof caps are too challenging to open but keep them out of children's reach.
- Take your medication exactly as labeled or as instructed by your doctor.
- Understand the directions clearly; if unsure, consult your doctor, pharmacist, or nurse.
- Do not share prescribed medication with friends or family members; it is tailored specifically for you.
- Do not discontinue prescribed medication or restart an old prescription without informing your doctor.
- Maintain a list of all medications you are taking, noting dosage and timing, and bring this list along with your medication bottles to doctor's visits.
- Keep medication information sheets provided by the pharmacy.
- Discuss any side effects that you experience with your doctor or nurse.
- Inform your doctor about all medications you are taking, including nonprescription drugs, for guidance on safe and proper use.
- Check medication labels for expiration dates.
- Inspect your medicines for stability, looking for signs of discoloration, residue, or dampness.
- Always securely replace the lids of your medication bottles.
- Store medications according to the instructions provided by the pharmacy or package insert.

CREATE A HOME EMERGENCY KIT

Water:

- Store bottled water, one gallon per person per day, for drinking and sanitation.
- Keep water in a cool, dark place and replace every six months.

Food:

- Have a supply of nonperishable food for 3-5 days per person.
- Include ready-to-eat canned meat, fruit, vegetables, juices, powdered milk, soup, crackers, granola, and trail mix.

Clothes:

- Prepare one change of clothes and footwear per person.
- Consider adding blankets, rain gear, and outerwear for inclement weather.

Medications:

- Gather three days' worth of prescription medicines, noting expiration dates.

Flashlight:

- Keep a bright flashlight handy in case of power outages.
- Consider a lantern-style light for hands-free use; avoid candles due to fire hazards.

Can Opener:

- Ensure you have a manual can opener in case of power loss.
- Consider purchasing items with pull-top openings.

Radio:

- Have a battery-powered radio for news and weather updates.
- Stock up on extra batteries in advance.

Hygiene Items:

- Include basic hygiene items like soap, toilet paper, toothbrush, and moist towels for sanitation.

First Aid:

- Have essential first aid supplies such as antiseptic, gloves, bandages, and non-prescription medicines.
- Consider purchasing a pre-made first aid kit from a pharmacy or grocery store.

In Case of Emergency:

- **Dial 911 for immediate assistance.**

For further details on emergency planning, reach out to your local emergency office for Montgomery County at 301-579-4555.

PATIENT ADMISSION CONSENT FORM

INSTRUCTIONS: This form serves to confirm receipt of our patient admission booklet and affirms your comprehension and acceptance of its contents. Your signature below signifies your agreement.

CONSENT TO RECEIVE SERVICES:

I, _____, hereby authorize QUALITY ONE CARE HOME HEALTH, INC (QOC) to provide appropriate home care services to the patient named above. I understand that the care will be administered by qualified home care personnel. I acknowledge my right to refuse treatment or discontinue services at any time by notifying the QOC office. Additionally, I understand that QOC may terminate services by notifying me of such termination and the reason.

EMERGENCY MEDICAL SERVICES AUTHORIZATION:

During my receipt of services from QOC, I authorize QOC and its employees/contractors to administer or obtain necessary medical treatment in the event of a medical emergency.

I agree to assume sole responsibility for all charges associated with such treatment.

RELEASE OF MEDICAL RECORDS:

I understand that my Protected Information may be used or disclosed for treatment purposes during my care with Quality One Care Home Health Inc. This may involve various personnel accessing my information to ensure quality care.

I also acknowledge that protected health information may be disclosed to individuals involved in my care after discharge from QOC.

I acknowledge that QOC does not provide insurance coverage for damages to my automobile, bodily injury, or property damage resulting from the use of my automobile by QOC employees/contractors.

PATIENT BILL OF RIGHTS STATEMENT:

I acknowledge that I have received verbal and written information regarding the statement of rights and responsibilities, QOC grievances procedure, Department of Health Home Health Complaint Hotline number, notice of privacy practices, OASIS privacy Notes, Basic Home Safety, Emergency planning related to a disruption in service, and infection control. I confirm that this information has been explained to me to the best of my knowledge.

