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Raleigh, NC 27605
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March 6, 2026

Ewurama Shaw-Taylor
Maryland Health Care Commission
Health Care Planning and Development
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Certificate of Need Application – First Healthcare Consultants LTD, Proposed Medicare-Certified Home Health Agency

Dear Ms. Shaw-Taylor:

On behalf of our client, First Healthcare Consultants LTD, PDA, Inc. respectfully submits a Certificate of Need application to establish a Medicare-certified Home Health Agency serving Baltimore City, Baltimore County, and Howard County.

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

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

Sincerely,

Kelly Ivey Palacio

Kelly Ivey Palacio
Project Manager

MARYLAND
Health Care
Commission

Revised July 2024

INSTRUCTIONS FOR
APPLICATION FOR CERTIFICATE OF NEED
HOME HEALTH AGENCY PROJECTS

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

REQUIRED FORMAT:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively.

The Table of Contents must include:

- **Responses to PARTS I, II, III and IV of this application form**
- **Responses to PART II must include responses to the standards in the State Health Plan chapter, COMAR 10.24.16, STATE HEALTH PLAN FOR FACILITIES AND SERVICES: HOME HEALTH AGENCY SERVICES.**
- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.)

SUBMISSION FORMATS:

We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215
- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.
- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to mhcc-confilings@maryland.gov

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

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APPLICATION SECTIONS

LIST OF TABLES (APPLICANT GENERATED)

LIST OF FIGURES

LIST OF EXHIBITS

For ease of use, Exhibits are independently page numbered beginning at 201.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. APPLICANT

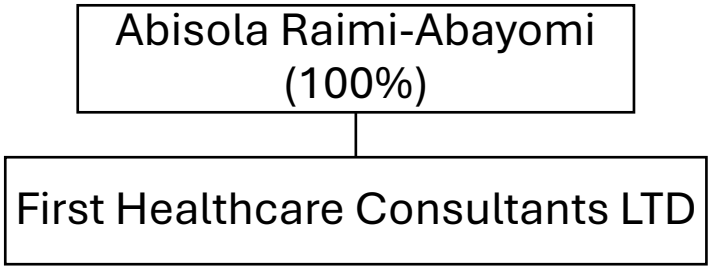
If the application has a co-applicant, provide the following information for that party in an attachment.

Legal Name of Project Applicant (Licensee or Proposed Licensee)	First Healthcare Consultants LTD d/b/a Abidaref Regal Healthcare Solutions
Address	12906 North Point Lane
City, State, ZIP, County	Laurel, MD, 20708, Prince George's
Telephone	301-725-1800
Name of Owner / Chief Executive Officer	Abisola Raimi-Abayomi

2. NAME OF OWNER

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

First Healthcare Consultants LTD d/b/a Abidaref Regal Healthcare Solutions ("FHC" or "Applicant") is a **privately held corporation** that is **100 percent owned by Ms. Abisola Raimi-Abayomi**. There are no additional individuals or entities with a 5 percent or greater ownership interest in the applicant. The company has no parent organizations or related entities with ownership interests.



3. FACILITY

Name of HHA Provider	First Healthcare Consultants LTD
Address	12906 North Point Lane
City, State, ZIP, County	Laurel, MD, 20708, Prince George's
Name of Owner (if different from Applicant)	

4. NAME OF LICENSEE OR PROPOSED LICENSEE

if different from the applicant:

Response: The licensee is the same as the Applicant, First Healthcare Consulting, LTD. Please see Exhibit 1 for a copy of FHC's existing Residential Services Agency license (R5352).

5. LEGAL STRUCTURE OF APPLICANT

(and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☒	Date and State of Incorporation: *November 16, 2012, Maryland*
	Partnership	☐	
C.	General		
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):	☐	
	Limited Liability Company	☐	
D.	Other (Specify):	☐	
E.	To be formed:	☐	
	Existing:	☐	

Response: Please see Exhibit 2 for a copy of the Articles of Incorporation for FHC.

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or Primary Contact:

Name and Title:	Abisola Raimi-Abayomi, Clinical Services Director
Address:	12906 North Point Lane
City, State, ZIP:	Laurel, MD, 20708
Telephone:	301-725-1800
Email (required):	abi.r@fheconsultantsus.com
Fax:	301-458-8175

B. Additional or Alternate Contact:

Name and Title	Nancy Lane, President
Company Name	PDA, Inc.
Address:	P.O. Box 12844
City, State, ZIP:	Raleigh, NC 27605
Telephone:	919-754-0303
Email (required):	nlane@pda-inc.net
Fax:	919-754-0328

If company name is different than applicant briefly describe the relationship

Response: PDA, Inc. is a healthcare consulting firm in Raleigh, NC. The Applicant, First Healthcare Consultants LTD, engaged PDA to assist with the certificate of need application process.

7. PROPOSED AGENCY TYPE: ☑

a. Health Department _____

b. Hospital Based _____

c. Nursing Home Based _____

d. Continuing Care Retirement Community Based _____

e. HMO Based _____

f. Freestanding X

g. Other (Please specify) _____

8. AGENCY SERVICES

(Please check ☑ all applicable.)

Service	Currently Provided	Proposed to be Provided in the Jurisdiction(s) that are the subject of this Application*
Skilled Nursing Services	X (R5352)	X
Home Health Aide	X (R5352)	X
Occupational Therapy	X (R5352)	X
Speech, Language Therapy	a	X
Physical Therapy	X (R5352)	X
Medical Social Services	a	X

* If proposing different services in different jurisdictions, note that accordingly.

Notes:

a. *If approved, a home health agency CON currently in review by MHCC would enable FHC to offer speech therapy and medical social services prior to the opening date for this proposed expansion.*

9. OFFICES

Identify the address of all existing main office, and branch office locations and identify the location (city and county) of all proposed main office, and branch offices, as applicable. (Add rows as needed.)

Response: First Healthcare Consulting LTD is not an existing home health agency. It is an existing Residential Service Agency in Maryland. The information in the table below pertains to the existing Residential Service Agency and the proposed new home health agency.

	Street	City	County	State	Zip Code	Telephone
Existing Main Office	12906 North Point Lane	Laurel	Prince George's	MD	20708	301-725-1800
Existing Branch Offices						
Locations of Proposed HHA Main Office	8643 Cherry Lane*	Laurel	Prince George's	MD	20707	301-725-1800
Locations of Proposed Branch Office						

**Note: FHC has recently moved to a new main office. At the time of this submission, the Applicant is filing all required documentation with Mayland OHCQ for the new address. The Applicant expects to be operational from the new location by Summer 2026. Therefore, the proposed service expansion presented in this application will operate from the new address. The information provided is not meant to imply a second office location or a branch office.*

10. PROJECT IMPLEMENTATION SCHEDULE FOR AN HHA

d) A project that does not involve construction or renovation shall document that the approved project is complete and operational within 18 months.

Response: Commission regulations at COMAR 10.24.01.12 state that *"home health agencies have up to 18 months from the date of the certificate of need to (i) become licensed and Medicare certified; and (ii) begin operations in the jurisdiction for which the certificate of need was granted."*

On January 9, 2026, First Healthcare Consulting, LLC ("FHC"), submitted an application to develop a new Medicare-Certified Home Health Agency ("HHA") serving Anne Arundel, Montgomery, Prince George's, and Southern jurisdictions ("Batch 1")[2]. Because the Commission's decision on FHC's pending Batch 1 application will not be issued before the submission of this filing for HHA service to Baltimore County, Howard County, and Baltimore City ("primary service area," "Batch2," or "PSA"), **FHC has prepared this application under the assumption that its earlier CON application will be approved**. This initiative aligns with recent COMAR updates that permit Residential Service Agencies ("RSA") to apply for CONs and obtain Medicare certification as HHAs, thereby enhancing continuity of care and access to skilled home health agency services for Maryland residents.

[2] Matter Nos. 26-R4-2487, 26-R4-2488, 26-R4-2489, and 26-R4-2490

This proposed Batch 2 project requires no construction or renovation and will operate from the same administrative office used for the RSA and the Batch 1 HHA. Clinical and administrative staff needed to initiate operations in Batch 2 will already be employed and working under the Batch 1 HHA, with only incremental staffing additions required to meet projected volumes in Baltimore City, Baltimore County, and Howard County. FHC currently employs or contracts with skilled nursing, home health aides, and therapy staff (PT/OT), and has identified qualified candidates for the additional disciplines required.

FHC is accredited by the Community Health Accreditation Partner ("CHAP"); see Exhibit 1. This accreditation remains valid through November 29, 2028, enabling the organization to pursue licensure and Medicare certification for Batch 1 jurisdictions through a deemed-status pathway.

To be successful and pace its growth appropriately, FHC proposes to stagger the provision of services in the Batch 2 service area by one year. The Batch 2 project will operate under the **same Medicare certification (CCN)** established in the Batch 1 project. After Maryland issues licensure for the additional jurisdictions (Baltimore City, Baltimore County, and Howard County), FHC will update its Maryland OHCQ license and the CMS-855A enrollment form to add these new service areas under its existing certified HHA.

Projections in Tables 2b, 3, 4, and 5 in Part IV of this application reflect the **incremental growth** associated with the staggered start dates.

Table A: Estimated Schedule of Available Services, FHC Batch 1 and 2 Jurisdictions

Milestone	**Estimated Date**
Batch 1 CON Issued	June 2026
Batch 2 CON Issued	August 2026
Batch 1 License Issued	September 2026
Batch 1 CMS Certification	December 2026
Batch 1 Services Offered	**January 2027**
Batch 2 License Issued	September 2027
Batch 2 CMS Certification	December 2027
Batch 2 Services Offered	**January 2028**

Even with this conservative staggered approach, FHC will still be able to offer services to clients in the Batch 2 jurisdictions within the 18-month timeframe.

For Home Health projects, please also provide:

A. Licensure 13 months from CON approval date.

B. Medicare Certification 17 months from CON approval date*

11. PROJECT DESCRIPTION:

Provide a summary description of the project immediately below. At minimum, include the jurisdictions to be served and all of the types of home health agency services to be established, expanded, or otherwise affected if the project receives approval.

Overview

FHC seeks approval to develop HHA services in Baltimore City, Baltimore County, and Howard County. As explained in the previous question, this project proposes to build on services developed through both its existing RSA and its approved Batch 1 HHA. Through its RSA, FHC has served patients in jurisdictions within both the Batch 1 and Batch 2 HHA service areas.

This approach allows for internally consistent utilization projections, staffing plans, operational assumptions, and financial estimates across both projects. Adding this proposed project to Batch 1 will expand the service area to include Baltimore City, Baltimore County, and Howard County jurisdictions. FHC will, at completion, serve a total of **nine Maryland counties across seven jurisdictions.** It will offer an integrated, regionally aligned home health service footprint.

Figure A: FHC Total Proposed Service Area, Batch 1 and Batch 2 Combined

These combined service area jurisdictions will support economies of scale, consistent clinical standards, and improved access to Medicare-certified home health services for residents. Should adjustments be required based on the Commission's determination in Batch 1, FHC will promptly align all projections and operational plans to ensure full compliance with the approved service configuration.

When fully licensed and CMS-certified, FHC will have on-call nurses and accept patient referrals at any time of day, seven days a week, 365 days a year.

FHC proposes to offer all home health agency services covered by Medicare and Medicaid. These include items and services furnished to individuals on a visiting basis in accordance with the patients' care plans:

- Skilled nursing care provided by or under the supervision of a registered nurse;
- Physical therapy services;
- Speech therapy;
- Occupational therapy;
- Home health aide and other therapeutic services; and,
- Medical social services under the supervision of a master's-prepared Medical Social Worker.

FHC is committed to expanding access to home-based clinical services for low-income, minority, and medically complex populations that are identified by MHCC data as disproportionately underrepresented among home health service users in the proposed four-jurisdiction service area.

FHC workforce that is representative of its client base with regard to race, ethnicity, and culture. Its staff lives in the proposed jurisdictions. This practice provides a solid foundation for cultural competency in patient care and will extend to the proposed HHA as well. Policies and procedures promote better care coordination, fewer avoidable hospital stays, and improved patient outcomes.

FHC will continue to collaborate with and expand its reach to new hospital discharge planners, primary care practices, and community-based organizations across the PSA, ensuring timely access to skilled home health services. Exhibit 4 identifies the continuum of care providers in the jurisdiction and notes those with whom FHC has an existing referral relationship.

First Healthcare Consultants Background

History of Licensure

FHC was established in July 2018 and initially licensed as an RSA Level 3 in October 2018. This allowed FHC to provide primarily personal care and related services. FHC served clients under this license continuously through December 2022.

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

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

FHC has consistently provided skilled nursing, physical, and occupational therapy services since November 2022.

Sources of Referrals and Payors

FHC is an enrolled Maryland Medicaid provider and maintains contracts with the Maryland Department of Health to deliver services under state-funded programs, including the Community First Choice Program. Under its RSA licensure, FHC provides private. Veterans Administration, and Medicaid personal care services, private duty nursing, physical therapy, and services through Community Alternatives Programs for adults and children. FHC also contracts with approved Maryland Medicaid Managed Care Organizations (MCOs) for these services, reflecting established payer relationships and compliance with credentialing requirements.

In addition to payer relationships, FHC maintains strong referral connections within the regional healthcare community. The agency is an active member of the Capital Area Healthcare Alliance Business Advisory Council (Prince George's County Chapter) and regularly utilizes the Maryland-National Capital Homecare Association ("MNCHA") for staff training and professional development, including participation in MNCHA's Leadership Program. These affiliations support ongoing engagement with hospitals, providers, and community partners throughout the service area.

FHC Leadership

An experienced interdisciplinary management team leads FHC. The team has extensive backgrounds in home- and community-based care, clinical operations, regulatory compliance, and healthcare administration. The leadership structure reflects both the organization's history as a Residential Service Agency and its readiness to operate as a Medicare-Certified Home Health Agency.

Abisola Raimi-Abayomi, R.N., MSN/MBA-HCM, serves as **Chief Executive Officer and Clinical Services Director**. Ms. Raimi-Abayomi brings nearly three decades of nursing and executive leadership experience across home health, correctional health, acute care, education, and community-based settings. Her background includes senior clinical and administrative roles overseeing large multidisciplinary teams, statewide nursing operations, regulatory compliance, quality improvement, and financial risk management. She holds dual graduate degrees in nursing and healthcare management. She has extensive experience in licensure, accreditation, and quality oversight, and provides strong clinical and operational leadership for FHC's transition to home health agency services. She is also a nursing instructor at Anne Arundel Community College.

Crystal Clark serves as **Chief Operating Officer and Administrator**. Ms. Clark has more than 30 years of experience in healthcare operations, organizational governance, and regulatory readiness. Her expertise includes operational infrastructure development, compliance oversight, performance management, budgeting, and executive reporting. She has held senior leadership roles supporting healthcare organizations, including home health and consulting entities. She has proven experience in aligning clinical and administrative functions to support sustainable growth and regulatory compliance.

Ms. Clark also serves as COO of the Bowie Business Innovation Center's Business Incubator, where she has spent nearly a decade supporting early-stage companies through financial planning, budgeting, and operational management. In this role, she regularly advises start-up organizations on financial controls, cash-flow management, and sustainable business growth, providing direct instruction and mentorship in finance and business management. This experience further strengthens her ability to oversee the financial operations of the proposed Home Health Agency and ensure responsible fiscal management during the agency's development and growth.

Joviel Tumenta, R.N., BSN, serves as **Director of Nursing and Quality Assurance/Performance Improvement (QAPI) Lead**. Mr. Tumenta has clinical and leadership experience in home health, skilled nursing, and long-term care settings, including serving as interim Director of Nursing and Clinical Director at large facilities. His responsibilities include overseeing day-to-day clinical operations, staff education, intake reviews, care planning, and quality improvement activities. His background includes Medicare compliance, staff supervision, and regulatory plan-of-correction development, supporting FHC's ability to meet Conditions of Participation requirements.

Donabelle Cadatal-Abellana, PT, serves as **Therapy Lead**. Ms. Cadatal-Abellana is a licensed physical therapist with more than 25 years of experience in home health, rehabilitation, and acute and post-acute care settings. Her background includes extensive home care experience with large Maryland providers and a demonstrated history of interdisciplinary collaboration, patient education, and evidence-based care planning. She provides leadership for therapy services and coordination with contracted therapy disciplines as FHC expands its service offerings.

Latame Aheto, R.N., BSN, serves as **Intake Coordinator and RN Case Manager**. Ms. Aheto brings significant experience in home health nursing, OASIS-E assessments, wound care, chronic disease management, and care coordination. Her background includes hands-on Medicare-compliant documentation, interdisciplinary communication, and supervision of nursing staff and aides. She supports intake review, assessment accuracy, and continuity of care across service transitions, contributing directly to quality and compliance functions.

Together, FHC's leadership team demonstrates the clinical expertise, operational capacity, and regulatory experience necessary to establish and sustain a Medicare-Certified Home Health Agency while maintaining continuity with the organization's existing service model.

Clinical Staff

FHC's RSA clinical team includes Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants (CNA I and II), Personal Care Assistants, and Licensed Physical Therapists, who collectively provide the full range of authorized RSA home care services.

In addition to direct clinical personnel, FHC's staff brings experience in public health, geriatrics, social work with individuals with disabilities, health information services, and home health operations. This interdisciplinary expertise supports coordinated, patient-centered care for medically complex and socially vulnerable populations.

Programming

All home health agency services will be furnished pursuant to a physician-approved plan of care, developed in collaboration with the patient and interdisciplinary care team. Plans of care will be reviewed and updated as clinically indicated, but no less frequently than every 60 days, in accordance with CMS Conditions of Participation. Services will be individualized to address each patient's medical condition, functional status, and goals of care.

FHC proposes to offer a comprehensive range of skilled home health services capable of addressing a broad spectrum of medical, post-acute, and post-surgical conditions, including but not limited to cardiac, pulmonary, dermatological, endocrine (including diabetes mellitus), digestive, musculoskeletal, neurological, psychiatric (including Alzheimer's disease and other dementias), urological, and complex chronic conditions. Services will be provided across the lifespan, including age-appropriate care for pediatric and geriatric populations. When clinically appropriate, FHC will use a multidisciplinary approach to care delivery for patients requiring rehabilitative services, complex medical management, support for neurodegenerative conditions, or recovery from acute exacerbations of chronic illnesses such as congestive heart failure and chronic obstructive pulmonary disease ("COPD").

Home health agency services will be available seven days per week, as required to meet patient needs and support the timely initiation of care following hospital or facility discharge.

Skilled Nursing Services

Licensed registered nurses will provide skilled nursing services and, when appropriate, licensed practical nurses will provide this care under physician direction. Nursing services will include comprehensive assessment, care planning, medication management, disease education, wound care, post-surgical monitoring, chronic disease management, and coordination with physicians and other members of the interdisciplinary team. Nurses will work closely with patients, families, and caregivers to promote recovery, prevent avoidable hospitalizations, and support safe home care management.

Pediatric Home Care Services

FHC will provide skilled nursing services to pediatric patients when ordered by a physician and clinically appropriate. Nurses providing pediatric home care will be trained to address the unique medical, developmental, and communication needs of children and their families. Pediatric services will emphasize family education, caregiver support, and coordination with pediatric providers to ensure continuity of care in the home setting.

Physical Therapy

Physical therapy services will focus on restoring mobility, improving functional independence, reducing pain, and preventing further injury. Services may include, but are not limited to:
Orthopedic rehabilitation

- Pain management
- Education on body mechanics and injury prevention
- Training in the use of assistive devices
- Hand therapy
- Range-of-motion improvement
- Muscle re-education
- Sports and activity-related rehabilitation
- Flexibility and strengthening exercises
- Back and neck care
- Pre- and post-surgical rehabilitation

Physical therapists will collaborate with nursing and other disciplines to support patient-centered recovery and functional improvement.

Occupational Therapy

Occupational therapy services will support patients' ability to perform activities of daily living safely and independently. Services may include, but are not limited to:

- Functional assessments and re-education
- Home safety evaluations and recommendations
- Energy conservation and fatigue management strategies
- Training in adaptive techniques for self-care tasks
- Education and training in the use of adaptive equipment
- Therapeutic program development and implementation
- Assistance with simplifying daily activities, including meal preparation, bathing, grooming, and household tasks.

Speech Therapy *(New Service)*

As a Medicare-Certified Home Health Agency, FHC will expand its scope of care to include speech-language pathology services. This service will be provided through qualified contracted providers. Speech therapy services will address communication, cognitive, and swallowing disorders resulting from stroke, neurological disease, injury, or other medical conditions. Services may include evaluation and treatment of speech and language deficits, cognitive-communication impairments, and dysphagia, to improve safety, functional communication, and quality of life.

Medical Social Work *(New Service)*

FHC will incorporate medical social work services into its interdisciplinary home health program. Medical social workers will assist patients and families in addressing psychosocial, environmental, and financial factors that affect health outcomes. Services may include counseling, resource coordination, advanced care planning support, referral to community-based services, and assistance with care transitions. Medical social work services will support patients' stability at home and help address non-medical barriers to successful treatment and recovery.

Personal Care Services

FHC recognizes that Medicare-Certified home health agencies place primary emphasis on skilled nursing and therapy services rather than long-term personal care. When ordered as part of a physician-approved plan of care and consistent with regulatory requirements, home health aide services may be provided to assist with activities of daily living, including bathing, dressing, hygiene, and mobility. These services will be delivered under the supervision of licensed nursing staff and will support, but not replace, skilled clinical care.

Special Programs

As an RSA, FHC has extensive experience delivering specialized in-home services to medically complex patients. Building on this foundation, FHC's proposed Medicare-certified Home Health Agency will formalize and expand these capabilities through structured clinical programs designed to address high-utilization, high-risk conditions commonly managed in the home setting. These special programs will be delivered under physician orders, integrated into the interdisciplinary plan of care, and monitored through the agency's Quality Assessment and Performance Improvement (QAPI) process to ensure safe, effective, and continuous care.

Wound Care Program

FHC's Homecare Wound Care Program provides evidence-based, physician-ordered wound care services in the home to promote healing, prevent infection and complications, and reduce avoidable emergency department visits and hospital readmissions. Services are provided by licensed nursing staff with wound care competency and are coordinated by an interdisciplinary team.

The program serves patients with acute, chronic, post-operative, and complex wounds, including pressure injuries, diabetic foot ulcers, venous and arterial ulcers, surgical wounds, skin tears, and minor burns. Licensed nurses conduct comprehensive wound assessments at initiation and throughout care, including wound measurement, tissue evaluation, infection surveillance, pain assessment, and documentation of healing progress. Individualized wound care plans are developed and updated in accordance with physician orders, assessment findings, and evidence-based practice.

Interventions may include skilled selection and modification of dressings, infection prevention and control, aseptic technique, pressure relief and offloading strategies, compression therapy when indicated, and coordination of wound care supplies and equipment. Patient and caregiver education focuses on wound care techniques, nutrition and hydration, pressure injury prevention, medication adherence, and early recognition of complications. Program oversight and outcomes are monitored through QAPI activities and implemented in compliance with Maryland Office of Health Care Quality requirements and professional standards of practice.

Diabetes Care Program

FHC's Diabetes Care Program provides skilled nursing services to help patients with diabetes mellitus manage their condition safely at home. Services focus on glycemic monitoring, medication management (including insulin administration when ordered), assessment for complications, and patient education to improve self-management and reduce preventable hospitalizations.

Nursing interventions include blood glucose monitoring; evaluation of symptoms related to hypo- or hyperglycemia; medication reconciliation; nutritional education coordinated with physician guidance; and monitoring for diabetes-related complications, such as neuropathy, skin breakdown, and foot wounds. Patient and caregiver education emphasizes understanding of the disease, medication adherence, dietary considerations, and early identification of symptoms requiring medical attention. Care is coordinated with the patient's physician and other members of the interdisciplinary team as appropriate.

Post-Surgical Care Program

FHC's Post-Surgical Care Program supports patients transitioning home following surgical procedures by providing skilled nursing and therapy services designed to promote recovery and prevent complications. Services may include postoperative assessment, incision monitoring, pain management support, medication education, mobility and safety evaluations, and coordination of rehabilitative services, as ordered.

Nurses monitor for signs of infection, complications, or delayed healing and provide education to patients and caregivers regarding activity restrictions, wound care, symptom monitoring, and follow-up appointments. When appropriate, therapy services are integrated into the plan of care to support functional recovery and safe return to daily activities. The program emphasizes timely initiation of care, patient education, and coordination with surgeons and referring providers to ensure continuity and quality of care.

Importance of Home Health Services to the Community

In-Home Visits as a Means to Reduce Hospital Readmissions

In-home skilled nursing and therapy visits are a proven, evidence-based strategy to reduce avoidable hospital utilization. The State of Maryland has explicitly prioritized reducing preventable readmissions through the Readmission Reduction Incentive Program (RRIP), administered by the Health Services Cost Review Commission (HSCRC). The RRIP program establishes annual statewide targets, noting that the all-cause, **unadjusted readmission rate for Maryland hospitals was 15.43 percent in CY2024**, underscoring the persistent need for stronger post-acute stabilization in the home.[3] *For reference, FHC's existing RSA reported a readmission rate of 3.9 in CY2024, significantly lower than that of Maryland. See additional detail in 10.24.01.08G(3)(h) below, p83.*

Home health services directly support the goals of RRIP by providing early, structured clinical oversight following hospital discharge. Early home health intervention—particularly within the first forty-eight hours—has been shown to significantly reduce the risk of rehospitalization among Medicare beneficiaries and medically complex older adults. A 2022 study published in the *Journal of the American Medical Directors Association* found that patients receiving their first home health visit within two days experienced substantially lower rates of readmission or emergency department use.[4]

FHC's proposed Home Health Agency will strengthen Maryland's statewide efforts to reduce avoidable hospital utilization through:

1. Early High-Intensity Post-Discharge Clinical Contact

Prompt initiation of skilled nursing, therapy, and medication-management visits reduces complications that commonly lead to return to the hospital.

2. Ongoing Disease Management and Patient/Caregiver Education

Skilled nurses monitor chronic conditions, reinforce medication adherence, and identify early warning signs that—if unmanaged—drive inpatient utilization.

3. Wound Care, Medication Reconciliation, and Safety Assessments

These clinically complex needs are frequently cited in the literature as primary causes of preventable readmissions. An in-home assessment provides immediate intervention.

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

[4] O'Connor, Maura, et al. "Risk of Rehospitalization or Emergency Department Visit Is Significantly Higher for Patients Who Receive Their First Home Health Visit Later Than Two Days After Hospital Discharge." *Journal of the American Medical Directors Association,* vol. 23, no. 10, 2022, pp. 1642–1647. doi:10.1016/j.jamda.2022.07.001.

4. Chronic Condition Support for High-Risk Populations

Older adults, dual-eligible beneficiaries, and medically complex patients—groups disproportionately represented in the PSA—experience lower readmissions when supported by structured home health services.

Taken together, these components position home-based care as a critical mechanism for achieving Maryland's statewide readmission-reduction goals while keeping patients stable, independent, and safely at home.

Lower-Cost Alternative to Hospital Care

Evidence also supports the cost-effectiveness of home health agency and other home-based care models relative to traditional hospital and long-term institutional care. Comparative analyses show fewer hospitalization days and lower direct costs for patients managed with home-based care models than for those managed in inpatient care, particularly among older and medically complex patients.[5]

These findings are especially relevant in the PSA, where approximately 11.3 percent of the population lives below the poverty level, making affordable care options essential (see details in Exhibit 7).[6] Home health services, delivered in patients' homes and focused on stabilization and recovery, can lower total system costs while enhancing patient comfort and independence.

