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April 23, 2026

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

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

**Matter Nos.: 26-R4-2492, 26-R4-2493, and 26-R4-2494**

Dear Ms. Gawel and Ms. Miles

On behalf of our client, First Healthcare Consultants LTD, PDA, Inc. respectfully submits responses to the questions regarding completeness received on April 1, 2026.

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

Should the Commission require any additional information or clarification during its review, please do not hesitate to contact us. PDA, Inc. appreciates the Commission's consideration of this application.

Sincerely,

*Kelly Palacio*

Kelly (Ivey) Palacio  
Project Manager

First Healthcare Consultants LTD

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Completeness Questions for  
Medicare-Certified Home Health Agency  
Baltimore City, Baltimore County,  
and Howard County

April 23, 2026

Applicant Responses

## Affidavit

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

21/04/2026

Date

*Abisola Raimi-Abayomi*

Abisola Raimi-Abayomi (Apr 22, 2026 12:10:07 EDT)

Signature of Owner or  
Authorized Agent of the Applicant

## **PART I: PROJECT IDENTIFICATION AND GENERAL INFORMATION**

### **Project Implementation Schedule**

**1. How will the same batch 1 staff meet the needs of the batch 2 population given distance and transportation constraints?**

The premise of this question assumes that the same fixed group of Batch 1 staff members will be solely responsible for serving the Batch 2 service area. That is not the Applicant's staffing model. Rather, the Applicant utilizes a scalable, market-responsive staffing approach that includes both existing personnel and an actively maintained pool of qualified clinicians. This will allow the Applicant to support expansion across approved service areas.

As described in the application, the Applicant maintains an established and growing network of licensed nurses and clinical staff. This includes a pool of experienced RNs who are actively seeking additional assignments and are available to support new FHC service areas as they are approved. Accordingly, staffing for Batch 2 will not be constrained by Batch 1 personnel availability.

In addition, the Applicant will assign staff based on their geographic proximity to patients to minimize travel time and improve efficiency. The Applicant's staffing model is designed to deploy clinicians within localized service zones, rather than requiring routine travel across the full combined Batch 1 and Batch 2 service areas. This approach ensures that distance and transportation constraints do not impede timely access to care.

The Applicant also has a demonstrated ability to recruit and onboard additional qualified staff as the census grows. Given its current workforce interest and the Applicant's existing recruitment pipeline, the Applicant is confident it can meet the needs of the Batch 2 population without overextending Batch 1 staff.

Therefore, the Applicant's staffing plan is both flexible and scalable, and appropriately structured to meet the needs of patients across both Batch 1 and Batch 2 service areas while accounting for geographic considerations.

## Project Description

### 2. How will FHC ensure adequate on-call nursing coverage and accept referrals 24/7, year-round, with only an additional 0.08 FTE RN and LPN combined?

The additional 0.08 FTE RN/LPN identified in the staffing table represents expected hours **used** to serve the forecast caseload. It does not represent the total resources **available** to support on-call coverage. Rather, it reflects only the incremental scheduled staffing associated with projected visit volumes. The Applicant's 24/7 on-call coverage model operates independently of these baseline FTE calculations.

The Applicant maintains a structured on-call system in which licensed nurses are assigned to provide coverage outside of standard operating hours, including nights, weekends, and holidays. On-call staff are compensated on a per-call basis, with additional compensation provided if an in-person visit is required. When a patient's need necessitates travel, the interaction is converted to a billable visit, consistent with standard home health industry practice.

Importantly, on-call coverage is supported by the Applicant's broader pool of qualified clinicians, not solely by dedicated positions. As a result of its RSA activity, the Applicant currently has access to a network of experienced home care nurses who are available to participate in on-call rotations, including clinicians seeking additional hours beyond their traditional schedules. This model allows for flexible scheduling and ensures that sufficient clinical personnel are available to respond to patient needs at all times.

Additionally, the Applicant's intake and referral processes are designed to support 24/7 operations. Referrals can be received and triaged at any time, with clinical staff available to initiate care or respond to urgent needs as appropriate.

Through this combination of dedicated on-call scheduling, per-call compensation structure, and access to a scalable pool of nursing staff, the Applicant will ensure continuous, reliable coverage and the ability to accept referrals 24 hours per day, seven days per week, year-round.

## PART II - CONSISTENCY WITH REVIEW CRITERIA AT COMAR

### Populations and Services

- 3. Provide growth projections for individuals under age 65, as the proposal includes serving all age groups, pediatric through adult, within this service area.**

Table R on page 67 shows, by year, the estimated number of patients under age 65 in the service area who will be served. Table Q shows that all of these patients are in Baltimore City. The number is small. The relatively small number of projected patients under age 44, and particularly under age 15, reflects the Applicant's use of MHCC's historical patient and population databases. The need methodology, beginning on page 58, uses these data to develop age-based use rates. Use rates in Table J on page 59 are per 1,000 residents. After age 4, use rates increase with age, but no age group exceeds 16 per 1,000. At a market share of 2.75 percent (Table P, page 65), the calculated number of patients served becomes very small. With no direct experience providing licensed home health agency services, the Applicant has only historical state data to base its forecasts.

Maryland requires a separate RSA license for pediatric care (PDN54). FHC has been pursuing this since 2019. The Maryland OHCQ process is very slow, and few – if any – of these licenses have been issued in any single year. Any pediatric patients that FHC has served have resulted in bad debt or charity, neither of which is sustainable in significant amounts.

The Applicant recognizes the importance of serving individuals under age 65, including those with chronic conditions, disabilities, and post-acute care needs. Utilization-based projections may underestimate the true demand for home health services in these age groups, particularly for children with special health care needs. National data indicate that a significant proportion of children with complex medical conditions do not consistently access home-based services due to barriers such as limited provider availability, workforce constraints, and referral practices.<sup>1</sup>

In short, once licensed, FHC will accept any referred patient that its staff is qualified to serve, regardless of age.

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<sup>1</sup> Agency for Healthcare Research and Quality. *Children with Special Health Care Needs: Barriers to Care and Health Outcomes*. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2022.

