Project Information

Submission Date	April 2, 2026
Document Type	**CON Application – Completeness Response**
Review Schedule	Schedule Two
CON Review Service	Home Health Agency (HHA) Services
Proposed Project	Establish a New Medicare-Certified **Home Health Agency**
Proposed Service Area	**Allegany, Frederick, Garrett, Washington and Carroll Counties**
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
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Key Contact for Submission Questions

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Key MHCC Deadlines (Schedule One)

Letter of Intent (LOI) Due	December 5, 2025
Pre-Application Conference	December 17, 2025
Full Application Due	February 6, 2026
Completeness Review Due	April 2, 2026

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

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April 2, 2026

VIA EMAIL & HAND DELIVERY

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

Re: Quality One Care Home Health, Inc., Responses to Completeness Questions dated March 5, 2026 to Establish a Home Health Agency in Western Maryland: Allegany County, Carroll County, Frederick County, Garrett County and Washington County

Matter # 26-R4-2491 Western Maryland Jurisdictions

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 CON application.

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

2. Regarding 10.24.16.08A(2), the table under "Organizational Structure: RSA vs HHA Separation Matrix" appears to refer to positions not included in the organization chart provided. Provide more information on how the RSA and HHA will provide staffing for the distinct services each organization provides.

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

The "Organizational Structure: RSA vs. HHA Separation Matrix" included in the CON application was intended to clearly distinguish the regulatory and operational roles of the existing Residential Service Agency (RSA) and the proposed Medicare-certified Home Health Agency (HHA). The Applicant acknowledges that certain positions referenced in the matrix were not explicitly labeled in the organizational chart and provides the following clarification to ensure full transparency and consistency.

Quality One Care has structured its operations so that the RSA and HHA function as **distinct service lines**, each with its own defined scope of services, staffing model, and regulatory obligations. While both operate under the same corporate entity, they are intentionally separated at the clinical, administrative, and compliance levels to ensure adherence to COMAR requirements and to prevent any commingling of services or resources.

(a) Positions Assigned to Each Entity

Residential Service Agency (RSA): The RSA division is limited to services permitted under COMAR 10.07.10 and is structured to support personal care and delegated nursing services. Staffing within the RSA includes an Administrator, a Clinical Supervisor (RN), registered nurses providing delegated nursing as appropriate, direct care staff, and administrative support personnel. These roles are fully contained within RSA operations and are not included in any HHA staffing projections or financial modeling.

In contrast, the proposed HHA is structured to meet all requirements under 42 CFR Part 484 and is designed to deliver Medicare-certified skilled services. The HHA includes a complete leadership and operational framework, consisting of an Administrator, a Director of Nursing (or Clinical Manager), intake and scheduling personnel, billing and revenue cycle staff, and designated support functions such as EHR / IT Support and human resources. Clinical staffing includes registered nurses, licensed practical nurses, home health aides, therapy providers, and medical social workers. In addition, a defined quality and compliance structure is established to support QAPI activities, survey readiness, and regulatory reporting.

This structure ensures that the HHA is not reliant on RSA staffing and is fully capable of operating as an independent, compliant Medicare-certified entity.

Here is a clear breakdown of the leadership structure:

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 (HHAs/CNAs)
- 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 structure reflects the full leadership and compliance framework required for Medicare certification and HHA licensure.

(b) Dedicated vs. Shared Staff

A key principle of QOC's organizational design is that **clinical staff are not shared between RSA and HHA operations**.

- **Clinical Staff:** All direct patient-care clinical personnel (RNs, LPNs, HHAs, therapy staff, MSW) are assigned specifically to either RSA or HHA operations. All direct patient-care personnel are assigned specifically to one service line based on licensure, scope of practice, and patient population. This ensures clarity in supervision, accountability, and documentation.

  There may be limited instances where a clinician transitions from one division to another; however, such changes are formal, documented, and accompanied by corresponding adjustments in staffing assignments and financial tracking. This prevents duplication of staffing or reporting and maintains clear operational boundaries.

In short:

  - Reassignment is documented
  - Staffing allocations are adjusted
  - No duplication of staffing or financial reporting occurs

- **Administrative Leadership:** The Administrative leadership within the HHA – including the Administrator and Director of Nursing – is fully dedicated to HHA operations and is responsible for ensuring compliance with Medicare Conditions of Participation. These roles are not shared with the RSA, reflecting the higher level of regulatory accountability required for home health services.

- **QA & Compliance Structure:** Quality oversight follows the same 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.

  To maintain compliance and financial integrity:

  - Each division operates under separate cost centers
  - Expenses are allocated using established accounting methodologies
  - Payroll and financial reporting are maintained independently

  This structure allows the organization to benefit from operational efficiencies while preserving the regulatory separation required between service lines.

(c) <u>Staffing Levels and Support of Distinct Services</u>

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Staffing levels within each division are aligned with the specific services provided and the applicable regulatory framework.

RSA staffing is structured to support personal care and delegated nursing services and remains independent of the HHA's clinical model.

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

In addition, the staffing model supports required functions such as OASIS documentation, care coordination, and ongoing quality improvement activities.

Because both RSA and HHA services are delivered in patients' homes, the organization emphasizes a **field-based care coordination model**, with supervisory and administrative staff structured to support clinicians in the field rather than centralized clinical operations.

Importantly, no personnel are double counted between RSA and HHA staffing projections. Each division maintains separate staffing plans, payroll systems, and compliance structures, ensuring full adherence to COMAR 10.24.01.08G(3) and eliminating any risk of resource commingling

Conclusion

The Applicant's organizational structure reflects a deliberate and compliant approach to operating both RSA and HHA services within a single corporate framework while maintaining clear operational separation.

By ensuring that clinical staff, leadership, financial systems, and compliance functions are appropriately divided, Quality One Care demonstrates its ability to support distinct service lines without overlap or ambiguity. This structure not only satisfies regulatory requirements but also provides a strong operational foundation for the successful implementation of the proposed Home Health Agency.

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FINANCIAL FEASIBILITY

3. 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 (Q3) – Basis for Proposed Staffing Model

Quality One Care Home Health, Inc. ("QOC") has developed its proposed staffing model based on a deliberate and data-driven analysis of projected service volume, discipline mix, productivity expectations, and the operational realities of delivering home health services across the Western Maryland region. The model is not theoretical – it is directly derived from the utilization projections and staffing schedules presented in Tables 2B and 5 of the CON application and is structured to ensure both clinical adequacy and financial feasibility.

At its core, the staffing approach reflects a **phased, utilization-driven model**, rather than a fixed or front-loaded structure. This ensures that staffing levels grow in alignment with actual patient demand, allowing the agency to maintain operational stability during early implementation while scaling responsibly over time.

All utilization, visit projections, and staffing levels referenced herein are directly derived from Table 2B (Statistical Projections) and Table 5 (Staffing Information) of the CON application.

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

Applicant Response (Q3a) - Assumptions Used to Determine Staffing Levels

Patient Volume and Visit Intensity

The foundation of QOC's staffing model begins with projected patient volume and visit intensity. As reflected in Table 2B, the agency anticipates a gradual ramp-up across the Western Maryland service area:

- 70 unduplicated clients and 1,060 visits in 2026
- 110 unduplicated clients and 1,661 visits in 2027
- 145 unduplicated clients and 2,189 visits in 2028

These projections translate to an average of approximately 15 visits per client annually, consistent with MHCC FY 2023 utilization data, as reflected in Table 2B projections, but consistent with MHCC FY 2023 utilization data and reflective of QOC's anticipated case mix as a Medicare-certified provider. As a

new Medicare-certified provider, QOC expects to serve a higher proportion of post-acute and medically complex patients, which typically require more frequent skilled interventions and coordinated care.

Importantly, the model incorporates a **98% billable visit assumption**, with a conservative 2% allocation for non-billable activities such as orientation, documentation training, supervisory oversight, and early operational inefficiencies. This reflects realistic start-up conditions and avoids overstating productivity.

From a clinical standpoint, visits are distributed across disciplines in a manner that reflects both regional utilization patterns and patient needs. Skilled nursing and home health aide services represent the majority of visits, supported by therapy services and medical social work. Rather than applying a uniform distribution, QOC's model intentionally weights services toward clinical complexity, ensuring that staffing aligns with patient acuity rather than arbitrary ratios.

Productivity and Geographic Considerations

A critical differentiator in this application is the recognition of the **Western Maryland geography**, which materially impacts staffing needs.

Unlike more densely populated jurisdictions, the proposed service area includes rural and semi-rural counties such as Garrett and Allegany, where travel distances between patient homes are significantly greater. This has a direct effect on productivity and staffing capacity.