FHC's proposed Home Health Agency offers a lower-cost alternative by providing clinically appropriate care in the least intensive and least expensive setting—the patient's home—thereby reducing reliance on higher-cost institutional care. Specifically:

1. Substitution for Higher-Cost Settings

Home health services can prevent or shorten hospital admissions, reduce emergency department utilization, and decrease length of stay in skilled nursing facilities and inpatient rehabilitation facilities. Evidence from a systematic review indicates that home-based care services are generally cost-saving or cost-effective compared with in-hospital care, resulting in lower overall expenditures while achieving similar outcomes outside institutional settings.[7, 8]

2. Prevention of Avoidable Utilization

Through skilled nursing oversight, medication reconciliation, chronic disease management, and therapy services, FHC will reduce preventable readmissions and complications that result in high-cost care.

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[5] Szylit, Charles J., et al. "Cost-Effectiveness of Home Care Versus Hospital Care: Retrospective Analysis." *Cost Effectiveness and Resource Allocation*, vol. 21, 2023, https://pubmed.ncbi.nlm.nih.gov/36732792/

[6] U.S. Census Bureau American Community Survey Selected Economic Characteristics, 1-Year Estimates Table DP03, 2024

[7] Curioni, C., et al. "The Cost-Effectiveness of Homecare Services for Adults and Older Adults: A Systematic Review." *International Journal of Environmental Research and Public Health*, vol. 20, no. 8, 2023.

[8] Medpac Report to Congress 2025, Home Health Chapter, p239 https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf

3. Cost Efficiency Through Community-Based Care

Delivering services in the home eliminates facility overhead associated with inpatient settings and supports personalized care.

4. Appropriate Utilization Management

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

5. Payer Neutrality and Medicare Compliance

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

Accordingly, FHC HHA services in these jurisdictions can provide a lower-cost alternative to institutional acute and post acute care settings, while maintaining quality, continuity, and regulatory compliance.

Care Coordination

FHC uses an electronic medical record platform, Alora Plus, that will permit it to transition quickly to home health agency care. This platform supports both home care and home health agency services, and FHC staff are trained to use it.

Exhibit 4 identifies agencies / providers with whom FHC works or intends to work.

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

INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. These criteria follow, 10.24.01.08G(3)(b) through 10.24.01.08G(3)(h).

10.24.01.08G(3)(a). "<u>The State Health Plan" Review Criterion</u>
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria. (Note:
HHA CON review standards may be found in COMAR 10.24.16.08. Furthermore, in a comparative review, CON preference rules may be found in COMAR 10.24.16.09

10.24.16.08 CERTIFICATE OF NEED REVIEW STANDARDS FOR HOME HEALTH AGENCY SERVICES.

The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new home health agency in Maryland or expand the services of an existing Maryland home health agency to one or more additional jurisdictions.

The following standards must be addressed by all home health agency CON applicants, as applicable. Provide a direct, concise response explaining the proposed project's consistency with each standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

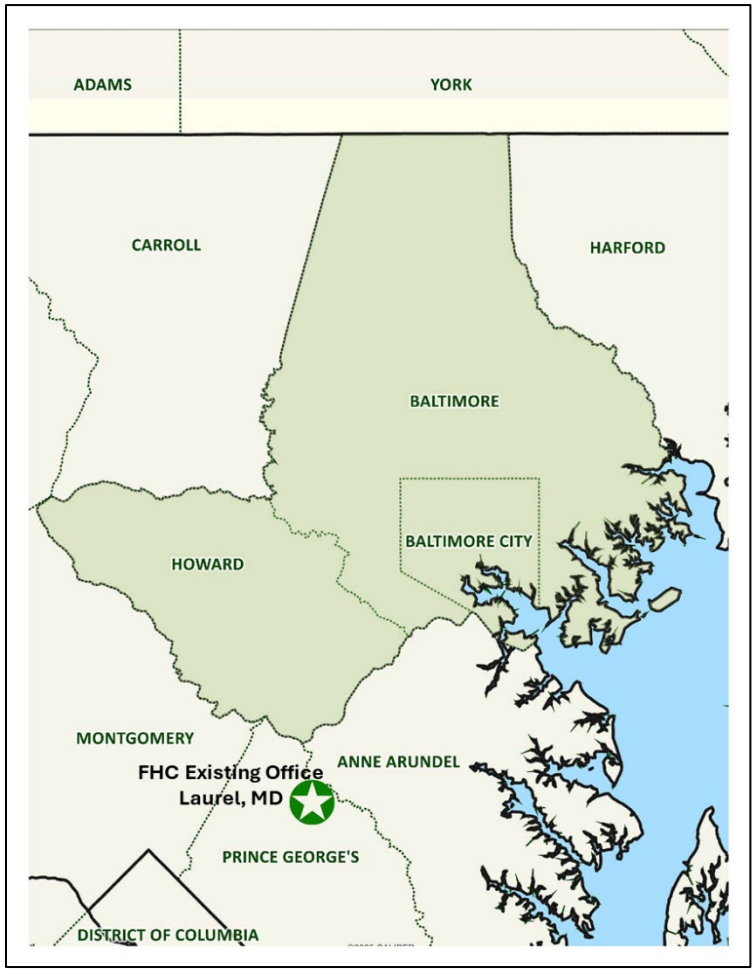
10.24.16.08A. Service Area.

An applicant shall:

(1) Designate the jurisdiction or jurisdictions in which it proposes to provide home health agency services; and

Response: FHC proposes to expand Medicare-certified HHA services to three jurisdictions/regions: Baltimore City, Baltimore County, and Howard. For purposes of this application, these are collectively referred to as the "primary service area," "PSA," or "Batch 2."

Figure B: FHC Proposed HHA Primary Service Area Jurisdictions Map, Batch 2



(2) Provide an overall description of the configuration of the parent home health agency and its interrelationships, including the designation and location of its main office, and each branch, as defined in this Chapter, or other major administrative offices recognized by Medicare.

Response: Please see Exhibit 3 for FHC's organizational chart. FHC has recently moved to a new main office located at 8643 Cherry Lane in Laurel Maryland. At the time of this submission, the Applicant is filing all required documentation with Mayland OHCQ to update the address. The Applicant expects to be operational from the new location by Summer 2026. Therefore, the proposed service expansion presented in this application will operate from the new address. The information provided is not meant to imply a second office location or a branch office. FHC will be able to serve the entire proposed service area from its existing office. All administrative functions are conducted at the main office.

10.24.16.08B. Populations and Services.

An applicant shall describe the population to be served and the specific services it will provide.

Response:

FHC proposes to provide care to clients of all ages and payer sources within the proposed three new jurisdictions. The following sections detail the population to be served and FHC's services to those clients.

Proposed Services

FHC will be consistent with the COMAR 10.24.16.02D, as well as COMAR 10.24.16.06A, the requested scope of services, and 10.24.16.08B. It proposes to add three new jurisdictions to a new Medicare-certified home health agency office for which it expects to receive CON approval in the summer of 2026 and licensure and certification by the fourth quarter of 2027.

The new jurisdictions, Baltimore City, Baltimore County, and Howard County, are easily reached from FHC offices in Laurel, Maryland. The newly proposed Medicare-Certified agency office will provide skilled services (including nursing, physical therapy, speech therapy, occupational therapy, medical social work, and home health aide services), a wide range of treatments, and availability seven days a week. It will have a highly trained workforce ready to provide care to special-needs populations. See Part I.11, page 17 above, the section called "Programming," for additional details regarding its proposed services.

Population Growth and Aging in the PSA

Population in the PSA is aging: The share of Maryland's residents aged 65 and older is high, and state projections indicate continued growth in the number of older adults over the next two decades; see Maryland State data in Exhibit 12. This pattern will increase demand for local services for older residents.

National survey data demonstrate that need for home-based support increases with age: in 2021, about 11.9 percent of U.S. adults age eighteen and older received care at home from a friend or family member in the prior twelve months, compared with **19.1 percent of adults aged 65 to 74, 19.4 percent of those aged 75 to 84, and nearly 40 percent of adults 85 and older.**[9] These data illustrate the increase in functional limitations, chronic disease burden, and caregiving needs associated with aging, underscoring that the oldest age groups have substantially higher rates of home health care needs than younger adults.

National and Maryland home health agency statistics demonstrate that most home health agency patients are Medicare beneficiaries. The most common qualifier for Medicare is age 65 or older. A small percentage of Medicare beneficiaries qualify based on disability. This suggests that older adults are more likely than younger adults to require assistance and to benefit from formal home health agency services as they age. According to the CMS Medicare Enrollment Dashboard, in November 2025, there were 333,610 Medicare Enrollees in the PSA – 18.7 percent of the PSA population.

In 2025, the PSA jurisdictions had a combined population of more than 1.7 million people – 17.7 percent of whom were over age 65. More importantly, the over-65 cohort is growing substantially faster than all other age groups in the PSA. By FY 2030, the state demographer forecasts that over 19 percent of the population will be in this older age cohort, approximately 348,000 people. See details in Table B below.

Table B: Population by Age Group by Year, FHC Primary Service Area Jurisdictions, CY2025-CY2030

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY25-CY30 CAGR
0 to 4	104,274	104,480	104,687	104,895,	105,104	105,314	0.2%
5 to 14	207,281	207,002	206,726	206,452	206,180	205,910	-0.1%
15 to 24	227,543	228,323	229,108	229,898	230,695	231,497	0.3%
25 to 44	498,574	497,225	495,884	494,551	493,226	491,908	-0.3%
45 to 64	429,111	428,516	427,937	427,375	426,830	426,301	-0.1%
65 to 74	181,400	183,150	184,925	186,725	188,550	190,402	1.0%
75 to 84	95,754	99,208	102,787	106,496	11-,339	114,321	3.6%
85+	38,764	39,681	40,631	41,616	42,638	43,698	2.4%
Total	**1,782,701**	**1,787,585**	**1,792,685**	**1,798,008**	**1,803,561**	**1,809,351**	**0.3%**
Total 65+	**315,918**	**322,039**	**328,343**	**334,836**	**341,527**	**348,421**	**2.0%**
% 65+	**17.7%**	**18.0%**	**18.3%**	**18.6%**	**18.9%**	**19.3%**	

Source: Maryland Department of Planning State Data and Analysis Center, Population Projections; MDP provides data for 2025 and 2030, and the Applicant interpolates all other years.

[9] Centers for Disease Control and Prevention (CDC). *QuickStats: Percentage of Adults Aged ≥18 Years Who Received Care at Home From a Friend or Family Member in the Past 12 Months, by Sex and Age Group — United States, July–December 2020.* **MMWR** 2022;71(2).

This trend is consistent across all PSA counties. In Howard County, the over-65 population is growing faster than the state's.

Table C: 2025 to 2030 Compound Annual Growth Rate of Population by Age Group by Primary Service Area Counties Compared to Maryland

Age Group	Baltimore City	Baltimore County	Howard	Maryland
0 to 4	-0.2%	0.4%	0.3%	0.6%
5 to 14	0%	-0.4%	0.3%	0.5%
15 to 24	-0.1%	0.4%	1.0%	0.2%
25 to 44	-0.5%	-0.3%	0.3%	0.1%
45 to 64	0.7%	-0.6%	-0.5%	-0.4%
65 to 74	0.4%	0.8%	2.3%	1.7%
75 to 84	3.6%	3.5%	4.0%	3.6%
85+	1.2%	1.8%	6.3%	4.1%
Total	**0.2%**	**0.2%**	**0.7%**	**0.5%**

Source: Maryland Department of Planning State Data and Analysis Center, Population Projections; MDP provides data for 2025 and 2030, and the Applicant interpolates all other years.

Aging of the PSA population and, more importantly, significant expansion of the older-age population will drive higher demand for home health agency services. The senior population segment has the highest prevalence of musculoskeletal, neurological, cardiovascular, and respiratory diseases, which are associated with high home health agency use.

Across all age groups, barriers to health care access include lack of insurance coverage, limited culturally competent care, limited geographic availability, disabilities, and limited income.[10]

Pediatrics

Although home health services are most commonly associated with older adults, pediatric home health care is an essential and growing component of the continuum of care for children with chronic health needs and complex medical conditions. National data indicate that home health use among children is more limited than among adults. Still, utilization patterns reflect the significant clinical and support needs of the pediatric population that receives these services. In an extensive Medicaid cohort study, approximately **0.8 percent of enrolled children under age eighteen used home health care**, with infants (<1 year) and adolescents accounting for a substantial proportion of pediatric users. Children receiving home health services often have multiple chronic conditions or technology dependence, demonstrating the clinical complexity typical of this population.[11]

[10] HealthyPeople.gov; Access to Health Services, 2030 Topics and Objectives;

[11] Bergman, Dana A., et al. "Home Health Care Utilization in Children With Medicaid." *Pediatrics*, vol. 149, no. 2, American Academy of Pediatrics, 2022, https://pubmed.ncbi.nlm.nih.gov/35028664/

Children who use home health agency services are heterogeneous with regard to age and cultures, but frequently experience chronic disease and functional limitations that require skilled nursing and ongoing support. Among Medicaid beneficiaries receiving pediatric home health care, nearly **one in five children with a complex chronic condition were hospitalized** during the study period, highlighting the vulnerability of pediatric patients without adequate home health support.[12]

Home health care also plays a crucial role in reducing hospital utilization and supporting family caregivers. Research reports demonstrate that home health services for medically complex populations are associated with lower inpatient costs and fewer readmissions than similar patients without home health support, suggesting that pediatric patients who receive coordinated home care may avoid more costly and disruptive institutional care.[13] Additionally, children with special healthcare needs — nearly **19.4 percent of U.S. children according to national surveys — often depend on home- and community-based services** for ongoing management of their conditions, underscoring the broader need for accessible pediatric home health services.[14]

Medicaid plays a central role in covering pediatric home health care, reflecting both the clinical intensity of needs and the socioeconomic profiles of many families with medically complex children. Families frequently provide extensive unpaid caregiving at home, with some reporting more than 21 hours per week devoted to direct care and care coordination responsibilities—a burden that skilled home health services help alleviate.[15]

In light of these utilization patterns and care demands, expanding access to high-quality pediatric home health services through the proposed FHC Home Health Agency will benefit the community. It will improve continuity of care, support complex pediatric care needs in the home setting, and potentially reduce avoidable hospitalizations for children with chronic and medically complex conditions.

Population Health

Health and prevention statistics from the Robert Wood Johnson County Health Rankings also indicate that health providers in the PSA will likely see high demand for home health services. See Exhibit 6 for these detailed metrics on community health status and risk factors for the PSA jurisdictions. A few deserve special attention:

- Rates of preventable hospitalizations in Baltimore and Howard Counties are higher than both the state and national averages (2022);
- Diabetes prevalence is as high as 14 percent (2022);
- Between 27 and 39 percent of adults are obese (2022); and,
- More than eight percent of adults in all counties are current smokers (2022).

[12] Ibid
[13] Ibid
[14] Grand View Research, Inc. *U.S. Pediatric Home Healthcare Market Size & Outlook, 2030*. Grand View Research, 2024, https://www.grandviewresearch.com/horizon/outlook/pediatric-home-healthcare-market/united-states
[15] Cohen, Ellen, et al. "Financing of Pediatric Home Health Care." *Pediatrics*, vol. 139, no. 3, American Academy of Pediatrics, 2017.

According to the Maryland Department of Planning population data, the PSA reflects substantial racial and ethnic diversity. In 2025, approximately 43.6 percent of the population identified as White or Caucasian, approximately 21.7 percent as African American, and approximately 8.1 percent as Hispanic or Latino (Exhibit 7). National and state research demonstrate that communities with greater racial and ethnic diversity are more likely to experience structural barriers to health care access, including gaps in insurance coverage, transportation challenges, language barriers, and shortages of community-based providers. These factors are associated with delayed care, higher disease burden, and increased reliance on acute-care settings.[16]

Research also indicates that culturally and linguistically responsive care— such as care delivered by a workforce trained to understand patients' cultural backgrounds and communication needs—is associated with improved patient engagement, satisfaction, and adherence to care plans. Accordingly, home health agencies serving diverse populations benefit from staffing models and care practices that promote cultural competence and effective communication, supporting equitable access and improved outcomes across all patient groups.[17]

Demographic data on social determinants of health status based on data from the U.S. Census Bureau, which are mutually related to poor health status and can indicate an increased need for home health services in specific communities. Poverty is the social determinant most closely correlated with poor health.[18] **In 2024, approximately 11.3 percent of PSA residents had incomes below the poverty level** (Exhibit 7)**.**[19] The cost of care is essential for people at the poverty level, and even those with incomes above the poverty level often struggle to address underinsurance. Price is a deterrent to access for this group. This area would benefit from affordable access to home health services.

These social snapshots support the clear need for preventive home health services in the PSA jurisdictions.

Home Health Use Rates

Residents of the PSA and their primary care providers recognize the benefits of home health services. Many people prefer to receive care at home rather than in a hospital because they feel more secure there, and home health services cost less than conventional hospital-based care.

[16] Centers for Disease Control and Prevention. *Racial and Ethnic Disparities in Health Care Access and Outcomes*. CDC, 2023, www.cdc.gov/minorityhealth/racism-disparities/index.html

[17] U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. HHS, updated 2022, https://thinkculturalhealth.hhs.gov

[18] Woolf, Stephen H.; et al; "How are Income and Wealth Linked to Health and Longevity?"; https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf; accessed April 5, 2021

[19] https://hdpulse.nimhd.nih.gov/data-portal/social/table?age=001&age_options=ageall_1&demo=00009&demo_options=poverty_3&race=00&race_options=race_7&sex=0&sex_options=sexboth_1&socialtopic=080&socialtopic_options=social_6&statefips=24&statefips_options=area_states

Despite recent declines in home health agency utilization (see Table D below), the evidence overwhelmingly suggests that this trend reflects **limited access rather than diminished need**.

During the COVID-19 pandemic, MedPAC reports that Medicare home health use fell by more than 6 percent between 2021 and 2022, with in-person home health visits declining nearly 10 percent over the same period. This change coincided with widespread staffing shortages and agency capacity constraints, rather than with improvements in population health.[20] At the same time, nearly **one-third of patients discharged home fail to access home health services within seven days**, a delay associated with a **41 percent higher mortality rate**, indicating that needed care is not being delivered.[21] Industry analyses similarly find that falling admission volumes "indicate unmet demand and reduced access," driven by agency closures, labor shortages, and reimbursement pressure.[22]

Table D: Home Health Use Rate History in the FHC Primary Service Area 2019-2023 (per 1,000 population)

Age Group	CY19	CY20	CY21	CY22	CY23	CAGR 2019-2023
0 to 4	9.5	9.6	7.9	6.9	7.5	-5.8%
5 to 14	0.5	0.5	0.6	0.5	0.8	0.4%
15 to 24	1.1	0.9	1.0	0.9	0.9	-3.1%
25 to 44	3.0	2.9	2.6	2.5	2.1	-8.6%
45 to 64	17.2	17.0	15.9	15.1	13.1	-6.5%
65 to 74	60.6	61.0	62.5	64.0	59.1	-0.6%
75 to 84	136.4	132.8	134.0	146.4	138.0	0.3%

Sources: MDP Population Data, MHCC HHA Utilization Table 13

These data run counter to research reports on need, suggesting an access barrier. As the number and percentage of older adults continue to grow, without more capacity, access barriers could increase.

[20] MedPAC report summary: https://www.hospicepalliativecaretoday.com/blogs/literature-review/2024/8/11/home-health-sees-spending-utilization-decline-as-hospice-equivalents-grow-medpac-reports--2

[21] HomeCare Magazine analysis on delayed access and mortality: https://www.homecaremag.com/news/cms-reduced-access-home-health

[22] McKnight's Home Care and Trella Health industry findings:

- https://www.mcknightshomecare.com/news/home-health-visits-admissions-fall-nationwide-industry-report-finds/
- https://www.trellahealth.com/wp-content/uploads/2023/05/Post-Acute-Care-Industry-Trend-Report-2023-Edition.pdf

Summary of Need

The PSA faces a confluence of demographic and health-system pressures that point to a clear and growing need for expanded home health capacity. Table B shows the population cohort aged 65+ increasing at the fastest rate across all PSA counties, with the 75–84 and 85+ age groups growing by an average of three percent annually. These populations have more chronic conditions, functional limitations, and post-acute care needs—yet home health utilization rates in the PSA have steadily declined. Evidence indicates that this decline reflects strained access, driven by workforce shortages and agency capacity limits, and delayed transitions from hospital to home. At the same time, the PSA shows elevated rates of preventable hospitalizations, diabetes, obesity, and smoking, as well as large low-income and minority populations who experience well-documented barriers to timely, culturally competent care. Collectively, these trends demonstrate that existing home health resources are no longer sufficient to meet the needs of a rapidly aging population with increasingly complex medical and social risk factors.

Pediatric demand for home health services in the PSA is driven by a distinct but equally compelling set of factors, including the growing prevalence of children with complex chronic conditions, developmental disabilities, and technology-dependent medical needs that require skilled clinical oversight in the home. National and state data show that children with medical complexity account for a disproportionate share of pediatric hospitalizations, emergency department use, and prolonged lengths of stay, underscoring the importance of effective post-acute and community-based care.

For these children, timely access to skilled nursing and therapy services at home supports clinical stability, caregiver capacity, and continuity of care after hospital discharge. Limitations in pediatric home health capacity—particularly staffing constraints and service availability—can lead to delayed discharges, caregiver strain, and avoidable hospitalizations. Expanded home health capacity within the PSA is therefore essential to support medically fragile and high-risk pediatric patients, reduce unnecessary institutional care, and allow children to receive medically necessary services in the least restrictive and most appropriate setting.

FHC is well-positioned to address these gaps by establishing a Medicare-certified Home Health Agency that provides expanded clinical capacity, comprehensive service offerings, and a proven commitment to serving economically and medically vulnerable residents. FHC's longstanding experience delivering skilled in-home care to Medicaid, waiver, and dual-eligible beneficiaries positions the organization to reduce disparities in access—particularly for low-income seniors and communities of color who comprise a significant share of the PSA. With seven-day-per-week availability, multidisciplinary clinical services, and an established approach to managing financial access challenges, FHC will strengthen care transitions, reduce avoidable readmissions, and offer a lower-cost alternative to inpatient or facility-based care. By combining demographic need, demonstrated access gaps, and FHC's operational readiness, the proposed HHA will meaningfully expand capacity and ensure that PSA residents—especially the growing older-population—can access timely, high-quality home health services.

FHC's current staff are experienced in both geriatric and pediatric care, and a sustained history of patient referrals reinforces its positive reputation.

10.24.16.08C. Financial Accessibility.

An applicant shall be or agree to become licensed and Medicare- and Medicaid-certified and agree to maintain Medicare and Medicaid certification and to accept clients whose expected primary source of payment is either or both of these programs.

Response: As a licensed RSA in Maryland, FHC already accepts Medicaid, VA, and private-pay patients. FHC agrees to pursue Medicare Certification once it is licensed as an HHA. FHC will accept and not discriminate against clients whose primary source of payment is Medicare or Medicaid.

10.24.16.08D. Fees and Time Payment Plan.

An applicant shall make its fees known to prospective clients and their families at the time of patient assessment, before services are provided, and shall:

(1) Describe its special time payment plans for an individual who is unable to make full payment at the time services are rendered; and

(2) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

Response: FHC has a Charity Care and Financial Policy (see Exhibit 8) that fully complies with COMAR 10.24.16.08E. The policy outlines the agency's commitment to providing prospective clients with transparent information about fees, charity care, discounted services, and time-payment plans. FHC's HHA clients will receive a copy of this policy during the intake process. Fees, financial assistance options, and payment expectations will be disclosed at the time of patient assessment and before the initiation of services, as required.

FHC's policy ensures that clients who are unable to pay in full at the time services are rendered have access to structured, interest-free time-payment arrangements. The policy includes:

- **A sliding fee scale** offering full charity care for clients with income at or below one hundred percent of the Federal Poverty Level (FPL) and discounted services up to three hundred percent of FPL.
- **Interest-free payment plans** for clients who do not qualify for charity care or discounted services, with flexible terms, low minimum monthly payments, and no late fees or interest charges.
- **Written notice of payment plan options**, provided to clients at admission, during financial counseling, and in their welcome packet. The policy will be posted in public areas and available on the agency's website.
- **A requirement that services are never denied, delayed, or discontinued** due to inability to pay or while a financial assistance application is pending.

- **Clear procedures** for determining probable eligibility for charity care or discounted services within two business days, in accordance with COMAR.

A written copy of this policy—including detailed descriptions of the sliding fee scale, payment plan mechanisms, eligibility criteria, and application process—will be submitted to the Commission and provided to each client consistent with COMAR 10.24.16.08E.

10.24.16.08 E. Charity Care and Sliding Fee Scale.

Each applicant for home health agency services shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual's ability to pay, and shall provide home health agency services on a charitable basis to qualified indigent and low-income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

(1) Determination of Eligibility for Charity Care and Reduced Fees. Within two business days following a client's initial request for charity care services, application for medical assistance, or both, the home health agency shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client.

Response: FHC's Financial Policy includes both charity care and the opportunity to participate in a sliding fee schedule or time payments. The policy will be provided to clients at intake. Please see Exhibit 8 for a copy of the policy.

The policy includes a provision that FHC shall determine probable eligibility for medical assistance, charity care, reduced fees, and / or timed payments within two business days following a client's initial request and communicate the eligibility determination to the client.

(2) Notice of Charity Care and Sliding Fee Scale Policies. Public notice and information regarding the home health agency's charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA's service area, and in a format understandable by the service area population. Notices regarding the HHA's charity care and sliding fee scale policies shall be posted in the business office of the HHA and on the HHA's website, if such a site is maintained. Prior to the provision of HHA services, an HHA shall address clients' or clients' families' concerns with payment for HHA services and provide individual notice regarding the HHA's charity care and sliding fee scale policies to the client and family.

Response: FHC recognizes that public notice and information about its charity care and sliding-fee scale policies are essential to ensuring equitable access for clients. In accordance with this rule, FHC will provide notice in the following ways:

1. **Onsite:** Notices outlining eligibility criteria, application procedures, and available financial assistance will be posted prominently in FHC's administrative office and client-facing areas. Posting materials will use clear, plain language and will include instructions for obtaining the full Charity Care and Sliding Fee Scale Policy (see Exhibit 8).
2. **Website:** Full copies of the Charity Care and Sliding Fee Scale Policy will be available on the FHC website in an easy-to-read and downloadable format optimized for both computer and mobile devices.
3. **In-Person**: Prior to the provision of services, each client—and/or their legally authorized representative—will receive individualized written notice and a verbal explanation of: FHC's Charity Care and Sliding Fee Scale Policy, eligibility requirements, required documentation, application instructions, and available payment support programs, including FHC's Time Payment Plan.

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each HHA's charity care policy shall include provisions for a sliding-fee scale and time-payment plans for low-income clients who do not qualify for full charity care but are unable to afford the full cost of services.

Response: FHC's charity care policy includes a comprehensive discounted care structure, a sliding fee scale based on Federal Poverty Guidelines, and an interest-free time-payment plan for clients who do not qualify for full charity care but cannot pay the full cost of services. A full copy of the policy is provided in Exhibit 8. Table E below summarizes the policy's major components, including eligibility thresholds, discount tiers, repayment terms, notification requirements, and protections for patients during financial assistance processing.