**4. Provide data to demonstrate need for pediatric home health services within the proposed service area.**

MHCC HHA Utilization Tables 15 and 16 provide the basis for need analysis in the application. Together, they show low use of home health agency services by pediatric residents under age 15. Tables L and O in the application show total need and unmet need in the service area based on these MHCC utilization rates. The unmet need in Table O for project years CY2028 through CY2031 is summarized here.

**Table W: Estimated Number of Unserved HHA Clients for Age Groups 0 to 4 and 5 to 14, Entire FHC PSA, CY2028 – CY2031**

Age Group	CY28	CY29	CY30	CY31
0 to 4	18	20	21	24
5 to 14	-	-	-	-

Source: Excerpt of Table O, Page 64 FH Application

By the fourth year, CY2031, the table above shows only 24 pediatric patients not served by existing home health agencies. Another way of looking at these data is the percentage of the population under age 15 in the service area who use home health agency services. Table X below calculates that.

**Table X: Percent of FHC PSA Population Aged 0 to 15 Utilizing Home Health Services, CY2019- CY2023**

Age Group 0 to 15	CY19	CY20	CY21	CY22	CY23
a. Population	310,786	310,892	310,998	311,118	311,250
b. Unduplicated Clients	1,130.0	1,055.0	913.0	802.0	922.0
c. % Population HHA Client	0.36%	0.34%	0.29%	0.26%	0.30%

Sources and Notes:

a. MDP Population Estimates by Year by Jurisdiction by Age Group

b. MHCC HHA Utilization Table 15 Unduplicated Clients by Age Group by Jurisdiction by Year

c. b / c

The Applicant looked at another state, North Carolina, that tracks home health agency use rates for pediatric patients. The *2026 North Carolina State Medical Facilities Plan*, Table 12B, reports that only 0.4 percent of this age group used home health agency services in 2024. This is only one-tenth of a percent more than what Maryland reports for 2023.

Most of this pediatric group who need home care will likely qualify for RSA services. As noted in the response to Question 3 above, FHC is actively pursuing the RSA License PDN54 to serve this population. The quest began seven years ago. The process is slow.

While the Applicant's projections are intentionally conservative and grounded in available utilization data, they should not be interpreted as limiting the Applicant's willingness or ability to serve pediatric patients. Rather, they reflect existing system constraints, which the proposed home health agency is intended to help address.

**5. Among patients discharged home, what proportion had a documented referral to a home health agency at discharge, and of those, how many initiated services within seven days?**

As an RSA, the Applicant does not receive or track hospital discharge referral data in the same manner as a Medicare-certified home health agency, nor does it have direct access to hospital discharge systems that capture referral-to-initiation metrics (e.g., hospital-based care coordination platforms). Accordingly, the Applicant's data access is generally limited to the point at which a referral is received rather than the full discharge-to-referral process.

That said, the Applicant does receive referrals originating from hospital discharges through managed care organizations ("MCOs"), hospital systems, and other community referral sources. Based on operational experience in the proposed service area, the Applicant can respond promptly to referrals upon receipt. Standard practice is to initiate patient contact within 24 hours and to complete the initial in-home visit within 24 to 48 hours, consistent with accreditation expectations and industry standards for timely access to care.

Importantly, the primary barrier to service initiation is not response time delays but rather limitations related to authorization and payer eligibility. As an RSA, the Applicant is not currently licensed to provide Medicare-certified skilled home health services. As a result, patients discharged from hospitals who require Medicare-covered home health services cannot be served by the Applicant, even when referrals are received. In some cases, these patients may experience delays in accessing care or may not be served at all if alternative providers are unavailable or unwilling to accept the referral. The applicant does not have access to these data.

The Applicant has direct experience with referrals for patients requiring skilled services—including Medicare beneficiaries—that it cannot accept under its current licensure. In certain instances, patients with complex needs or less favorable payer sources may face additional barriers to placement, further contributing to gaps in service initiation.

Once a complete and authorized referral is received for services within the RSA's scope, the Applicant can promptly initiate care within established timeframes. If patient contact cannot be established immediately, staff make repeated outreach attempts and, when appropriate, conduct in-person follow-up to ensure patient safety and continuity of care.

While the Applicant does not track the specific proportion of hospital discharges with home health referrals or seven-day initiation metrics, its local experience indicates that delays in service initiation are more closely associated with system-level access constraints—such as provider availability, authorization requirements, and payer limitations—rather than the Applicant's ability to respond once a referral is received. Unfortunately, the Applicant cannot legally serve many of the referrals.

The proposed Medicare-certified home health agency will directly address these gaps by allowing the Applicant to accept and initiate services for a broader range of patients, including Medicare beneficiaries, thereby improving timely access to care within the proposed service area.

## Charity Care

### 6. Provide the percentage of FHC patients by payer source for CY 2025, 2024, and 2023.

As a Residential Service Agency (RSA), the Applicant's historical data systems are structured primarily around billing and service delivery, rather than patient-level reporting by payer category in the format typically associated with Medicare-certified home health agencies. Accordingly, precise historical percentages of patients served by payer source are not maintained in a standardized reporting format for prior years.

However, based on a review of billing records and operational experience, the Applicant can approximate payer mix for CY 2023 through CY 2025. The Applicant's patient population has historically been composed primarily of Medicaid beneficiaries and managed Medicaid enrollees, with a small proportion of private-pay patients. The approximate payer distribution is as follows:

**Table Y: Estimated Payor Distribution, FHC 2023-2025**

Payor	CY2023	CY2024	CY2025
Medicaid / MCO	41.8%	47.8%	46.3%
Private Pay	4.1%	0.0%	2.4%
Charity Care	0.7%	0.8%	0.1%
Other	53.4%	51.3%	61.0%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

The Applicant does not have a CON to participate in the Medicare home health benefit, and therefore, the Medicare payer category is zero percent for these periods. For additional detail, see attached [Exhibit 18](#).

With respect to charity care, the Applicant has historically provided services on a limited basis to individuals unable to pay. However, it handles these services on a case-by-case basis and does not track them as a discrete payer category within its billing system. As a result, charity care is not reflected in the payer mix percentages above. Under the proposed home health agency license, the Applicant will implement a formal charity care policy, including defined tracking and reporting mechanisms, consistent with regulatory expectations. See [Exhibit 8](#) for a copy of the proposed Charity Care Policy.