Each full-time equivalent (FTE) is based on 2,080 paid hours annually, with a **0.85 productivity adjustment factor** applied to account for non-productive time, including:

- Travel between visits
- Documentation (including OASIS)
- Care coordination and case conferencing
- Required supervisory activities

As a result, QOC adopts a **conservative productivity standard of approximately 4.5 to 5 visits per day**, which is both realistic and necessary to ensure safe and compliant care delivery across geographically dispersed counties.

This approach is intentional. It prioritizes **quality and safety over volume maximization**, and it ensures that clinicians have sufficient time to manage complex patients without compromising care standards.

FTE Staffing Structure

Consistent with these assumptions, staffing levels are scaled directly to projected utilization and reflect a measured, phased expansion:

- Approximately **1.40 FTEs in Year 1 (2026)**
- Approximately **2.20 FTEs in Year 2 (2027)**

- Approximately **2.95 FTEs in Year 3 (2028)**

These FTEs include a combination of administrative leadership, nursing staff (RN and LPN), home health aides, and contracted clinical specialists. The structure is deliberately lean during the initial phase, leveraging QOC's existing administrative infrastructure while building clinical capacity in alignment with demand.

This ensures that:

- Staffing is sufficient to meet patient needs
- Resources are not overextended during early operations
- Financial performance remains stable and sustainable

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

Applicant Response (Q3b) – Approach to OASIS and HHCAHPS

QOC's approach to data collection and reporting is designed to ensure full compliance with federal requirements while maintaining internal accountability.

OASIS assessments will be completed by trained Registered Nurses and reviewed internally under the supervision of the Director of Nursing. All data will be submitted through a CMS-compliant electronic health record system, with built-in validation and monitoring processes.

Accuracy and completeness will be continuously evaluated through the agency's Quality Assurance and Performance Improvement (QAPI) program.

In contrast, HHCAHPS survey administration will be conducted through a CMS-approved external vendor.

This ensures adherence to standardized survey methodologies and reporting requirements, while allowing QOC leadership to focus on performance oversight and quality improvement initiatives based on survey outcomes.

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

Applicant Response (Q3c) – Staffing Scalability Across Counties

QOC's staffing model is inherently scalable and directly tied to measurable service growth.

As patient volume increases across the five-county region, staffing adjustments will be implemented based on clearly defined operational triggers. These include increases in admissions, visit volume, and service demand by discipline.

Key scaling principles include:

- Nursing staff increases aligned with skilled visit growth
- Home health aide staffing expanding with stabilized aide visit demand
- Administrative support increasing with intake, scheduling, and billing complexity
- Therapy roles transitioning as volume supports consistent utilization

Rather than applying arbitrary thresholds, QOC evaluates staffing needs based on **active census, visit density, and geographic distribution of patients**, ensuring that staffing decisions are both responsive and efficient.

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

Applicant Response (Q3d) – Use of Contracted Staff

During early operations, QOC will utilize contracted clinicians, particularly for therapy services and medical social work, to maintain flexibility and control fixed costs.

This approach is appropriate given the variability inherent in start-up operations and allows the agency to:

- Respond to fluctuating referral patterns
- Ensure coverage across geographically dispersed counties
- Access specialized clinical expertise without overcommitting resources
- Maintain financial discipline during ramp-up

Contracted staffing is not a substitute for permanent workforce development, but rather a strategic tool to ensure operational responsiveness during early phases.

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

Applicant Response (Q3e) – Transition to Employed FTE Positions

As service volume increases and operations stabilize, QOC will transition select contracted roles to employed FTE positions.

This transition is driven by clear and measurable conditions, including:

- Sustained and predictable visit volume across multiple periods
- Sufficient annualized visits to support full-time caseloads
- Revenue levels that support salary and benefits without adverse margin impact
- Improved geographic clustering of patients, reducing travel inefficiencies

This phased transition model allows QOC to balance flexibility with long-term workforce stability, ensuring that staffing evolves in a financially responsible and operationally sound manner.

Conclusion

QOC's staffing model is carefully constructed, data-driven, and fully aligned with the projected utilization presented in the CON application. It reflects a clear understanding of both clinical requirements and regional operational challenges, particularly those associated with serving a geographically diverse and partially rural service area.

By aligning staffing levels directly with patient volume, incorporating realistic productivity assumptions, and utilizing a phased growth strategy, QOC ensures that the proposed Home Health Agency will be:

- Clinically capable
- Operationally efficient
- Financially sustainable
- Fully compliant with COMAR and CMS requirements

This approach provides a strong and defensible foundation for both initial implementation and long-term viability.

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4. What is the number and percentage of total home health clients and visits projected by QOC by county compared to the total number of home health clients and visits in each county?

Applicant Response (Q4) – County Level Clients and Visits Comparison

Quality One Care Home Health, Inc. ("QOC") evaluated its projected service volume relative to existing home health utilization within each county of the proposed Western Maryland service area using MHCC FY 2023 utilization data.

As reflected in Table G-1 of the CON application, the five-county region (Allegany, Frederick, Garrett, Washington, and Carroll Counties) generated a combined:

- **16,716 unduplicated home health clients**, and
- **252,832 total home health visits annually**

QOC's projected utilization, as reflected in Table 2B, represents a **modest and incremental level of service** distributed across these counties.

Projected Clients and Visits by County (Year 3 – 2028)

QOC's projected Year 3 utilization of **145 clients and 2,189 visits** is distributed proportionally across the five-county region based on population, referral patterns, and anticipated service demand.

The table below compares QOC's projected utilization to MHCC-reported county totals:

County Level Comparison - Clients

County	MHCC Clients (FY 2023)	QOC Projected Clients (2028)	% of County Total
Allegany	1,811	~16	~0.9%
Frederick	5,145	~45	~0.9%
Garrett	711	~6	~0.8%
Washington	4,206	~37	~0.9%
Carroll	4,843	~41	~0.8%
Total	**16,716**	**145**	**~0.87%**

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County Level Comparison –-Visits

County	MHCC Visits (FY 2023)	QOC Projected Visits (2028)	% of County Total
Allegany	30,978	~280	~0.9%
Frederick	77,159	~680	~0.9%
Garrett	13,383	~120	~0.9%
Washington	62,393	~550	~0.9%
Carroll	68,919	~560	~0.8%
Total	**252,832**	**2,189**	**~0.9%**

Interpretation of County Level Impact

As demonstrated above, QOC's projected utilization represents **less than one percent of total clients and visits in each individual county**, as well as across the region as a whole.

This consistent proportional distribution reflects a deliberate planning approach that aligns service expansion with existing demand patterns while avoiding concentration in any single jurisdiction. From an operational perspective, QOC's presence will be:

- **Geographically distributed**, supporting access across both urban and rural areas
- **Incremental in scale**, ensuring no disruption to existing provider volumes
- **Responsive to referral patterns**, rather than fixed or artificially allocated

Importantly, even in counties with lower overall utilization – such as Garrett and Allegany – QOC's projected volume remains modest and proportionate, reinforcing that the project is designed to **supplement existing capacity rather than compete for limited patient volume**.

Conclusion

Based on MHCC county-level utilization data and QOC's conservative projections, the proposed Home Health Agency will account for approximately **0.8% - 0.9% of total clients and visits within each county**. This minimal and evenly distributed market share demonstrates that:

- The project is **not dependent on capturing patients from existing providers**
- The impact on any individual county is **negligible**
- The proposed services will **enhance access without disrupting the existing delivery system**

Accordingly, QOC's projected utilization is consistent with maintaining a balanced and stable home health market across the Western Maryland region.

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IMPACT STANDARD

5. **Based on how QOC determined/estimated the proportion/share of county visits for the six-county area that it will capture in 2028, how will QOC know that it is capturing new clients rather than displacing clients from exiting HHAs?**

Applicant Response (Q5) – Basis for Determining Non-Displacement of Clients

Quality One Care Home Health, Inc. ("QOC") understands this question to refer to the five-county Western Maryland service area identified in the application, consisting of Allegany, Frederick, Garrett, Washington, and Carroll Counties.

The Applicant developed its projected market share using a conservative, data-driven methodology based on MHCC FY 2023 county-level utilization data and the projected service volumes presented in Table 2B. As demonstrated in the application, QOC's projected utilization represents approximately **0.87% of total clients and approximately 1% of total visits across the Western Maryland region.**

While these figures confirm that the project is modest in scale, QOC recognizes that market share alone does not fully address whether growth reflects new demand or displacement of existing patients. Accordingly, QOC's operational approach is designed to ensure that its growth is driven by **incremental access and unmet service needs**, rather than the redistribution of patients from existing providers.