Table E: FHC Discounted Care / Sliding Fee Scale / Timed Payment Plan Policy Highlights

Topic	Summary Description
Sliding Fee Scale Eligibility	Discounts available for households from **one hundred percent to three hundred percent of the Federal Poverty Level (FPL)**; full charity care at or below one hundred percent of FPL.
Discount Tiers	Full (one hundred percent) discount for incomes at one hundred percent FPL; reduced fees for incomes between one hundred percent and three hundred percent FPL.
Probable Eligibility Determination	Determination issued **within two business days** of a request for assistance, a financial aid application, or a Medicaid application.
Notice to Clients	Policy provided during admission, in patient packets, on the website, and posted publicly in office areas; available in multiple languages.
Time-Payment Plan Availability	Clients who do not qualify for Medicaid or charity care may enroll in **interest-free payment plans** with flexible terms and low minimum monthly payments.
Minimum Monthly Payments	Payment plans may include monthly payments as low as **ten dollars**, depending on financial circumstances.
Maximum Repayment Period	Repayment terms may extend up to **eighteen months** to ensure affordability.

Topic	Summary Description
Protection from Service Denial	Care will **not be denied, delayed, or discontinued** during the financial-assistance application process.
Documentation Requirements	Proof of income, household size, Medicaid status, and financial hardship may be required; handled confidentially per HIPAA.
Appeals and Reconsideration	Clients may appeal determinations within fifteen days; FHC responds within ten business days.
Recordkeeping	All financial-assistance records are retained for **seven years**, in compliance with MHCC and Medicare regulations.
Annual Review	The policy is reviewed annually and updated as needed to reflect regulatory changes and operational updates.

(4) Policy Provisions. An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve during the most recent year for which data is available. The applicant shall demonstrate that:

(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and

Response: FHC has extensive experience delivering skilled in-home services to individuals with limited financial resources, including those enrolled in Maryland Medicaid, Medicaid waiver programs, and Medicare–Medicaid dual-eligible coverage. Over several years of operating as an RSA, FHC has developed workflows and care-management practices to support residents who rely on publicly funded programs, coordinate benefits, and ensure that patients with limited financial means can access needed in-home care.

Although RSAs are not required to submit charity-care reporting to the Maryland Health Care Commission, as illustrated in the table below, FHC's history of serving high-need, publicly insured, and fixed-income clients reflects its ability to navigate financial-access barriers and consistently deliver care to populations that often struggle to pay for services. This organizational background provides a strong foundation for FHC's transition to a Medicare-certified Home Health Agency. It demonstrates its readiness to meet, monitor, and sustain the charity-care obligations outlined in COMAR 10.24.16.08E.

MHCC HHA utilization data indicate that charity care is limited. As shown in Table F below, across all three PSA counties, 26 clients and 142 visits were reported under the payer category, charity care, resulting in charity care of 0.1 percent or less in each jurisdiction.

Table F: Charity Care Clients and Visits by County, FY2023

County	Clients			Visits		
	Charity	Total	% Charity	Charity	Total	% Charity
Baltimore City	6	12,511	0.0%	27	179,005	0.0%
Baltimore	20	21,456	0.1%	115	315,476	0.0%
Howard	-	5,811	0.0%	-	83,372	0.0%
Total PSA	26	39,778	0.1%	142	577,853	0.0%

Source: MHCC HHA Utilization Tables 13, 14, and 25

FHC's proposed commitment to 0.5 percent charity care exceeds the PSA-reported figure.

(b) It has a specific plan for achieving the level of charity care to which it is committed.

Response: Despite the PSA's low average charity care rate (0.1 percent), FHC will meet or exceed the benchmark by implementing the charity care program outlined in Exhibit 8. FHC's plan is designed to proactively identify eligible clients, ensure timely financial screening, and make discounted or no-cost services accessible to people who qualify. The program includes clearly defined processes for eligibility determination, payment alternatives, reporting, and oversight.

FHC's approach to achieving its charity care commitment includes four operational pillars:

1. **Financial Support:**
   FHC maintains dedicated funds for charity care and discounted services, supported by its sliding-fee scale and an interest-free time-payment plan. These mechanisms ensure that cost is never a barrier to receiving medically necessary home health services.
2. **Targeted Outreach:**
   FHC will consistently inform clients, families, referral partners, and community organizations about the availability of charity care and discounted services. Written materials are provided at intake, posted publicly, and included in welcome packets to ensure broad awareness.
3. **Staff Accountability:**
   Intake, billing, and clinical staff are trained to identify clients who may qualify for charity care or reduced fees. Staff are required to offer financial-assistance screening, explain the policy, and document all outreach and determinations in the patient record.
4. **Management Review:**
   Leadership will review charity care performance quarterly, monitor probable-eligibility determinations, and ensure continuous compliance with COMAR requirements and internal quality standards.

To ensure that clients with limited financial resources receive the care they need, FHC will implement the following operational strategies:

1. **Minimum Charity Commitment:**
   FHC will meet or exceed the required charity-care benchmark each year by tracking utilization, monitoring eligibility trends, and adjusting outreach and financial-assistance processes as needed.
2. **Structured Eligibility and Discount Systems:**
   The policy's sliding-fee scale (100 percent charity to 300 percent FPL discounts) and interest-free payment plans provide multiple access points for low-income clients who cannot pay the full charge but do not qualify for full charity care.
3. **Proactive Identification and Outreach:**
   FHC conducts financial screening during intake and within two business days of any request for assistance or Medicaid application. Staff are required to offer assistance without waiting for clients to self-identify financial hardship.
4. **Ongoing Monitoring and Reporting:**
   FHC will track charity care volume, discount levels, and payment-plan participation, with quarterly internal reports to ensure accountability and enable adjustments to outreach or support strategies.

Together, these processes ensure that charity care is not only available but actively delivered, supporting equitable access to home health services across the PSA.

10.24.16.08F. Financial Feasibility.

An applicant shall submit financial projections for its proposed project that must be accompanied by a statement containing the assumptions used to develop projections for its operating revenues and costs. Each applicant must document that:

(1) Utilization projections are consistent with observed historic trends of HHAs in each jurisdiction for which the applicant seeks authority to provide home health agency services;

Response: FHC developed its utilization projections based on observed historical trends for HHAs in the PSA. Section 10.24.01.08G(3)(b) below includes the full methodology and assumptions used; all resulting projections are provided in the required Table 2B. The following is an overview of the methods and assumptions used to develop those projections:

1. FHC utilized population data from the Maryland Department of Planning and historical HHA utilization data from the Maryland Department of Public Health to calculate the FY2023 HHA use rate by age group by jurisdiction.
    a. FHC assumes that the data provided by Maryland are accurate and a reasonable source for projection.
2. The Applicant applied the FY2023 use rate to population by age for 2025 through 2031 to estimate the number of HHA clients in the PSA.
    a. The Applicant assumes that the HHA use rates by age group by jurisdiction will remain constant through 2031 at the 2023 rates.
3. FHC then subtracted the number of HHA clients expected to be served by existing providers from the estimated total number of clients. **This resulted in an unmet need of HHA clients in the PSA.**
    a. FHC assumes that existing providers are operating at capacity and will therefore be unable to capture the growth need in future years.
    b. Declining resident HHA use rates, as described in section "Home Health Use Rates" above on page 27, indicate insufficient access to services to support the calculated need.
4. FHC estimates it will capture 2.75 percent of the **unmet need** of HHA clients from the PSA by 2031, its fourth year of operation.
    a. A 2.75 percent market share is reasonable because FHC will be one of 27 total HHAs serving the PSA jurisdictions (26 existing + 1 new FHC = 27).
    b. Its estimated number of unduplicated clients from the PSA will represent only 0.4 percent of the **total calculated need** in 2031 (189 FHC clients / 46,466 estimated PSA clients = 0.4%).
    c. Total estimated unduplicated clients from the PSA in FHC's third project year do not exceed the number of reported unduplicated clients from any existing HHA in the PSA.

5. FHC's combined utilization across all seven jurisdictions remains modest even when both projects are fully underway. By CY 2030—Project Year 4 for Batch 1 jurisdictions and Project Year 3 for Batch 2 jurisdictions—FHC projects it will serve **542 unduplicated clients**, representing approximately **0.5 percent of the total calculated home health need across all seven jurisdictions**.

Table G: FHC Market Share Estimations of Unduplicated Clients by Jurisdictions and Entire Facility, 2030

CY2030	Batch 1 Only	Batch 2 Only	Entire Facility
Estimated Unduplicated Clients	418	124	542
Estimated Total Need	66,340	45,675	112,015
FHC as a Percent of Total Need	0.6%	0.3%	0.5%
Estimated Unmet Need	15,194	6,105	21,299
FHC as a Percent of Unmet Need	2.8%	2.0%	2.5%

This demonstrates that, even at maturity, FHC's combined market presence remains proportionate, conservative, and well below levels that would materially affect existing provider caseloads. The consolidated projections confirm that the agency's anticipated utilization remains aligned with unmet need and easily absorbed within the region's overall home health capacity.

(2) Projected revenue estimates are consistent with current or anticipated charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction; and

Response: Projected revenue estimates are consistent with established charge levels, reimbursement rates, and contractual adjustments as follows:

Medicare Reimbursement Rates Medicare revenue projections use the CMS CY 2026 Home Health Prospective Payment System (HH PPS) rates as published in CMS-1828-F (Federal Register Vol. 90, No. 229, December 2, 2025). All Medicare-certified home health agencies in Maryland are subject to this same rate methodology. Rates were adjusted for each proposed jurisdiction using the applicable CBSA wage index. A conservative case-mix weight of 1.0 is applied with no acuity adjustment. LUPA (Low Utilization Payment Adjustment) per-visit rates are derived from CMS Table 16 and are adjusted for wages by jurisdiction.

Medicaid Reimbursement Rates: Per-visit rates are based on the Maryland Medicaid fee schedule, effective January 1, 2025, which varies by county. These published rates are applied without an inflation adjustment, per MHCC requirements.

Payor Mix Assumptions Payor mix percentages are derived from jurisdiction-specific data in the MHCC Home Health Agency Annual Survey, Fiscal Year 2023, Table 19: Total Number of Home Health Visits by Jurisdiction of Residence, Payment Source, and Geographic Region. Medicaid percentages were adjusted upward (to at least 2%) from raw survey data to reflect anticipated market positioning and community need focus.

Revenue Deductions: A 2.5 percent bad-debt allowance is based on the applicant's existing home care experience and is supported by an analysis of Medicare Cost Reports for comparable Maryland agencies, which confirms its reasonableness. A contractual allowance of 10 percent of gross revenue is deemed reasonable based on an analysis of Medicare Cost Reports for comparable agencies. Charity Care of 0.5 percent of net revenue exceeds the charity care levels reported in MHCC survey data (Table 25) for existing agencies in the proposed service area.

Medicare Advantage and Commercial Rate Assumptions: Per-visit rates for Medicare Advantage, Commercial Insurance, Self-Pay, and Other payers are estimated using the nationally published LUPA per-visit payment rates by discipline from the CY 2026 HH PPS Final Rule (CMS-1828-F), adjusted for each jurisdiction using the applicable CMS pre-floor, pre-reclassification hospital wage index. LUPA rates represent the baseline Medicare per-visit payment, stripping away higher case-mix-adjusted episodic payments. This approach provides a conservative, defensible estimate for the following reasons:

- Medicare Advantage: Unlike traditional Medicare fee-for-service, Medicare Advantage plans predominantly bypass episodic payment models in favor of aggressively managed, negotiated per-visit contracts. Because MA reimbursement generally yields lower margins than traditional Medicare, the statutory LUPA per-visit rate serves as an accurate baseline proxy for MA-contracted rates without overstating episodic upside.
- Commercial Insurance: Private insurers customarily negotiate reimbursement at a premium to Medicare payment levels. Pegging commercial revenue to the LUPA floor provides a built-in margin of safety and leaves room for upside in actual collections.[23]

Accordingly, this methodology establishes a revenue floor unlikely to overstate actual collections across non-Medicare-FFS payers.

Collectively, each of these revenue assumptions provides a realistic, data-supported financial foundation for FHC's proposed Medicare-certified home health agency and demonstrates that the organization's revenue model aligns with the reimbursement landscape of the PSA counties it intends to serve.

[23] https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-home-health-prospective-payment-system-final-rule-cms-1828-f

(3) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction.

Response: FHC's projected staffing levels and operating expenses are aligned with its anticipated utilization and reflect the cost structures currently observed among Medicare-certified home health agencies serving the PSA jurisdictions. As a newly proposed HHA, FHC developed its staffing model by analyzing recent MHCC-reported workforce patterns, wage levels, and visit volumes from comparable agencies operating in the PSA. These benchmarks ensure that projected full-time equivalents ("FTEs"), productivity expectations, and labor costs are appropriate for the agency's planned service mix and patient acuity. Significantly, FHC's staffing projections are based directly on the organization's experience operating as an RSA. Through its RSA work, FHC has managed recruitment, scheduling, and retention of clinical staff across diverse patient needs—an experience that provides valuable insights into realistic staffing ratios, visit capacity, and workload distribution. This background enabled FHC to develop staffing assumptions grounded not only in statewide HHA norms but also in its history of maintaining a reliable clinical workforce and delivering consistent in-home services. FHC has experience with meeting home care outcome goals within a limited number of visits, through its RSA contracts with Maryland Medicaid Managed Care Organizations, for example, Maryland Physician Care and JAI Medical.

Personnel assumptions incorporate regionally appropriate compensation levels for skilled nursing, therapy services, social work, home health aides, and administrative support, using prevailing wage data and current labor market conditions across the PSA. Non-labor operating expenses — including medical supplies, mileage, durable equipment, IT systems, and regulatory compliance — were similarly developed based on expenditure patterns from established Maryland HHAs and FHCs' experience running their RSA.

FHC has demonstrated the ability to recruit, hire, and retain qualified clinical and support staff through multiple established recruitment channels and professional relationships developed through its ongoing operations as an RSA. The majority of staff required for the proposed Medicare-certified HHA will transition from FHC's existing RSA workforce, providing continuity of care and minimizing the need for large-scale new hiring. As the census grows, FHC is well-positioned to add staff incrementally without adversely affecting the regional labor market.

FHC utilizes a diversified recruitment strategy that includes online job platforms such as LinkedIn and Indeed, professional networking, and—most successfully—word-of-mouth referrals from current staff and professional contacts. In addition, FHC benefits from direct connections to local workforce development pipelines.
The agency's principal, Abisola Raimi-Abayomi, serves as an instructor at Anne Arundel Community College, where she regularly engages with nursing students and graduates, including registered nurses and certified nursing assistants reentering the workforce. This relationship provides FHC with access to newly trained clinicians and experienced professionals seeking flexible, community-based care roles.

FHC also maintains professional relationships within the therapy community, including connections through physical therapy professional associations and academic and career placement programs. One of them is Handshake, a widely used career development platform that connects employers with students and recent graduates in health care disciplines. These relationships support recruitment of therapy staff, including physical therapists and therapy assistants, as service demand increases.

Maryland Department of Labor Local Area Unemployment Statistics ("LAUS") show recent unemployment rates of approximately 4.9 percent in Baltimore City, 3.6 percent in Baltimore County, and 3.1 percent in Howard County. These rates reflect active and stable labor markets within the broader Washington–Baltimore metropolitan healthcare corridor. See Exhibit 5.

Baltimore and Howard Counties are each part of a designated Maryland Workforce Development Area, which provides employment tracking, occupational projections, and healthcare workforce training partnerships. A structured workforce infrastructure supports ongoing recruitment and professional training for licensed nurses and therapists.

Each PSA jurisdiction has a community college with established health-science pipelines that closely align with entry-level and licensed roles required for home health operations. For example, Howard County Community College reported 144 nursing graduates in its Class of 2025; see other details in Table H below.

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

School	Training Programs
Howard Community College	• Associate of Science in Nursing (ASN) / Registered Nurse (RN) Pathway • Practical Nursing Certificate (LPN) or LPN Pathway • Physical Therapist Assistant (PTA) Program • Health Sciences & Rehabilitation Support Courses (e.g., Anatomy & Physiology, Kinesiology)
Baltimore City Community College	• Associate of Applied Science in Nursing (ASN) • Practical Nursing Certificate (LPN) • Physical Therapist Assistant (PTA) Program • Health Sciences Coursework (Anatomy/Physiology, Therapeutic Modalities)
Community College of Baltimore County	• Associate of Science in Nursing (ASN) • Practical Nursing Certificate (LPN) • Physical Therapist Assistant (PTA) Program • Occupational Therapy Assistant (OTA) Program • Health Science Pathways (e.g., Anatomy, Clinical Procedures, Rehabilitation Support)

Source: community college websites, accessed February 2026

These local training pathways support FHC's plan to add incremental staffing for its Medicare-certified HHA without creating a material adverse staffing impact on existing providers, particularly because FHC will transition experienced RSA staff into the HHA and recruit only targeted incremental roles (for example, MSW and contracted speech therapy).

Collectively, these recruitment channels, combined with FHC's existing workforce, positive organizational reputation, and leadership presence in local education and professional networks, provide a reliable and sustainable foundation for staffing the proposed HHA. FHC's incremental growth approach ensures that staffing expansion is aligned with utilization, maintaining service quality while avoiding disruption to other providers' staffing resources within the PSA.

By combining its prior RSA staffing experience with established HHA benchmarks, FHC believes that its operating budget is financially feasible, appropriately resourced, and capable of supporting high-quality care delivery. These assumptions reflect a realistic cost structure that aligns with anticipated utilization and positions the agency to meet staffing and service requirements under COMAR 10.24.16 while maintaining efficient, patient-centered operations.

Finally, FHC already employs nursing and therapy staff in the Batch 2 service area. With access to additional client volume through Medicare certification, existing staff will be able to increase their hours; additionally, these staff members have their own network of nurses, aides, and therapists seeking job opportunities.

10.24.16.08G. Impact.

An applicant shall address the impact of its proposed home health agency service on each existing home health agency authorized to serve each jurisdiction or regional service area affected by the proposed project. This shall include impact on existing HHAs' caseloads, staffing, and payor mix.

Response: MHCC has identified a need for additional HHA services in the PSA jurisdictions. As discussed in 10.24.16.08B, the PSA population has multiple risk factors that support the need for further access to home-based services.

According to MHCC HHA utilization data, approximately 26 HHAs served the PSA in FY2023. Together, these providers served 39,768 unduplicated clients – over 30 percent of all Maryland HHA clients that year. Providers include several large, well-established HHAs, such as Adventist, Bayada, Johns Hopkins, and Medstar Health. Data show that these HHAs often serve multiple counties and that no single provider dominates the market, ensuring clients have adequate choices.

Caseload Impact

FHC's utilization projections assume that existing home health agencies will continue to serve the majority of PSA residents who currently access care. However, MHCC utilization data and population projections indicate that these providers are not positioned to meet the full level of need, leaving a measurable portion of the PSA population without access to home health agency services. FHC intends to draw its projected cases from this unmet need rather than from the caseloads of established agencies. FHC has been reasonable and conservative in its forecasts of HHA need. In this context, focusing on the unmet need and reasonable FHC capacity for growth, by Project Year 4 (2031), FHC anticipates serving approximately 189 clients, representing only 2.75 percent of the estimated unmet **need and just 0.4 percent of the total projected need of 46,466 home health clients in the PSA.** See details in Tables I, M, and Q in Section 10.24.01.08G(3)(b) beginning on page 56 below.

Given the scale of unmet demand relative to FHC's modest projected census, the proposed HHA will have little to no impact on existing providers' caseloads.

Staffing Impact

FHC does not anticipate any adverse impact on the staffing capacity of existing home health agencies in the PSA. Because FHC already delivers many of the same in-home disciplines through its established RSA, it has the infrastructure to support the HHA expansion. The majority of clinical and administrative personnel required for the proposed HHA will transition from the current RSA operations, reducing the need for new hires. Additional staffing requirements include medical social work and speech therapy, both representing limited, targeted needs.

In its previous proposal, FHC projected requiring 5.8 direct-care FTEs (nurses, therapists, aides, and medical social workers) in Year 1 (2027), increasing to 6.7 FTEs by Year 4 (2030). These staffing levels reflect the clinical capacity needed to deliver skilled nursing, therapy, aide, and social work services for the proposed home health agency. To accommodate the incremental increase proposed in this application, FHC will need an additional 0.2 direct-care FTEs in Year 1 (2028), growing to 3.1 by Year 4 (2031).

The social work plan includes services provided by qualified social workers under the supervision of a Master of Social Work (MSW). FHC will contract with an MSW who meets the Medicare Conditions of Participation to provide the required supervision and oversight. Speech therapy will be contracted.

FHC anticipates a proportional increase in demand for MSW services. While not all home health patients require MSW intervention, FHC recognizes that total census growth will increase the absolute number of patients needing psychosocial assessment, care coordination, and discharge-planning support. FHC will therefore scale MSW staffing in alignment with actual utilization. This reflects a maximum increase from 0.01 FTEs in CY2028 to 0.05 FTEs in CY2031. This increase will not affect the proposed structure regarding MSW and qualified social workers. FHC has identified individuals interested in these positions.

Maryland Department of Labor Local Area Unemployment Statistics ("LAUS") show recent unemployment rates of approximately 4.9 percent in Baltimore City, 3.6 percent in Baltimore County, and 3.1 percent in Howard County. These rates reflect active and stable labor markets within the broader Washington–Baltimore metropolitan healthcare corridor. See Exhibit 5.

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

Together, these new hires will not materially affect the labor supply available to other HHAs. Workforce data for the PSA jurisdictions demonstrate a strong, diverse pool of licensed nurses, therapists, and support staff, and the modest scale of FHC's incremental hiring ensures existing providers will retain sufficient access to qualified personnel.

FHC's staffing plan supports the viability of its proposed HHA without significantly impacting the staffing resources of other agencies operating in the region. Moreover, FHC maintains a waitlist of individuals interested in joining the FHC staff for all HHA clinical positions. Until it has an HHA license and certification, FHC cannot attain the patient scale and size required to support these staff.

Payor Mix Impact

MHCC HHA Utilization Tables 11, 13, and 14 demonstrate that Medicare is, by a substantial margin, the predominant payor for home health agency services in both the PSA and the state overall. Because FHC's current RSA license does not permit it to serve Medicare beneficiaries, the organization's existing payor mix does not yet reflect the Medicare-driven distribution typical of certified HHAs in the PSA. With the transition to a Medicare-certified HHA, FHC anticipates a realignment of its payer mix to more closely reflect prevailing PSA patterns, consistent with the demographic and clinical needs of the populations it will serve.

The relatively modest census expected in the initial years of operation ensures that this shift will not alter or adversely affect the broader payer distribution in the PSA or the payer profiles of existing agencies.

10.24.16.08H. Financial Solvency.

An applicant shall document the availability of financial resources necessary to sustain the project. Documentation shall demonstrate an applicant's ability to comply with the capital reserve and other solvency requirements specified by CMS for a Medicare-certified home health agency.

Response: To enroll as a Medicare-certified home health agency, an applicant must demonstrate that it has **sufficient financial resources to sustain the operation**, including compliance with federally mandated capitalization and solvency standards. Under federal regulations, a new home health agency must maintain initial operating reserve **funds available at the time of Medicare application and throughout the enrollment process**, as well as for the first three months after Medicare billing privileges are granted. This requirement is intended to ensure the agency can operate reliably during its early service period without interruption, excluding projected Medicare accounts receivable.[24]

Specifically, 42 CFR § 489.28 establishes the capitalization requirements for new HHAs. Documentation of these funds must include **proof of availability**, such as bank statements or cash equivalents in readily liquid accounts, with an attestation from the financial institution confirming the funds are immediately accessible. At least **50 percent of the required reserve must consist of non-borrowed funds, with the remaining portion supported by borrowed funds or a line of credit, subject to** appropriate documentation.

Exhibit 9 includes a letter from Atlantic Union Bank attesting that the Applicant possesses the financial resources necessary to meet the FHC forecast of CMS capitalization requirement and sustain operations as a Medicare-certified HHA. This documentation includes verified cash and cash equivalents sufficient to cover expected operating costs for the first three months of Batch 2 and the ongoing operations of Batch 1. This is supported by a letter from FHC's CPA. FHC's financial plan also reflects prudent budgeting, operating reserves, and access to additional liquidity if needed, ensuring compliance with CMS solvency expectations and positioning the agency for stable, uninterrupted service delivery in the PSA.

As demonstrated in Exhibit 16, this project will benefit from cash flow from an established HHA. This proposed expansion of jurisdictions will not occur until the 13th operating month of FHC HHA. Exhibit 16 demonstrates that FHC has sufficient funds for operating capital to establish the HHA. (These data are repeated from the Batch 1 completeness response, Matter Nos. 26-R4-2487, 26-R4-2488, 26-R4-2489, and 26-R4-2490).

[24] https://www.law.cornell.edu/cfr/text/42/489.28?utm_source=chatgpt.com

10.24.16.08I. Linkages with Other Service Providers.

An applicant shall document its links with hospitals, nursing homes, continuing care retirement communities, hospice programs, assisted living providers, Adult Evaluation and Review Services, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

(1) A new home health agency shall provide this documentation when it requests first use approval.

(2) A Maryland home health agency already licensed and operating shall provide documentation of these linkages in its existing service area and document its work in forming such linkages before beginning operation in each new jurisdiction it is authorized to serve.

Response: FHC will be a new Medicare-certified home health service in Maryland and will establish formal linkages with hospitals, nursing homes, continuing care retirement communities, hospice providers, assisted living facilities, Adult Evaluation and Review Services, adult day programs, local Departments of Social Services, and home-delivered meal programs within its proposed service area upon approval.

Exhibit 4 provides a comprehensive inventory of entities in each category across the PSA jurisdictions, and FHC will use this list as the basis for developing formal relationships once its HHA is authorized. As an established RSA, FHC already maintains working relationships with several of these organizations, and Exhibit 4 identifies where these existing linkages are in place.

10.24.16.08J. Discharge Planning.

An applicant shall document that it has a formal discharge planning process, including the ability to provide appropriate referrals to maintain continuity of care. It will identify all the valid reasons upon which it may discharge clients or transfer clients to another health care facility or program.

Response: FHC maintains a formal discharge planning process as part of its current RSA operations (Exhibit 10) and will implement an enhanced version of this process for its Medicare-certified Home Health Agency. The process is fully aligned with COMAR requirements and CMS Conditions of Participation, ensuring safe, orderly, and clinically appropriate transitions of care. FHC's discharge procedures are designed to maintain continuity of care, support patient and caregiver participation, and ensure referral to appropriate follow-up services whenever a client's needs change or home health services are no longer clinically indicated.

FHC's discharge planning process begins at admission. The agency conducts ongoing assessments of each client's clinical status, functional abilities, home environment, and anticipated care needs. Discharge planning includes coordinated communication with the attending physician, all ordering providers, caregivers, and any post-discharge practitioners involved in the patient's continued care.

The policy requires timely communication of all revisions to the discharge plan to the patient, representative, caregivers, and post-discharge providers.

FHC's HHA discharge policy also incorporates structured procedures for care coordination and transition planning. Discharge planning begins at admission and is revisited throughout care delivery, with documentation of reassessments and the expected discharge date. When transfer to another provider is required, the agency assists patients in selecting a post-acute care facility based on quality and resource-use measures. It ensures that all necessary medical information—including the course of treatment, goals of care, and patient preferences—is transmitted to the receiving provider.