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself.

I Have Completed and Executed the Following:

- Living will ☐ Yes ☐ No
- Durable power of attorney ☐ Yes ☐ No
- Do Not Resuscitate Order ☐ Yes ☐ No
- Advance Directives ☐ Yes ☐ No

I certify that all information given by me to QOC is correct for requesting and applying for payment under Title XVIII (Medicaid/Medicare), Title XIX (Medicaid) of the Social Security Act, or from any third-party payer. I understand and agree to pay deductibles, co-payments, spend downs, and any amount due after payment of benefits on my behalf by all third-party payers.

I verify that I am not a participating member of an HMO (Health Maintenance Organization). If I enroll in one, I will immediately notify QOC.

I understand that services provided to me by QOC will be billed as follows:

- Medicare fee for service (Projected 100% covered). My Payment liability is $0.00.
- Medicaid (Projected 100% covered after meeting spend down and/or other requirements). My Payment liability is $0.00.
- Private insurance: Insurance coverage ___% Co-Pay ___%.
- Private pay (See private Pay Rate Sheet. Patient is responsible for the timely payment of all charges).

Patient/Authorized Representative Signature: _____

Date: _____

PRIVACY POLICY NOTIFICATION

****IMPORTANT: This Notice Outlines How Your Medical Information May Be Utilized or Disclosed and How You Can Access This Information. Please Review It Carefully.**

Our agency utilizes your Protected Health Information (PHI) for your treatment, payment processing, and operational purposes, such as enhancing the quality of care we offer. We are dedicated to upholding your confidentiality and safeguarding your health information. By law, we are mandated to provide you with this notice, detailing our health information privacy practices, including those of our affiliated healthcare providers.

This notice pertains to all information and records associated with your care that our agency workforce members and Business Associates have received or created. It also encompasses healthcare professionals and organizations providing care through our agency. It outlines potential uses and disclosures of your Protected Health Information and outlines your rights and our obligations concerning this information.

We Are Legally Obliged To:

• Maintain the confidentiality of your Protected Health Information.

• Provide you with this comprehensive Notice detailing our legal duties and privacy practices concerning your Protected Health Information.

• Adhere to the terms of this Notice currently in effect. We retain the right to amend the terms of this Notice, with notification to you or your personal representative by letter in the event of any material changes.

I. With Your Consent, We May Use and Disclose Your Protected Health Information for Treatment, Payment, And Healthcare Operations.

You will be requested to provide consent, allowing us to utilize and disclose your Protected Health Information to facilitate your treatment, secure payment for our services, and manage our healthcare operations.

Here are examples illustrating how we may use and disclose your health information:

- **For Treatment:** We may utilize or disclose your Protected Health Information for treatment purposes. During your care with Quality One Care Home Health Inc., various personnel involved in your care, such as physicians, nurses, nurses' aides, therapists, and consultants, may require access to your protected information to ensure the provision of quality care. For instance, patients with compromised immunity, communicable diseases, or any condition that spreads through contact, will have their diagnosis communicated to all personnel involved in their care. Additionally, we may disclose protected health information to individuals who will be participating in your care following your discharge from Quality One Care Home Health, Inc.
- **For Payment:** Our Agency may employ and disclose your Protected Health Information to facilitate billing for your health care services and obtain payment. For example, we may incorporate your health information into our claim submitted to your insurance company, Medicaid/Medicare, or Medicaid to secure payment for services rendered to you. We may also disclose your health information to other healthcare providers to facilitate payment.
- **For Health Care Operations:** We may utilize and disclose your Protected Health Information for the operational needs of our Agency. These uses and disclosures are essential for the efficient operation of our Agency and ensuring that all our patients receive quality care. For instance, we may use your health information to conduct reviews of our treatments and services, as well as to evaluate the performance of our staff or other contracted agencies such as laboratories.

II. We May Use and Disclose Your Protected Health Information for Other Specific Purposes

- **Business Associates:** We may share your Protected Health Information with our vendors and agents who handle PHI for certain functions or activities on behalf of the Agency. These are our "Business Associates." To ensure the protection of your health information, we require our Business Associates and their subcontractors to appropriately safeguard your information.