The Applicant has experience providing services to patients with significant financial barriers, including situations in which medically necessary care—such as wound care—was provided despite the lack of reimbursement. Although not formally counted, anecdotal evidence demonstrates the Applicant's commitment to ensuring access to care for vulnerable populations.

**7. What remedial plan or policy is in place if the agency does not meet its annual charity care benchmark?**

The Applicant is committed to meeting or exceeding its annual charity care benchmark and will implement a formal monitoring and corrective action process to ensure ongoing compliance.

The Applicant will track charity care provision on a routine basis, including periodic (e.g., monthly and quarterly) reviews of total services provided relative to the established benchmark. This monitoring will be incorporated into the agency's administrative and compliance oversight functions.

In the unanticipated event that performance falls below the projected charity care level at any point during the reporting period, the Applicant will implement targeted corrective actions. These actions may include reinforcing internal protocols with intake and case management staff to ensure that patients with financial need are appropriately identified and considered for charity care services. The Applicant's clinical and administrative leadership will also review referral patterns and community outreach efforts to ensure that underserved populations and their referral sources are aware of and able to access available services.

Under the proposed home health agency license, the Applicant will formalize documentation of its practices through written policies and tracking mechanisms, ensuring that charity care obligations are not only met, but actively managed throughout the year.

## Impact

**8. What specific operational impacts will the RSA experience from reallocating existing clinical and administrative staff to the proposed HHA, and what measures are in place to prevent service disruptions or capacity reductions within the RSA?**

The proposed HHA is not expected to adversely impact the operations or capacity of the Applicant's existing RSA. The Applicant has structured its staffing model to ensure that any reallocation of personnel supports the development of the HHA while maintaining continuity and service levels within the RSA.

The RSA and the proposed HHA will serve complementary but distinct roles. The RSA primarily provides non-skilled services, while the HHA will deliver Medicare-certified skilled services to all types of beneficiaries. As the HHA becomes operational, certain patients currently served through the RSA who require skilled care may transition to the HHA, allowing the Applicant to provide services under the most clinically appropriate and reimbursable setting. Referred patients will have access to a larger range of services. The Applicant does not intend to reduce the number of patients served. It will instead optimize the alignment of patient needs with the appropriate level of care.

To support this model, the Applicant will reassign certain clinical staff to the HHA while maintaining sufficient staffing within the RSA to serve those patients who do not qualify for HHA services, by drawing on its existing workforce and recruitment pipeline. Importantly, the Applicant maintains access to a pool of qualified caregivers and nurses available for additional hours. As described earlier, this staffing pool arrangement will enable the organization to provide staff as needed to meet variable demand. This approach ensures that patients who only qualify for RSA-level care, including Medicaid beneficiaries, will continue to receive uninterrupted services.

Administrative functions will also be managed to support both entities without disruption. Shared infrastructure and leadership oversight will allow for efficient coordination while maintaining appropriate staffing levels for each operation. The Applicant cautiously proposes slow growth in the early years of this proposed expansion to ensure its systems are in place and functioning well during the transition. Once established, the Applicant fully intends to accept more patients and to become an active participant in the referral networks of the three geographic areas.

Through this approach, the Applicant will preserve the RSA's service capacity and continuity of care while expanding access to skilled home health services through the proposed HHA.

## Project Impact Review Criterion

**9. How does the agency justify its conclusion that the proposed Medicare-certified HHA will significantly improve patient access, given its projection that only a small number of previously unserved patients will be reached particularly during the start up?**

The Applicant's conclusion that the proposed Medicare-certified HHA will improve patient access is not based solely on the number of previously unserved patients in the initial startup period, but on broader considerations related to continuity of care, referral network stability, and the availability of appropriately licensed services.

First, the proposed HHA will allow the Applicant to provide a full continuum of home-based care, including Medicare-covered skilled services that it cannot provide through its RSA license. A home health agency CON and license for FHC will mean that patients referred to FHC can receive care from a single, consistent provider as their clinical needs evolve, rather than being referred out to other agencies for skilled services and engaging in cumbersome transitions when the HHA benefit ends, and the patient still needs home support. This continuity will improve access by reducing fragmentation and delays in these unwanted care transitions.

Second, the Applicant's ability to offer Medicare-certified services is critical to maintaining participation in certain Medicaid managed care and referral networks, including relationships with managed care organizations (MCOs) and managed service organizations (MSOs). Without the license to furnish skilled home health services, the Applicant risks exclusion from many of these networks. Exclusion limits its ability to receive referrals and serve patients across payer types. Present managed care exclusions have made it too difficult for the Applicant to offer anything other than limited care in the PSA. With an HHA license for the PSA, the Applicant can offer referral agencies a full range of services. Referral agencies are stretched thin and must act quickly. Fewer barriers to care will strengthen managed care referral pathways, thereby sustaining access for both existing and future patients.

Third, while the number of newly served patients may be modest during the initial startup period, the project enhances access by ensuring that patients can receive clinically appropriate services within the service area. There is a documented need. No other agency has proposed expansion. Patients who might otherwise not receive care, face potentially longer wait times, or experience limited capacity will have an additional option for timely, local service delivery.

Accordingly, the proposed HHA improves access not only by incrementally increasing the number of patients served, but by strengthening care continuity, preserving referral relationships, and expanding the availability of Medicare-certified services within the community.

## Character and Competence

**10. What are the key factors that attributed to FHC success rate in reducing hospital admissions other than initiating care/ services within the first 48 hours?**

In addition to the timely initiation of services, the Applicant's success in reducing avoidable hospital admissions is driven by a combination of clinical expertise, proactive patient engagement, and responsive care delivery practices.

A key factor is the use of skilled nursing staff to perform comprehensive assessments and identify potential complications early. Registered nurses play a central role in evaluating patients' conditions, managing chronic and post-acute needs, and implementing interventions to help stabilize patients in the home setting. This level of clinical oversight supports early detection of issues that might otherwise result in emergency department visits or hospital admissions.