The policy defines all valid circumstances under which a client may be discharged or transferred. These include, but are not limited to:

- Completion of treatment goals or clinical improvement such that home health services are no longer required.
- Patient or caregiver choice to discontinue services or request transfer.
- Physician discontinuation of orders for home health care.
- Changes in medical condition requiring a higher level of care (e.g., SNF, IRF, LTCH, or hospitalization).
- Safety concerns, unsafe home environment, or behavior that jeopardizes staff or patient safety after all interventions have failed.
- Patient relocation outside the geographic service area.
- Provision of care by another agency or duplication of services.
- Non-adherence to treatment or refusal of medically necessary supervision.
- Exhaustion of covered benefits when the agency cannot continue to provide no-cost care, with appropriate referral.
- Patient death or institutionalization.

The policy also includes the federally required delivery of the Notice of Medicare Non-Coverage (NOMNC) at least two days before the final visit, along with appeal instructions, contact information for the Quality Improvement Organization (QIO), and procedures for circumstances in which NDMC (CMS Form 1003) must be used instead.

Upon discharge, the attending physician is notified, and a written discharge summary—including patient status, services rendered, progress toward goals, education provided, and referrals made—is sent to the physician within five business days, with a copy maintained in the medical record.

Through this comprehensive policy, FHC ensures that every client experiences a coordinated, clinically appropriate, and patient-centered transition of care. The policy preserves patient autonomy, supports continuity, and meets all requirements for safe discharge and transfer under State and federal regulations.

10.24.16.08K. Data Collection and Submission.

An applicant shall demonstrate ongoing compliance or ability to comply with all applicable federal and State data collection and reporting requirements, including, but not limited to, the Commission's Home Health Agency Annual Survey, CMS' Outcome and Assessment Information Set (OASIS), and CMS' Home Health Consumer Assessment of Healthcare Providers (HHCAHPS).

Response: FHC is well-positioned to comply with all applicable federal and State data collection and reporting requirements for Medicare-certified home health agencies, based on the systems, processes, and quality infrastructure it already maintains as a CHAP-accredited Residential Service Agency.

As part of its RSA operations, FHC currently utilizes the Outcome and Assessment Information Set (OASIS) during intake and clinical assessment, demonstrating familiarity with structured patient assessment tools and their role in care planning, quality monitoring, and documentation integrity. The agency also administers two formal patient feedback instruments:

- A Post-Admission Survey; and,
- A Patient Satisfaction Survey administered at or near discharge.

In CY2025, FHC collected Post-Admission Surveys from approximately **60 percent of admitted patients,** reflecting a proactive approach to patient feedback. Historically, discharge survey response rates mirrored national voluntary survey trends, particularly when paper-based methods were used. Recognizing the importance of survey participation for quality monitoring and CMS Star Ratings, FHC implemented targeted process improvements beginning in the third quarter of 2025 to increase response rates and reduce barriers to participation. Results speak for themselves. FHC will incorporate similar processes for HHA patient satisfaction surveys.

These enhancements include:

- **Point-of-Care Distribution:** Surveys are provided at admission with a stamped return envelope, and patients are encouraged to complete them during the visit when feasible.
- **QR-Code Implementation (Q3 2025):** Surveys may now be accessed via QR code and completed electronically in under two minutes using a personal device.
- **Technology Access Support:** For patients without compatible devices, staff provide agency-issued devices at the time of visit to facilitate participation.
- **Confidential Submission Process:** Survey responses are transmitted directly to a designated agency email and are not accessible to the visiting staff member, reinforcing confidentiality and candid feedback.
- **Caregiver Inclusion:** Surveys may be completed by a primary caregiver when appropriate, particularly for medically complex or elderly patients.

FHC recognizes that CMS Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) response rates may influence Star Ratings. The agency's transition to QR-based dissemination, point-of-care completion options, and technology-assisted access demonstrates its proactive strategy to mitigate non-response challenges reported by many agencies.

Upon Medicare certification, FHC will expand its existing data infrastructure to fully comply with CMS Conditions of Participation and Maryland Health Care Commission requirements. The agency will:

- Complete and transmit OASIS assessments in accordance with CMS regulations;
- Participate in the HHCAHPS survey process through an approved vendor, as required;
- Submit timely and accurate data through the Commission's Home Health Agency Annual Survey; and
- Monitor performance metrics through its Quality Assessment and Performance Improvement (QAPI) program.

FHC's current CHAP-compliant documentation systems, combined with planned enhancements for Medicare certification, provide a strong foundation for ensuring data integrity, reporting accuracy, regulatory compliance, and continuous quality improvement.

Exhibits 1 and 11 include sample intake processes, patient satisfaction survey instruments, and accreditation documentation demonstrating the agency's established capacity to meet federal and State reporting obligations.

10.24.16.09 CERTIFICATE OF NEED PREFERENCE RULES IN COMPARATIVE REVIEWS.

The Commission shall use the following preferences, in the order listed, to limit the number of CON applications approved in a comparative review.

10.24.16.09A. Performance on Quality Measures.

Higher levels of performance will be given preference over lower levels of performance.

10.24.16.09B. Maintained or Improved Performance.

An applicant that demonstrates maintenance or improvement in its level of performance on the selected process and outcome measures during the most recent three-year reporting period will be given preference over an applicant that did not maintain or improve its performance.

10.24.16.09C. Proven Track Record in Serving all Payor Types, the Indigent and Low-Income Persons.

An applicant that served a broader range of payor types and the indigent will be given preference over an applicant that served a narrower range of payor types and provided less service to the indigent and low-income persons.

10.24.16.09D. Proven Track Record in Providing a Comprehensive Array of Services.

An applicant that provided a broader range of services will be given preference over an applicant that provided a narrower range of services.

10.24.16.09E. These preferences will only be used in a comparative review of

applications when it is determined that approval of all applications that fully comply with standards in Regulation .08 of this Chapter would exceed the permitted number of additional HHAs provided for in a jurisdiction or multi-jurisdictional region as provided in Regulation .10.

Response: As confirmed by MHCC staff in an email on January 5, 2026, the number of Applicants does not exceed the number of available HHAs in the Baltimore City, Baltimore County, and Howard jurisdictions. **This application is not competitive; therefore, COMAR 10.24.16.09A through E are not applicable.**

10.24.01.08G CRITERIA FOR REVIEW OF APPLICATION

10.24.01.08G(3)(b). The "Need" Review Criterion

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated a need for the proposed project.

INSTRUCTIONS: Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan.

Please assure that all sources of information used in the need analysis are identified and identify all the assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), and the relevant population considered in the analysis with information that supports the validity of these assumptions. The existing and/or intended service area population of the applicant should be clearly defined.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

Response to MHCC Published Need

Based on the MHCC's 2025 Review Guidance, the jurisdictions included in this Batch 2 application—Baltimore County, Baltimore City, and Howard County—each qualify for additional Medicare-certified home health agency capacity under COMAR 10.24.16.04, see excerpt in Exhibit 15. These counties meet the State Health Plan need criteria for *Insufficient Choice of Quality-Performing HHAs*, as confirmed by MHCC's published quality-performance tables.

Insufficient Choice of Quality-Performing HHAs

Under COMAR 10.24.16.04A(3), a jurisdiction qualifies for need when 60 percent or more of home health clients are served by HHAs that do not meet MHCC's applicable quality-performance benchmarks. MHCC's published analysis identifies Baltimore County, Baltimore City, and Howard County as jurisdictions in which most Medicare beneficiaries are enrolled with HHAs that fall below these benchmark thresholds, including substandard CMS Star Ratings and HHCAHPS scores.

This means that the majority of home health users across all three counties do not currently have access to enough agencies that meet the Commission's minimum quality expectations. The existing provider mix does not offer adequate consumer choice among high-performing HHAs and, in many cases, leaves referring hospitals and physicians with limited options for recommended care transitions.

Why FHC Meets This Need

FHC's proposed Medicare-certified Home Health Agency directly addresses the quality-access gap identified in these counties. As an established and accredited RSA, FHC brings:

- A strong clinical and quality infrastructure that exceeds minimum standards and supports higher performance than many agencies currently serving these jurisdictions.
- A proven record of caring for medically complex, high-acuity, and financially vulnerable patients, demonstrating the capability to meet quality criteria associated with care coordination, patient engagement, and clinical documentation.
- Structured, interdisciplinary care planning models designed to improve timeliness of admission, reduce preventable hospitalizations, and enhance patient satisfaction—areas in which MHCC has identified deficiencies among current providers.
- Seven-day service availability and expanded clinical programming, which increase access for Medicare beneficiaries who currently struggle to secure timely home health placement.

In addition to its internal quality controls, FHC is accredited by CHAP (Exhibit 1), a nationally recognized accrediting organization approved by CMS. CHAP accreditation requires compliance with nationally recognized standards for patient care, documentation, infection control, quality improvement, and administrative oversight.[25] Continued accreditation reflects ongoing survey review and independent validation of the agency's operational and clinical standards.

FHC is also an enrolled provider with Maryland Medicaid and maintains contracts with Medicaid Managed Care Organizations. Participation in the Maryland Medicaid program requires credentialing review, regulatory compliance, and ongoing adherence to state and federal program requirements.[26] The agency's continued approval to serve Medicaid beneficiaries demonstrates sustained compliance with public payer standards and oversight mechanisms.

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

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

Allowing FHC into the market expands the range of agencies meeting MHCC quality standards and improves patient choice in every Batch 2 jurisdiction.

[25] Community Health Accreditation Partner (CHAP). *About CHAP Accreditation*. CHAP, https://chapinc.org. Accessed 17 Feb. 2026.
[26] Maryland Department of Health. *Maryland Medicaid Provider Participation Requirements*. Maryland Department of Health, https://health.maryland.gov/mmcp. Accessed 17 Feb. 2026.

Documented Referral Demand and Access Barriers

During CY2025 (January 1 through December 31), FHC records indicate that almost 16 percent of its referrals (39 of 244) could not be served because FHC was not Medicare certified. FHC maintains internal documentation of referrals declined after intake review.

FHC maintains internal documentation of referrals declined after formal intake review. However, electronic referral platforms do not consistently generate comprehensive reporting for cases that are not formally accepted into the system. Accordingly, referral activity that has not progressed to full intake processing may not be reflected in internal tracking logs. The documented payer-related declines, therefore, represent a **conservative estimate** of the number of otherwise appropriate Medicare beneficiaries FHC was unable to serve during CY2025.

This documented referral activity provides objective evidence of unmet demand within the proposed service area. These patients were clinically appropriate for home health services and were referred by existing providers, yet could not be accepted solely due to payer-participation limitations.

Approval of the proposed Medicare-certified Home Health Agency expansion would eliminate this structural barrier and allow FHC to accept and serve these Medicare and Medicare Advantage beneficiaries, thereby directly addressing the identified access gaps.

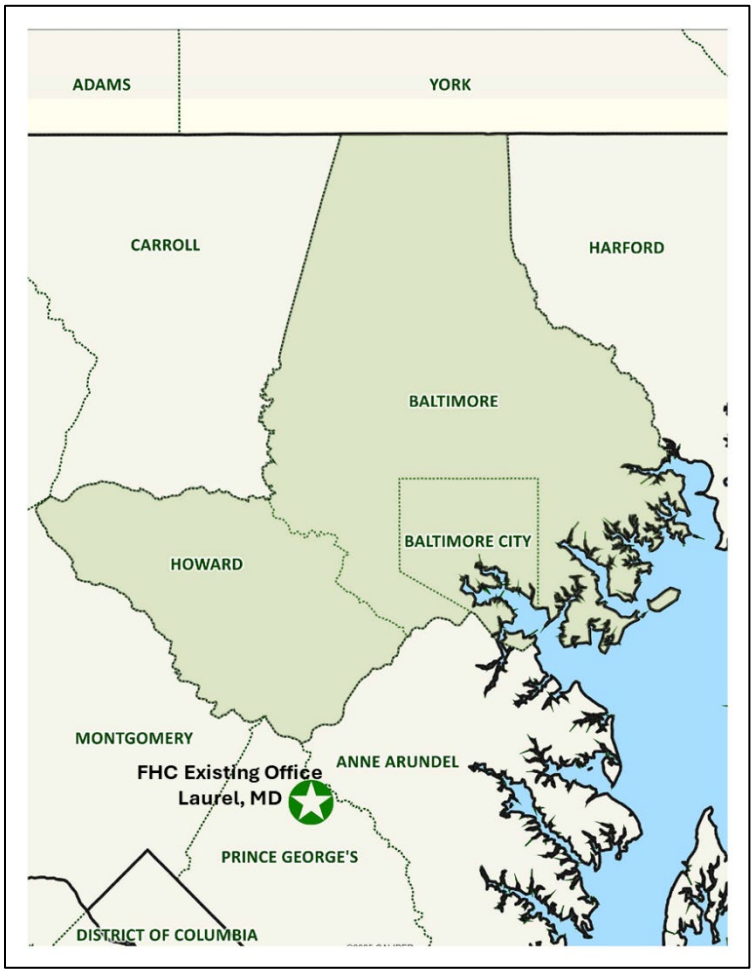
Conclusion

FHC's proposed expansion into Baltimore County, Baltimore City, and Howard County is fully responsive to the MHCC's published need findings. All three jurisdictions meet the need criterion due to insufficient availability of quality-performing HHAs, and FHC's entry will directly address these deficiencies by offering a high-performing, Medicare-certified provider with robust clinical, operational, and quality-monitoring capacity. The project aligns with COMAR 10.24.16.04 and supports the State Health Plan goals of improving access, enhancing quality, and strengthening patient choice across Maryland.

Quantitative Overview

The Applicant, FHC, proposes to develop a new Medicare-certified HHA office in Laurel, Prince George's County, to serve the three jurisdictions of Baltimore County, Baltimore City, and Howard County. The following sections describe the quantitative measures the Applicant used to support the published need for an additional HHA in the PSA.

Figure C: FHC Proposed HHA Primary Service Area Jurisdictions Map



The Applicant forecasted the number of unduplicated clients and client visits for the first four years of operation using data from the following sources:

- Maryland Department of Planning State Data & Analysis Center: 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other, and Hispanic by Age and Gender[27]; and

[27] https://planning.maryland.gov/MSDC/Pages/5_projections/population-and-households.aspx

- Maryland Health Care Commission Home Health Public Use Files, Tables 1 through 25 for 2019-2023.[28]

The Applicant assumes that MDP and MHCC data are reasonable sources for forecasting PSA need and utilization.

All data presented in this methodology are organized by age group, consistent with MHCC's HHA utilization reporting format. Maintaining these age cohorts allows the Applicant to account for differences in service use across the population, as home health utilization varies significantly by age. Using the same age groupings ensures that the projections more accurately reflect actual patterns of home health service demand.

The Applicant forecasts home health utilization separately for each jurisdiction within the PSA to account for geographic variations in population size, demographics, and existing service availability. Service use and access can vary significantly by jurisdiction, and projecting at this level enables a more precise estimate of both current and unmet need. Independent jurisdiction-level forecasts ensure the methodology accurately captures local patterns in home health demand and supports targeted service delivery planning.

FHC's fiscal year is January 1 through December 31. The project **proposes to start on March 1, 2027.** Therefore, 2027 will serve as a transition year as FHC continues to grow services in the Batch 1 PSA and adds services in the Batch 2 PSA. The transition from one PSA to two will be fully realized by 2028 and reach full utilization within four years. Therefore, the methodology forecasts in this application utilization from January 1, 2028, through December 31, 2031.

Throughout this methodology, "clients" refers to unduplicated HHA clients. The primary service area ("PSA") includes all three jurisdictions: Baltimore County, Baltimore City, and Howard County.

Population data is provided in calendar years by MDP; utilization data is provided in Federal Fiscal Years by MHCC. The Applicant forecasts all need and utilization in calendar years. FHC assumes any discrepancies between FFY and CY data are insignificant.

The following sections include all methodology steps and related assumptions used to estimate need and utilization for FHC. The Applicant has included two copies of Required Table 2B: Statistical Projections - Projected Home Health Agency Services In The Proposed Project. One summarizes all final client and visit projections for the incremental growth proposed in this application for the Batch 2 PSA; the second includes projections for the entire agency. Both are included in Part IV as requested. See page 84.

[28] https://mhcc.maryland.gov/public_use_files/homehealthdownload.html

Forecast Need

Step 1: Determine Population by Age Group by Jurisdiction, 2025-2031

MDP forecasts population by age group and county in five-year increments from the 2020 US Census through 2045. The Applicant interpolated population by year for CY2026 through CY2029 using the Compound Annual Growth Rate ("CAGR") for population between CY2025 and CY2030 for each PSA jurisdiction. The Applicant performed the same calculation for CY2031 using the CAGR from CY2030 to CY2035. Tables I, 1 through 3 below summarize the populations by age group, year, and jurisdiction. See calculation details in Exhibit 12.

Table I: Population by Age Group by Year, CY2025 – CY2031

1. Baltimore City

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	36,854	36,798	36,743	36,688	36,632	36,577	36,578
5 to 14	62,467	62,476	62,485	62,493	62,502	62,511	63,050
15 to 24	80,425	80,373	80,321	80,269	80,218	80,166	79,995
25 to 44	194,120	193,064	192,014	190,969	189,930	188,897	186,914
45 to 64	137,545	138,562	139,587	140,619	141,659	142,706	145,266
65 to 74	54,127	54,329	54,532	54,735	54,939	55,133	54,168
75 to 84	25,488	26,396	27,337	28,311	29,319	30,364	31,197
85+	8,969	9,079	9,191	9,304	9,419	9,535	9,849
Total	**599,995**	**601,078**	**602,209**	**603,388**	**604,618**	**605,900**	**607,017**

Notes:

a. *MDP provided population projections for CY2025 and CY2030*
b. *CY2026 – CY2029 were interpolated using the CY2025 to CY2030 CAGR*
CAGR = ((CY30 Population / CY25 Population)$^{(1/5)}$) - 1

2. Baltimore County

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	46,600	46,796	46,993	47,190	47,389	47,588	47,962
5 to 14	99,092	98,672	98,255	97,839	97,424	97,012	97,415
15 to 24	108,634	109,094	109,555	110,019	110,484	110,952	110,641
25 to 44	212,654	212,111	211,570	211,030	210,491	209,954	210,069
45 to 64	204,707	203,510	202,321	201,138	199,963	198,794	198,989
65 to 74	92,972	93,745	94,525	95,311	96,104	96,903	96,004
75 to 84	50,151	51,887	53,682	55,540	57,462	59,451	60,904
85+	23,748	24,170	24,601	25,038	25,484	25,937	26,897
Total	**838,558**	**839,986**	**841,501**	**843,106**	**844,801**	**846,591**	**848,881**

3. Howard

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	20,820	20,885	20,951	21,017	21,083	21,149	21,038
5 to 14	45,722	45,854	45,987	46,120	46,253	46,387	46,412
15 to 24	38,484	38,856	39,231	39,610	39,993	40,379	40,673
25 to 44	91,800	92,050	92,301	92,552	92,804	93,057	92,917
45 to 64	86,859	86,443	86,030	85,618	85,209	84,801	84,938
65 to 74	34,301	35,076	35,868	36,679	37,508	38,355	38,376
75 to 84	20,115	20,925	21,768	22,645	23,557	24,506	25,168
85+	6,047	6,431	6,839	7,273	7,735	8,226	8,772
Total	**344,148**	**346,521**	**348,975**	**351,514**	**354,141**	**356,860**	**358,295**

Step 2: Determine the HHA Use Rate per 1,000 Population by Age Group and Jurisdiction, CY2023

To establish baseline home health agency utilization, the Applicant analyzed Maryland's FY2023 HHA client data by age group and by jurisdiction. Using this data, the Applicant calculated the HHA client utilization rate per 1,000 population for each jurisdiction and age cohort. This methodology provides a consistent, population-adjusted measure of service use that informs the project's demand projections. Table J below details the final FY2023 use rates. Supporting data and methods for developing the use rates are in Exhibit 12.

Table J: HHA Client Use Rates by Age Cohort and Jurisdiction per 1,000 Population, FY2023

Age Group	Baltimore City	Baltimore County	Howard
0 to 4	8.2	8.7	3.2
5 to 14	0.8	0.9	0.4
15 to 24	1.0	1.0	0.8
25 to 44	2.3	2.3	1.2
45 to 64	15.8	13.8	7.4
65 to 74	72.6	58.9	38.3
75 to 84	140.7	144.4	117.7
85+	255.8	236.4	289.6
Total	**20.9**	**25.7**	**17.2**

Sources: See calculations in Exhibit 12

Step 3: Forecast Estimated Number of HHA Clients in the PSA by Age Cohort and Jurisdiction, CY2025 – CY2031

Using the FY2023 use rates developed in Step 2, the Applicant applied these rates to the projected populations identified in Step 1 to estimate the anticipated number of home health clients from CY2025 through CY2031. This approach produces a consistent, demand-driven forecast of future service need based on observed utilization patterns and expected demographic changes. Tables K, 1 through 3, present the estimated home health client need for each projection year by age cohort and jurisdiction.

Table K: Estimated Number of HHA Clients by Age Group by Year by Jurisdiction, CY2025 – CY2031

1. Baltimore City

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	303	303	302	302	301	301	301
5 to 14	53	53	53	53	53	53	53
15 to 24	78	78	78	78	78	78	78
25 to 44	440	437	435	433	430	428	423
45 to 64	2,177	2,193	2,210	2,226	2,242	2,259	2,299
65 to 74	3,928	3,942	3,957	3,972	3,987	4,001	3,931
75 to 84	3,585	3,713	3,845	3,982	4,124	4,271	4,388
85+	2,295	2,323	2,352	2,381	2,410	2,440	2,520
Total	**12,859**	**13,042**	**13,231**	**13,426**	**13,625**	**13,831**	**13,994**

*Calculation: Step 1: population by age group, year, and jurisdiction * Step 2: use rate by age group and jurisdiction / 1,000*

2. Baltimore County

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	407	409	410	412	414	416	419
5 to 14	86	86	85	85	85	84	85
15 to 24	105	105	105	106	106	107	106
25 to 44	487	486	484	483	482	481	481
45 to 64	2,821	2,805	2,788	2,772	2,756	2,740	2,742
65 to 74	5,475	5,521	5,567	5,613	5,660	5,707	5,654
75 to 84	7,244	7,495	7,754	8,022	8,300	8,587	8,797
85+	5,614	5,714	5,816	5,919	6,025	6,132	6,359
Total	**22,240**	**22,620**	**23,011**	**23,413**	**23,827**	**24,253**	**24,644**

3. Howard

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	67	67	67	67	68	68	68
5 to 14	18	18	18	18	19	19	19
15 to 24	30	30	30	31	31	31	32
25 to 44	109	109	109	110	110	110	110
45 to 64	640	637	634	631	628	625	626
65 to 74	1,315	1,345	1,375	1,406	1,438	1,471	1,471
75 to 84	2,368	2,464	2,563	2,666	2,774	2,885	2,963
85+	1,751	1,862	1,981	2,106	2,240	2,382	2,540
Total	**6,299**	**6,533**	**6,778**	**7,036**	**7,307**	**7,591**	**7,829**

Table L below summarizes the estimated total number of HHA clients in the PSA by age group and year.

Table L: Estimated Number of HHA Clients by Age Group by Year, Entire PSA, CY2025 – CY2031

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	777	778	780	781	783	784	787
5 to 14	157	157	157	156	156	156	157
15 to 24	212	213	214	214	215	216	216
25 to 44	1,035	1,032	1,029	1,025	1,022	1,019	1,014
45 to 64	5,639	5,635	5,632	5,629	5,626	5,624	5,668
65 to 74	10,718	10,808	10,899	10,991	11,085	11,179	11,056
75 to 84	13,198	13,672	14,162	14,671	15,198	15,744	16,149
85+	9,660	9,900	10,148	10,406	10,675	10,954	11,419
Total	**41,397**	**42,195**	**43,021**	**43,875**	**44,760**	**45,675**	**46,466**

Calculation: Sum of estimated clients by age group by year, Table K, 1 through 3

Assumptions

1. Using the FY2023 use rate through CY2031 is reasonable because FY2023 reflects the most recent, stable post-pandemic utilization patterns, capturing current referral behavior, care management practices, and patient preferences for home-based care.
2. Home health utilization trends have remained relatively consistent over time, with no significant regulatory or reimbursement changes anticipated that would materially alter demand patterns during the projection period.
3. Population growth by age cohort is expected to be the primary driver of increased home health need, making it appropriate to hold the use rate constant while allowing demographic shifts to influence future demand.
4. The FY2023 HHA use rate is derived from a full statewide dataset, representing typical service use across all jurisdictions and age cohorts, which supports its continued application through the projection horizon.

Step 4: Determine the Number of HHA Clients Served by Existing HHAs in the PSA by Age Group and Jurisdiction, FY2023

To determine the number of PSA home health clients currently served by existing providers, the Applicant analyzed MHCC FY2023 home health utilization data. This dataset identifies HHA client volumes by provider and by jurisdiction, allowing the Applicant to quantify baseline service levels within the PSA. Table M summarizes the FY2023 utilization of existing providers serving the PSA.

Table M: HHA Clients Served by Existing HHA Providers in the PSA by Age Cohort and Jurisdiction, FY2023

Age Group	Baltimore City	Baltimore County	Howard
0 to 4	294	404	65
5 to 14	54	87	18
15 to 24	76	104	30
25 to 44	443	486	106
45 to 64	2,206	2,884	649
65 to 74	3,768	5,262	1,249
75 to 84	3,334	6,628	2,089
85+	2,330	5,593	1,603
Total	**12,505**	**21,448**	**5,809**

Sources: MHCC HHA Utilization Table 13: Total Number of Home Health Agency Clients (Unduplicated Count) by Jurisdiction of Residence, Payment Source, and Agency: Maryland

Step 5: Estimate the Number of Unserved HHA Clients by Age Group, Jurisdiction, and Year, CY2025-CY2030

To quantify unmet home health need within the PSA, the Applicant subtracted the number of clients served by existing providers in FY2023 (Step 4) from the projected client count for CY2025 through CY2031 (Step 3). This calculation was performed by jurisdiction and age cohort, yielding annual estimates of unmet need for the projection period. Tables N, 1 through 3 present the Applicant's calculated unmet need by year, age group, and jurisdiction.

Table N: Estimated Number of Unserved HHA Clients by Age Group by Year by Jurisdiction, CY2025 – CY2031

1. Baltimore City

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	9	9	8	8	7	7	7
5 to 14	-	-	-	-	-	-	-
15 to 24	2	2	2	2	2	2	2
25 to 44	-	-	-	-	-	-	-
45 to 64	-	-	4	20	36	53	93
65 to 74	160	174	189	204	219	233	163
75 to 84	251	379	511	648	790	937	1,054
85+	-	-	22	51	80	110	190
Total	**422**	**564**	**736**	**932**	**1,134**	**1,342**	**1,509**

Calculation: Step 3 estimated HHA clients by age group, year, and jurisdiction - Step 4 FY2023 served HHA clients by age group and jurisdiction

2. Baltimore County

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	3	5	6	8	10	12	15
5 to 14	-	-	-	-	-	-	-
15 to 24	-	1	1	2	2	3	2
25 to 44	1	-	-	-	-	-	-
45 to 64	-	-	-	-	-	-	-
65 to 74	213	259	305	351	398	445	392
75 to 84	616	867	1,126	1,394	1,672	1,959	2,169
85+	21	121	223	326	432	539	766
Total	**855**	**1,253**	**1,662**	**2,082**	**2,514**	**2,958**	**3,344**

3. Howard

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	2	2	2	2	3	3	3
5 to 14	-	-	-	-	-	-	-
15 to 24	-	-	-	-	1	1	2
25 to 44	3	3	3	4	4	4	4
45 to 64	-	-	-	-	-	-	-
65 to 74	66	96	126	157	189	222	222
75 to 84	279	375	474	577	685	796	874
85+	148	259	378	503	637	779	937
Total	**498**	**735**	**983**	**1,244**	**1,518**	**1,806**	**2,042**

Assumptions

1. The Applicant assumes that the number of clients served by existing providers remains constant through CY2031, reflecting the fact that current providers are operating at or near capacity.
2. Declining use rates represent capacity issues for existing providers. Thus, holding their served client count constant provides a conservative estimate of unmet need in the PSA.
3. This approach isolates demographic growth as the primary driver of projected service demand, ensuring that unmet need estimates accurately reflect the portion of demand that cannot currently be met by existing capacity.