Basis for Anticipated Growth

QOC's projected volume is expected to be generated through a combination of referral expansion, service accessibility, and patient choice, rather than provider displacement.

First, the Western Maryland region includes a mix of urban, suburban, and rural jurisdictions, where access to home health services can vary significantly. In counties such as Garrett and Allegany, geographic dispersion and travel constraints can limit provider reach, particularly for higher-acuity patients requiring frequent or specialized care. QOC's staffing model – specifically designed to account for travel time and regional coverage – positions the agency to serve patients who may otherwise experience delays or limited access to services.

Second, referral dynamics in home health care are not static. Hospitals, physicians, and discharge planners routinely evaluate providers based on responsiveness, capacity, and ability to meet specific patient needs. QOC's entry into the market introduces additional capacity and flexibility, allowing referral sources to place patients more efficiently without displacing existing provider relationships.

Third, broader healthcare trends support continued growth in home-based care. Increased emphasis on post-acute care management, hospital readmission reduction, and aging-in-place initiatives contributes

to sustained demand for home health services. QOC's projections reflect a measured participation in this ongoing demand rather than an assumption of capturing existing provider volume.

Operational Safeguards Against Displacement

In addition to its conservative projections, QOC has established operational practices that further support non-displacement of existing patients.

- **Referral-Based Growth:** Patient admissions will be driven by external referrals from hospitals, physicians, and care coordinators, rather than active solicitation of patients currently receiving services from other HHAs.
- **Capacity-Driven Acceptance:** QOC will accept patients based on its ability to provide timely and appropriate care, particularly in areas or situations where existing provider capacity may be limited.
- **Geographic Coverage Strategy:** By structuring staffing to address multi-county travel and rural access challenges, QOC will focus on expanding service reach rather than concentrating volume in already saturated areas.
- **Service Differentiation:** QOC's experience in managing higher-acuity and complex patients allows it to complement, rather than compete directly with, existing providers that may focus on lower-intensity service lines.

These practices ensure that growth is aligned with **access improvement and service availability**, not patient displacement.

Consistency with Market Data

The minimal share of projected utilization – less than one percent across both clients and visits – further reinforces that QOC's presence in the market will be incremental.

At this scale:

- The volume is insufficient to materially impact existing providers
- Growth is more appropriately attributed to **distributed demand across a large regional base**
- Any individual provider would experience negligible impact

This is consistent with the overall regional utilization of more than **16,700 clients and 250,000 visits annually**, which supports multiple providers operating simultaneously without disruption

Conclusion

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QOC will know that it is capturing new clients – rather than displacing existing patients – through the combination of:

- Conservative market share projections
- Referral-driven admissions
- Geographic and capacity-based service expansion
- Alignment with regional demand trends

Taken together, these factors demonstrate that the proposed project is designed to **expand access to home health services within the Western Maryland region**, rather than reallocate existing patient volume.

Accordingly, QOC's projected utilization reflects **incremental growth within an established and growing market**, consistent with MHCC's Impact Standard and the goals of the State Health Plan.

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FINANCIAL SOLVENCY

6. **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 (Q6) – Financial Solvency and Funding Capacity

Quality One Care Home Health, Inc. ("QOC") acknowledges the observed fluctuation in net income during the 2022–2024 period and provides the following clarification regarding the resources available to support the proposed Home Health Agency (HHA) and the Applicant's overall financial position.

The temporary decline in net income during this period does not reflect deterioration in core operations and was not indicative of financial instability, but rather reflects a combination of operational investments, workforce-related cost increases, and broader industry conditions affecting home-based care providers, including increased reliance on contract staffing and elevated labor costs. These factors were experienced across the industry and were actively addressed by QOC through internal operational adjustments and cost management strategies.

Importantly, the Applicant's most recent financial performance demonstrates that these corrective measures have been effective. As reflected in the Applicant's current financial statements (submitted as an exhibit), QOC has returned to **positive net income in 2025**, with continued revenue growth and improved cost management. This transition reflects a clear stabilization of operations and a return to sustainable financial performance.

As further evidence of financial strength, QOC generated approximately **$17.46 million in revenue in 2025**, with **net income of $89,344** and approximately **$630,851 in cash on hand**. These results demonstrate both the scale of existing operations and the organization's ability to maintain liquidity while supporting continued growth.

Resources Available to Fund HHA Start-Up

The proposed HHA will be funded entirely through **existing organizational resources**, consistent with the project budget presented in Table 1. As reflected in the application:

- Total capital costs are limited to **$35,000**, consisting primarily of movable equipment and contingency
- The overall project budget is approximately **$153,000**, with the majority allocated to working capital to support early operations

The project is **100% equity-funded**, with no reliance on external debt or financing.

QOC maintains sufficient financial capacity to support this investment, including:

- Strong and consistent revenue generation from established RSA operations
- Positive cash flow sufficient to support routine operational needs
- Available liquidity to support start-up costs and early operating periods
- A solid equity position, with minimal liabilities relative to total assets

Because the project leverages existing infrastructure – including administrative systems, compliance oversight, and centralized support functions – capital requirements remain limited and controlled.

Path to Profitability and Operational Sustainability

The proposed HHA is structured as a **phased, volume-driven expansion**, ensuring that expenses align directly with projected service utilization. As reflected in Table 4 of the CON application:

- Revenue increases proportionally with projected visits
- Expenses that scale proportionally with utilization, avoiding unnecessary fixed cost exposure
- Net income is positive in each projection year and increases over time

This disciplined approach minimizes early fixed cost exposure and ensures that the HHA contributes positively to overall organizational performance without requiring cross-subsidization from RSA operations.

Competitive Positioning and Financial Stability

QOC's ability to remain competitive with existing comprehensive HHAs is not dependent on scale alone, but on operational flexibility, service responsiveness, and targeted care delivery. The proposed HHA represents a **distinct, Medicare-certified service line that operates independently of RSA services while complementing the organization's overall care delivery model**. This addition strengthens QOC's financial position through service diversification, expanding beyond RSA-based personal care into Medicare-certified skilled services.

The Applicant's competitive strengths include:

- A flexible staffing model aligned with patient demand, allowing rapid response to referrals without overextending fixed payroll
- Experience in home-based and targeted service delivery, including skilled and high-acuity patient management
- Geographic adaptability, enabling service coverage across both urban and rural areas

- Established administrative infrastructure, reducing overhead and improving efficiency
- Referral responsiveness, which is a key determinant in provider selection by hospitals and physicians

In addition, QOC benefits from existing operational infrastructure, including its owned headquarters and centralized administrative support. This reduces overhead costs and allows the HHA to operate efficiently without duplicating corporate functions.

This approach allows QOC to remain competitive with larger HHAs while maintaining a controlled and sustainable cost structure. Rather than attempting to replicate the scale of larger HHAs, QOC's model focuses on **efficient, high-quality service delivery at a manageable and sustainable volume**, which is appropriate for the Western Maryland market.

Integration with Existing Operations

The addition of the HHA is not expected to strain RSA operations. Instead, it represents a strategic addition of a distinct, Medicare-certified service line that complements existing services while operating independently. This is supported by:

- Established administrative and compliance systems
- Existing leadership structure and clinical oversight
- Gradual staffing ramp-up aligned with utilization

As a result, the HHA operates as a natural extension of QOC's service platform, rather than a separate or resource-intensive undertaking.

Conclusion

While QOC experienced a temporary decline in net income during the 2022–2024 period, the organization has demonstrated clear financial recovery and operational stabilization, as evidenced by its return to profitability in 2025.

The proposed HHA is fully supported by existing resources, aligned with a conservative and scalable financial model, and designed to operate efficiently within the Western Maryland market. The limited capital requirements, absence of debt financing, and disciplined growth strategy ensure that the project can be implemented and sustained without placing financial strain on the organization.

Accordingly, QOC affirms that it has the financial capacity to successfully implement and sustain the proposed project while maintaining overall organizational profitability.

Linkages with Other Service Providers

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7. What proportion, if any, of the QOCs clients are expected to be children? Many of QOCs' current links are with youth-serving agencies and providers. If serving adults, please include linkages with adult services as well.

Applicant Response (Q7) – Linkages with Other Service Providers

Quality One Care Home Health, Inc. ("QOC") anticipates that pediatric patients will represent a **very limited proportion** of the projected Home Health Agency (HHA) census within the five-county Western Maryland service area (Allegany, Frederick, Garrett, Washington, and Carroll Counties).

The utilization projections reflected in Table 2B are based primarily on adult and geriatric home health utilization patterns derived from MHCC FY 2023 data. Consistent with these data, the proposed HHA is structured to primarily serve **post-acute, medically complex adult and Medicare-eligible populations**, which represent the dominant user group for Medicare-certified home health services in the region.