- **Family and Friends Involved in Your Care:** With your consent, we may disclose your Protected Health Information to a family member, close friend, or clergy who is involved in your care or payment for that care.
- **Disaster Relief**: We may disclose your Protected Health Information to organizations assisting in disaster relief efforts.
- **Personal Representative:** If you have a personal representative, such as a legal guardian, we will treat them as if they were you regarding disclosures of your health information. If you pass away, we may disclose health information to your estate's executor or administrator or to your next of kin, as permitted by law.
- **Public Health Activities:** We may disclose your Protected Health Information for public health activities, including disease reporting, public health surveillance, and intervention, as well as notifying individuals who may have been exposed to a communicable disease.
- **Health Oversight Activities:** Your Protected Health Information may be disclosed to health oversight agencies authorized by law to conduct audits, investigations, and licensure actions.
- **Reporting Victims of Abuse, Neglect, or Domestic Violence:** If we suspect that you have been a victim of abuse, neglect, or domestic violence, we may use and disclose your Protected Health Information to notify the appropriate authorities or with your consent.
- **Law Enforcement:** Your Protected Health Information may be disclosed for specific law enforcement purposes or other governmental functions.
- **Judicial and Administrative Proceedings:** Your Protected Health Information may be disclosed during certain judicial or administrative proceedings.
- **Research:** We will obtain your written authorization before using or disclosing your Protected Health Information for research purposes.
- **Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations:** We may release your health information to coroners, medical examiners, funeral directors, or organ procurement organizations. If you are an organ donor, your information may be disclosed to organizations involved in organ and tissue donation.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or

safety, or that of the public or another person. Such disclosures will only be made to individuals able to assist in preventing the threat.

- **Military and Veterans:** If you are a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.
- **Workers' Compensation:** We may use or disclose your Protected Health Information to comply with laws related to workers' compensation or similar programs.
- **National Security and Intelligence Activities; Protective Services:** We may disclose health information to authorized federal officials conducting national security and intelligence activities or as necessary to provide protection to the President of the United States or other important officials.
- **Marketing:** In most cases, we are required by law to obtain your written authorization before using or disclosing your health information for marketing purposes. Under no circumstances will we sell patient lists or health information to a third party without your prior written authorization.
- **As Required by Law:** We will disclose your Protected Health Information when mandated by law.

III. Your Authorization Is Required for Other Uses of Your Protected Health Information.

- We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written Authorization. You may revoke your Authorization to use or disclose Protected Health Information in writing, at any time. To revoke your Authorization, contact the nursing department. If you revoke your Authorization, we will no longer use or disclose your Protected Health Information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

IV. Your Rights Regarding Your Health Information

You have the following rights regarding medical information we maintain about you:

- **Request for Restrictions:** You may request in writing a restriction on certain uses or disclosures of your medical information for treatment, payment, or health care operations. While we will consider your request, we are not legally required to agree to it, except in

cases where you have paid out of pocket in full for a service and request a restriction on disclosure to a health plan. It is your responsibility to notify other providers about any agreed-upon restrictions.

- **Obtain a Paper Copy of Notice:** You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive it electronically. You can contact the Admitting or Registration Department to request a copy.
- **Inspect and Obtain a Copy of Medical Information**: In most cases, you have the right to inspect and obtain a copy of your medical information. If you request a copy (paper or electronic), we may charge you a reasonable, cost-based fee.
- **Request for Amendment:** You may request in writing an amendment to your records if you believe the information is incorrect or important information is missing. We may deny your request if the information was not created by us, is not maintained by us, or if we determine the record is accurate. In California, you have the right to appeal a decision by us not to amend your record in writing. Even if we deny your request for amendment, you have the right to submit a written addendum to your record.
- **Accounting of Disclosures:** You can request an accounting of disclosures stating who and where your medical information has been disclosed for purposes other than treatment, payment, health care operations, or where you specifically authorized a use or disclosure in the past six (6) years. After the first request, there may be a charge for additional requests made within a twelve (12) month period.
- **Request for Communication Preferences:** You may request that medical information about you be communicated to you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

V. Complaints

If you believe that your privacy rights have been violated, you may file a complaint in writing with our office by contacting the Quality Improvement Office at **301-658-7141.**

VI. Changes to This Notice

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice.