Table O below summarizes the total estimated unmet home health need in the PSA for CY2025 through CY2031. These totals represent the portion of projected client demand not currently met by existing providers and reflect the incremental need associated with population growth.

Table O: Estimated Number of Unserved HHA Clients by Age Group by Year, Entire PSA, CY2025 – CY2030

Age Group	CY25	CY26	CY27	CY28	CY29	CY30	CY31
0 to 4	14	15	17	18	20	21	24
5 to 14	-	-	-	-	-	-	-
15 to 24	2	3	3	4	5	6	6
25 to 44	4	3	3	4	4	4	4
45 to 64	-	-	4	20	36	53	93
65 to 74	439	529	620	712	806	900	777
75 to 84	1,147	1,621	2,111	2,620	3,147	3,693	4,098
85+	170	381	622	880	1,149	1,428	1,893
Total	**1,775**	**2,552**	**3,381**	**4,258**	**5,167**	**6,105**	**6,896**

Calculation: Tables N 1 through 3 summed

Forecast Utilization

Step 6: Estimate the FHC Market Share of Unserved HHA Clients from the PSA, CY2028-CY2031

FHC conservatively forecasts a slower increase in home health agency patients in these three jurisdictions (Baltimore City, Baltimore County, and Howard County) than in the Batch 1 jurisdictions. This allows it to absorb and adjust to operational changes associated with the shift from RSA to HHA services. Table P translates this to the market share of forecast unserved HHA clients in the PSA.

Table P: Estimated Annual FHC Market Share of PSA Unmet Need for HHA Clients, CY2028 – CY2031

Metric	CY28	CY29	CY30	CY31
Market Share	0.26%	1.03%	2.06%	2.75%

Assumptions

1. The projected annual market shares for the PSA reflect the gradual expansion of services to these jurisdictions while simultaneously scaling operations in the Batch 1 PSA. Because Batch 2 development will start in the second year of Batch 1 implementation, a slower initial ramp for Batch 2 is reasonable and consistent with maintaining quality as new policies and procedures are implemented.
2. Although FHC is an established RSA with existing referral relationships throughout central Maryland, FHC anticipates that early-year growth in Batch 2 will be modest as it allocates staff, builds Medicare-certified visibility, and establishes referral pathways in this second set of jurisdictions. For this reason, an initial market share of 0.26 percent in CY 2028 is appropriate.
3. As FHC strengthens its operational presence, builds brand recognition as a Medicare-certified provider, and expands workforce capacity, its market share will increase, stabilizing at 2.75 percent by PY4 (CY 2031). These percentages reflect a conservative, sustainable market share.
4. FHC's operational capacity, staffing resources, and clinical infrastructure will grow in step with this gradual market share, and no external factors (such as regulatory changes, reimbursement disruptions, or major shifts in referral patterns) will materially restrict FHC's ability to capture the projected share of unmet need.

Step 7: Estimated Number of FHC HHA Clients by Age Group by Jurisdiction by Year, CY2028-CY2031

To estimate FHC's projected client volumes, the Applicant applied the market share assumptions developed in Step 6 to the annual unmet need identified in Step 5. This calculation was applied individually to each jurisdiction and age cohort for each projection year. Tables Q, 1 through 3, present the resulting forecasted utilization by year, age group, and jurisdiction.

Table Q: Estimated Annual FHC HHA Clients by Age Group by Jurisdiction, CY2028 – CY2031

1. Baltimore City

Age Group	CY28	CY29	CY30	CY31
0 to 4	-	-	-	-
5 to 14	-	-	-	-
15 to 24	-	-	-	-
25 to 44	-	-	-	-
45 to 64	-	-	1	3
65 to 74	1	2	5	4
75 to 84	2	8	19	29
85+	-	1	2	5
Total	**3**	**11**	**27**	**41**

*Calculation: Step 5 estimated unserved HHA clients by age group, year, and jurisdiction * Step 6 estimated market share by year*

2. Baltimore County

Age Group	CY28	CY29	CY30	CY31
0 to 4	-	-	-	-
5 to 14	-	-	-	-
15 to 24	-	-	-	-
25 to 44	-	-	-	-
45 to 64	-	-	-	-
65 to 74	1	4	9	11
75 to 84	4	17	40	60
85+	1	4	11	21
Total	**6**	**25**	**60**	**92**

3. Howard

Age Group	CY28	CY29	CY30	CY31
0 to 4	-	-	-	-
5 to 14	-	-	-	-
15 to 24	-	-	-	-
25 to 44	-	-	-	-
45 to 64	-	-	-	-
65 to 74	-	2	5	6
75 to 84	1	7	16	24
85+	1	7	16	26
Total	**2**	**16**	**37**	**56**

Table R below summarizes the total estimated FHC home health clients from the PSA for CY2028 through CY2031.

Table R: Estimated Annual FHC HHA Clients by Age Group, Entire PSA, CY2028 – CY2031

Age Group	CY28	CY29	CY30	CY31
0 to 4	-	-	-	-
5 to 14	-	-	-	-
15 to 24	-	-	-	-
25 to 44	-	-	-	-
45 to 64	-	-	1	3
65 to 74	2	8	19	21
75 to 84	7	32	75	113
85+	2	12	29	52
Total	**11**	**52**	**124**	**189**

Calculation: Tables Q 1 through 3 summed

Step 8: Forecast FHC HHA Visits by Category, CY2028-CY2031

To forecast home health visits by billable versus non-billable status and by discipline, the Applicant first determined the Maryland five-year state average of visits per client for each category. These average visit rates were then applied to the projected client volumes developed in Step 7, generating a forecast of total visits by type and discipline for each projection year. Table S presents the resulting visit projections by year, discipline, and billing status. See supporting details in Exhibit 13.

Table S: Forecast FHC HHA Visits by Billing Status and Service Discipline by Year, CY2028 – CY2031

Metric	Visits per Client	CY28	CY29	CY30	CY31
Total Clients		***11***	***52***	***124***	***189***
Billable	15.85	174	824	1,966	2,996
Non-Billable	0.45	5	24	56	86
Total Visits		**179**	**848**	**2,022**	**3,082**
Skilled Nursing	6.21	68	323	770	1,173
Home Health Aide	0.67	7	35	83	126
Occupational Therapy	2.10	23	109	261	398
Physical Therapy	6.37	70	331	790	1,204
Speech Therapy	0.40	4	21	49	75
Medical Social Work	0.10	1	5	13	19

Note: See calculations for visits by billing status and service discipline in Exhibit 13

Assumptions

1. The Maryland five-year state average of visits per client is a reasonable proxy for expected FHC utilization because it reflects stable, statewide practice patterns and accounts for variability across agencies and patient populations.
2. These visit rates remain constant through CY2031, reflecting the expectation that FHC's care delivery patterns, client mix, and service intensity will generally align with established statewide norms.
3. No significant changes in regulations, reimbursement policies, or clinical practice standards that would materially alter visit intensity over the projection period.

Step 9: Total Unduplicated Clients and Client Visits, FHC Entire Facility, CY2027-2031

The following tables present FHC's projected unduplicated clients and total visit volumes by discipline for the proposed Home Health Agency, combining activity from both FHC's Batch 1 CON application PSA and the proposed Batch 2 PSA to illustrate the agency's full operating footprint. These projections incorporate the market-share assumptions, utilization rates, and clinical service patterns detailed in prior steps of the methodology, as well as the phased market share increases associated with expanding into nine counties across seven jurisdictions. The combined tables reflect a consolidated view of expected agency patient utilization and capacity. They show how FHC's integrated operations will support growth in skilled nursing, therapy services, and medical social work while ensuring adequate staffing and clinical resources to meet patient needs across the PSAs. The totals included here represent the anticipated full scope of FHC's home health once both projects are active.

Table T: Estimated Number of FHC HHA Clients by Year, Entire Facility Seven Jurisdictions, Nine Counties, CY2027 – CY2031

Metric	Batch 1 only	Batches 1 and 2 Jurisdictions			
	CY27	CY28	CY29	CY30	CY31
a. Batch 1: Anne Arundel, Montgomery, Prince George's, Southern	199	283	367	418	418
b. Batch 2: Baltimore County, Baltimore City, Howard County		11	52	124	189
c. Total Facility FHC HHA	**199**	**294**	**419**	**542**	**607**

Notes:

a. FHC Batch 1 Application, page 62
b. Step 7, Table R
c. a + b

Table U: Forecast FHC HHA Visits by Billing Status and Service Discipline by Year, Entire Facility, CY2027 – CY2031

Metric	Visits per Client	CY27	CY28	CY29	CY30	CY31
Total Clients		**199**	***294***	**419**	**542**	**607**
Billable	15.85	3,155	4,661	6,642	8,592	9,623
Non-Billable	0.45	91	134	191	247	276
Total Visits		**3,245**	**4,795**	**6,833**	**8,839**	**9,899**
Skilled Nursing	6.21	1,235	1,825	2,601	3,364	3,768
Home Health Aide	0.67	133	196	280	362	405
Occupational Therapy	2.10	419	619	882	1,141	1,278
Physical Therapy	6.37	1,268	1,873	2,670	3,454	3,868
Speech Therapy	0.40	79	117	167	216	242
Medical Social Work	0.10	20	30	43	56	62

10.24.01.08G(3)(c). Alternatives to the Project Review Criterion

The Commission shall consider the alternative approaches to meeting the need identified for the project that were considered by the applicant in planning the project and the basis for the applicant's choice of the project among considered alternatives. In a comparative review of applications within the same review cycle, the Commission shall compare the costs and the likely effectiveness of alternative projects in meeting identified needs, improving the availability and accessibility of care, and improving the quality of care.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project, or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Response: FHC evaluated multiple alternatives for addressing the identified need in Baltimore City, Baltimore County, and Howard County. It considered effectiveness in meeting the Commission's published need, operational feasibility, staffing sustainability, and long-term financial viability. The following analysis of alternatives builds on the approach used in FHC's HHA Batch 1 CON application and reflects this Batch 2 project as an extension of the former.

1. Maintain Current Operations (No Expansion into Batch 2 Counties)

Under this alternative, FHC would continue to operate only in the Batch 1 jurisdictions and would not expand Medicare-certified HHA services to the additional counties.

Effectiveness: This approach would leave documented need unaddressed in all three Batch 2 jurisdictions. More importantly, it would require FHC to continue declining Medicare referrals from providers who depend on FHC for service in these three jurisdictions.

Conclusion: Rejected. This alternative fails to address the Commission's identified need.

2. Expand Through Partnership or Limited Geographic Scope

FHC considered entering into a joint venture with an existing HHA or expanding into only one or two of the three Batch 2 jurisdictions.

Effectiveness: While partnership or selective expansion could partially increase resident access to HHA services, the option would limit FHC's ability to maintain consistent clinical standards, financial-access policies, and quality oversight across all service areas. Limiting geography would also fail to fully address identified need in the remaining qualifying counties.

Conclusion: Rejected. Partial expansion does not adequately meet regional need or support integrated, sustainable FHC operations.

3. Expand with Alternative Timing or Scale

FHC evaluated both deferring expansion until Batch 1 operations were fully mature and accelerating the expansion of Batch 2 with a full staffing build-out in Year 1.

1. **Deferred Expansion** would delay access improvements in jurisdictions already identified as lacking sufficient quality-performing HHAs.
2. **Accelerated Expansion** would increase short-term staffing and financial strain on FHC and could raise concerns regarding workforce scalability.

Conclusion: Both alternatives were rejected in favor of a phased approach that balances responsiveness with operational prudence.

4. Expand as Proposed with Phased Staffing and Conservative Utilization (Preferred Alternative)

The proposed project expands Medicare-certified home health services into Baltimore City, Baltimore County, and Howard County using conservative annual market-share increases and incremental staffing growth.

This approach:

- Directly addresses the insufficient availability of quality-performing HHAs.
- Scales FHC staffing proportionately with HHA census growth.
- Utilizes established workforce pipelines.
- Avoids disruption to existing provider staffing pools.
- Supports long-term financial sustainability for FHC.

Conclusion: The proposed phased expansion represents the most balanced, effective, and operationally sustainable alternative.

Conclusion

This comparative analysis shows that all other alternatives are either insufficient, less financially sustainable, or ineffective at addressing the documented need for expanded home health access. The proposed Batch 2 phased expansion represents the most balanced, effective, and operationally sustainable alternative.

10.24.01.08G(3)(d). Project Financial Feasibility and Facility or Program Viability Review Criterion.

The Commission shall consider the availability of resources necessary to implement the project and the availability of revenue sources and demand for the proposed services adequate to ensure ongoing viability and sustainability of the facility to be established or modified or the service to be introduced or expanded.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- **Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required (Tables H and I for all applicants and Table F for existing facilities and/or Table G, for new facilities, new services, and when requested by MHCC staff). Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the health care facility exists or is proposed, explain why the projected Medicare percentages are reasonable.**

- **Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.**

- **If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.**

- **Describe and document relevant community support for the proposed project.**

- **Identify the performance requirements applicable to the proposed project (see Part I question 15) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).**

Response: The proposed HHA project will be funded through the applicant's existing equity, as documented in the letter from FHC's bank in Exhibit 9. The letter attests that FHC has sufficient cash to cover all start-up costs and working capital needs. No external grants or philanthropic funding are currently required to initiate the project. The Applicant considered alternative financing mechanisms, including traditional debt financing, and determined that such methods were unnecessary given the availability of internal funds. This approach was chosen to ensure timely implementation and financial stability while minimizing financial risk. Moreover, as demonstrated in the cash flow projections in Exhibit 16, the proposed Batch 1 agency will generate additional cash in the last months of its first year (CY2027). That cash will supplement documented cash on hand.

All methods and assumptions for financial and staffing projections are detailed in Part IV immediately following required Tables 3, 4, and 5 (see page 102). These tables demonstrate that the proposed project is financially sustainable, with projected revenues covering ongoing operational costs and staffing requirements. Where Medicare percentages exceed the jurisdictional median, the projections are based on documented referral patterns and historical experience. These requests were the foundation for FHC's decision to pursue this CON and further support the reasonableness of projected Medicare utilization.

Assumptions regarding staffing needs, recruitment, and retention are consistent with FHC's history as an RSA and its established capacity to manage and deliver home-based care. See Section 10.24.16.08F(3) on page 42 above for additional information on how FHC does and will recruit and maintain staff from the PSA.

The applicant has significant experience in managing a similar project – the operation of its existing RSA. This experience supports both administrative operational strength and grounded financial planning.

Community support for the proposed HHA is reflected in FHC's established referral relationships, longstanding community engagement, and documented unmet demand for Medicare-certified services. FHC currently receives referrals from hospitals, physicians, rehabilitation providers, and community-based organizations across the proposed PSA, including for Medicare beneficiaries. FHC cannot accept these care requests under its current RSA licensure. These documented referrals—including those declined due to lack of Medicare certification—demonstrate tangible community need and provider reliance on FHC's services.

Exhibit 14 includes letters of support from community stakeholders affirming the value of expanding FHC's services as a Medicare-certified HHA. In addition, FHC's established client base, consistent referral patterns, and active linkages with healthcare providers throughout the PSA reflect strong operational integration within the regional care continuum. These relationships, further described in Section 10.24.16.08I and Exhibit 4, provide a stable foundation for sustainable growth and the successful implementation of the proposed project.

In summary, the proposed funding plan leverages FHC's existing resources to fully support the start-up and ongoing operations of the HHA, ensuring financial sustainability, readiness for implementation, and continued ability to meet the identified community need.

10.24.01.08G(3)(e). The "Compliance with Terms and Conditions of Previous Certificates of Need" Review Criterion.

An applicant shall demonstrate compliance with all terms and conditions of each previous CON granted to the applicant.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Response: Neither FHC, its parent organization, nor any related affiliates have been issued a CON in the state of Maryland. FHC's Batch 1 CON is still under review at the time of this submission. Therefore, it has no obligations to any terms or conditions set forth by MHCC. This criterion is not applicable.

10.24.01.08G(3)(f). Project Impact Review Criterion.

The Commission shall consider the impact of the proposed project on the costs and charges of existing providers of the facilities and services included in the project and on access to those facilities and services in the service area of the project.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs of the health care delivery system.

If the applicant is an existing health care facility, provide a summary description of the impact of the proposed project on costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Response: FHC forecasts small market shares of patients not currently served. It anticipates that the proposed Medicare-certified HHA will have minimal impact on existing providers within the PSA while significantly improving patient access to care. The analysis below summarizes the expected impacts on volumes, payer mix, access, and costs, along with the assumptions underlying these conclusions.

a. Volumes

The proposed project is designed to address unmet need in the PSA while minimizing the displacement of existing HHA providers. Current providers are unable to fully meet demand, and FHC maintains that, conservatively, 16 percent of its referrals were unserved because it lacks Medicare certification. By targeting this population, FHC expects to capture a portion of the unmet need rather than divert patients from existing agencies. Assumptions about service volumes are based on historical referral patterns, projected demand growth, and FHC's capacity to provide care as a Medicare-certified HHA.

b. Payer Mix

With CON approval, FHC will accept Medicare patients, thereby changing its own payer mix. However, the project is not expected to significantly affect the payer mix of other providers in the PSA, as the majority of patients served by FHC would otherwise have limited or no access to home health services. Revenue assumptions reflect standard Medicare and commercial reimbursement rates consistent with regional norms. Payor Mix for the proposed FHC HHA is consistent with that of other providers in the area, with Medicaid (both traditional and MCO) increasing by at least 2 percent and Medicare decreasing by the same amount. Payor mix data were derived from the MHCC HHA Annual Survey, FY23, Table 19.

c. Access

The proposed project will expand access to home health services in the PSA. By offering both RSA and services associated with a Medicare-certified HHA, FHC will serve patients who currently lack access to home-based care, provide timely in-home visits, reduce care delays, and improve continuity of care for post-acute and chronic care management. This improved access is based on documented unmet need, FHC's existing referral sources, and community demand, ensuring that the project addresses service gaps rather than competing for existing patients.

d. Cost of the Healthcare Delivery System

The project is expected to have a neutral to positive effect on overall healthcare system costs. Providing appropriate HHA services can prevent unnecessary hospital admissions, reduce avoidable emergency department visits, and support earlier hospital discharge, thereby lowering system-wide costs. Charges for HHA services will follow standard Medicare and payer guidelines and align with those of other providers in the region. FHC's operational experience as an RSA ensures efficiency, minimizes overhead, and avoids unnecessary cost escalation. The project expands access without unnecessarily increasing overall costs and enhances equity and efficiency within the local healthcare delivery system.

Summary

In summary, the proposed HHA project addresses substantial unmet need while having minimal or not impact on existing providers' patient census and payer mix. The proposed project will improve patient access to home health services, maintain cost efficiency, and support sustainable care delivery within the PSA. The assumptions regarding demand, payer mix, and access are grounded in Maryland patterns, FHC's historical operations, community referrals, and documented unmet need, providing a robust basis for these conclusions.

10.24.01.08G(3)(g) Health Equity.

The Commission shall consider how a proposed project will address health care disparities in availability, accessibility, and quality of care among different populations within the service area. The Commission shall consider how social determinants of health within the service area of the proposed project create disparities in the delivery of health care.

INSTRUCTIONS: In evaluating proposed projects for health equity, the Commission will scrutinize the project's impact on health care disparities and social determinants within the service area. Health equity involves the fair distribution of resources and opportunities, ensuring individuals, regardless of background, have the chance to achieve their highest level of health. It further encompasses addressing disparities and systemic barriers that affect different populations.

With health equity in mind, the applicant shall identify the specific medically underserved area(s)/group(s)[29] within the designated service area and outline how the proposed project will address the unique health needs and quality of care for each identified group.

Applicants are expected to furnish a detailed overview of their organization's expertise and experience in health care access and service delivery. Emphasis should be placed on highlighting any relevant background that underscores the organization's commitment to equitable health care. This encompasses efforts to integrate implicit bias and cultural competency training within the health facility and among current staff members.

Please provide a comprehensive account of how the applicant planned with the community during the preparations for this project and how it will continue to engage with the community. Include a description of any specific initiatives and programs aimed at improving community well-being that are relevant to the proposed project. If applicable, the applicant should acknowledge any unintended barriers caused by the project that may have been identified through community discourse and propose proactive solutions to mitigate and rectify potential issues.

Response: FHC's proposed Medicare-certified HHA is intentionally designed to reduce long-standing disparities in access, timeliness, and continuity of home-based care for medically underserved populations across the PSA. These jurisdictions include large and diverse communities that face disproportionate barriers related to income, transportation, disability, the burden of chronic disease, and limited provider participation—particularly among Medicaid fee-for-service, Medicaid Managed Care, **and dual-eligible beneficiaries who rely on both programs for coordinated coverage**.

Dual-eligible individuals represent some of the most medically complex and socially vulnerable patients in the PSA; they experience higher hospitalization rates, more frequent care transitions, and greater difficulty accessing Medicare-covered home health services when agencies restrict participation or lack capacity. Dual-eligible HHA patients will appear as Medicare patients because Medicare is the primary payer, and HHA is a Part A Medicare service.

[29] According to HRSA, medically underserved populations and areas are identified as those which lack access to primary care services. These groups may face economic, cultural, or language barriers to health care. Some examples include People experiencing homelessness, people who are low-income, people who are eligible for Medicaid, Native Americans and other historically disadvantaged populations of color, migrant farm workers, etc. (https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups)

The PSA is also home to significant racial and ethnic minority populations, including African American and Hispanic residents, who historically experience delayed access to post-acute care, lower rates of referral to home health, and greater challenges navigating fragmented coverage systems.

By expanding Medicare-certified home health capacity, FHC will help address systemic gaps and ensure that low-income seniors, adults with disabilities, and dual-eligible beneficiaries receive timely, coordinated, high-quality care in the home setting.

Declining home health utilization across the PSA does not reflect improved health. It does imply some strain in the existing delivery system. Industry and Medicare data show that workforce shortages, agency closures, and reimbursement pressures are limiting access, leading to delayed or unmet home health referrals. These delays disproportionately affect older adults, low-income families, and publicly insured populations. FHC's proposed expansion directly confronts these gaps by adding new, stable, and comprehensive home-based clinical capacity with seven-day-per-week availability. The proposed agency will ensure that medically and socially complex residents—including individuals with chronic cardiac, pulmonary, neurological, diabetic, musculoskeletal, and psychiatric conditions—receive timely admission and a full continuum of skilled care.

Identification of Medically Underserved Areas and Groups

Based on demographic, socioeconomic, and health-status data for the PSA, the following groups are identified as medically underserved:

- **Older adults**, especially individuals aged seventy-five and older, are a cohort expanding by over three percent annually.
- **Low-income residents**, approximately 11 percent of the PSA, live below 150 percent of the federal poverty level.
- **Racial and ethnic minority communities**, particularly African American and Hispanic residents, who represent about 46.5 percent of the PSA population and have higher rates of diabetes, obesity, hypertension, and preventable hospitalizations.
- **Residents with disabilities or limited mobility**, including those who cannot reliably travel to outpatient settings.
- **Individuals with complex chronic conditions**, including COPD, CHF, diabetes, Alzheimer's disease, dementia, and musculoskeletal or neurological disorders.
- **Post-acute patients transitioning from hospital to home**, who face higher risks of readmission without timely skilled services.

FHC's proposed HHA will directly address the needs of people in these profile categories by both its inclusive acceptance policy and the proposed expansion of access to skilled nursing, therapy, home health aide services, and multidisciplinary care across the region, with particular emphasis on residents who have historically faced the greatest barriers to healthcare access.

How the Proposed Project Improves Equity for Underserved Populations

1. **Expanded Access to Affordable, Timely Home Health Services:** FHC's program is structured to ensure prompt admission for Medicare, Medicaid, and dual-eligible patients. As an organization with a documented commitment to charity care, FHC will continue to provide financial assistance to low-income patients who otherwise face cost-related barriers. This is particularly important in the PSA, where many households struggle with underinsurance and where home health provides a significantly lower-cost alternative to hospitalization.
2. **Seven-Day-a-Week Availability to Reduce Delays and Readmissions:** FHC will offer nursing, therapy, and aide services seven days per week, supporting the timely initiation of care after hospital discharge—a critical component in reducing preventable readmissions. Research indicates that home health services initiated soon after hospital discharge are associated with reduced risk of hospital readmission and improved outcomes among older adults, particularly when visits occur within the first forty-eight hours and reflect clinically appropriate intensity.[30] FHC's model strengthens this impact through reliable scheduling and multidisciplinary care plans.
3. **Comprehensive Service Scope for Complex Medical and Social Needs:** The proposed HHA will deliver a wide range of disciplines—skilled nursing, PT, OT, ST, MSW, and home health aide services—capable of addressing acute, chronic, postoperative, neurological, pediatric, and geriatric needs. This breadth ensures that high-risk patients, including those with multiple comorbidities, receive coordinated home-based care that is often unavailable or difficult to obtain in the PSA due to capacity constraints.
4. **Targeted Support for Pediatric and Geriatric Populations:** FHC has specialized pediatric nurses and experienced geriatric clinicians trained to communicate effectively with children, older adults, and family caregivers. These populations often experience unique communication, functional, and behavioral needs that require specialized in-home care.

Organizational Background and Experience Supporting Health Equity

FHC currently operates as an experienced home-based care provider with a longstanding commitment to serving Medicaid, waiver, and medically fragile populations. As an RSA, FHC has provided personal care, supportive services, home health aide services, and skilled care coordination to low-income and minority residents for many years. This history has strengthened the organization's familiarity with the social and cultural needs of vulnerable households and its capacity to deliver trauma-informed, culturally sensitive care.

FHC is accredited by the Community Health Accreditation Partner (CHAP) and already maintains robust data-collection processes, including OASIS assessments and patient-satisfaction surveys. These systems will transition and expand seamlessly within the proposed HHA, ensuring compliance with federal and state reporting requirements and supporting continuous monitoring of health equity outcomes.

Staff training at FHC includes cultural humility, awareness of implicit bias, communication with persons with disabilities, language support strategies, and trauma-informed care. These training programs will continue and expand under the proposed HHA, reinforcing the organization's commitment to equitable care delivery.

[30] O'Connor, Maura, et al. "Risk of Rehospitalization or Emergency Department Visit Is Significantly Higher for Patients Who Receive Their First Home Health Visit Later than Two Days after Hospital Discharge." *Journal of the American Medical Directors Association*, vol. 23, no. 10, Oct. 2022, pp. 1642–1647, doi:10.1016/j.jamda.2022.07.001.

Community Engagement and Planning for the Proposed Project

FHC's preparation for this project has been informed by its longstanding relationships with community referral sources, including hospitals, physician practices, case managers, social service agencies, and managed care organizations that regularly coordinate care for older adults and medically complex residents of the PSA. As a Residential Service Agency, FHC routinely receives referral requests—particularly for Medicare beneficiaries—that it cannot accept due to its current licensure status. These repeated requests have provided direct, ongoing feedback from the community regarding unmet need for skilled home health services. In developing this project, FHC also engaged informally with key referral partners and community-based professionals to better understand barriers to timely home-based care, particularly delays in discharging Medicare patients who require home nursing or therapy services. Letters of support included in Exhibit 14 reflect this outreach and demonstrate strong community endorsement for expanding access through a Medicare-certified HHA.