While QOC maintains existing relationships with youth-serving agencies through its Residential Service Agency (RSA) operations, these linkages do not define the projected service population for the proposed HHA. Pediatric referrals may be accepted on a case-by-case basis where clinically appropriate and within the scope of HHA licensure; however, the HHA is not designed or projected as a pediatric-focused service.

Accordingly, pediatric patients are expected to comprise **a minimal share of total admissions**, and their inclusion does not materially impact staffing projections, visit modeling, or financial assumptions presented in this application.

Linkages with Adult and Community-Based Providers

Consistent with its projected service population, QOC has established and will continue to develop linkages with providers and organizations serving adult and geriatric populations across the Western Maryland region. These include:

- Hospitals and health systems facilitating post-acute discharge planning
- Primary care providers and specialty physicians managing chronic and complex conditions
- Rehabilitation providers and therapy services supporting recovery and functional improvement
- Community-based organizations serving aging, disabled, and medically vulnerable populations
- Case management entities and care coordination programs

These relationships support coordinated care transitions, continuity of services, and appropriate patient placement within the home health setting.

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Conclusion

While QOC maintains diverse community linkages, including those with youth-serving organizations, the proposed HHA is primarily structured to serve adult and geriatric patients. Pediatric clients, if served, are expected to represent only a **very small proportion of total census** and do not form the basis of the utilization projections or operational model.

The Applicant's linkage strategy is therefore aligned with the projected patient population and supports effective integration with adult-focused healthcare providers across the Western Maryland service area.

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Project Financial Feasibility and Facility or Program Viability

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

Applicant Response (Q8) – Current Liabilities as of December 31, 2024

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

This presentation reflects the timing of year-end financial reporting and indicates that, as of December 31, 2024:

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

The absence of current liabilities at year-end does not indicate that the organization does not incur routine operating obligations. Rather, it reflects that such obligations are **incurred and settled within normal operating cycles**, and that balances outstanding at the reporting date were minimal or fully reconciled prior to closing.

This is consistent with QOC's financial management approach, which emphasizes:

- Maintaining low short-term debt exposure
- Timely settlement of vendor and payroll obligations
- Operating primarily on a cash and equity-supported basis

Accordingly, the $0 balance in current liabilities represents a **point-in-time reporting outcome** and is not indicative of omitted liabilities or atypical financial practices.

If requested, the Applicant can provide additional supporting documentation or clarification from its CPA regarding year-end accounting treatment and liability recognition.

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9. What is the telehealth business with a COGS of $250K indicated under 2024? This has impacted the Net Operating Revenue. Will this business continue?

Applicant Response (Q9) – Unrecurring Telehealth Activity

The CPA-prepared Statements of Revenues and Expenses (Tax Basis) reflect a $250,000 Cost of Goods Sold (COGS) 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, confirming that this telehealth-related activity occurred only during 2024 and did not continue into 2025.

This line item represents a **discrete, non-recurring business activity** and is not part of QOC's ongoing service model. Its discontinuation aligns with the organization's return to **positive net income in 2025**, reflecting improved operational focus and cost control.

The proposed Home Health Agency (HHA) is a **distinct, Medicare-certified service line** focused exclusively on traditional home health services, including Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Work, and Home Health Aide services. The HHA does not include or rely upon any telehealth-related business activity.

Accordingly:

- The $250,000 telehealth-related COGS recorded in 2024 is **non-recurring**
- No telehealth-related expenses are reflected in 2025 or in any projected financial statements
- The proposed HHA financial projections (Table 4) are based solely on traditional home health service delivery

As a result, the 2024 telehealth activity does not represent an ongoing operating cost and **will not affect the financial feasibility or projected performance** of the proposed HHA.

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

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

Applicant Response (Q10) – Working Capital Requirements

The proposed Home Health Agency (HHA) does not require capital construction or project debt and is structured with sufficient working capital to support operations during the start-up and reimbursement period.

As reflected in the Applicant's most recent financial statements (to be submitted as an exhibit), QOC reports approximately **$630,851 in cash on hand** and minimal current liabilities, demonstrating strong liquidity and the ability to support ongoing operations without reliance on external financing.

Working Capital Allocation

The project budget (Table 1) includes a dedicated **working capital allocation of $100,000**, specifically intended to support:

- Clinical payroll during the CMS certification and initial billing period
- Regional operating expenses, including administrative and field support
- Early-stage operational costs prior to reimbursement stabilization

This allocation reflects a deliberate and conservative approach to financial planning and ensures that sufficient funds are available during the initial operating phase.

Coverage of Payroll and Operating Expenses

Based on Table 4 projections, Year 1 operating expenses are approximately **$183,760 annually**, or roughly **$15,000 per month**.

Under a conservative assumption of a **three to six-month delay in CMS reimbursement**, the combined effect of:

- Existing cash reserves (~$630,000), and
- Dedicated working capital allocation ($100,000)

provides more than sufficient coverage of projected payroll and operating expenses during the start-up period.

This structure ensures that staff compensation and operational obligations can be met **without interruption and without reliance on borrowing**.

Financial Management Approach

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QOC's approach to working capital reflects disciplined financial management, including:

- Maintaining low short-term debt exposure
- Aligning staffing levels with actual patient volume (phased ramp-up)
- Utilizing contract staff where appropriate to manage early cost variability
- Leveraging existing administrative infrastructure to minimize overhead

These factors collectively reduce financial risk during the start-up phase and support stable operations throughout the reimbursement cycle.

Conclusion

The proposed HHA is supported by both **existing liquidity and a dedicated working capital reserve**, ensuring that payroll and operating expenses can be fully sustained during the CMS enrollment and reimbursement period.

Accordingly, no additional external working capital financing is required. The Applicant will utilize existing resources to support operations until reimbursement cycles are established, ensuring continuity of care and financial stability from project initiation.

11. Telehealth business was included as a one off in December 2024. Will this be a recurring cost? What are the projections for this business line?

Applicant Response (Q11) – Telehealth Business (One-Off Expense)

As noted in the response to Question 9, the telehealth-related expense reflected in 2024 is **non-recurring** and does not represent an ongoing business line.

The CPA-prepared Statements of Revenues and Expenses (Tax Basis) include a $250,000 Cost of Goods Sold (COGS) 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, confirming that this activity occurred only during 2024 and did not continue into 2025.

This reflects a **discrete, one-time operational activity** that has since been discontinued. No telehealth-related expenses are reflected in current operations or in any projected financial statements.

The proposed Home Health Agency (HHA) is a **distinct, Medicare-certified service line** focused exclusively on traditional home health services, including Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Work, and Home Health Aide services. The HHA does not include or rely upon any telehealth-related business activity.

Accordingly:

- The telehealth expense recorded in 2024 is **not a recurring cost**
- There are **no projections associated with a telehealth business line**
- No telehealth-related revenue or expenses are included in Table 4 or any financial projections

As a result, the 2024 telehealth activity does not impact the projected financial performance, cost structure, or viability of the proposed HHA.

12. 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 (Q12) – Cost of Goods Sold (COGS) and Operational Sustainability

The increase in Cost of Goods Sold (COGS) relative to revenue growth in 2023 and 2024 is primarily attributable to **direct wages and subcontractor expenses**, as reflected in the Applicant's CPA-prepared Statements of Revenues and Expenses (Tax Basis).

Specifically, for the period ended October 31, 2024, COGS included:

- $2,181,160 in direct wages
- $11,077,903 in subcontractor costs
- A one-time $250,000 telehealth-related expense

These cost increases reflect broader industry conditions, including workforce shortages and increased reliance on contract staffing to maintain service coverage, rather than structural inefficiencies within the organization.

Non-Recurring and Transitional Cost Drivers

A significant portion of the observed cost escalation is attributable to **non-recurring and transitional factors**, including:

- The $250,000 telehealth expense, which did not recur in 2025 (reflected as $0)
- Elevated use of subcontracted labor during a period of workforce volatility
- Strategic operational adjustments made to maintain service continuity

Importantly, these factors were temporary in nature.

As reflected in the Applicant's most recent financial performance, the discontinuation of telehealth activity and improved cost management resulted in a **return to positive net income of $89,344 in 2025**, demonstrating stabilization of operations.

Capital Investment vs. Operating Costs

During the 2022–2024 period, the Applicant also undertook significant capital investment in long-term infrastructure, including acquisition of its headquarters property and facility improvements.

These expenditures, reflected on the balance sheet, contributed to short-term margin compression through:

- Transaction-related costs
- Renovation expenditures
- Depreciation

However, these are **capital investments**, not ongoing operating costs, and they strengthen the organization's long-term cost structure by reducing lease obligations and supporting operational scalability.