The Applicant also emphasizes persistent and proactive patient engagement. When patients or caregivers are difficult to reach by phone, staff make additional efforts to establish contact, including in-person visits when appropriate. This approach helps ensure that care is not delayed by communication barriers and that patients remain connected to necessary services.

Additionally, the Applicant's care model prioritizes ongoing monitoring and responsiveness to changes in patient condition. Staff are trained to recognize early warning signs and respond promptly, whether through direct intervention, coordination with physicians, or adjustment of care plans. This continuous attention helps prevent minor issues from escalating into acute events requiring hospitalization.

Through this combination of skilled clinical care, active outreach, and timely intervention, the Applicant supports improved patient outcomes and reduces the likelihood of avoidable hospital utilization.

## Revenues and Expenses

**11. Provide the metrics in table 3 for CY 23, CY 24, and CY 25 as it relates to RSA operations.**

Please see Additional Table 3: Revenues and Expenses in the attached [Exhibit 18](#). This table includes the requested metrics for the Applicants RSA business only

**12. Given the anticipated shift in payor mix from Medicaid to Medicare, how will FHC address and mitigate potential disparities to ensure continued access and service for the Medicaid population?**

The Applicant does not anticipate that the introduction of Medicare-certified home health services will reduce access for Medicaid beneficiaries. To the contrary, the addition of Medicare as a payer source is expected to enhance the Applicant's financial stability and support the continued provision of services to Medicaid beneficiaries. Older Medicaid beneficiaries are generally dually eligible for both Medicare and Medicaid services. Medicare is the primary payor for such individuals. Hence, the same person who can today receive only Medicaid RSA services from the Applicant will be eligible for Medicare benefits. In some cases, the Medicare benefit will be more robust and will replace Medicaid.

Medicare reimbursement for skilled home health services is generally a little higher than Medicaid reimbursement rates. This allows the Applicant to establish a more balanced revenue stream, which in turn supports a little extra income to support the provision of services to lower-reimbursing populations. For example, Medicaid reimbursement rates may not always fully cover staffing costs, particularly when accounting for wage requirements such as overtime. Medicare better anticipates administrative costs, hence, serves as a stabilizing factor that helps offset the cost of serving Medicaid patients.

The Applicant remains committed to serving Medicaid beneficiaries and does not intend to reduce Medicaid service capacity as a result of the proposed project. Dual-eligible patients who qualify for Medicare-covered services may receive skilled care through the home health agency while continuing to access Medicaid-supported services as appropriate. This coordination of benefits allows for more comprehensive care delivery and can improve access by aligning services with available coverage.

The Applicant has experience serving Medicaid patients under reimbursement structures that may not fully reflect the cost of service delivery, including situations where it had to supplement out-of-pocket, and additional resources were required to meet patient needs. Having a license to offer Medicare-certified services will enhance the Applicant's ability to continue serving these patients without compromising access or quality.

Accordingly, the proposed shift in payer mix will not create disparities but rather will support a more sustainable model that preserves and strengthens access to care for the Medicaid population.

## Staffing Information

**13. Given that speech therapy is a newly introduced and actively promoted service, what is the rationale for allocating only 0.01 FTE to speech therapy in the region?**

Upon establishing the Medicare-certified home health agency, the Applicant will expand its capacity to serve both therapy and non-therapy patients, while maintaining its commitment to individuals who may otherwise face barriers to accessing care. Speech therapy and other skilled services will be provided as clinically indicated.

The 0.01 FTE allocated to speech therapy reflects the **incremental staffing associated with projected patient volume within the Batch 2 service area**, rather than the total speech therapy resources available to the Applicant. As presented in the application, staffing tables reflect only the **additional personnel hours required** to support projected utilization within specific service areas during the initial planning period.

Speech therapy services are typically **episodic and referral-driven**, with utilization dependent on patient-specific clinical needs such as post-stroke care, neurological conditions, and swallowing disorders. Within the local market, all HHA therapy services are more readily accepted by larger providers and hospital-affiliated agencies. They can be higher-reimbursing and more standardized in delivery, and they provide easier avenues to patient satisfaction and related quality scores. In contrast, the Applicant has historically focused on serving patients with more complex social and support needs, including those requiring aide services and ongoing assistance in the home—populations that may be more difficult to place or less attractive to larger providers, and because their conditions are chronic, they are less easily satisfied.

As a result, speech therapy represents a smaller proportion of overall home health volume, particularly during early program implementation, and the Applicant's projections are intentionally conservative and aligned with anticipated startup demand.

- **How will this staffing level adequately meet anticipated patient demand?**

Patient demand for speech therapy services will be met through a **scalable and flexible staffing model**. The 0.01 FTE reflects only the anticipated incremental hours of service associated with the Batch 2 service area. The expected FTE requirement does not reflect an intended limitation on the Applicant's ability to provide services.

Importantly, "FTE" (full-time equivalent) is a conversion unit that reflects the total staff hours required to meet projected patient demand, not a fixed number of individual personnel available to provide the service. Therapy services are scheduled based on patient needs and staff availability, and clinicians are deployed across the service area using a pool of staff from different geographic areas. **The Applicant** groups patients geographically to maximize staff efficiency. Under this model, multiple part-time or per-visit therapists may collectively fulfill the equivalent of the projected FTE.

The Applicant has a current pool of qualified therapists who prefer to work within a Medicare-certified home health agency. Once licensed, the Applicant can scale staffing as needed. The combined staffing for Batches 1 and 2, as reflected in additional Table 5 in [Exhibit 17](#), represents the **aggregate full-time equivalent staffing required to support projected visits**. Staffing will be adjusted accordingly as utilization increases.

As the number of patient visits grows, therapy staffing—including speech therapy—will be increased proportionally to maintain appropriate clinical coverage.

- **Please clarify whether batch 1 and batch 2 share the same FTE allocation for speech therapy.**

The staffing figures presented in the application are **incremental and service-area-specific**, and do not represent separate or fixed staffing pools of different individuals for Batch 1 and Batch 2. Speech therapy resources are part of the **overall staffing complement** for the proposed home health agency, which spans all counties included in both batches.