Going forward, FHC will continue to engage with the community through ongoing discussions with referring providers, collaboration with local hospitals and care coordinators, participation in discharge-planning networks, and continued outreach to social service agencies and community organizations. As part of its commitment to community well-being, FHC will maintain a robust charity care and financial-assistance policy, offer culturally and linguistically responsive care, and ensure seven-day-per-week availability to improve care transitions and reduce avoidable hospital use. No unintended barriers have been identified through community discourse to date; however, FHC is committed to monitoring patient and provider feedback, assessing for access or equity concerns, and implementing proactive solutions—such as targeted outreach, bilingual communication materials, or service expansion—if any issues arise. Through these ongoing practices, FHC will remain responsive to community needs and support equitable access to high-quality home health services across the PSA.

Ongoing Community Engagement

FHC will continue proactive community involvement through:

- Quarterly meetings with referring hospitals, senior centers, federally qualified health centers (FQHCs), and community-based organizations.
- Patient and caregiver feedback surveys.
- Engagement with county aging offices and chronic-disease coalitions.
- Collaboration with organizations addressing food insecurity, transportation, disability services, and home-safety modifications.

FHC will screen all patients for social determinants of health—including food availability, caregiver support, home environment, access to medications, and transportation—ensuring that clinical care is paired with appropriate resource referrals and community partnerships.

Identification and Mitigation of Potential Unintended Barriers

FHC has not identified any unintended access barriers resulting from the proposed project; however, through its community planning process, several potential issues were considered:

- **Language barriers:** FHC employs and will continue to employ multilingual staff and interpreter services. Approximately 85 percent of FHC staff today speak at least one language in addition to English. FHC also contracts with Language Line, a HIPAA-compliant, medical-translation-specific service.
- **Transportation limitations:** While services occur in the home, FHC will coordinate transportation for follow-up medical appointments when appropriate through community partners.
- **Financial barriers:** FHC's charity care program and willingness to serve publicly insured patients without restriction mitigate cost-related inequities.
- **Digital barriers:** Recognizing the limitations of many of its potential clients, FHC will use phone-based communication and in-home visits rather than relying heavily on patient technology.

Should any additional concerns arise, FHC is committed to immediate operational adjustments—including staffing additions, policy changes, and expanded community outreach—to ensure equitable access for all PSA residents.

Conclusion

The PSA faces rapid growth in its older-adult population, elevated chronic-disease burden, widespread socioeconomic barriers, and declining home-health utilization caused by system strain rather than reduced demand. These factors disproportionately affect low-income residents, publicly insured individuals, and communities of color. FHC's proposed Medicare-certified HHA directly addresses these inequities by expanding clinical capacity, strengthening post-acute transitions, and delivering comprehensive, multidisciplinary care seven days per week. With its strong organizational foundation, established commitment to vulnerable populations, and ongoing community engagement strategy, FHC is well-prepared to improve health equity and ensure that all residents—regardless of age, income, race, or insurance type—can access timely, high-quality home health services.

10.24.01.08G(3)(h) Character and Competence.

The Commission shall assess the character and competence of an applicant based upon experience and past performance, including any records of violation in operating a health care service or facility.

INSTRUCTIONS: In evaluating proposed projects for Character/Competence, the Commission will review the information provided in response to Part IIII of the application and look for a detailed narrative response highlighting any past issues and how any issues have now been corrected or addressed. If there have not been any past issues please include in your narrative any history that has been a positive reflection of character/competence. The response should include, at minimum:

- **names/addresses of all owners and individuals responsible for the proposed project and its implementation. This includes any person with 5% or more ownership interest in the real property, bed rights or operations of the facility**
- **for each individual identified disclose any involvement in the ownership, development, or management of another health care facility**
- **for each individual and facility identified disclose if any license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years**
- **for each individual and facility identified disclose inquiries in the last from 10 years from any federal (CMS) or state authority (OHCQ), or other regulatory body regarding possible non-compliance with any state, or federal requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions**
- **disclose if any owners and individuals responsible for the project have identified above have ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities**

REMEMBER TO SUBMIT THE COMPANION TABLE SET FEATURING THE PROJECT BUDGET, STATISTICAL PROJECTIONS, REVENUE AND EXPENSE PROJECTIONS, AND WORKFORCE INFORMATION

Response: Please see the responses to Part III.1-5 for additional information regarding FHC's Character and Competence. All required tables, including the project budget, statistical projections, revenue and expense projections, and workforce information, are included in Part IV, beginning on page 88.

Regulatory Compliance and Accreditation

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

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

Quality and Clinical Performance

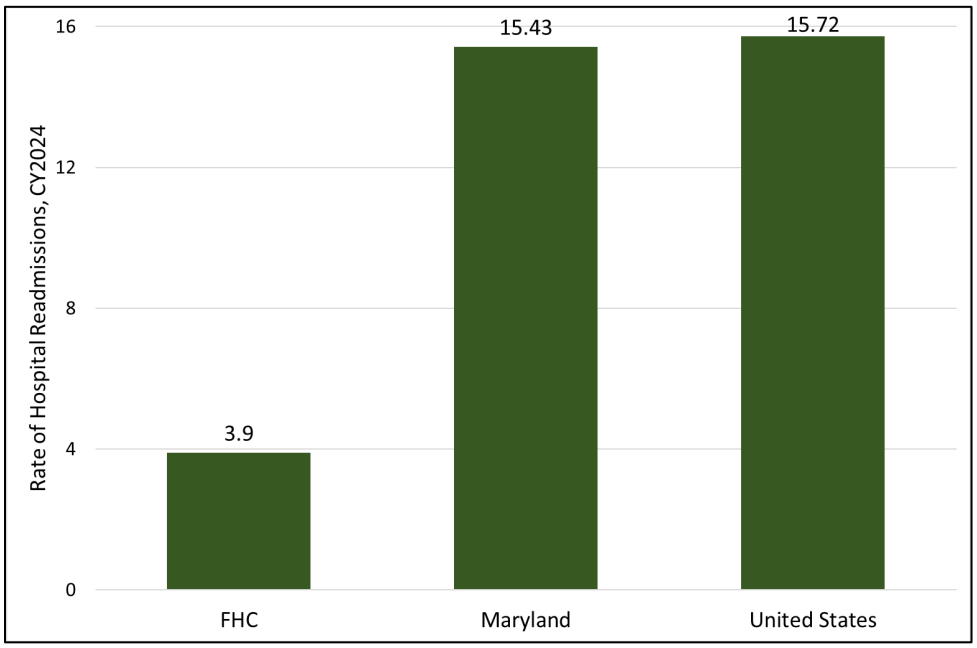
FHC maintains an active Quality Assessment and Performance Improvement (QAPI) program led by its Director of Nursing. The agency tracks key clinical indicators, including infection-control events, incident-reporting trends, documentation accuracy, and patient satisfaction. Internal review processes have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

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

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

FHC has demonstrated the ability to stabilize medically complex patients at home, reducing avoidable care escalations and supporting safe transitions after hospital discharge. Notably, **FHC's 2025 client rehospitalization rate was 3.9 percent** – a significant difference from the Maryland average of 15.43 percent as of CY2024.[31]

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



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

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

Workforce Stability and Professional Development

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

The agency invests in continuing education and professional development, including participation in Maryland-National Capital Homecare Association (MNCHA) leadership training and ongoing clinical education programs. Staffing models emphasize local recruitment within the PSA, reducing travel burden and promoting workforce stability. **FHC has a stable workforce. Some staff have been with the RSA for as long as ten years. Today, the primary reason for turnover in clinical staff is FHC's inability to generate demand for its services because it cannot serve Medicare patients.**

Community Engagement and Referral Relationships

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

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

Financial Stability and Operational Readiness

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

Organizational Character

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

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

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

Response: First Healthcare Consultants LTD is a **privately held limited company**, **100 percent owned by Ms. Abisola Raimi-Abayomi**. There are no additional individuals or entities with a 5% or greater ownership interest in the applicant.

Abisola Raimi-Abayomi
12906 North Point Lane
Laurel, Maryland 20708
Prince George's County

2. Is the applicant, or any person listed above now involved, or has ever been involved, in the ownership, development, or management of another health care facility or program? If yes, provide a listing of each facility or program, including facility name, address, and dates of involvement.

Response: Neither Ms. Raimi-Abayomi nor FHC has had any involvement in the ownership, development, or management of any other health care facility or program.

3. Has the Maryland license or certification of the applicant home health agency, or any of the facilities or programs listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner, or other person responsible for implementation of the Project was not involved with the facility or program at the time a suspension, revocation, or disciplinary action took place, indicated in the explanation.

Response: Neither Ms. Raimi-Abayomi nor FHC has had their licenses suspended or revoked, nor have they been subject to any disciplinary action (such as a ban on admission) in the last 10 years.

4. Is any facility or program with which the applicant is involved, or has any facility or program with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility or program. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility or program, and any final disposition reached by the applicable governmental authority.

Response: Neither Ms. Raimi-Abayomi nor FHC has ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services, which have led to an action to suspend, revoke, or limit the licensure or certification at any facility or program. Furthermore, neither has ever been found non-compliant with any state or federal requirements for the provision, quality, or payment for health care services, resulting in actions that could lead to penalties, admission bans, probationary status, or other sanctions.

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or program or any health care facility or program listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

Response: Neither Ms. Raimi-Abayomi nor FHC has ever pled guilty to or been convicted of any criminal offense related to the ownership, development, or management of the applicant facility or program.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed home health agency service.

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.

04/03/2026	Abisola Raimi-Abayomi Abisola Raimi-Abayomi (Mar 4, 2026 12:01:27 EST)
Date	Signature of Owner or Authorized Agent of the Applicant

Note: Authorization page eSigned by Applicant. Original included with PDF and electronic submission.

PART IV: HOME HEALTH AGENCY APPLICATION: CHARTS AND TABLES SUPPLEMENT

Table 1 - Project Budget

Table 2a: Statistical Projections – For HHA Services In Maryland

Table 2b: Statistical Projections – For Proposed Jurisdictions

Table 3: Revenues And Expenses - For HHA Services In Maryland

Table 4: Revenues And Expenses - Proposed Project

Table 5: Staffing Information

TABLE 1: PROJECT BUDGET

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

A. USE OF FUNDS	
1. CAPITAL COSTS (if applicable):	
a. New Construction	
1) Building	
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc.)	
a. SUBTOTAL New Construction	
b. Renovations	
1) Building	
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc.)	
b. SUBTOTAL Renovations	
c. Other Capital Costs	
1) Movable Equipment	$20,000
2) Contingency Allowance	
3) Gross Interest During Construction	
4) Other (Specify)	
c. SUBTOTAL Other Capital Cost	*$20,000*
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	
Non-Current Capital Cost	
d. Land Purchase Cost or Value of Donated Land	
e. Inflation (state all assumptions, including time period and rate	
TOTAL PROPOSED CAPITAL COSTS (sum of a - e)	**$20,000**
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	
b. Bond Discount	
c. CON Application Assistance	
c1. Legal Fees	
c2 Other (Specify and add lines as needed)	
d. Non-CON Consulting Fees	
d1. Legal Fees	
d2. Other (Specify and add lines as needed)	$40,000
e. Debt Service Reserve Fund	
f. Other (Specify)	

TOTAL (a - e)	**$40,000**
3. WORKING CAPITAL STARTUP COSTS	**$6,174**
TOTAL USES OF FUNDS (sum of 1 - 3)	**$66,174**

B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	$66,174
2. Pledges: Gross _____, less allowance for uncollectable _____= Net	
3. Gifts, bequests	
4. Authorized Bonds	
5. Interest income (gross)	
6. Mortgage	
7. Working capital loans	
8. Grants or Appropriation	
a. Federal	
b. State	
c. Local	
9. Other (Specify)	
TOTAL SOURCES OF FUNDS (sum of 1-9)	**$66,174**

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

TABLE 2A: STATISTICAL PROJECTIONS – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND

Instructions: Table 2A applies to an applicant that is an existing home health agency and should be completed showing historic and projected utilization *for all home health agency services provided in Maryland*.

Table should report an *unduplicated count of clients* and should indicate whether the reporting period is Calendar Year (CY) or Fiscal Year (FY).

Response: FHC is not an existing HHA. However, its Batch 1 CON application is under review as of this submission. For transparency purposes, the Applicant has included the total utilization for the entire proposed agency. This includes the projections for Batch 1 Table 2b, extended to CY2031, and the incremental growth for Batch 2 presented in this application.

Metric	Two Most Current Actual Years		Projected years – ending with first year at full utilization				
Calendar Year	**CY2023**	**CY2024**	**CY2027**	**CY2028**	**CY2029**	**CY2030**	**CY2031**
Client Visits							
Billable			3,155	4,661	6,642	8,592	9,623
Non-Billable			91	134	191	247	276
TOTAL			3,245	4,795	6,833	8,839	9,899
# of Clients and Visits by Discipline							
Total Clients (Unduplicated Count)			***199***	***294***	***419***	***542***	***607***
Skilled Nursing Visits			1,235	1,825	2,601	3,364	3,768
Home Health Aide Visits			133	196	280	362	405
Physical Therapy Visits			1,268	1,873	2,670	3,454	3,868
Occupational Therapy Visits			419	619	882	1,141	1,278
Speech Therapy Visits			79	117	167	216	242
Medical Social Services Visits			20	30	43	56	62
Other Visits (Non-Billable)			91	134	191	247	276

Source: FHC Batch 1 Completeness Responses, Table 2b. Matter Nos. 26-R4-2487, 26-R4-2488, 26-R4-2489, and 26-R4-2490; March 2, 2026. CY2031 projections conservatively remain constant at CY2030 volumes. Table 2b below.

TABLE 2B: STATISTICAL PROJECTIONS - PROJECTED HOME HEALTH AGENCY SERVICES IN THE PROPOSED PROJECT

Instructions: All applicants should complete Table 2B for the proposed project, showing projected utilization *only for the jurisdiction(s) which is the subject of the application*. **As in Table 2A above, this table should report an unduplicated count of clients, and should indicate whether the reporting period is Calendar Year (CY) or Fiscal Year (FY).**

Response: The table below shows projected unduplicated HHA clients and client visits for the first four project years of the Batch 2 jurisdictions.

Metric	Projected years ending with first year at full utilization			
Calendar Year	**CY2028**	**CY2029**	**CY2030**	**CY2031**
Client Visits				
Billable	174	824	1,966	2,996
Non-Billable	5	24	56	86
TOTAL	**179**	**848**	**2,022**	**3,082**
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	***11***	***52***	***124***	***189***
Skilled Nursing Visits	68	323	770	1,173
Home Health Aide Visits	7	35	83	126
Physical Therapy Visits	70	331	790	1,204
Occupational Therapy Visits	23	109	261	398
Speech Therapy Visits	4	21	49	75
Medical Social Services Visits	1	5	13	19
Other Visits (Non-Billable)	5	24	56	86

TABLE 3: REVENUES AND EXPENSES – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND (INCLUDING PROPOSED PROJECT)

Instructions: an existing home health agency must complete Table 3, showing historic and projected revenues and expenses for all home health agency services provided *in Maryland.*

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

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

Response: FHC is not an existing HHA. However, its Batch 1 CON application is under review as of this submission. For transparency purposes, the Applicant has included the total revenues and expenses for the entire proposed agency. This includes the projections for Batch 1 Table 4, extended to CY2031, and the incremental growth for Batch 2 presented in this application.

Metric	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)				
Calendar Year	CY23	CY24	CY25	CY2027	CY2028	CY2029	CY2030	CY2031
1. Revenue								
Gross Patient Service Revenue				$834,823	$1,231,918	$1,747,585	$2,254,470	$2,517,451
Allowance for Bad Debt				$20,871	$30,798	$43,690	$56,362	$62,936
Contractual Allowance				$83,482	$123,192	$174,758	$225,447	$251,745
Charity Care				$3,631	$5,359	$7,602	$9,807	$10,951
Net Patient Services Revenue				$726,296	$1,071,769	$1,520,399	$1,961,389	$2,190,182
Other Operating Revenues (Specify)				-	-	-	-	-
Net Operating Revenue				$726,296	$1,071,769	$1,520,399	$1,961,389	$2,190,182
2. Expenses								
Salaries, Wages, and Professional Fees, (including fringe benefits)				$583,809	$789,664	$1,078,916	$1,337,263	$1,473,327
Contractual Services (please specify)				-	-	-	-	-
Interest on Current Debt				$832	$1,295	$1,724	$2,027	$2,027
Interest on Project Debt				-	-	-	-	-

Metric	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)				
Calendar Year	**CY23**	**CY24**	**CY25**	**CY2027**	**CY2028**	**CY2029**	**CY2030**	**CY2031**
Current Depreciation				-	-	-	-	-
Project Depreciation				$2,857	$5,714	$5,714	$5,714	$5,714
Current Amortization				-	-	-	-	-
Project Amortization				-	-	-	-	-
Supplies				$14,561	$21,512	$30,658	$39,658	$44,414
Other Expenses (Specify)				$136,471	$202,936	$287,077	$369,381	$409,707
Total Operating Expenses				$738,530	$1,021,121	$1,404,088	$1,754,043	$1,935,189
3. Income								
Income from Operation				($12,234)	$50,648	$116,310	$207,346	$254,993
Non-Operating Income				-	-	-	-	-
Subtotal				($12,234)	$50,648	$116,310	$207,346	$254,993
Income Taxes				-	-	-	-	-
Net Income (Loss)				($12,234)	$50,648	$116,310	$207,346	$254,993
4A. - Payor Mix as Percent of Total Revenue								
Medicare				72.7%	72.8%	72.9%	72.8%	72.8%
Medicare Advantage				15.0%	14.9%	14.7%	14.6%	14.5%
Medicaid				1.5%	1.5%	1.5%	1.6%	1.6%
Medicaid MCO				1.8%	1.8%	1.8%	1.9%	1.9%
Blue Cross				0.0%	0.0%	0.0%	0.0%	0.0%
Commercial Insurance				7.5%	7.5%	7.6%	7.7%	7.9%
Self-Pay				0.0%	0.0%	0.0%	0.0%	0.0%
Other (Specify)				1.5%	1.5%	1.5%	1.4%	1.4%
TOTAL REVENUE	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%
4B. Payor Mix as a Percent of Total Visits								
Medicare				65.6%	65.8%	65.8%	65.7%	65.7%
Medicare Advantage				18.8%	18.6%	18.4%	18.2%	18.2%
Medicaid				1.9%	2.0%	2.0%	2.0%	2.0%
Medicaid MCO				2.4%	2.4%	2.4%	2.4%	2.4%
Blue Cross				0.0%	0.0%	0.0%	0.0%	0.0%
Other Commercial Insurance				9.3%	9.3%	9.5%	9.7%	9.9%

Metric	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)				
Calendar Year	**CY23**	**CY24**	**CY25**	**CY2027**	**CY2028**	**CY2029**	**CY2030**	**CY2031**
Self-Pay				0.0%	0.0%	0.0%	0.0%	0.0%
Other (Specify)				1.9%	1.8%	1.8%	1.8%	1.8%
TOTAL VISITS	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: FHC Batch 1 Completeness Responses, Table 4. Matter Nos. 26-R4-2487, 26-R4-2488, 26-R4-2489, and 26-R4-2490; March 2, 2026. Table 4 below.

NOTE: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS.

TABLE 4: REVENUES AND EXPENSES – PROJECTED HOME HEALTH AGENCY SERVICES FOR PROPOSED PROJECT

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

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

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

Response: The table below includes projected HHA revenues and expenses for the Batch 2 incremental growth during its first four project years ending in CY2031.

Metric	Projected Years (ending with first full year at full utilization)			
Calendar Year	**CY2028**	**CY2029**	**CY2030**	**CY2031**
1. Revenue				
Gross Patient Service Revenue	$42,911	$209,545	$497,501	$760,482
Allowance for Bad Debt	$1,073	$5,239	$12,438	$19,012
Contractual Allowance	$4,291	$20,955	$49,750	$76,048
Charity Care	$187	$912	$2,164	$3,308
Net Patient Services Revenue	$37,333	$182,305	$432,826	$661,619
Other Operating Revenues (Specify)	-	-	-	-
Net Operating Revenue	$37,333	$182,305	$432,826	$661,619
2. Expenses				
Salaries, Wages, and Professional Fees, (including fringe benefits)	$17,520	$117,744	$305,468	$441,532
Contractual Services (please specify)	-	-	-	-
Interest on Current Debt	-	-	-	-
Interest on Project Debt	-	-	-	-
Current Depreciation	-	-	-	-
Project Depreciation	$2,857	$2,857	$2,857	$2,857
Current Amortization	-	-	-	-
Project Amortization	-	-	-	-
Supplies	$805	$3,805	$9,073	$13,829
Other Expenses (See assumptions)	$6,372	$32,930	$80,272	$120,598
Total Operating Expenses	$27,555	$157,336	$397,670	$578,817
3. Income				
Income from Operation	$9,778	$24,969	$35,156	$82,803
Non-Operating Income	$0	$0	$0	$0
Subtotal	$9,778	$24,969	$35,156	$82,803
Income Taxes	$0	$0	$0	$0
Net Income (Loss)	$9,778	$24,969	$35,156	$82,803

Metric	Projected Years (ending with first full year at full utilization)			
Calendar Year	**CY2028**	**CY2029**	**CY2030**	**CY2031**
4A. - Payor Mix as Percent of Total Revenue				
Medicare	75.03%	73.10%	72.83%	72.69%
Medicare Advantage	14.18%	13.52%	13.63%	13.77%
Medicaid	0.87%	1.52%	1.49%	1.49%
Medicaid MCO	1.73%	1.70%	1.84%	1.81%
Blue Cross	0.00%	0.00%	0.00%	0.00%
Commercial Insurance	8.19%	8.98%	8.97%	9.04%
Self-Pay	0.00%	0.00%	0.00%	0.00%
Other (Specify)	0.00%	1.18%	1.24%	1.19%
TOTAL REVENUE	100.00%	100.00%	100.00%	100.00%
4B. Payor Mix as a Percent of Total Visits				
Medicare	68.07%	65.90%	65.56%	65.40%
Medicare Advantage	18.07%	16.99%	17.04%	17.22%
Medicaid	1.20%	2.06%	2.04%	2.07%
Medicaid MCO	2.41%	2.31%	2.55%	2.51%
Blue Cross	0.00%	0.00%	0.00%	0.00%
Other Commercial Insurance	10.24%	11.29%	11.22%	11.30%
Self-Pay	0.00%	0.00%	0.00%	0.00%
Other (Specify)	0.00%	1.46%	1.58%	1.50%
TOTAL VISITS	100.00%	100.00%	100.00%	100.00%

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 in Maryland. The following shows incremental staff required for this application. See the assumptions in the following pages for the methodology used to estimate salaries, FTEs, and benefits. Note that payroll taxes are included in Other Expenses.

Year 1: 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	-	-	-	-	-	-	-	-
Registered Nurse	-	-	0.06	-	$80,000	-	$4,683	-
Licensed Practical Nurse	-	-	0.02	-	$65,000	-	$1,024	-
Physical Therapist	-	-	0.06	-	$75,000	-	$4,776	-
Occupational Therapist	-	-	0.02	-	$75,000	-	$1,592	-
Speech Therapist	-	-	0.01	-	$75,000	-	$796	-
Home Health Aide	-	-	0.01	-	$40,000	-	$424	-
Medical Social Worker	-	-	0.01	-	$90,000	-	$955	-
Other (Nurse Supervisor)	-	-	-	-	$85,000	-	-	-
						Benefits	$2,137	
						TOTAL	**$16,387**	

***** Indicate method of calculating benefits cost

Year 2: 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	-	-	0.25	-	$50,000	-	$12,500	-
Registered Nurse	-	-	0.29	-	$80,000	-	$23,414	-
Licensed Practical Nurse	-	-	0.08	-	$65,000	-	$5,119	-
Physical Therapist	-	-	0.31	-	$75,000	-	$23,082	-
Occupational Therapist	-	-	0.10	-	$75,000	-	$7,163	-
Speech Therapist	-	-	0.02	-	$75,000	-	$1,592	-
Home Health Aide	-	-	0.04	-	$40,000	-	$1,698	-
Medical Social Worker	-	-	0.02	-	$90,000	-	$1,910	-
Other (Nurse Supervisor))	-	-	0.25	-	$85,000	-	$21,250	-
						Benefits	$14,659	
						TOTAL	**$112,387**	

***** Indicate method of calculating benefits cost

Year 3: 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	-	-	1.00	-	$81,500	-	$81,500	-
Registered Nurse	-	-	0.69	-	$80,000	-	$55,524	-
Licensed Practical Nurse	-	-	0.19	-	$65,000	-	$12,140	-
Physical Therapist	-	-	0.72	-	$75,000	-	$54,122	-
Occupational Therapist	-	-	0.23	-	$75,000	-	$17,510	-
Speech Therapist	-	-	0.05	-	$75,000	-	$3,980	-
Home Health Aide	-	-	0.12	-	$40,000	-	$4,669	-
Medical Social Worker	-	-	0.04	-	$90,000	-	$3,820	-
Other (Nurse Supervisor))	-	-	0.25	-	$85,000	-	$21,250	-
						Benefits	$38,177	
						TOTAL	**$292,693**	

***** Indicate method of calculating benefits cost

Year 4: 2031

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	-	-	1.25	-	$75,200	-	$94,000	-
Registered Nurse	-	-	1.06	-	$80,000	-	$84,959	-
Licensed Practical Nurse	-	-	0.29	-	$65,000	-	$18,575	-
Physical Therapist	-	-	1.10	-	$75,000	-	$82,776	-
Occupational Therapist	-	-	0.35	-	$75,000	-	$26,265	-
Speech Therapist	-	-	0.08	-	$75,000	-	$6,367	-
Home Health Aide	-	-	0.17	-	$40,000	-	$6,792	-
Medical Social Worker	-	-	0.05	-	$90,000	-	$4,776	-
Other (Nurse Supervisor))	-	-	0.50	-	$85,000	-	$42,500	-
						Benefits	$55,051	
						TOTAL	**$422,061**	

***** Indicate method of calculating benefits cost

FINANCIAL ASSUMPTIONS

Project Budget Assumptions (Table 1)

1. Fixed Capital Costs

Movable Equipment: $20,000 for office furniture, computer equipment, and other fixtures required to establish the HHA administrative operations. This includes desks, chairs, filing systems, computers, printers, and other standard office equipment. The equipment will be depreciated over a 7-year useful life using straight-line depreciation ($2,857 annually).

2. Project Timeline And Service Commencement

This application represents the second batch of jurisdictions filed for FHC's proposed Home Health Agency. Per MHCC direction, the first batch application (Batch 1) is treated as approved for purposes of this filing, and these projections reflect only the incremental volume and costs associated with the Batch 2 service areas. Because Batch 1 operations commence in January 2027 and the agency will have already completed the Medicare certification survey process during Batch 1's first year, no additional CMS certification period is required for Batch 2. Accordingly, Batch 2 incremental services begin in January 2028 (Month 1 of Batch 1's second year of operations) with all payer categories, including Medicare FFS and Medicaid, commencing simultaneously from the first month of Batch 2 operations.