Distinction Between RSA Cost Structure and HHA Model

The cost structure of the proposed HHA is **fundamentally different** from the RSA cost trends observed during 2023–2024.

The HHA is designed as a **distinct, Medicare-certified service line** with:

- A **phased staffing model**, aligned directly with patient volume (Table 2B)
- Strategic use of contract staff during early ramp-up to control fixed costs
- Gradual transition to employed staff as volume stabilizes
- No capital construction or project debt (Table 1)

This structure ensures that expenses are **variable and scalable**, rather than fixed and front-loaded.

Financial Sustainability of the Proposed HHA

The financial projections for the HHA (Table 4) demonstrate that:

- Revenue growth is directly tied to visit volume
- Expenses scale proportionally with utilization
- Net income is positive in each projected year

Unlike the RSA trends observed during a period of industry disruption and capital investment, the HHA model is built on **controlled growth, disciplined cost management, and alignment between staffing and demand**.

In addition, the Applicant maintains:

- Strong liquidity (~$630,000 in cash)
- Minimal short-term liabilities
- No reliance on debt financing

These factors provide a stable financial foundation for sustaining operations.

Conclusion

While COGS increased at a higher rate than revenue during 2023–2024, this was driven by **temporary workforce conditions, non-recurring telehealth activity, and capital investment**, rather than ongoing structural cost imbalance.

The Applicant has since demonstrated **operational stabilization and return to profitability in 2025**, and the proposed HHA is structured with a materially different and more controlled cost model.

Accordingly, QOC is well-positioned to sustain the operating costs of the proposed HHA project through:

- Scalable, utilization-driven staffing
- Elimination of non-recurring cost drivers
- Strong existing liquidity and financial discipline

The proposed HHA is therefore financially sustainable and does not depend on continued cost escalation within RSA operations.

CON TABLE PACKAGE

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13. 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 (Q13) – Staffing Growth Relative to Visit Volume

The apparent difference between the rate of growth in projected visits (Table 2B) and staffing levels (Table 5) reflects the Applicant's **productivity-based staffing model**, rather than a linear staffing approach.

The HHA staffing model is intentionally structured to maximize clinical productivity while maintaining safe and compliant care delivery. As a result, staffing does not increase at the same rate as visit volume because each clinician is capable of delivering multiple visits per day.

Productivity-Based Staffing Model

All clinical staffing projections are based on:

- **2,080 paid hours per FTE annually**
- A **0.85 productivity factor** (to account for non-productive time)
- A conservative expectation of approximately **4.5 – 5 visits per day**

This means that each incremental FTE can support a **significant increase in visit volume**, reducing the need for proportional staffing increases. For example:

- RN/LPN staffing increases from approximately **0.50 FTE to 1.10 FTE**, while skilled nursing visits increase from **374 to 773 visits**
- HHA staffing increases from **0.40 to 0.85 FTE**, while aide visits increase from **348 to 718 visits**

This reflects efficient utilization of staff rather than under-allocation.

Use of Contracted Clinical Staff

Another key factor is the use of **contracted clinicians**, particularly for therapy services (PT, OT, ST) and Medical Social Work during early years.

This allows the Applicant to:

- Meet fluctuating demand without committing to full-time FTEs
- Scale services flexibly across multiple counties
- Avoid underutilized staff during ramp-up

As volume stabilizes, these roles gradually transition to employed positions, which is reflected in Table 5.

Geographic Efficiency and Visit Density

The Western Maryland region includes both urban and rural service areas. As operations mature:

- Patient clustering improves
- Travel routes become more efficient
- Visit density increases within assigned territories

This allows clinicians to complete more visits per day over time, further reducing the need for proportional staffing increases.

Phased Administrative Growth

Administrative staffing is also scaled gradually:

- 0.50 FTE in Year 1
- 0.75 FTE in Year 2
- 1.00 FTE in Year 3

This reflects increasing coordination needs as volume grows, while leveraging existing corporate infrastructure to minimize overhead.

Conclusion

The relationship between visit growth and staffing levels reflects a **deliberate, productivity-driven model**, rather than an underestimation of staffing needs. The combination of multi-visit clinician productivity, strategic use of contract staff, geographic efficiency gains, and phased staffing increases ensures that staffing levels remain sufficient, efficient, and financially sustainable as service volume grows.

Accordingly, the Applicant affirms that the staffing projections in Table 5 are appropriate and fully support the projected utilization presented in Table 2B.

a) Please complete the information outlined in the table below for analysis:

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Applicant Response Q13(a) – FTE, Change in FTE and Visits by Year table

FTE, Change in FTE, and Visits by Year

Position	2026 Change in FTE	2026 Volume	2027 Change in FTE	Total 2027 FTE	2027 Volume	2028 Change in FTE	Total 2028 FTE	2028 Volume
RN/LPN	0.5	374	0.3	0.8	586	0.3	1.1	773
PTs	0.10 (contract)	262	0.06	0.16	410	0.06	0.22	541
OTs	0.05 (contract)	57	0.03	0.08	90	0.03	0.11	118
STs	0.02 (contract)	11	0.01	0.03	17	0.01	0.04	22
HHAs	0.4	348	0.25	0.65	545	0.2	0.85	718
Med. Soc.	0.03 (contract)	8	0.02	0.05	13	0.02	0.07	17
Admin	0.5	—	0.25	0.75	—	0.25	1	—
Nurse Supervisor	Included in RN/Admin structure	—	—	—	—	—	—	—

b) Review Table 5 totals between years to verify any calculation discrepancies between 2026–2027–2028.

Applicant Response Q13(b) – Verification of Table 5 Calculations (2026 – 2028)

The Applicant has reviewed Table 5 (Staffing Information) across the three projected years (2026, 2027, and 2028) and confirms that the staffing totals and associated calculations are internally consistent and reflect a structured, phased increase in staffing aligned with projected service volume. The progression of total FTEs across the three years is as follows:

- **2026:** Approximately 1.40 total FTEs
- **2027:** Approximately 2.20 total FTEs
- **2028:** Approximately 2.95–3.00 total FTEs

These totals are derived from the sum of position-level FTE allocations, including administrative, nursing, aide, and contracted clinical staff, as presented in Table 5 for each respective year.

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Consistency of Calculation Methodology

All FTE calculations are based on a uniform methodology applied consistently across all three years:

- **2,080 paid hours per FTE annually**
- A **0.85 conversion factor** to account for non-productive time (e.g., leave, training, documentation)
- Position-level allocations that reflect either employed or contracted staffing

There are no changes in calculation assumptions between years; differences in totals are solely the result of **planned staffing increases** tied to projected utilization growth. This verification includes both agency-employed and contracted FTEs as reflected in Table 5, ensuring that all clinical and administrative staffing components are fully accounted for in the year-to-year totals.

Explanation of Year-to-Year Changes

The increase in FTEs from 2026 through 2028 reflects a **phased staffing model**, rather than recalculation or inconsistency.

Specifically:

- Nursing, aide, and administrative roles increase incrementally in response to projected patient census and visit volume
- Therapy and Medical Social Work staffing grows gradually, with early reliance on contracted staff transitioning to higher utilization over time
- Administrative staffing expands in proportion to operational complexity and intake volume

These increases are intentional and correspond directly to the projected growth in clients and visits presented in Table 2B.

Salary and Expense Alignment

Salary projections in Table 5 also reflect:

- Consistent application of position-specific salary benchmarks
- A standard **3% annual increase** in salary levels across projection years
- A uniform **20% benefits calculation** applied to agency-employed staff

Variations in total salary expense between years are therefore attributable to: Increased FTE counts, Standardized salary escalation, and Gradual transition from contract to agency staff in certain roles

Conclusion

The Applicant has conducted a detailed review of Table 5 across the 2026–2028 projection period to ensure that all staffing, salary, and expense calculations are accurate, internally consistent, and aligned with the overall utilization and operational assumptions presented in the CON application. This review confirms that the staffing model is both methodologically sound and appropriately structured to support the proposed HHA.

Based on this review, the Applicant confirms that:

- There are **no calculation discrepancies** in Table 5 across the 2026–2028 projection period, and all totals reconcile to the position-level FTE allocations presented in each year
- All FTE, salary, and expense figures are derived using a **consistent and uniform methodology**, including the application of 2,080 annual paid hours, a 0.85 productivity factor, and standardized salary and benefit assumptions
- Year-to-year differences reflect **intentional, phased operational growth**, aligned with projected increases in patient volume and visit intensity, rather than inconsistencies or calculation errors
- Staffing adjustments across disciplines are proportionate to service demand and reflect a **structured transition from initial contract utilization to increased operational capacity over time**

Accordingly, Table 5 provides an accurate, internally consistent, and methodologically sound representation of the staffing model supporting the proposed HHA. The staffing projections are fully aligned with the utilization assumptions presented in Table 2B and demonstrate a scalable approach that supports both operational efficiency and financial sustainability.

c) Confirm travel time assumptions are included in FTE calculations.