The total staffing for the entire service area, inclusive of both Batch 1 and Batch 2, is presented in an additional version of Table 5 in [Exhibit 17](#). Accordingly, speech therapy services will be provided throughout the service area based on patient need, and individuals will be zoned as much as possible, but will not be restricted to serving a single geography.

- **Will the staffing budget for this position from batch 1 carry over into batch 2?**

Yes. The staffing budget is structured on a **combined, agency-wide basis**, rather than being segregated by batch. As such, staffing resources—including speech therapy—are allocated across the full proposed service area based on patient volume and clinical need.

The financial projections presented in an additional version of Table 5 in [Exhibit 17](#) reflect the **total staffing budget for the entire proposed home health agency**, inclusive of both Batch 1 and Batch 2. This approach enables efficient deployment of personnel and ensures that patient care needs are met without artificial constraints across service areas.

**14. Given the addition and expansion of services, explain how the patient care needs will be met with minimal increase in staff for this proposed service area.**

The Applicant's staffing projections reflect a conservative, phased approach to program implementation. As requested, the Applicant shows the incremental resources required to expand its reach to Batch 2 geographies.

Projected incremental patients during the startup period are intentionally modest, allowing the Applicant to leverage existing clinical and administrative infrastructure to support early operations. This approach ensures that systems, workflows, and care coordination processes are fully established and functioning effectively before significant expansion occurs.

The Applicant's staffing model is designed to scale with the patient census. As the number of patients increases, the model shows additional clinical and support staff added to maintain appropriate staffing ratios and ensure high-quality care delivery. The minimal increase in staff reflected in the initial projections corresponds to the limited number of patients expected during the early stages of operation, not a long-term staffing constraint.

In addition, the Applicant maintains access to a pool of qualified clinicians who will be available for additional hours or assignments as needed. This provides the flexibility to accommodate demand fluctuations without delay and supports a responsive staffing approach during the ramp-up period.

Accordingly, though the Applicant has cautiously planned for a slow and steady start-up, it will meet patient care needs through a combination of conservative projections, efficient use of existing resources, and a scalable staffing model that expands in step with service demand.

## Proposed Revenue Assumptions

15. The Commission staff reviewed Tables 19 and 20 of the 2023 Home Health and Utilization Data available in the Public Use files on the Commission website. Please provide a detailed explanation of the basis for the adjustments reflected in these tables. Additionally, clarify the methodology used to compare the data and how this analysis led to the conclusion of a two percent reduction in the Medicaid market within the target service area.

### Overview Tables 19 and 20

Table 20 shows the geographic distribution of patients by payor type. For example, 10 percent of all Maryland Medicare Traditional home health agency patients live in Anne Arundel County. This table does not show payor mix of individual jurisdictions.

The Applicant derived payer mix assumptions for its primary service area from **MHCC Table 19: Total Number of Home Health Visits by Jurisdiction of Residence, Payment Source, and Geographic Region** for Baltimore City, Baltimore County, and Howard County. The Applicant then mapped the Table 19 data into the seven payer categories used in the financial projections: Medicare Traditional, Medicare Advantage, Medicaid Traditional, Medicaid Managed Care, Commercial Insurance, Self-Pay, and Other. These jurisdiction-specific percentages were then applied consistently across all projection years.

**Table Z: Home Health Clients by Payor by Jurisdiction, FHC PSA, 2023**

Geographic Region / Jurisdiction of Client's Residence	Medicare Traditional	Medicare Advantage	MD Medicaid Traditional	MD Medicaid Managed Care	Other Government	Commercial Insurance	Self-Pay	Other	Total
Baltimore City	103,716	38,822	4,566	6,377	909	23,508	193	914	179,005
Baltimore County	207,354	57,353	4,358	7,646	1,660	34,506	172	2,427	315,476
Howard County	58,555	9,979	1,160	791	408	11,045	48	1,386	83,372
<b>TOTAL PSA</b>	<b>369,625</b>	<b>106,154</b>	<b>10,084</b>	<b>14,814</b>	<b>2,977</b>	<b>69,059</b>	<b>413</b>	<b>4,727</b>	<b>577,853</b>

Source: MHCC Home Health Utilization Table 19

**Table AA: Home Health Client Payor Mix Percentage by Payor Category by Jurisdiction, FHC PSA, 2023**

Geographic Region / Jurisdiction of Client's Residence	Medicare Traditional	Medicare Advantage	MD Medicaid Traditional	MD Medicaid Managed Care	Other Government	Commercial Insurance	Self-Pay	Other	Total
Baltimore City	57.9%	21.7%	2.6%	3.6%	0.5%	13.1%	0.1%	0.5%	100.0%
Baltimore County	65.7%	18.2%	1.4%	2.4%	0.5%	10.9%	0.1%	0.8%	100.0%
Howard County	70.2%	12.0%	1.4%	0.9%	0.5%	13.2%	0.1%	1.7%	100.0%
<b>TOTAL PSA</b>	<b>64.0%</b>	<b>18.4%</b>	<b>1.7%</b>	<b>2.6%</b>	<b>0.5%</b>	<b>12.0%</b>	<b>0.1%</b>	<b>0.8%</b>	<b>100.0%</b>

Note: Percentages for each jurisdiction and the entire PSA calculated by Applicant; e.g., Baltimore City Medicare Traditional: 103,716 / 179,005 \* 100 = 57.9%

Medicaid

The Applicant respectfully clarifies that it did **not** model a two percent reduction in the Medicaid market within the target service area. Rather, the Applicant used jurisdiction-specific payer distributions from the Maryland Health Care Commission’s 2023 Home Health Agency Annual Survey, Table 19, and applied a limited adjustment only where the raw percentages for **individual Medicaid categories** fell below a two percent minimum floor.