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information already received and maintained by the Agency as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in the Agency. In addition, we will provide a copy of the revised Notice to all patients by mailing or hand-delivering a hard copy to them or their personal representatives as requested.

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the Director of Compliance/Privacy Officer at 301-658-7141.

☐ I _____, acknowledge that I have been provided with a copy of Quality One Care Home Health Inc. private policy notification.

Signature: _____ **Date: _____**

OASIS PRIVACY NOTICE

Statement of Patient Privacy Rights

As a home health patient, you have these privacy rights:

- **You have the right to know why we need to ask you questions.**
  We're required by law to collect health information to make sure you get quality health care, and that payment for Medicare and Medicaid patients is correct.
- **You have the right to have your personal health care information kept confidential.**
  We may ask you to tell us information about yourself so that we'll know which home health services will be best for you. We keep anything we learn about you confidential. This means only those legally authorized or with a medical need to know will see your personal health information.
- **You have the right to refuse to answer questions.**
  We may need your help to collect your health information. If you choose not to answer, we'll fill in the information as best we can. You don't have to answer every question to get services.
- **You have the right to look at your personal health information.**
  It's important that the information we collect about you is correct. If you think we made a mistake, ask us to correct it. If you're not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services (the federal Medicare and Medicaid agency) to see, review, copy or correct your personal health information.

  See the Privacy Policy Notification for more details about your privacy rights.

To see, review, copy, or correct your personal health information in federal records, call 1-800-MEDICARE (1-800-633-4227) for help contacting the HHA

PATIENT PROFILE

DNR (Do Not Resuscitate): ☐ YES ☐ NO

Location: _____

EMERGENCY CONTACT

Full Name:

Relationship:

Phone Number:

YOUR HOME CARE TEAM

Nurse: Physical Therapist:

Nurse: Occupational Therapist:

Home Health Aide: Speech Therapist:

Quality One Care Home Health, Inc.
9221 Colesville Road, Silver Spring, MD 20910
Tel: 301-658-7141 | Fax: 301-579-4845

IMPORTANT AGENCY INFORMATION

For inquiries about your home care, scheduling, visit changes, or to voice concerns, please feel free to contact us via mail or phone at the details provided below.

Quality One Care always have someone available to assist you 24 hours a day, 7 days a week.

Quality One Care Home Health, Inc.
9221 Colesville Road,
Silver Spring, MD 20910

Tel: 301-658-7141
Fax: 301-579-4845
Email: info@qualityonecare.com
Web: www.qualityonecare.com

Referenced Financials Statements

2023 – 2024

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CPA Prepared Financial Statements

SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA
MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

TO: Mohamed Matope
Quality One Care Home Health, Inc.

Date: March 25, 2025

The following items are enclosed:

☐ **E-file authorization forms for signature and tax returns for review**
E-file authorization form(s) and tax returns are in your portal. You should review the tax returns before returning the signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

a. Return via DocuSign
b. Mail to our office via First Class Mail
c. Upload signed E-file forms in your portal

☐ **Tax Reports that cannot be filed electronically/must be filed on paper with instructions for filing**
Follow the enclosed instructions. Copies of your tax report(s) are in your portal.

☐ **Client Agreement and/or Engagement Letter**
Electronically sign via DocuSign by clicking each tag and following the instructions to add your electronic signature or initials where required. Confirm your signature by clicking "FINISH". Alternatively, mail, fax, or upload to your portal. Follow any terms listed at the asterisk (*) on the Client Agreement.

☐ **Original documents and/or paper copies of tax returns**

☑ 12/31/24 Financial Statements

☐ **If you have questions, call Paul at (301) 657- 8080 extension 102.**

Remarks:

As a client of Sullivan & Company, CPAs, you receive a secure client portal. The portal is the best way to send documents to us and receive them. To access the portal, go to esullivan.net, client portal, and enter your username and password to log in and access the applicable folder. If you need assistance navigating the portal, call our office, and one of our administrative team members can assist you.