Applicant Response (Q13c) – Travel Time Assumptions in FTE Calculations

Yes, travel time assumptions are fully incorporated into the FTE calculations reflected in Table 5. Projected visit volumes in Table 2B were developed using MHCC utilization data for the Western Maryland service area (Allegany, Frederick, Garrett, Washington, and Carroll Counties). Staffing projections in Table 5 were then derived by applying conservative, industry-standard productivity assumptions to those projected visits.

While MHCC utilization tables report visits volume and client counts, they do not account for operational productivity factors. Accordingly, QOC's FTE model incorporates productivity benchmarks that reflect real-world home health operations, including:

- Documentation and OASIS-related activities
- Care coordination and case conferencing
- **Travel time between patient locations**

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These benchmarks are intentionally set below theoretical maximum visit capacity to ensure realistic and sustainable staffing levels.

Travel time is not calculated as a separate line-item variable; rather, it is **embedded within the productivity standards** used to determine annual visit capacity per FTE. This approach is consistent with standard home health staffing methodology.

Importantly, the Western Maryland service area includes both urban and rural jurisdictions, with certain counties, such as Garrett and Allegany, requiring greater travel time between patient locations. The productivity assumptions applied in the model account for these geographic conditions and ensure that staffing projections reflect actual service delivery realities.

Accordingly, the FTE calculations in Table 5 incorporate travel time as an integral component of productivity, resulting in a staffing model that is both operationally realistic and aligned with the geographic characteristics of the service area.

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Health Equity

14. 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 (Q14) – Medically Underserved Populations and Access

Quality One Care Home Health, Inc. ("QOC") identified medically underserved populations within the proposed service area through a combination of objective utilization data, regional demographic characteristics, and direct operational experience providing home-based care services.

Rather than relying on a single source, the Applicant's assessment reflects a **convergence of data and real-world service experience**, ensuring that the populations identified are both measurable and operationally relevant.

1. Source of Assumptions Identifying Medically Underserved Populations

The primary data source for this analysis is the Maryland Health Care Commission (MHCC) FY 2023 Home Health Agency Utilization Tables 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 datasets provide a comprehensive view of service utilization patterns across the Western Maryland service area (Allegany, Frederick, Garrett, Washington, and Carroll Counties).

Collectively, these data indicate that the region includes approximately **16,716 unduplicated home health clients and 252,832 total visits annually**, with utilization heavily concentrated among older adults and Medicare beneficiaries. This confirms that the service area is characterized by a **predominantly aging population with complex clinical needs**, many of whom depend on home-based services for ongoing care and stabilization.

Beyond utilization levels, the geographic distribution of the region also plays a critical role. Western Maryland includes both urban centers and more rural jurisdictions, where patients may experience longer travel distances, fewer provider options, and greater barriers to consistent outpatient care. These conditions are particularly relevant for individuals who are homebound, mobility-limited, or managing multiple chronic conditions.

QOC's own operational experience further supports these findings. Through its RSA services, the organization routinely serves individuals who face overlapping challenges—financial constraints, limited caregiver support, and functional limitations. In practice, these factors often intersect, reinforcing the need for a care model that is both flexible and responsive.

2. How QOC Will Address Identified Challenges

QOC's approach to serving medically underserved populations is not theoretical; it is built into the structure of the proposed HHA and supported by defined policies and operational practices.

For individuals facing financial barriers, QOC will implement a formal charity care and sliding fee scale framework, which includes:

- A formal **Charity Care and Sliding Fee Scale Policy**
- Eligibility for **100% charity care up to 200% of the Federal Poverty Level (FPL)**
- Graduated discounts above 200% FPL
- A **two-business-day eligibility determination process**
- Interest-free payment plan options

Patients meeting income eligibility thresholds will have access to reduced-cost or fully subsidized services, with determinations made promptly to avoid delays in care. Importantly, services will not be denied based solely on inability to pay, ensuring compliance with financial accessibility standards.

For older adults with chronic conditions, the model emphasizes continuity and coordination. Skilled nursing oversight, medication reconciliation, and structured care planning are integrated with ongoing reassessment through OASIS-based documentation. These interventions are designed to reduce avoidable hospitalizations and support patients in maintaining stability at home.

Given the predominance of older adults in the service area, QOC will provide:

- Skilled nursing and interdisciplinary care planning
- Chronic disease management protocols

- Medication reconciliation and patient education
- OASIS-based ongoing reassessment
- Coordination with hospital discharge planners to reduce readmissions

These interventions are designed to support **aging in place and continuity of care**.

Individuals with disabilities and functional limitations are addressed through a more individualized approach. Home safety assessments, mobility evaluations, and coordination with community-based services – such as AERS and social support programs – allow care plans to be tailored to each patient's environment and support system. In these cases, medical social work plays a key role in bridging clinical care with community resources.

Geographic access challenges are addressed through the design of the service model itself. QOC will deploy a mobile, field-based clinical workforce across all five counties, supported by a centralized administrative structure and a Frederick-based coordination hub. To address geographic and access-related barriers, QOC will:

- Deploy a **mobile, field-based clinical workforce** across all five counties
- Utilize a **hub-and-spoke model**, with Frederick serving as a regional coordination hub
- Maintain centralized administrative support to improve efficiency and responsiveness
- Coordinate with hospitals, physicians, and community organizations
- Incorporate screening for social determinants of health during intake

This model allows the agency to extend services into less densely populated areas and improves **timeliness of care, continuity of services, and access to Medicare-certified home health care** across both urban and rural areas without compromising responsiveness or efficiency.

In addition, intake processes will incorporate screening for social determinants of health, enabling early identification of barriers such as transportation limitations, financial hardship, or lack of caregiver support.

Conclusion

The identification of medically underserved populations in this application is grounded in both **objective MHCC utilization data and practical service experience**, ensuring that the populations identified reflect real and measurable needs within the Western Maryland region.

QOC's response to these needs is embedded within its operational model through a combination of policy-driven financial accessibility, targeted clinical interventions, and a geographically responsive service delivery structure. Together, these measures support improved access, continuity of care, and equitable service availability across the proposed service area.

These approaches are consistent with COMAR requirements and align with the Commission's broader goals related to access, equity, and quality of care.

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

Applicant Response (Q15) – 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 significant barriers to timely access to medically necessary care, particularly for underserved populations. In practice, these denials often affect older adults, low-income patients, and individuals with disabilities who may already face challenges navigating the healthcare system.

For that reason, QOC approaches denials not simply as administrative events, but as situations that require **active clinical advocacy and structured follow-through** to ensure that appropriate care is ultimately delivered.

I. Proactive Measures to Reduce Denials

QOC's first line of defense is prevention. Before care begins, clinical and administrative teams work together to ensure that each case is properly supported.

This includes:

- Verifying eligibility and payer benefits prior to initiation of care
- Confirming that physician orders meet Medicare Conditions of Participation
- Ensuring documentation clearly supports homebound status and skilled need
- Completing OASIS assessments accurately and on time
- Conducting internal claim review prior to submission

These steps are routine but essential. When done consistently, they significantly reduce avoidable denials tied to documentation or technical deficiencies.

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 any appeal is grounded in **clear, defensible clinical justification**. All clinical review and appeal activities are conducted under the authority of the HHA Administrator and Director of Nursing, consistent with Medicare Conditions of Participation (42 CFR Part 484), ensuring that determinations of medical necessity and documentation standards meet federal regulatory requirements.

C. Formal Appeals and Follow-Through

When resubmission is not sufficient, QOC proceeds with a formal appeal. In those cases:

- Appeals are submitted within required payer timelines
- Supporting documentation includes clinical records, physician certification, and any additional justification
- Appeal status is tracked and followed through to resolution

This process is conducted in accordance with Medicare, Medicaid, and managed care requirements to ensure compliance and consistency.

III. Support for Underserved Patients During the Appeal Process

QOC recognizes that denials can disproportionately affect underserved populations, who may have limited resources or difficulty navigating the appeals process.

To address this, QOC provides additional support by:

- Communicating clearly with patients and caregivers about denial reasons and next steps
- Assisting patients in understanding payer correspondence and appeal requirements

- Coordinating with case managers, social services, or community resources when appropriate

Where permitted, QOC may also implement:

- Charity care or sliding fee scale options
- Temporary continuation of services when clinically appropriate and compliant

These measures help ensure that medically necessary care is not interrupted solely due to administrative or financial barriers.