**Table BB: Weighted Average Payor Mix – FHC PSA**

Metric	Medicare Traditional	Medicare Advantage	MD Medicaid Traditional	MD Medicaid Managed Care	Other Government	Commercial Insurance	Self-Pay	Other	Total
a. Original Weighted Average	64.0%	18.4%	1.7%	2.6%	0.5%	12.0%	0.1%	0.8%	100.0%
b. Adjusted Weighted Average	64.0%	18.4%	2.2%	2.7%	0.5%	11.4%	0.1%	0.8%	100.0%
c. Difference	0.0%	0.0%	0.4%	0.2%	0.0%	-0.6%	0.0%	0.0%	0.0%

Notes:

a. Table AA above

b. Applicant adjusted payor mix

c. b – c

The adjustment was not a reduction in Medicaid. Instead, where the raw Table 19 percentages for **Medicaid Traditional** or **Medicaid Managed Care** fell below two percent, those payor categories were adjusted **upward** to a two percent floor to reflect the Applicant's anticipated market positioning and community-need focus. This affected:

- Medicaid Traditional in Baltimore County;
- Medicaid Traditional in Howard County; and
- Medicaid Managed Care in Howard County.

The MHCC payor mix for Baltimore City was used as reported because both Medicaid categories exceeded the floor. For Baltimore County and Howard County, the offsetting reductions were applied to the **Commercial Insurance** category. Thus, the modeled adjustment increased, rather than decreased, Medicaid representation in the projected payer mix for those jurisdictions.

### Medicare

The Applicant further clarifies that the projected increase in Medicare share reflects the transition from an RSA-only service to a Medicare-certified home health agency. Under its current RSA operations, the Applicant cannot offer or bill for the Medicare home health benefit; therefore, the Applicant's historical payer mix shows zero percent Medicare home health. Once the proposed HHA is established, the Applicant will be able to accept and serve Medicare-covered skilled patients.

This projected increase in Medicare does **not** mean that the Applicant expects to serve fewer Medicaid patients or diminish access for the Medicaid population. To the contrary, the Applicant remains committed to serving Medicaid beneficiaries and expects Medicaid patients to continue to be an important part of its service population. Some patients may be **dually eligible** for Medicare and Medicaid. For Medicare-covered services furnished to dually eligible beneficiaries, Medicare is generally the primary payer and pays first, while Medicaid may cover additional services or cost-sharing or nothing, depending on the beneficiary's eligibility category and the service involved.<sup>2</sup>

Accordingly, a shift in reported primary payer from Medicaid to Medicare for some patients may reflect **coordination of benefits** rather than a loss of service for Medicaid beneficiaries. Similarly, certain patients may receive Medicare-covered skilled services through the HHA while continuing to receive Medicaid-covered or Medicaid-authorized services, to the extent permitted and clinically appropriate. CMS guidance states that Medicare pays first for covered services for dually eligible beneficiaries, while Medicaid may cover additional benefits not covered by Medicare.<sup>3</sup>

The Applicant's objective in seeking Medicare certification is to expand the number and type of patients it can serve, particularly patients requiring skilled home health services that cannot presently be furnished under RSA licensure alone. That includes Medicare beneficiaries, dual-eligible beneficiaries, and Medicaid patients with complex needs.

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<sup>2</sup> Centers for Medicare & Medicaid Services. *Beneficiaries Dually Eligible for Medicare and Medicaid*. U.S. Department of Health and Human Services, 2023.

<sup>3</sup> Centers for Medicare & Medicaid Services. *Coordination of Benefits & Recovery Overview*. U.S. Department of Health and Human Services, 2023.

The Applicant does not intend to reduce its commitment to Medicaid patients; rather, the addition of Medicare-certified services will strengthen the agency's financial and operational capacity to serve a broader and more clinically complex population.

For these reasons, the Applicant respectfully submits that:

1. The "two percent adjustment" is a minimum Medicaid floor, not a reduction in Medicaid eligible persons served;
2. The projected increase in Medicare reflects the new permission to provide Medicare service. The necessarily changes payer mix percentages.
3. Serving dually-eligible Medicaid patients under HHA licensure will classify as Medicare; it does not indicate any planned reduction in access for Medicaid patients.

**EXHIBITS**

17. Additional Table 5: Batches 1 and 2 Combined Staffing ..... 354

18. Additional Table 3: Historical Revenue and Expenses for the Residential Services Agency ..... 364

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## **Exhibit 17**

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**TABLE 5: STAFFING INFORMATION**

**Instructions:** List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours. NOTE: PROVIDE A TABLE 5 FOR EACH PROJECTED YEAR.

**Response:** FHC is not an existing HHA. However, its Batch 1 CON application is under review as of this completeness submission. For transparency purposes, the Applicant has included the total staffing FTEs and salaries for the entire proposed agency. This includes the projections for Batch 1 Table 5, extended to CY2031, and the incremental growth for Batch 2 presented in this application. The Applicant assumes that staffing for Batch 1 Year 4 will remain constant through Year 5. Data presented are not adjusted. It is the simple addition of Table 5 from the Batch 1 completeness questions submitted on March 2, 2026 (included with this exhibit) and Table 5 from the Batch 2 application submitted March 20, 2026.

**2027: Y1 Batch 1**

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	2.50	-	\$82,000	-	\$205,000	-
Registered Nurse	-	-	1.06	-	\$80,000	-	\$84,470	-
Licensed Practical Nurse	-	-	0.28	-	\$65,000	-	\$18,468	-
Physical Therapist	-	-	0.36	-	\$75,000	-	\$27,000	-
Occupational Therapist	-	-	1.06	-	\$75,000	-	\$79,500	-
Speech Therapist	-	-	0.08	-	\$75,000	-	\$6,000	-
Home Health Aide	-	-	0.17	-	\$40,000	-	\$6,800	-
Medical Social Worker	-	-	0.06	-	\$90,000	-	\$5,400	-
Other (Nurse Supervisor)	-	-	0.25	-	\$85,000	-	\$21,250	-
<b>Benefits</b>							\$68,083	
<b>TOTAL</b>							<b>\$521,971</b>	