3. Expense Timing And CMS Visit Ratio

Because the agency will already be CMS-certified and fully operational under Batch 1 by the time Batch 2 services commence in January 2028, there is no pre-certification period or phased expense ramp-up for this filing. All incremental operating expenses associated with Batch 2 are incurred at full run-rate beginning in Month 1. Revenue and expenses are recognized on the same timeline, with no CMS revenue delay.

4. Start-Up Expenses

No start-up expenses are required for this Batch 2 filing. The HHA will already be fully operational under Batch 1 by January 2028, with all administrative infrastructure, staff onboarding, marketing launch activities, and operational systems already in place. The incremental jurisdictions in Batch 2 are served by the existing agency platform, and no pre-opening costs are required.

5. Working Capital for Operations

FHC estimates the first months of Batch 2 operations will require **$6,174** for working capital**.** This represents three months (one quarter) of incremental cash operating expenses before the proposed expansion generates new revenue. This is possible because FHC will obtain CMS Medicare and Medicaid HHA certification as part of its Batch 1 HHA project. FHC projects positive monthly cash flow for the Batch 1 jurisdictions before Batch 2 services commence in January 2028. Thus, the only working capital required to support Batch 2 operations is for the incremental costs associated with the Batch 2 expansion during the initial collection cycle. Batch 2 will not require the full startup subsidy associated with a new HHA. FHC Batch 1 HHA achieves positive monthly cash flow by Month 8 of its first year of operations (August 2027). Thus, FHC's HHA will have approximately five consecutive months of positive cash flow before it incurs any Batch 2 costs. For details, see Exhibit 16.

6. Total Project Budget Requirement

Total uses of funds includes the initial operations subsidy, start up, new fixed capital purchases and CON consulting costs. FHC HHA Batch 2 will have no pre-opening start-up. It will be an existing HHA.

Project Budget Summary:

Incremental Working Capital for Operations Batch 2	$6,174
Start-up Expenses	$0
Months to Positive Cash Flow	3
Fixed Capital Cost (FF&E)	20,000
Other Cash Requirements (CON Consultant)	40,000
Total Uses of Funds (Table 1)	**66,174**

7. Source Of Funds

The total project cost of $66,174 consists of $20,000 in fixed capital (FF&E), $40,000 in CON application consulting fees (reduced from the Batch 1 amount, as this filing benefits from the analytical work completed in the first batch), and $6,174 in working capital (three months of incremental Batch 2 cash operating expenses. The total project cost will be funded from FHC's existing cash reserves, supplemented by cumulative positive cash flow generated during the first year of Batch 1 operations. Batch 1 achieves positive monthly cash flow by Month 8 (August 2027), providing approximately five months of positive cash generation before Batch 2 costs are incurred in January 2028. No debt financing is required for this project.

8. Annual Lease Costs

Annual lease costs for a building lease for office space were included in Batch 1. No land, movable equipment, or other lease costs are anticipated. No incremental annual lease costs for Batch 2 operations.

Lease Category	Annual Cost	Notes
Land	$0	N/A
Building	$0	N/A
Moveable Equipment	$0	N/A
Other	$0	N/A

Proposed Revenue Assumptions (Table 4)

1. Payor Mix

Payor mix percentages are derived from the Maryland Health Care Commission (MHCC) Home Health Agency Annual Survey, Fiscal Year 2023, Table 19: Total Number of Home Health Visits by Jurisdiction of Residence, Payment Source and Geographic Region. Jurisdiction-specific data was used for each Batch 2 service area (Baltimore City, Baltimore County, and Howard County). The payor mix is applied consistently across all projection years for each jurisdiction.

Seven payor categories are modeled: Medicare Traditional, Medicare Advantage, Medicaid Traditional, Medicaid Managed Care, Commercial Insurance, Self-Pay, and Other (which combines Other Government and Other from the MHCC survey). The resulting visit distributions by payor and jurisdiction are shown in detail on Table 4.

Adjustment: Where the raw MHCC survey percentages for Medicaid Traditional or Medicaid Managed Care fell below 2.0%, they were adjusted upward to a 2.0% floor to reflect anticipated market positioning and community need focus. This adjustment applied to Medicaid Traditional for Baltimore County (raw 1.4%) and Howard County (raw 1.4%), and to Medicaid Managed Care for Howard County (raw 0.9%). Baltimore City percentages were used as reported, as both Medicaid categories already exceeded the floor. The offsetting reductions were applied to the Commercial Insurance category in each affected jurisdiction.

2. Medicare Reimbursement

Medicare reimbursement is calculated using CMS CY 2026 Home Health Prospective Payment System (HH PPS) rates (see following pages for support) with jurisdiction-specific wage index adjustments.

Key Assumptions:

Assumption	Value	Source / Rationale
Average Case-Mix Weight	1.0	Conservative assumption; no acuity adjustment applied
Avg Visits per 30-Day Period	7.41	Based on analysis of comparable HHA Medicare Cost Report data
LUPA Visits Threshold	4	CMS CY 2026 HH PPS Final Rule
LUPA Visits per Period	3	Conservative estimate for LUPA periods
LUPA Percentage	10%	Industry benchmark; ~10% of periods fall below threshold
Inflation Adjustment		None Per MHCC requirements; projections in current dollars

30-Day Period Payment Rates by Jurisdiction:

Jurisdiction	Wage Index	CY 2026 Base Payment	Source
Baltimore City	0.9508	$1,963.11	CMS HH PPS Wage Index File; CBSA 12580
Baltimore County	0.9508	$1,963.11	CMS HH PPS Wage Index File; CBSA 12580
Howard	0.9508	$1,963.11	CMS HH PPS Wage Index File; CBSA 12580

Note: All three Batch 2 jurisdictions fall within the same CBSA (12580, Baltimore-Columbia-Towson, MD), resulting in identical wage-adjusted rates across jurisdictions.

Rate Calculation Methodology:

The CY 2026 30-day period payment is calculated using the CMS Home Health PPS wage-adjusted methodology:

Step	Calculation	Example (Baltimore City)
1	National Base Rate × Case-Mix Weight	$2,038.22 × 1.0 = $2,038.22
2	Labor Portion = Step 1 × 74.9%	$2,038.22 × 0.749 = $1,526.63
3	Wage-Adj Labor = Step 2 × Wage Index	$1,526.63 × 0.9508 = $1,451.52
4	Non-Labor Portion = Step 1 × 25.1%	$2,038.22 × 0.251 = $511.59
5	Final Payment = Step 3 + Step 4	$1,451.52 + $511.59 = $1,963.11

Key Parameters:

- National Base Rate: $2,038.22
- Labor Share: 74.9%
- Non-Labor Share: 25.1%

Source: CMS-1828-F, Federal Register Vol. 90, No. 229, December 2, 2025.

3. Lupa & Non-Medicare Per-Visit Rates

LUPA per-visit rates are derived from CMS Table 16 and adjusted for the wage index. These rates are also used for Medicare Advantage, Insurance, Self-Pay, and Other.

LUPA Per-Visit Rates by Jurisdiction:

Discipline	Baltimore City	Baltimore County	Howard
Skilled Nursing	$170.44	$170.44	$170.44
Home Health Aide	$77.17	$77.17	$77.17
Physical Therapy	$186.29	$186.29	$186.29
Occupational Therapy	$187.56	$187.56	$187.56
Speech Therapy	$202.50	$202.50	$202.50
Medical Social Services	$273.19	$273.19	$273.19

Source: CMS Table 16 - Per-Visit Rates, wage-adjusted using the same methodology as 30-day rates above.

4. Medicaid Reimbursement

Medicaid per-visit rates are based on Maryland Medicaid fee schedules effective January 1, 2025 (see following pages for support), which vary by county.

Medicaid Per-Visit Rates by Jurisdiction:

Discipline	Baltimore City	Baltimore County	Howard
Skilled Nursing	$155.27	$155.27	$155.27
Home Health Aide	$75.32	$75.32	$75.32
Physical Therapy	$167.89	$167.89	$167.89
Occupational Therapy	$171.51	$171.51	$171.51
Speech Therapy	$168.59	$168.59	$168.59
Medical Social Services	N/A	N/A	N/A

Note: Medicaid Managed Care (MCO) visits are reimbursed at the same rates as Traditional Medicaid.

5. Visit Distribution By Discipline

Visits are distributed by discipline based on the utilization methodology detailed in Step 8, Table P of the Forecast Utilization section (COMAR 10.24.01.08G(3)(b), "Need" Review Criterion). The discipline mix reflects typical home health agency service patterns with Skilled Nursing and Physical Therapy comprising the majority of visits:

Representative Discipline Mix:

Discipline	% of Total Visits
Skilled Nursing	39.2%
Home Health Aide	4.2%
Physical Therapy	40.2%
Occupational Therapy	13.3%
Speech Therapy	2.5%
Medical Social Services	0.6%

This discipline distribution is applied consistently across all payer categories within each jurisdiction.

6. Revenue Deductions

Revenue deductions from Gross Patient Service Revenue are calculated as follows:

Deduction	% of Gross Revenue	Basis
Bad Debt Allowance	2.5%	% of Gross Revenue; conservative estimate based on industry experience and analysis of Medicare Cost Reports
Contractual Allowance	10.0%	% of Gross Revenue; conservative estimate based on analysis of Medicare Cost Reports
Charity Care	0.5%	% of Net Revenue. Equivalent to existing agencies in the area per COMAR Section .08E

Note: Some home health agencies set Gross Revenue equal to Net Revenue with minimal contractual allowances. The conservative deductions shown reflect anticipated collection experience while ensuring compliance with charity care obligations equivalent to existing providers in the service area.

7. Revenue Summary By Year

Metric	Year 1 (2028)	Year 2 (2029)	Year 3 (2030)	Year 4 (2031)
Total Patients	11	52	124	189
Total Billable Visits	174	824	1,966	2,996
Total Visits	179	848	2,022	3,082
Gross Revenue	$42,911	$209,545	$497,501	$760,482
Net Patient Revenue	$37,333	$182,305	$432,826	$661,619

Revenue projections represent a ramp-up from initial operations (Year 1) to full utilization (Year 4), with visits and patients increasing proportionally across all four service jurisdictions.

Proposed Expense Assumptions (Table 4)

Because Batch 1 has already been filed and is treated as approved, Batch 2 expenses are projected as truly incremental costs — reflecting only the additional resources required to serve the new jurisdictions. The methodology for each expense category is summarized below, with detailed line-item descriptions provided in Sections 2 and 3.

1. Incremental Expense Methodology

Staffing & Compensation: Salaries are derived from a detailed staffing model (Table 5). Clinical FTEs are calculated using statewide visits-per-FTE productivity benchmarks from the MHCC HHA Annual Survey (FY2023, Tables 9 & 11), and administrative positions reflect only the incremental headcount required above what Batch 1 already filed. Fringe benefits are calculated as a percentage of salaries based on Medicare Cost Report data from comparable agencies. Payroll taxes are applied at statutory rates, and payroll processing fees are based on FHC's actual 2024 cost as a percentage of salaries.

Per-Visit Costs: Medical supplies and auto/travel expenses are projected on a per-visit basis using benchmarks derived from Medicare Cost Reports of comparable Maryland home health agencies, applied to Batch 2's projected visit volume each year.

Per-Client and Per-FTE Shared Costs: For overhead line items that scale with volume — marketing, information technology, insurance, telecommunications, professional fees, and training — the per-unit cost implied by Batch 1's CY2030 projection (the first year at full scale, 418 clients / 11.14 FTEs) is used as the cost benchmark. Each item's Batch 1 CY2030 expense is divided by the applicable denominator to derive a per-client or per-FTE unit cost, which is then multiplied by Batch 2's projected client count (or FTEs for training) in each year.

Percentage-of-Revenue Costs: Other indirect operating expenses are projected as a percentage of Batch 2 net revenue, based on FHC's actual operating experience.

Fixed/Project Costs: Project depreciation reflects the straight-line depreciation of Batch 2-specific FF&E over a 7-year useful life.

Zero Incremental Cost Items: Several Table 4 line items carry no incremental cost for Batch 2, as they are fully covered by Batch 1's filed projections: Interest on Current Debt, Interest on Project Debt, Current Depreciation/Amortization, Rent, Utilities, Repairs & Maintenance, and Taxes (Non-Income). No new debt, lease, or facility costs are required for the Batch 2 jurisdictions.

2. Salaries and Wages, And Professional Fees (Including Fringe Benefits)

- **Salaries:** Based on the detailed staffing model presented in Table 5 - Staffing. Clinical FTEs are derived from the Maryland Statewide Productivity Model (MHCC HHA Annual Survey FY2023, Tables 9 & 11), which divides projected Batch 2 visits by statewide visits-per-FTE benchmarks: Skilled Nursing (923), Physical Therapy (1,156), Occupational Therapy (1,198), Speech-Language Pathology (973), Medical Social Work (352), and Home Health Aide (773). A PTO adjustment of 6.1% is applied (120 PTO hours ÷ 1,960 annual work hours). Administrative staffing reflects only the incremental FTEs required beyond those already filed by Batch 1 — e.g., an additional 0.25 FTE for intake coordination, DON oversight, and QAPI as Batch 2 volume grows. The RN/LPN breakdown within Skilled Nursing uses proportional FTE distributions based on Medicare Cost Reports for comparable agencies. Note: In CY2029, the blended average salary for incremental staff appears low (~$50,000) because the only non-Nursing Supervisor administrative position added that year is the Bookkeeper at $50,000. This is arithmetically correct given the limited incremental headcount at that stage of the ramp-up; by CY2030, the blended average normalizes as additional clinical and administrative positions are added.
- **Fringe Benefits:** Calculated at 15% of salaries, based on analysis of Medicare Cost Report data from comparable home health agencies. Benefits include health insurance, retirement contributions, paid time off, and other standard employee benefits.
- **Professional Fees**: Batch 1 CY2030 cost of $43,064 ÷ 418 clients = $103.02 per client × Batch 2 clients per year. Covers Medical Director compensation, compliance consulting, and other professional services. This is included with Salaries and Wages on Table 4

3. All Other Expenses

The following Table 4 line items carry zero incremental cost for Batch 2, as they are fully covered by Batch 1's filed projections: Interest on Current Debt, Interest on Project Debt (none — funded from cash reserves), Current Depreciation/Amortization, Rent, Utilities, Repairs & Maintenance, and Taxes (Non-Income). No new debt, lease, or facility costs are required for the Batch 2 jurisdictions.

- **Contractual Services**: No incremental contractual clinical services are projected. All patient care will be provided by employed staff.
- **Project Depreciation**: Based on $20,000 of FF&E for the Batch 2 office setup with a 7-year useful life. Annual straight-line depreciation of $2,857. No project amortization is applicable.
- **Medical Supplies**: $4.49 per visit based on the average of Medicare Cost Report data from comparable Maryland HHAs (Amedisys 2024: $5.48; Interim Healthcare 2024: $3.36; Chesapeake Home Health 2023: $4.62). Applied to Batch 2 projected visits each year.
- **Payroll Taxes**: 7.65% of Batch 2 incremental salaries (6.2% Social Security + 1.45% Medicare).
- **Auto/Trave**l: $5.78 per visit based on Medicare Cost Report data (Chesapeake Home Health 2023: $5.61; Amedisys 2024: $3.43 — highest selected and inflated 3% for FY2023 data).

Accounts for geographic spread across three Batch 2 jurisdictions (Baltimore City, Baltimore County, and Howard County). No annual inflation applied through the projection years.

- **Marketing**: Batch 1 CY2030 cost of $5,346 ÷ 418 clients = $12.79 per client × Batch 2 clients per year. Supports referral development and community outreach in Baltimore City, Baltimore County, and Howard County.
- **Information Technology**: Batch 1 CY2030 cost of $50,686 ÷ 418 clients = $121.26 per client × Batch 2 clients per year. Covers EMR/clinical software, point-of-care documentation, and OASIS assessment tools.
- **Training**: Batch 1 CY2030 cost of $4,920 ÷ 11.14 FTEs = $441.65 per FTE × Batch 2 incremental FTEs (admin + clinical) per year. Supports OASIS training, clinical competency, and Medicare compliance education.
- **Insurance:** Batch 1 CY2030 cost of $61,883 ÷ 418 clients = $148.05 per client × Batch 2 clients per year. Covers professional liability/malpractice for skilled nursing and therapy services.
- **Telecommunication**s: Batch 1 CY2030 cost of $9,304 ÷ 418 clients = $22.26 per client × Batch 2 clients per year. Covers phone lines and mobile devices for field staff.
- **Payroll Processing**: 0.55% of Batch 2 incremental salaries, based on FHC's 2024 actual rate.
- **Other Indirect Expenses**: 1.97% of Batch 2 net revenue, based on FHC's 2024 actual rate. Includes office supplies, postage, printing, bank fees, and other general operating costs.

4. Expense Summary By Year

Metric	Year 1 (2027)	Year 2 (2028)	Year 3 (2029)	Year 4 (2030)
Total Visits	179	848	2,022	3,082
Total Operating Expenses	$27,555	$157,336	$397,670	$578,817
Cost per Visit	$153.60	$185.53	$196.65	$187.79
Net Revenue	$37,333	$182,305	$432,826	$661,619
Operating Margin	$9,778	$24,969	$35,156	$82,803

Expense projections show cost per visit rising from $153.60 in Year 1 to $196.65 in Year 3 as fixed overhead is added ahead of volume, then moderating to $187.79 in Year 4 as scale benefits take hold. The agency achieves positive operating margins in all projection years, with the operating margin growing from $9,778 in Year 1 to $82,803 in Year 4.

EXHIBITS

The following pages include all supporting documentation as referenced in the Application. For ease of use, Exhibits are independently page numbered beginning at 201.

Exhibit 1

STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

7120 SAMUEL MORSE DRIVE
SECOND FLOOR
COLUMBIA, MARYLAND 21046-3422

License No: R5352

Issued to: First Healthcare Consultants LTD
d/b/a Abidaref Regal Healthcare Solutions
12906 North Point Lane
Laurel, MD 20708

Type of Agency: **RESIDENTIAL SERVICE AGENCY**

Date Issued: January 4, 2023

Service(s) Provided: Skilled Nursing, Physical Therapy, Speech Therapy, Occupational Therapy, and Medical Social Services

Population: Adults and Pediatrics

Other: N/A

Authority to operate in this State is granted to the above entity pursuant to the Health-General Article, Section 19-4A et Seq., Annotated Code of Maryland and is subject to any and all statutory provisions including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration: NON-EXPIRING

Patricia Tomaka May MD

Executive Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality
55 Wade Avenue - Bland Bryant Building
Catonsville, MD 21228
410.402.8040

October 15, 2018

Abisola Raimi-Abayomi, Administrator
First Healthcare Consultants LTD
14000 Jericho Park Drive
Suite 2304
Bowie, MD 20715

RE: NOTICE OF COMPLIANCE WITH HEALTH COMPONENT REQUIREMENTS

Dear Mrs. Raimi-Abayomi:

We have reviewed and accepted the Plan of Correction received on October 5, 2018, as result of an initial survey conducted at your agency on August 9, 2018.

This survey found that your agency is in compliance with the health requirements for COMAR10.07.05 for a **Level Three: Complex Care Provided by RN/LPN and RN Supervision of Aides** Residential Service Agency (RSA). First Healthcare Consultants LTD will be issued the balance of the RSA license.

If you have any questions, please call me at (410) 402-8039.

Sincerely,

Michel Briggs

Michel Briggs, Program Coordinator
Ambulatory Care
Office of Health Care Quality

cc: Dawn Williams
Warren Sraver
File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RS4257	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST HEALTHCARE CONSULTANTS LTD	14000 JERICO PARK DRIVE SUITE 2304 BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Based upon an approved application for a Level Three: Skilled Nursing and Aides; Level of Care: Complex Care provided by Registered Nurses (RN)/Licensed Practical Nurses and RN supervision of Aides, an initial survey was conducted at First Healthcare Consultants LTD, on 08/09/18. The approved application included the agency's policy and procedure manual and submission of a signed affidavit affirming compliance with Code of Maryland Regulations (COMAR), 10.07.05. The survey included a tour of the agency's office, the review of personnel files, the review of patient records, the review of the complaint/incident process, the review of selected policies and procedures and interviews with the Governing Body (GB). A demonstration of complex care (wound dressing) was observed to evaluate the agency's Registered Nurse (RN) skills. The GB was kept informed of the findings as the survey progressed and was given the opportunity to present information relative to the findings during the course of the survey. The administrator was given the DHMH Financial Issue Form and information on how to complete the survey questionnaire using survey monkey. The financial issue form was completed and returned to this surveyor at the exit conference. An exit conference was conducted with the agency's administrator (AD) on 8/09/18. The survey findings were reviewed. The agency's level three license will be approved after an acceptable plan of correction has been received.	A 000	RECEIVED MARYLAND DEPT. OF HEALTH OCT - 5 2018 OFFICE OF HEALTH CARE QUALITY	

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Director of Nursing/CEO 9/30/18

STATE FORM 6599 11VG11 If continuation sheet 1 of 5

Office of Health Care Quality

PRINTED: 09/10/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RS4257	A. BUILDING _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST HEALTHCARE CONSULTANTS LTD	14000 JERICO PARK DRIVE SUITE 2304 BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Continued From page 1 The AD was directed to submit a written plan of correction within ten calendar days of receipt of the deficiency statement. The agency staff was informed that failure to submit an acceptable plan of correction could lead to the denial of licensure approval.	A 000		
A1000	.08 (B) (1) (e) .08 Administration. (e) Environment and safety, including: (i) Preparation and storage of enteral formulas, intravenous therapies, other supplies, equipment, and similar items; (ii) Infection control procedures; (iii) Disposal of biomedical waste; (iv) Maintenance of equipment; and (v) Emergency procedures. This Regulation is not met as evidenced by: Based upon direct observation, the agency's skilled nurse failed to practice infection control prevention strategies during a complex care procedure. Failure to ensure use of infection control measures placed agency patients at risk for not receiving safe quality healthcare. Findings included: Standard precautions are the most basic level of infection control and prevention that should be used at all times when providing patient care at any level. The elements of standard precautions includes hand hygiene, use of gloves, barriers (such as eye protection, face shields, gowns and a non- permeable barrier between surface and	A1000	1. Infection Control - a. Infection control training conducted and all staff re-educated on infection control process. Always use a protective barrier. b. Date 0of corrective action: 8/11/018 c. Director of Nursing 8/11/2018 d. Every employee, both current and new will have to go through an infection control training as part of the new employee orientation. With emphasis on the use of a protective barrier.	8/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RS4257	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST HEALTHCARE CONSULTANTS LTD	14000 JERICO PARK DRIVE SUITE 2304 BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1000	Continued From page 2 bags) and proper gathering and preparation of patient care equipment and linen. Standard infection control should be applied whenever providing care to protect the patient and caregiver against the spread of germs. During the procedure of cleaning a wound the registered nurse failed to apply any non-permeable barrier(If a membrane is non-permeable, it is respective of the chemical composition of the membrane itself and/or the mechanism of transfer. In other words, it is a barrier for which an object has no means of crossing,except with the aid of a transport mechanism) between the table and the nursing bag of supplies On 8/09/18, during an interview with the governing authority, the importance of practicing good infection control techniques were discussed.	A1000		
A1360	.12 (B)(1) .12 Services Provided B. Provision of Services. (1) A registered nurse shall assess each new client who requires skilled services and assistance with the activities of daily living. This Regulation is not met as evidenced by: Based on the review of patient records and interview with the agency's governing authority (GA), the registered nurse (RN) failed to develop a complete, initial comprehensive assessment (CA) of newly admitted patients. Findings included:	A1360	2. The initial assessment at time of survey was done on form 485 and the forms per approved policy. a. All patient assessments form documentation process has been changed to the approved form only. All staff in-serviced. b. In-service conducted on 8/11/2018. 8/11/18 c. Director of nursing and every RN. d. Chart review process to be implemented as part of the QI process	

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RS4257	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST HEALTHCARE CONSULTANTS LTD	14000 JERICO PARK DRIVE SUITE 2304 BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1360	Continued From page 3 Nursing assessment is the gathering of information about a patient's physiological, psychological, sociological, and spiritual status by a licensed RN. Nursing assessment is the first step in the nursing process. Nursing assessment is used to identify current and future patient care needs. It incorporates the recognition of normal versus abnormal body physiology. Prompt recognition of pertinent changes along with the skill of critical thinking allows the nurse to identify and prioritize appropriate interventions. To obtain a baseline of the patient's health status and to ensure safe, quality patient care, every newly admitted patient has to have a CA by the agency's RN. Patients' admitted to the agency for personal care services and complex care had no evidence that the agency's RN had completed a CA (no complete medication profile or past medical diagnosis). On interview, 8/09/18, the GA was unable to provide additional documentation.	A1360	3. One patient chart had discontinued medications listed. a. Staff in-serviced on data gathering and to always ask the patient what medications they are currently taking. Follow up with a phone call to the patient's PCP to verify. b. Date of corrective action: 8/11/2018. 8/11/18 c. Director of Nursing and all RN d. Chart review process to be implemented as part of the QI process.	
A1370	.12 (B)(2)(a) .12 Services Provided. (2) The registered nurse shall also: (a) Participate in developing the client's plan of care and in assigning appropriate personnel; This Regulation is not met as evidenced by: Based on review of patient records and interview with agency staff, there was no evidence that the agency's registered nurse (RN) developed patient care plans (PCP) for the aides prior to providing patient care for patients reviewed. Failure to develop written PCP's placed the patients at risk	A1370	4. Staff in-serviced on data gathering and care plan development for all patients even when there is only a skilled services provider to ensure continuity of care. a. Date of corrective action: 8/11/2018. 8/11/18 b. Director of Nursing and all RN. c. Chart review process to be implemented aspart of the QI proecess	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RS4257	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST HEALTHCARE CONSULTANTS LTD	14000 JERICO PARK DRIVE SUITE 2304 BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1370	Continued From page 4 for receiving inadequate care. Findings included: It is the responsibility of the agency's RN to assess each patient and to develop an individualized PCP, which contains the nursing assistant's/aide's work assignment (personal care tasks: bathing, feeding, dressing the patient, medication reminders, and assisting with ambulation/transfer) and other specific information of the patient's condition to ensure safe patient care. The written PCP has to be completed before the assistants/aides provide patient care and has to be available for the staff at the patient's home. Review, on 8/09/18, of patient records found the there was no evidence that a written PCP had been developed by the agency's RN. On interview, on 8/09/18, the Governing Authority was unable to provide additional documentation.	A1370		

CHAP Community Health Accreditation Partner

Certificate of Accreditation

This is to certify that the following organization has met the requirements of the Community Health Accreditation Partner (CHAP) Standards of Excellence, and demonstrated a commitment to providing quality patient care and services.

First Healthcare Consultants Ltd
DBA: Abidaref Regal Healthcare Solution

Laurel, MD

is therefore granted accreditation for the following:

Home Care

Effective: November 29, 2022

Expiration: November 29, 2025

Nathan J. DeGodt
President and CEO, CHAP

COMMUNITY HEALTH ACCREDITATION PARTNER
CHAP
EST. 1965
SEAL OF ACCREDITATION

Cordt Kassner
Chair, CHAP Board of Directors

CHAP is an independent, nonprofit accrediting body for organizations providing home and community-based health care services in accordance with nationally recognized CHAP Standards of Excellence. Additional information regarding CHAP Accreditation and a listing of individual accredited organizations can be obtained by visiting www.CHAPinc.org.