IV. Ongoing Oversight and Continuous Improvement

Denial management is also part of QOC's broader quality oversight framework.

The organization:

- Monitors denial trends through routine administrative review
- Incorporates findings into its **Quality Assurance and Performance Improvement (QAPI)** program
- Provides targeted staff training to reduce recurring denial patterns
- Maintains documentation practices aligned with Medicare and State requirements

Over time, this approach strengthens performance and reduces repeat issues. Denial management activities are incorporated into QOC's Quality Assurance and Performance Improvement (QAPI) program, with defined administrative and clinical accountability to ensure ongoing compliance with federal and State regulatory standards.

Conclusion

QOC's approach to overturning denials combines **proactive prevention, structured clinical review, and persistent follow-through**. More importantly, it reflects a commitment to ensuring that patients, particularly those who are underserved, are not denied access to medically necessary care due to avoidable administrative or documentation barriers. QOC's will commit to:

- 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. By

integrating clinical advocacy with operational discipline, QOC works to secure appropriate coverage while maintaining continuity of care and compliance with federal and State requirements.

Character and Competence

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

Applicant Response (Q16) – 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 multiple jurisdictions, including Frederick County and surrounding regions relevant to the proposed Western Maryland service area.

A. Health System and Referral Integration

QOC maintains structured referral coordination and service relationships with a range of healthcare providers and community-based organizations. These include established referral pathways and coordination with:

- Major hospital systems and specialty providers
- The Coordinating Center for REM and Model Waiver programs
- Community-based organizations serving individuals with disabilities
- Public school systems and care coordination entities where appropriate

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

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B. Culturally Responsive Service Delivery

QOC serves a demographically diverse population across both suburban and rural communities. Its operational practices emphasize cultural responsiveness and patient-centered care.

This is reflected through:

- Recruitment of staff reflective of the communities served
- Delivery of services in languages commonly spoken within the service area, where feasible
- Inclusion of patients, families, and caregivers in care planning discussions
- Communication standards that prioritize respect, cultural sensitivity, and clarity

These practices are embedded into agency policy and supported through staff training and supervisory oversight.

C. Structured SDOH Screening and Referral Practices

QOC incorporates assessment of social determinants of health (SDOH) into its intake and care coordination processes.

Routine evaluation includes factors such as:

- 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 service agencies, case management entities, and local support organizations.

This structured approach strengthens continuity of care and reflects QOC's experience serving vulnerable and medically underserved populations.

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

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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. This accreditation 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 validation demonstrates QOC's established 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
- Ongoing policy review and compliance monitoring

These systems provide structured governance and align with expectations for Medicare-certified home health agencies.

C. Operational Stability and Experience

QOC has operated continuously since 2009, with sustained service delivery across multiple jurisdictions. Its operational history, financial stability, and maintained licensure reflect organizational maturity and reliability.

This experience provides a strong foundation for the implementation of a Medicare-certified HHA.

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III. Planned Ongoing Community Engagement

Upon CON approval and HHA licensure, QOC will expand its engagement within the Western Maryland service area (Allegany, Frederick, Garrett, Washington, and Carroll Counties).

Planned activities include:

- Formalized linkages with hospitals, nursing facilities, assisted living providers, and community-based organizations
- Continued collaboration with discharge planners and care coordination programs
- Integration of SDOH screening into HHA intake workflows
- Outreach to organizations serving older adults, individuals with disabilities, and medically underserved populations
- Continued development of a culturally responsive workforce

This approach is designed to strengthen access, improve care transitions, and support equitable service delivery across both urban and rural portions of the service area.

IV. Leadership Ethics and Governance Accountability

QOC's leadership structure reflects a commitment to ethical governance, regulatory compliance, and accountability.

The organization 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 State and federal regulatory standards
- Maintenance of financial transparency and responsible fiscal management

QOC's governing body and administrative leadership prioritize patient welfare, regulatory compliance, and long-term service sustainability.

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 operate a **distinct, Medicare-certified Home Health Agency** within the Western Maryland service area with professionalism, integrity, and regulatory compliance.

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

Applicant Response (Q17) – 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. His role is administrative and technical in nature, supporting regulatory readiness and operational coordination, and does not include clinical or governing authority.

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 key 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.

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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.

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 and 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 and Policies (Staffing, Visit Totals, & Exhibit 5)

Alignment Across Tables

18. 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 (Q18) – 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-prepared 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 with the CPA statement.

For CY 2024, total salaries and wages (including payroll service fees and pension expense) equal **$3,159,132**, which also agrees with the CPA statement.

Contractual services reflected in Table G reconcile to subcontractor-related expenses reported in the CPA financial statements for each respective year. These amounts include both routine subcontracted clinical services and the one-time telehealth-related activity previously described.

Table L reflects current staffing levels (CY 2024) and total personnel costs of **$3,159,132**, which reconcile directly to the salaries and wages (including benefits) reported in Table G for CY 2024 and to the CPA statement for the same period.

Accordingly, Tables G and L are fully aligned with the CPA financial statements for CY 2023 and CY 2024, and all reported amounts are consistent across the application.

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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 … 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… Equivalents (FTEs) should be … table are consistent with expenses provided in uninflated … rojections in Tables F and G. … e that the projections in this

		CURRENT 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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19. Table G2 on page 34 states there will be 2,610 visits in 2028. However, Table 2B on page 81 states the total is 2,189. Please review and provide the correct total.

Applicant Response (Q19) – Reconciliation of Projected Visit Totals

The Applicant has reviewed the discrepancy between Table G2 and Table 2B regarding projected 2028 visit totals.

Table 2B reflects the **primary statistical projection model** for the proposed Home Health Agency and is based on detailed assumptions regarding patient volume, visit intensity, and discipline-specific allocation. As such, Table 2B represents the **authoritative source for projected utilization**.

Accordingly, the correct total projected visits for 2028 are **2,189 total visits**, as reflected in Table 2B.

The higher figure of 2,610 visits shown in Table G2 reflects a **derived planning estimate**, which was not updated to align precisely with the finalized utilization projections in Table 2B. This difference is attributable to earlier modeling assumptions and rounding or allocation adjustments used during intermediate planning stages.

The Applicant confirms that Table 2B contains the **correct and controlling visit projections**.

- All staffing (Table 5) and financial projections (Table 4) are based on the **2,189-visit total**
- The 2,610 figure in Table G2 does not affect any underlying calculations or conclusions within the application and does not impact the overall conclusions of the impact analysis, as the corrected figure continues to represent approximately **1% of total regional utilization**, maintaining the Applicant's position that the project will have no material adverse impact on existing providers.

Accordingly, Table G2 is superseded by the finalized utilization projections presented in Table 2B.

20. Check the totals for Table 4 because of this volume discrepancy. Submit corrected tables with an explanation of the volume and revenue totals.

Applicant Response (Q20) – Reconciliation of Table 4 Volume and Revenue Totals

The Applicant has reviewed Table 4 volume discrepancy identified in Q19 and confirms that Table 4 has been reviewed and is confirmed to be based on the finalized utilization projections reflected in Table 2B, including 2,189 total visits for 2028. Accordingly, Table 4 does not require revision.

The previously identified discrepancy (2,610 visits) was limited to Table G-2 and does not affect the financial projections presented in Table 4.

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Volume Alignment

- Table 2B (2028 total visits): **2,189 visits**
- Table 4 projections were developed using this same finalized visit volume

Accordingly, **no revisions to Table 4 visit assumptions are required**, as the financial model is already aligned with the correct utilization.

Revenue Calculation Methodology

Table 4 revenue projections are not based on a single flat per-visit rate, but rather reflect a blended, payer-adjusted and discipline-weighted reimbursement model, consistent with Maryland home health agency payment structures. Specifically:

- Revenue incorporates a **mix of services** (skilled nursing, home health aide, therapy, and ancillary services), each with different reimbursement levels
- The projections reflect a **payer mix dominated by Medicare and Medicare Advantage**, consistent with MHCC FY 2023 utilization data
- Higher reimbursement services (e.g., skilled nursing and therapy) are proportionally represented in the projected case mix
- Contractual adjustments, bad debt, and charity care are applied to gross revenue, consistent with standard financial modeling practices

As a result, total projected revenue exceeds a simple "visits × average rate" calculation and instead reflects a **realistic, multi-variable reimbursement structure**

Financial Consistency

Table 4 remains internally consistent with:

- Table 2B utilization projections
- Table 5 staffing levels
- Payer mix assumptions and reimbursement methodology

Conclusion

Table 4 has been reviewed and is consistent with the corrected visit total of 2,189 visits for 2028. The discrepancy identified in Table G2 does not impact the financial projections, as Table 4 was developed using the finalized utilization assumptions reflected in Table 2B.