\* Indicate method of calculating benefits cost

**2028: Y2 Batch 1, Y1 Batch 2**

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	4.00	-	-	-	-	-
Registered Nurse	-	-	1.56	-	\$80,000	-	\$124,454	-
Licensed Practical Nurse	-	-	0.42	-	\$65,000	-	\$27,210	-
Physical Therapist	-	-	0.58	-	\$75,000	-	\$43,776	-
Occupational Therapist	-	-	1.53	-	\$75,000	-	\$114,842	-
Speech Therapist	-	-	0.13	-	\$75,000	-	\$9,796	-
Home Health Aide	-	-	0.25	-	\$40,000	-	\$10,024	-
Medical Social Worker	-	-	0.09	-	\$90,000	-	\$8,155	-
Other (Nurse Supervisor)	-	-	0.25	-	\$85,000	-	\$21,250	-
<b>Benefits</b>							\$70,221	
<b>TOTAL</b>							<b>\$429,727</b>	

\* Indicate method of calculating benefits cost

2029: Y3 Batch 1, Y2 Batch 2

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	4.25	-	\$50,000	-	\$212,500	-
Registered Nurse	-	-	2.24	-	\$80,000	-	\$179,116	-
Licensed Practical Nurse	-	-	0.60	-	\$65,000	-	\$39,161	-
Physical Therapist	-	-	0.98	-	\$75,000	-	\$73,332	-
Occupational Therapist	-	-	2.05	-	\$75,000	-	\$153,413	-
Speech Therapist	-	-	0.17	-	\$75,000	-	\$12,842	-
Home Health Aide	-	-	0.36	-	\$40,000	-	\$14,498	-
Medical Social Worker	-	-	0.13	-	\$90,000	-	\$11,810	-
Other (Nurse Supervisor)	-	-	0.50	-	\$85,000	-	\$42,500	-
<b>Benefits</b>							\$130,076	
<b>TOTAL</b>							<b>\$869,248</b>	

\* Indicate method of calculating benefits cost

2030: Y4 Batch 1, Y3 Batch 2

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	5.00	-	\$81,500	-	\$407,500	-
Registered Nurse	-	-	2.91	-	\$80,000	-	\$232,659	-
Licensed Practical Nurse	-	-	0.78	-	\$65,000	-	\$50,868	-
Physical Therapist	-	-	1.48	-	\$75,000	-	\$111,122	-
Occupational Therapist	-	-	2.45	-	\$75,000	-	\$184,010	-
Speech Therapist	-	-	0.22	-	\$75,000	-	\$16,730	-
Home Health Aide	-	-	0.48	-	\$40,000	-	\$19,069	-
Medical Social Worker	-	-	0.16	-	\$90,000	-	\$14,620	-
Other (Nurse Supervisor)	-	-	0.50	-	\$85,000	-	\$42,500	-
<b>Benefits</b>							\$162,162	
<b>TOTAL</b>							<b>\$1,241,240</b>	

\* Indicate method of calculating benefits cost

2031: Y5 Batch 1, Y4 Batch 2

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	5.25	-	\$75,200	-	\$394,800	-
Registered Nurse	-	-	3.28	-	\$80,000	-	\$262,093	-
Licensed Practical Nurse	-	-	0.88	-	\$65,000	-	\$57,303	-
Physical Therapist	-	-	1.86	-	\$75,000	-	\$139,776	-
Occupational Therapist	-	-	2.57	-	\$75,000	-	\$192,765	-
Speech Therapist	-	-	0.25	-	\$75,000	-	\$19,117	-
Home Health Aide	-	-	0.53	-	\$40,000	-	\$21,192	-
Medical Social Worker	-	-	0.17	-	\$90,000	-	\$15,576	-
Other (Nurse Supervisor)	-	-	0.75	-	\$85,000	-	\$63,750	-
<b>Benefits</b>							\$179,036	
<b>TOTAL</b>							<b>\$1,345,408</b>	

\* Indicate method of calculating benefits cost

**TABLE 5: Staffing Information**

Updated figures are highlighted for reference.

Year 1: 2027

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	2.50	-	\$82,000	-	\$205,000	-
Registered Nurse	-	-	1.06	-	\$80,000	-	\$84,470	-
Licensed Practical Nurse	-	-	0.28	-	\$65,000	-	\$18,468	-
Physical Therapist	-	-	1.17	-	\$75,000	-	\$87,551	-
Occupational Therapist	-	-	0.37	-	\$75,000	-	\$27,857	-
Speech Therapist	-	-	0.08	-	\$75,000	-	\$6,000	-
Home Health Aide	-	-	0.17	-	\$40,000	-	\$6,800	-
Medical Social Worker	-	-	0.06	-	\$90,000	-	\$5,400	-
Other (Please specify.)	-	-	0.25	-	\$85,000	-	\$21,250	-
<b>Benefits</b>							\$70,532	
<b>TOTAL</b>							\$540,745	

\* Indicate method of calculating benefits cost

Year 2: 2028

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	3.25	-	\$82,000	-	\$266,500	-
Registered Nurse	-	-	1.50	-	\$80,000	-	\$119,771	-
Licensed Practical Nurse	-	-	0.40	-	\$65,000	-	\$26,186	-
Physical Therapist	-	-	1.66	-	\$75,000	-	\$124,163	-
Occupational Therapist	-	-	0.53	-	\$75,000	-	\$39,796	-
Speech Therapist	-	-	0.12	-	\$75,000	-	\$9,000	-
Home Health Aide	-	-	0.24	-	\$40,000	-	\$9,600	-
Medical Social Worker	-	-	0.08	-	\$90,000	-	\$7,200	-
Other (Please specify.)	-	-	0.25	-	\$85,000	-	\$21,250	-
<b>Benefits</b>							\$95,097	
<b>TOTAL</b>							\$729,079	

\* Indicate method of calculating benefits cost

Year 3: 2029

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	4.00	-	\$82,000	-	\$328,000	-
Registered Nurse	-	-	1.95	-	\$80,000	-	\$155,702	-
Licensed Practical Nurse	-	-	0.52	-	\$65,000	-	\$34,042	-
Physical Therapist	-	-	2.14	-	\$75,000	-	\$160,776	-
Occupational Therapist	-	-	0.68	-	\$75,000	-	\$50,939	-
Speech Therapist	-	-	0.15	-	\$75,000	-	\$11,250	-
Home Health Aide	-	-	0.32	-	\$40,000	-	\$12,800	-
Medical Social Worker	-	-	0.11	-	\$90,000	-	\$9,900	-
Other (Please specify.)	-	-	0.25	-	\$85,000	-	\$21,250	-
<b>Benefits</b>							<b>\$119,753</b>	
<b>TOTAL</b>							<b>\$918,107</b>	