Signed: Paul Sullivan
Karla Romero

4709 MONTGOMERY LANE, SUITE 201, BETHESDA, MD 20814 • TEL (301) 657-8080 • FAX (301) 657-9055
MEMBER AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS
www.eSullivan.net • pSullivan@eSullivan.net

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

December 31, 2024

	Dec 31, 24
ASSETS	
Current Assets	
Checking/Savings	
First Citizens Bank 2213	779,563
Truist 5249	319,554
Truist 5257	500
Truist 5265	30,357
Truist 5273	1,912
Total Checking/Savings	1,131,887
Accounts Receivable	
Accounts Receivable (A/R)	(1,000,000)
Total Accounts Receivable	(1,000,000)
Other Current Assets	
Payroll Tax Receivable	71,286
Undeposited Funds	1,000,000
Total Other Current Assets	1,071,286
Total Current Assets	1,203,172
Fixed Assets	
Accum. Depreciation	(153,990)
Computers	34,279
Furnitures and Equipment	47,303
Leasehold Improvements E&M Inve	406,777
Printers	7,386
Total Fixed Assets	341,755
TOTAL ASSETS	1,544,927

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

December 31, 2024

	Dec 31, 24
LIABILITIES & EQUITY	
Liabilities	
Long Term Liabilities	
EIDL SBAD TREAS	137,779
Total Long Term Liabilities	137,779
Total Liabilities	137,779
Equity	
Capital	20,000
Contributions Mohamed	291,314
Retained Earnings	1,642,613
Net Loss	(546,779)
Total Equity	1,407,148
TOTAL LIABILITIES & EQUITY	1,544,927

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended December 31,2024 and 2023

	Jan - Dec 24	Jan - Dec 23	% of Income
Ordinary Income/Expense			
Income			
Service Revenues	17,235,327	16,482,073	100%
Total Income	17,235,327	16,482,073	100%
Cost of Goods Sold			
Business Telehealth	250,000	0	1%
Direct Wages	2,538,061	2,216,891	15%
Subcontractors - COS	13,379,501	12,437,863	78%
Total COGS	16,167,562	14,654,754	94%
Gross Profit	1,067,764	1,827,319	6%
Expense			
Accounting	27,809	27,379	0%
Advertising	9,000	0	0%
Auto Expenses	8,904	8,222	0%
Bank & Merchant Fees	3,326	626	0%
CHARITY	0	5,000	0%
Depreciation Expense	23,813	21,603	0%
Dues & Subscriptions	37,323	3,280	0%
Education and Training Expen...	0	870	0%
Insurance	56,464	12,665	0%
Interest Expense	0	1,434	0%
Legal & Professional Fees	92,800	94,783	1%
Office Expenses	97,594	64,264	1%
Parking	0	690	0%
Payroll Service Fees	9,282	8,302	0%
Penalties	0	124	0%
Pension Expense	44,225	52,631	0%
Rent or Lease	238,870	258,216	1%
Repair & Maintenance	98,244	68,253	1%
Salaries and Wages, Other	373,344	363,327	2%
Salary, Officer	194,220	226,000	1%
Taxes & Licenses	263,132	227,864	2%
Telephone Expenses	16,675	18,701	0%
Travel	600	5,183	0%
Utilities	13,481	14,905	0%
Total Expense	1,609,106	1,484,322	9%
Net Ordinary Income	(541,342)	342,997	(3)%
Other Income/Expense			
Other Income			
Interest Earned	52	0	0%
Total Other Income	52	0	0%

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended December 31,2024 and 2023

	Jan - Dec 24	Jan - Dec 23	% of Income
Other Expense			
Penalties, Other	5,490	0	0%
Maryland Income Taxes	0	108,413	0%
Total Other Expense	5,490	108,413	0%
Net Other Income	(5,437)	(108,413)	(0)%
Net Income	(546,779)	234,584	(3)%