Accordingly, the Applicant confirms that the financial projections presented in Table 4 are accurate and do not require revision.

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21. If Table 5 for 2026 has agency staff of .35 for RN, .15 for LPN, and .4 for home health aide, then explain why Table 5 for 2027 has zero for current FTEs in that year, and likewise in Table 5 for 2028?

a) Explain if the column labeled change in FTE is actually the total current FTE for that year.

b) The current number of columns should be the total for that calendar year, and the change in FTE should be the change, plus or minus, from the previous year.

c) Resubmit the tables with any adjustments required.

Response to Q21: Clarification and Correction of Table 5 Staffing Presentation

The Applicant acknowledges MHCC's observation regarding the presentation of staffing levels in Table 5. The tables below reflect the corrected Table 5 format as resubmitted with this response.

a. Clarification of "Change in FTE" Column

In the originally submitted tables, the "Change in FTE" column was inadvertently used to reflect total projected staffing levels for each year, rather than the incremental change from the prior year. As a result, the "Current FTE" column was incorrectly shown as zero in each projection year.

b. Corrected Methodology

Consistent with MHCC guidance:

- The **"Current FTE" column now reflects total staffing levels for each year**, and
- The **"Change in FTE" column reflects the incremental change from the prior year**

This correction results in a cumulative staffing model consistent with a phased ramp-up of operations.

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c. Corrected Table 5 – Staffing Levels

Table 5: FY 2026 (Baseline)

Position	Current FTE	Change
Admin	0.5	0.5
RN	0.35	0.35
LPN	0.15	0.15
HHA	0.4	0.4
PT (contract)	0.1	0.1
OT (contract)	0.05	0.05
ST (contract)	0.02	0.02
MSW (contract)	0.03	0.03

Table 5: FY 2027 (Corrected)

Position	Current FTE	Change
Admin	0.75	0.25
RN	0.55	0.2
LPN	0.25	0.1
HHA	0.65	0.25
PT (contract)	0.16	0.06
OT (contract)	0.08	0.03
ST (contract)	0.03	0.01
MSW (contract)	0.05	0.02

Table 5: FY 2028 (Corrected)

Position	Current FTE	Change
Admin	1.00	0.25
RN	0.75	0.2
LPN	0.35	0.1
HHA	0.85	0.2
PT (contract)	0.22	0.06
OT (contract)	0.11	0.03
ST (contract)	0.04	0.01
MSW (contract)	0.07	0.02

Conclusion

This correction is limited to table formatting and presentation. There are no changes to total staffing levels, productivity assumptions, salary calculations, or financial projections. The staffing model remains fully aligned with projected utilization (Table 2B) and financial projections (Table 4).

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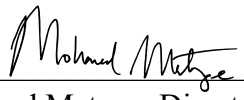
AFFIRMATION

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



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

04/02/2026
Date

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EXHIBITS

Exhibit #	Exhibit Description
Exhibit 1	Revised Ex 5- QOC Admission & Discharge Policy - Revised for Western MD
Exhibit 2	Financial Statements - 10/31/2025
Exhibit 3	con__application_table_package_20170501_table-G-L (submitted as excel via email and USB Drive
Exhibit 4	Corrected Table 5 - Staffing Levels

EXHIBIT 1

Revised QOC Admission & Discharge Policy

QOC Quality One Care
Home Health, Inc
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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 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 counties/jurisdiction from Western Maryland: Frederick, Carroll, Washington, Allegany, Garrett 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.

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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 include:

- 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)

EXHIBIT 2

Financial Statements - 10/31/2025

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: January 8, 2026

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**

☑ 10/31/2025 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
Jane Huserova

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of October 31, 2025

	Oct 31, 25
ASSETS	
Current Assets	
Checking/Savings	
First Citizens Bank 2213	595,646
Truist 5249	30,064
Truist 5257	500
Truist 5265	3,275
Truist 5273	1,366
Total Checking/Savings	630,851
Accounts Receivable	
Accounts Receivable (A/R)	(1,000,000)
Total Accounts Receivable	(1,000,000)
Other Current Assets	
Undeposited Funds	1,000,000
Total Other Current Assets	1,000,000
Total Current Assets	630,851
Fixed Assets	
Accum. Depreciation	(179,475)
Computers	34,279
Furnitures and Equipment	47,303
Leasehold Improvements	8,719
Leasehold Improvements E&M Inve	445,123
Printers	7,386
Total Fixed Assets	363,334
TOTAL ASSETS	994,185
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Child Support Payable	96
Total Other Current Liabilities	96
Total Current Liabilities	96
Long Term Liabilities	
EIDL SBAD TREAS	119,854
Total Long Term Liabilities	119,854
Total Liabilities	119,950

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of October 31, 2025

	Oct 31, 25
Equity	
Capital	20,000
Distributions Mohamed	(341,742)
Retained Earnings	1,106,633
Net Income	89,344
Total Equity	874,235
TOTAL LIABILITIES & EQUITY	994,185

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended October 31,2025 and 2024

	Jan - Oct 25	Jan - Oct 24	% of Income
Ordinary Income/Expense			
Income			
Service Revenues	17,460,992	14,049,549	100%
Total Income	17,460,992	14,049,549	100%
Cost of Goods Sold			
Business Telehealth	0	250,000	0%
Direct Wages	3,878,999	2,181,160	22%
Subcontractors - COS	12,528,603	11,077,903	72%
Total COGS	16,407,602	13,509,063	94%
Gross Profit	1,053,390	540,486	6%
Expense			
Accounting	20,590	18,890	0%
Advertising	0	9,000	0%
Auto Expenses	1,313	730	0%
Bank & Merchant Fees	1,637	1,082	0%
CHARITY	5,297	0	0%
Depreciation Expense	25,485	19,025	0%
Dues & Subscriptions	8,854	7,410	0%
Health Insurance	1,942	0	0%
Insurance	16,343	49,653	0%
Legal & Professional Fees	1,000	92,800	0%
Meals Business	1,410	0	0%
Office Expenses	79,522	28,439	0%
Payroll Service Fees	30,729	7,328	0%
Pension Expense	34,566	40,219	0%
Rent or Lease	15,000	218,115	0%
Repair & Maintenance	166,725	89,520	1%
Salaries and Wages, Other	0	270,753	0%
Salary, Officer	130,560	157,000	1%
Software	59,338	17,399	0%
Taxes & Licenses	314,804	215,991	2%
Telephone Expenses	12,244	14,218	0%
Travel	3,590	0	0%
Utilities	8,153	13,481	0%
Total Expense	939,100	1,271,054	5%
Net Ordinary Income	114,289	(730,568)	1%
Other Income/Expense			
Other Income			
Interest Earned	54	12	0%
Total Other Income	54	12	0%

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended October 31,2025 and 2024

	Jan - Oct 25	Jan - Oct 24	% of Income
Other Expense			
Maryland Income Taxes	25,000	0	0%
Total Other Expense	25,000	0	0%
Net Other Income	(24,946)	12	(0)%
Net Income	89,344	(730,556)	1%

EXHIBIT 3

CON Table Package – Table G & L – Excel Format

Submitted via:

Email & USB Drive

EXHIBIT 4

Corrected Table 5 – Staffing Levels

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328
Email: info@qualityonecare.com / Web: http://www.qualityonecare.com

Exhibit 4: Corrected Table 5

Table 5: FY 2026 (Baseline)

Position	Current FTE	Change
Admin	0.5	0.5
RN	0.35	0.35
LPN	0.15	0.15
HHA	0.4	0.4
PT (contract)	0.1	0.1
OT (contract)	0.05	0.05
ST (contract)	0.02	0.02
MSW (contract)	0.03	0.03

Table 5: FY 2027 (Corrected)

Position	Current FTE	Change
Admin	0.75	0.25
RN	0.55	0.2
LPN	0.25	0.1
HHA	0.65	0.25
PT (contract)	0.16	0.06
OT (contract)	0.08	0.03
ST (contract)	0.03	0.01
MSW (contract)	0.05	0.02

Table 5: FY 2028 (Corrected)

Position	Current FTE	Change
Admin	1.00	0.25
RN	0.75	0.2
LPN	0.35	0.1
HHA	0.85	0.2
PT (contract)	0.22	0.06
OT (contract)	0.11	0.03
ST (contract)	0.04	0.01
MSW (contract)	0.07	0.02