\* Indicate method of calculating benefits cost

Year 4: 2030

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	-	-	4.00	-	\$82,000	-	\$328,000	-
Registered Nurse	-	-	2.21	-	\$80,000	-	\$177,135	-
Licensed Practical Nurse	-	-	0.60	-	\$65,000	-	\$38,728	-
Physical Therapist	-	-	2.44	-	\$75,000	-	\$183,061	-
Occupational Therapist	-	-	0.77	-	\$75,000	-	\$58,102	-
Speech Therapist	-	-	0.17	-	\$75,000	-	\$12,750	-
Home Health Aide	-	-	0.36	-	\$40,000	-	\$14,400	-
Medical Social Worker	-	-	0.12	-	\$90,000	-	\$10,800	-
Other (Please specify.)	-	-	0.25	-	\$85,000	-	\$21,250	-
<b>Benefits</b>							<b>\$128,965</b>	
<b>TOTAL</b>							<b>\$988,730</b>	

\* Indicate method of calculating benefits cost

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## **Exhibit 18**

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**TABLE 3: REVENUES AND EXPENSES - HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND**

Note: This is for First Health Consultants LTD Resident Services Agency Only

Line Item	Years per MHCC Request		
	CY: 2023	CY: 2024	CY: 2025
<b>1. REVENUE</b>			
Gross Patient Service Revenue	\$1,352,927	\$2,675,558	\$3,048,083
Allowance for Bad Debt	(\$62,865)	(\$38,682)	(\$291,391)
Contractual Allowance	-	-	(\$28,826)
Charity Care	-	(\$49,815)	(\$2,126)
<b>Net Patient Services Revenue</b>	<b>\$1,290,062</b>	<b>\$2,587,061</b>	<b>\$2,725,740</b>
Other Operating Revenues (Specify)	-	-	-
<b>Net Operating Revenue</b>	<b>\$1,290,062</b>	<b>\$2,587,061</b>	<b>\$2,725,740</b>
<b>2. EXPENSES</b>			
Salaries, Wages, and Professional Fees (including fringe benefits)	\$790,374	\$1,810,115	\$1,965,625
Contractual Services (please specify)	\$25,411	\$42,645	\$86,980
Interest on Current Debt	\$17,000	\$2,817	\$12,514
Interest on Project Debt	-	-	-
Current Depreciation	-	-	-
Project Depreciation	-	-	-
Current Amortization	-	-	-
Project Amortization	-	-	-
Supplies	\$15,799	\$17,302	\$6,435
Other Expenses (Specify)	\$52,538	\$186,377	\$281,479
<b>Total Operating Expenses</b>	<b>\$901,123</b>	<b>\$2,059,255</b>	<b>\$2,353,032</b>
Other expenses includes: Advertising and Promotion; Automobile (incl. auto ins., fuel, maint.); Bank Charges; Computer and Internet; Continuing Education; Course Materials (COGS); Dues & Subscriptions; Employee Onboarding Fees; Insurance: Business (excl. Health & WC); License & Fees; Meals and Entertainment; Office/General Administrative; Postage and Delivery; Rent; Repairs and Maintenance; Personal Property Tax; Telephone (Landline + Wireless); Travel; Utilities; Printing; Shopping; and Uncategorized Expense.			
<b>3. INCOME</b>			
<b>Income from Operation</b>	<b>\$388,939</b>	<b>\$527,806</b>	<b>\$372,708</b>
Non-Operating Income	\$1,573	\$3,581	\$15,960
<b>Subtotal</b>	<b>\$390,512</b>	<b>\$531,387</b>	<b>\$388,668</b>
Income Taxes	-	-	-
<b>Net Income (Loss)</b>	<b>\$390,512</b>	<b>\$531,387</b>	<b>\$388,668</b>
<b>4A. PAYOR MIX AS PERCENT OF TOTAL REVENUE</b>			
Medicare	-	-	-
Medicare Advantage	-	-	-
Medicaid	15.1%	7.3%	19.3%
Medicaid MCO	10.7%	9.9%	7.3%
Blue Cross	-	-	-
Commercial Insurance	4.2%	3.8%	2.1%
Self-Pay	-	4.6%	2.4%
Other - VA Community Care via Optum	70.0%	74.5%	68.9%
<b>TOTAL REVENUE</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>
<b>4B. PAYOR MIX AS PERCENT OF TOTAL VISITS</b>			
Medicare	-	-	-
Medicare Advantage	-	-	-
Medicaid	12.3%	13.3%	13.3%
Medicaid MCO	29.5%	34.5%	23.0%
Blue Cross	-	-	-
Other Commercial Insurance	-	-	0.3%
Self-Pay	4.1%	-	2.4%
Charity Care	0.7%	0.8%	0.1%
Other - VA Community Care via Optum	53.4%	51.3%	61.0%

**TABLE 3: REVENUES AND EXPENSES - HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND**

*Note: This is for First Health Consultants LTD Resident Services Agency Only*

Line Item	Years per MHCC Request		
	2023	2024	2025
<b>TOTAL VISITS</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>
<b>CHECKS: OURS vs PBC (Prepared By Client)</b>			
Net Operating Revenue (Ours)	\$1,290,062	\$2,587,061	\$2,725,740
Net Operating Revenue (P&L)	\$1,290,062	\$2,587,061	\$2,725,740
Net Op Revenue Diff	-	-	-
Total Operating Expenses (Ours)	\$901,123	\$2,059,255	\$2,353,032
Total Op Expenses less Bad Debt (P&L)	\$901,123	\$2,059,255	\$2,353,032
Total Op Expenses Diff	-	-	-
Net Income (Ours)	\$390,512	\$531,387	\$388,668
Net Income (P&L)	\$390,512	\$531,387	\$388,668
<b>Net Income Diff</b>	<b>-</b>	<b>-</b>	<b>-</b>