Customer ID: 3006139

23

Exhibit 2

CORPORATE CHARTER APPROVAL SHEET

**** EXPEDITED SERVICE**** **** KEEP WITH DOCUMENT ****

DOCUMENT CODE 02 BUSINESS CODE 03

_____

Close _____ Stock / Nonstock _____

P.A. _____ Religious _____

Merging (Transferor) _____

1000362004075166

ID # D14954200 ACK # 1000362004075166
PAGES: 0002
FIRST HEALTHCARE CONSULTANTS LTD

11/26/2012 AT 03:36 P WO # 0004054791

Surviving (Transferee) _____

New Name _____

FEES REMITTED

	Base Fee:	100
	Org. & Cap. Fee:	20
	Expedite Fee:	~~50~~ 70
	Penalty:	
	State Recordation Tax:	
	State Transfer Tax:	
1	Certified Copies	2.1
	Copy Fee:	
	Certificates	
	Certificate of Status Fee:	
	Personal Property Filings:	
	Mail Processing Fee:	
	Other:	
	TOTAL FEES:	~~210~~ 211

Credit Card _____ Check / Cash ~~X~~

_____ Documents on _____ Checks

Approved By: JB 11/26/13

Keyed By: JB

COMMENT(S): Walk-IN

_____ Change of Name
_____ Change of Principal Office
_____ Change of Resident Agent
_____ Change of Resident Agent Address
_____ Resignation of Resident Agent
_____ Designation of Resident Agent and Resident Agent's Address
_____ Change of Business Code
_____ Adoption of Assumed Name
_____ Other Change(s)

Code _____

Attention: Abisola Laimo - Abayomi

X Mail: Name and Address
12620 Bear Creek Terrace,
Beltsville MD 20705

Stamp Work Order and Customer Number HERE

CUST ID:0002838211
WORK ORDER:0004054791
DATE:11-26-2012 03:36 PM
AMT. PAID:$211.00

ARTICLES OF INCORPORATION FOR A STOCK CORPORATION

FIRST: The undersigned Abisola Raimi-Abayomi and Christina Oliyide

whose address is 12906 North Point Lane Laurel MD/ 12620 Bear Creek Terrace B **, being at least eighteen years of age, do(es) hereby form a corporation under the laws of the State of Maryland.**

SECOND: The name of the corporation is
First Healthcare Consultants Ltd

THIRD: The purposes for which the corporation is formed are as follows:
Provider of Health care quality, risk management, health and safety services and training. Health education and corporate wellness services and programs. Procurement and contracting for medical equipments and Services for health care and health management. General healthcare training and nursing education.

FOURTH: The street address of the principal office of the corporation in Maryland is
12620 Bear Creek Terrace, Beltsville. MD. 20705

FIFTH: The name of the resident agent of the corporation in Maryland is
Abisola Raimi-Abayomi

whose address is 12906 North Point Lane, Laurel, MD. 20708

SIXTH: The corporation has authority to issue 100,000 **shares at $** 1.00 **par value per share.**

SEVENTH: The number of directors of the corporation shall be 2 **which number may be increased or decreased pursuant to the bylaws of the corporation. The name(s) of the director(s) who shall act until the first meeting or until their successors are duly chosen and qualified is/are** ~~Abisola Raimi-Abayomi~~
Christina Oliyide

IN WITNESS WHEREOF, I have signed these articles and acknowledge the same to be my act.

SIGNATURE(S) OF INCORPORATOR(S):

I hereby consent to my designation in this document as resident agent for this corporation.

SIGNATURE OF RESIDENT AGENT LISTED IN FIFTH:

Filing Party's Name and Return Address:

CUST ID:0002838211
WORK ORDER:0004054791
DATE:11-26-2012 03:36 PM
AMT. PAID:$211.00

Exhibit 3

First Healthcare Consultants HHA Staffing Structure

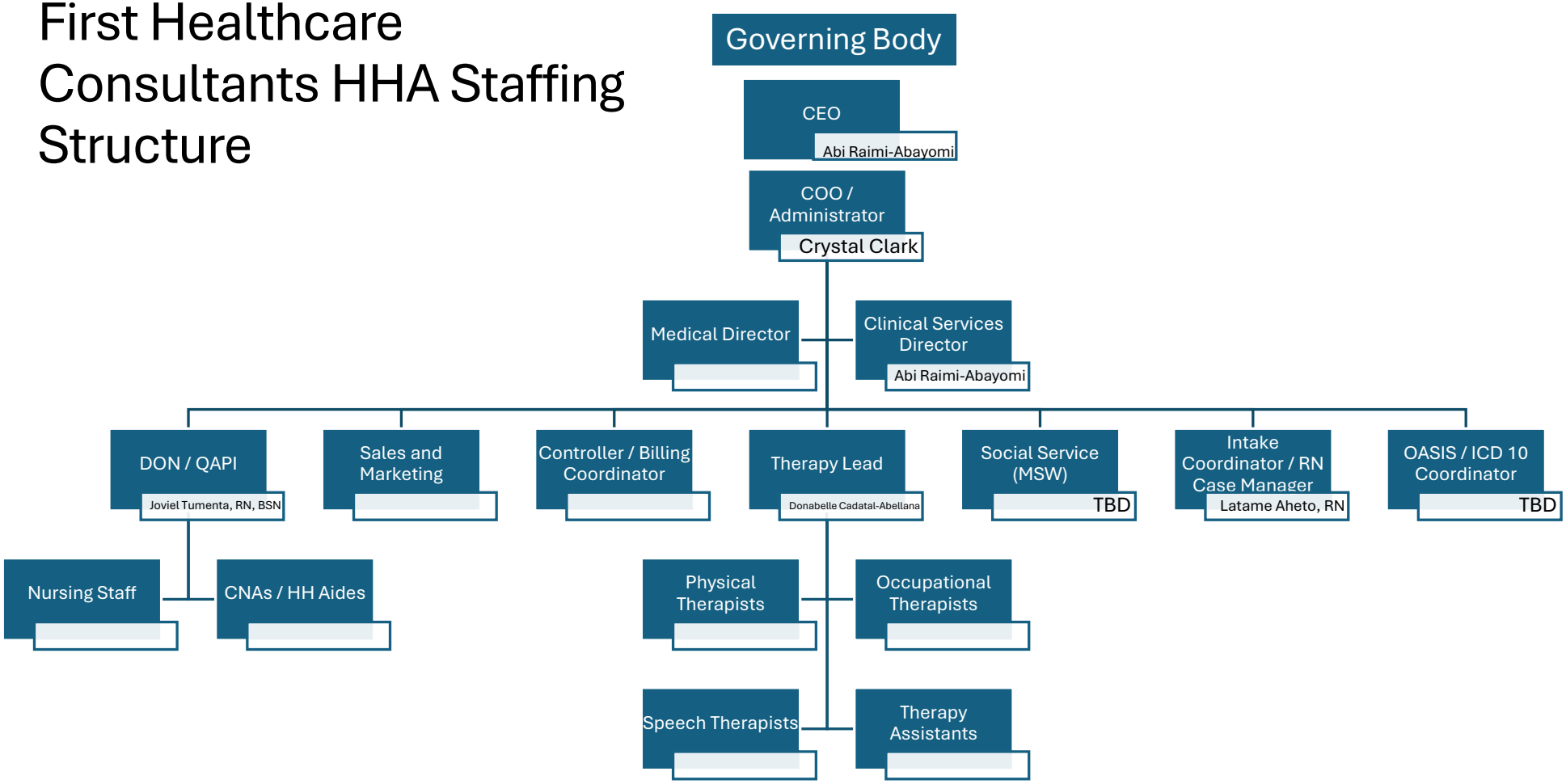


Exhibit 4

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Hospitals					
Spring Grove Hospital Center	Wade Avenue Cantonsville	x			
The Sheppard and Enoch Pratt Hospital	6501 North Charles Street Baltimore	x			
Levindale Hebrew Geriatric Center And Hospital	2434 West Belvedere Avenue Baltimore	x			
Greater Baltimore Medical Center	6701 North Charles Street Baltimore	x			x
Medstar Franklin Square Medical Center	9000 Franklin Square Drive Baltimore	x			x
Northwest Hospital Center	5401 Old Court Road Randallstown	x			
University Of Maryland St Joseph Medical Center	7601 Osler Drive Towson	x			
Bon Secours Hospital	2000 West Baltimore Street Baltimore		x		x
University of MD Rehabilitation & Orthopaedic Institute	2200 Kernan Drive Baltimore		x		
Johns Hopkins Bayview Medical Center	4940 Eastern Avenue Baltimore		x		x
Johns Hopkins Hospital, The	600 North Wolfe Street Baltimore		x		x
University of MD Medical Center Midtown Campus	827 Linden Avenue Baltimore		x		x
Medstar Good Samaritan Hospital	5601 Loch Raven Boulevard Baltimore		x		x
Medstar Harbor Hospital	3001 South Hanover Street Baltimore		x		x
Medstar Union Memorial Hospital	201 East University Parkway Baltimore		x		
Mercy Medical Center Inc	301 Saint Paul Place Baltimore		x		x
Saint Agnes Hospital	900 Caton Avenue Baltimore		x		
Sinai Hospital Of Baltimore	2401 West Belvedere Avenue Baltimore				
University Of Maryland Medical Center	22 South Greene Street Baltimore		x		x
Kennedy Krieger Institute	707 North Broadway Baltimore		x		
Mount Washington Pediatric Hospital	1708 West Rogers Avenue Baltimore		x		
Howard County General Hospital	5755 Cedar Lane Columbia			x	x
Clifton T Perkins Hospital Center	8450 Dorsey Run Road Jessup			x	
Local Departments of Social Services					
Baltimore City Health Department	City Hall Room 250 100 N Holliday St Baltimore		x		
Baltimore County Department of Health	6401 York road Baltimore	x			
Howard County Health Department	8930 Stanford Blvd Columbia			x	
Adult Day Care Programs					
Alice Manor Adult Day Care		x			
Active Day of Baltimore			x		
Active Day of Arbutus		x			
Active Day of Parkville		x			
Active Day of Randallstown		x			
Caring Hands Adult Medical Day Care of Dundalk		x			
Dar's Place Adult Day Center		x			
Easter Seals Adult Day Care		x			
Friends and Family Adult Day Program		x			
Mosaic		x			
Pikesville Adult Day Services		x			
Stella Maris Adult Day Center		x			
Action in Maturity	2601 N Howard Street Baltimore		x		
Cherry Hill Senior Center	3301 Waterview Avenue Baltimore		x		
Forest Park Senior Center	4801 Liberty Heights Avenue Baltimore		x		
Harford Senior Center	4920 Harford Road Baltimore		x		
Hatton Senior Center	2825 Fait Avenue Baltimore		x		
Greenmount Senior Center	425 E Federal Street Baltimore		x		
Edward A Myerberg Senior Center	3101 Fallstaff Road Baltimore		x		
Oliver Senior Center	1700 N Gay Street Baltimore		x		
Sandtown Winchester Senior Center	1601 Baker Street Baltimore		x		
Senior Network of North Baltimore	5828 York Road Baltimore		x		
Waxter Center for Seniors	1000 Cathedral Street Baltimore		x		
Zeta Center for Healthy and Active Aging	4501 Reisterstown Road Baltimore		x		
Hospice Programs					
Seasons Hospice & Palliative Care	5457 Twin Knolls Road, Suite 100 Columbia				
Joseph Richey Hospice	828 North Eutaw Street Baltimore		x		
Professional Healthcare Resources Of Baltimore	1501 South Edgewood Street, Suite A Baltimore		x		

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Amedisys Hospice Of Greater Chesapeake	7106 Ridge Road, Suite 140 Rosedale	x			
Gilchrist Hospice Care - Joseph Richey House	11311 Mccormick Road, Suite 350 Hunt Valley	x			
Heartland Hospice Services	4 East Rollng Crossroads, Suite 307 Baltimore	x			
Stella Maris Inc Hospice Care	2300 Dulaney Valley Road Timonium	x			
Nursing Homes (SNF)					
Greater Baltimore Medical Center Sub Acute Unit	6701 North Charles Street Baltimore	x			
Manorcare Health Services - Roland Park	4669 Falls Road Baltimore	x			
Oak Crest Village	8800 Walther Boulevard Parkville	x			
Augsburg Lutheran Home	6811 Campfield Road Baltimore	x			
Broadmead, Inc	13801 York Road Cockeysville	x			
Catonsville Commons	16 Fusting Avenue Catonsville	x			
Charlestown Community, Inc	709 Maiden Choice Lane Catonsville	x			
Chestnut Green Health Center Blakehurst	1055 West Joppa Road Towson	x			
Courtland, LLC	7920 Scotts Level Road Baltimore	x			
Cromwell Center	8710 Emge Road Baltimore	x			
Edenwald	800 Southerly Road Towson	x			
Brinton Woods Health & Rehab Center of Pikesville	7 Sudbrook Lane Pikesville	x			
Forest Haven Nursing Home	701 Edmondson Avenue Catonsville	x			
Franklin Woods Center	9200 Franklin Square Drive Baltimore	x			
Frederick Villa Nursing & Rehab Center	711 Academy Road Catonsville	x			
Future Care Cherrywood	12020 Reisterstown Road Reisterstown	x		x	
Future Care Northpoint	1046 North Point Road Baltimore	x			
Future Care Old Court	5412 Old Court Road Randallstown	x			
Glen Meadows Retirement Community	11630 Glen Arm Road Glen Arm	x			
Heritage Center	7232 German Hill Road Dundalk	x			
Holly Hill Nursing And Rehabilitation Center	531 Stevenson Lane Towson	x			
Little Sisters of The Poor	601 Maiden Choice Lane Baltimore	x			
Loch Raven Center	8720 Emge Road Baltimore	x			
Lorien Mays Chapel	12230 Round Wood Road Timonium	x			
Manorcare Health Services - Dulaney	111 West Road Towson	x			
Manorcare Health Services - Rossville	6600 Ridge Road Baltimore	x			
Manorcare Health Services - Ruxton	7001 Charles Street Towson	x			
Manorcare Health Services - Woodbridge Valley	1525 North Rolling Road Catonsville	x			
Manorcare Health Services -Towson	509 East Joppa Road Towson	x			
Maria Health Care Center, Inc.	6401 North Charles Street Baltimore	x			
Maryland Masonic Homes	300 International Circle Cockeysville	x			
Mid-Atlantic of Chapel Hill, LLC	4511 Robosson Road Randallstown	x			
King David Nursing and Rehabilitation Center	4204 Old Milford Mill Road Baltimore	x			
Multi-Medical Center	7700 York Road Towson	x			
North Oaks	725 Mount Wilson Lane Baltimore	x			
Northwest Hospital Center	5401 Old Court Road Randallstown	x			
Oakwood Care Center	1300 Windlass Drive Baltimore	x			
Patapsco Valley Center	9109 Liberty Road Randallstown	x			
Perring Parkway Center	1801 Wentworth Road Baltimore	x			
Pickersgill Retirement Community	615 Chestnut Avenue Towson	x			
Powerback Rehabilitation	515 Brightfield Road Lutherville	x			
Ridgeway Manor Nursing & Rehabilitation Center	5743 Edmondson Avenue Catonsville	x			
Riverview Rehabilitation & Health Center	1 Eastern Boulevard Baltimore	x			
St. Joseph's Nursing Home	1222 Tugwell Drive Catonsville	x			
Stella Maris, Inc.	2300 Dulaney Valley Road Timonium	x			
Summit Park Health And Rehabilitation Center	1502 Frederick Road Catonsville	x			
Autumn Lake Healthcare at Alice Manor	2095 Rockrose Avenue Baltimore		x		
Blue Point Nursing & Rehab Center	2525 West Belvedere Baltimore		x		
Bridgepark Healthcare Center	4017 Liberty Heights Avenue Baltimore		x		

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Brinton Woods Health & Rehab Center at Arlington West	3939 Penhurst Avenue Baltimore		x		
Caton Manor	3330 Wilkens Avenue Baltimore		x		
Fayette Health And Rehabilitation Center	1217 West Fayette Street Baltimore		x		
Future Care Canton Harbor	1300 South Ellwood Avenue Baltimore		x		
Future Care Charles Village, LLC	2327 North Charles Street Baltimore		x		
Future Care Cold Spring	4700 Harford Road Baltimore		x		
Future Care Homewood	2700 North Charles Street Baltimore		x		
Future Care Irvington	22 South Athol Avenue Baltimore		x		
Future Care Sandtown-Winchester	1000 North Gilmore Street Baltimore		x		
Good Samaritan Nursing Center Operator, LLC	1601 East Belvedere Avenue Baltimore		x		
Keswick Multi-Care Center	700 West 40Th Street Baltimore		x		
Levindale Hebrew Geriatric Center & Hospital	2434 West Belvedere Avenue Baltimore		x		
Lochearn Nursing Home, LLC	4800 Seton Drive Baltimore		x		
Long Green Center	115 East Melrose Avenue Baltimore		x		
Maryland Baptist Aged Home	2801 Rayner Avenue Baltimore		x		
Northwest Healthcare Center	4601 Pall Mall Road Baltimore		x		
Overlea Health and Rehabilitation Center	6116 Belair Road Baltimore		x		
Roland Park Place	830 West 40Th Street Baltimore		x		
St. Elizabeth Rehabilitation & Nursing Center	3320 Benson Avenue Baltimore		x		
The Nursing and Rehab Center at Stadium Place	1010 East 33rd Street Baltimore		x		
Transitional Care Services at Mercy Medical Center	301 Saint Paul Place Baltimore		x		
Westgate Hills Rehab & Healthcare Center	10 North Rock Glen Road Baltimore		x		
Homewood Center	6000 Bellona Avenue Baltimore		x		
Brinton Woods Post Acute Care Center	5009 Frankfort Avenue Baltimore		x		
Ellicott City Health & Rehabilitation Center	3000 North Ridge Road Ellicott City			x	
Encore at Turf Valley	11150 Resort Road Ellicott City			x	
Lorien Health Systems - Columbia	6334 Cedar Lane Columbia			x	
Lorien Nursing & Rehab Center - Elkridge	7615 Washington Boulevard Elkridge			x	
Vantage House	5400 Vantage Point Road Columbia			x	
The Lutheran Village at Miller's Grant	9000 Fathers Legacy Ellicott City			x	
CCRCs					
Blakehurst	1055 W. Joppa Road Towson	x			
Broadmead	13801 York Road Cockeysville	x			
Edenwald	800 Southerly Road Towson	x			
Charlestown Retirement Center	715 Maiden Choice Lane Catonsville		x		
Fairhaven	7200 Third Avenue Sykesville			x	
Glen Meadows Retirement Community	11630 Glen Arm Road Glen Arm	x			
Luthern Village at Miller's Grant	9000 Fathers Legacy Ellicott City			x	
Maryland Masonic Homes	300 International Circle Cockeysville	x			
Roland Park Place	830 W. 40th Street Baltimore		x		
North Oaks	725 Mount Wilson Pikesville	x			
The Residences at Vantage Point	5400 Vantage Point Road Columbia			x	
The Village at Augsburg	6811 Campfire Road Baltimore		x		
The Wesley Inc. (under development)	1400 Front Street Lutherville	x			
Assisted Living Facilities					
Brightview Perry Hall	9657 Belair Road Nottingham	x			
Angels Quality Assisted Living & Respite Care	8610 McDaniel Road Rosedale	x			
Blessing Away From Home (A)	5701 Leiden Road Baltimore	x			
New Glenmore	3523 Glenmore Avenue Baltimore	x			
Brightview White Marsh	8100 Rossville Boulevard White Marsh	x			
Sweet P's Joyceful	3603 Rexmere Road Baltimore	x			
T & J Home Health Care Services, Inc.	1223 Cochran Road Baltimore	x			
Golden Jemz Assisted Living	7811 Beverly Avenue Parkville	x			
Serenity Grace Assisted Living	6025 Alta Avenue Baltimore	x			
India & Hearts, LLC	5303 Sipple Avenue Baltimore	x			
Brightview Towson	20 East Burke Avenue Towson	x			

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Villa (The)	6806 Bellona Avenue Baltimore	x			
The Waterfalls of Catonsville, LLC	305 North Rolling Road Catonsville	x			
Rehoboth God Has Made Room Assisted Living	125 Nunnery Lane Catonsville	x			
Charlestown Renaissance Gardens Terrace	721 Maiden Choice Lane Baltimore	x			
Brightview Catonsville	912 South Rolling Road Catonsville	x			
Broadmead, INC	13801 York Road Cockeysville	x			
Greenview Assisted Living, LLC	39 Caraway Road Reisterstown	x			
Gaines Quarters, LLC	125 Cedarmere Road Owings Mills	x			
Berkshire Hills Assisted Living, LLC	8023 McDonogh Road Pikesville	x			
Assurance Care Provider Services, LLC	9100 Meadow Heights Road Randallstown	x			
New Beginning at Branchleigh, LLC	9851 Branchleigh Road Randallstown	x			
A Perfect Fit Assisted Living	9700 Ames Court Randallstown	x			
Smoke Tree House	9105 Allenswood Road Randallstown	x			
Legacy Manor LLC	3806 Collier Road Randallstown	x			
Mohawk Manor 4	4000 Spruce Drive Baltimore	x			
Assured Living, LLC	4201 Towanda Avenue Baltimore	x			
Wylie Assisted Living	3027 Wylie Avenue Baltimore	x			
Queensberry Assisted Living	5028 Queensbury Avenue Baltimore	x			
Newton Manor Assisted Living 2, LLC	5706 Woodcrest Avenue Baltimore	x			
Hamds of Harmony Home Care 2	3018 Rockwood Avenue Baltimore	x			
Mohawk Manor 2	5611 Magnolia Avenue Baltimore	x			
Lily's Quality Care Assisted Living	5329 Hamlin Avenue Baltimore	x			
Rosa's Place Assisted Living	4412 Springdale Avenue Baltimore	x			
Maine Manor, LLC	4511 Maine Avenue Baltimore	x			
Mohawk Manor 3	3602 Mohawk Avenue Baltimore	x			
Taylor Gardens Senior Living	3813 West Coldspring Lane Baltimore	x			
Taylors Assisted Living, LLC	4211 Granada Avenue Baltimore	x			
National Cultural Living, LLC	4205 Penhurst Avenue Baltimore	x			
T & T Assisted Living II	4310 Belvieu Avenue Baltimore	x			
Angels Arm, LLC	5205 Pembroke Avenue Baltimore	x			
Trusted Home Care, LLC	6205 Norvo Road Baltimore	x			
Mission Possible	3715 Gwynn Oak Avenue Baltimore	x			
Q & C - Your Way Thru Assisted Living Home	9115 Field Avenue Pikesville	x			
2 Hearts Alf, LLC	3 Jameson Lane Pikesville	x			
Rolling Meadows	303 North Rolling Road Catonsville	x			
A & W Assisted Living	6600 Liberty Road Baltimore	x			
Amazing Home LLC	4744 Byron Road Pikesville	x			
An Angel's Better Living Care, LLC	9820 Lyons Mill Road, Unit 9822 Owings Mills	x			
Angels Among Us	12820 Eastern Avenue Baltimore	x			
Angels And Blessing II	5614 Saint Marys Street Baltimore	x			
Angels And Blessings Assisted Living	5913 Charles Street Baltimore	x			
Arden Courts Of Pikesville	8909 Reisterstown Road Pikesville	x			
Arden Courts Of Towson	8101 Bellona Avenue Towson	x			
Arise Assisted Living	3703 Essex Road Baltimore	x			
Assisted Living At Buckingham Manor	4010 Buckingham Road Baltimore	x			
Atrium Village	4730 Atrium Court Owings Mills	x			
Augsburg Lutheran Home Maryland	6811 Campfield Road Baltimore	x			
Because We Care Assisted Living LLC	3525 Essex Road Baltimore	x			
Bed Of Roses Assisted Living & Respite Care LLC	3725 Eastman Road Randallstown	x			
Beechwood Assisted Living LLC	101 North Beechwood Avenue Baltimore	x			
Best Care Assisted Living, LLC	639 Main Street Reisterstown	x			
Best Care Asssisted Living, LLC Site 64	64 Main Street Reisterstown	x			
Blakehurst Retirement Community	1055 West Joppa Road Towson	x			
Brightview Mays Chapel Ridge	12261 Roundwood Road Timonium	x			
Brightview RolIIng Hills	848 South Rolling Road Catonsville	x			
Brookdale Pikesville	1840 Reisterstown Road Pikesville	x			
Brookdale Towson	6451 North Charles Street Baltimore	x			
Care Matters Assisted Living	4003 Buckingham Road Baltimore	x			
Caring Corners I	9217 Allenswood Road Randallstown	x			

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Caring Corners II	3720 Lamoine Road Randallstown	x			
Caring Corners III	9208 Allenwood Road Randallstown	x			
Caring Place (A)	7700 Oakleigh Road Parkville	x			
Cassie's Corner	7007 Brompton Road Baltimore	x			
Cheryl's Place #1	8707 Trumps Mill Road Baltimore	x			
Clem & Doll II	8335 Liberty Road Baltimore	x			
Clem And Doll Assisted Living I	8337 Liberty Road Baltimore	x			
College Manor, Inc	300 West Seminary Avenue Lutherville	x			
Comfort Care Of Kensington	4219 Kensington Road Baltimore	x			
Comforts At Catonsville, LLC (The)	1306 Lincoln Woods Drive Catonsville	x			
Comforts Of Home (The)	9101 Bengal Road Randallstown	x			
Comforts Of Home 2 (The)	4 Marbledale Court Reisterstown	x			
Crystal Manor Assisted Living, Inc	5610 Gwynndale Avenue Baltimore	x			
Curtis Manor Alf	6307 Carlynn Avenue Baltimore	x			
Dee's Assisted Living	3712 Chatham Road #B Baltimore	x			
Denise Holley Assisted Living	1406 Bellona Avenue Lutherville	x			
Dulaney Valley Assisted Living At Hunt Valley	10815 Powers Avenue Cockeysville	x			
Dulaney Valley Assisted Living Inc	5001 Carroll Manor Road Baldwin	x			
Eastman Retirement Home	3700 Eastman Road Randallstown	x			
Edenwald	800 Southerly Road Towson	x			
Eveline Gardens Assisted Living	3211 Doycron Court Baltimore	x			
Eveline Gardens II	3209 Doycron Court Baltimore	x			
Family Touch 2	7165 Fairbrook Road Windsor Mill	x			
Family Touch Assisted Living, LLC (The)	7167 Fairbrook Road Windsor Mill	x			
Forever Care, Inc.	827 Southridge Road Catonsville	x			
Glen Meadows Retirement Community	11630 Glen Arm Road Glen Arm	x			
Gloria Friends Home, Inc	929 Back River Neck Road Baltimore	x			
Glynn Taff, Inc.	5741 Edmondson Avenue Catonsville	x			
Homestyle, LLC	6729 Windsor Mill Road Gwynn Oak	x			
Greenfield Senior Living At Cockeysville 1	10881 York Road Cockeysville	x			
Greenfield Senior Living At Cockeysville 2	10883 York Road Cockeysville	x			
H And T Parsons	6601 Parsons Avenue Baltimore	x			
Hampton Meadows, LLC	1412 Providence Road Baltimore	x			
Hands Of Harmony Home Care, LLC	6007 Johnnycake Road Baltimore	x			
Inspirations Memory Care of Lutherville I	1414 Front Avenue Lutherville	x			
Inspirations Memory Care of Lutherville ll	1420 Front Avenue Lutherville	x			
Heavenly Home	22 Chandelle Road Baltimore	x			
Helping Hands In Maryland	8802 Maplebrook Road Randallstown	x			
Home Away From Home Assisted Living	6923 Blanche Road Baltimore	x			
Homestyle Assisted Living, LLC	8222 Brattle Road Pikesville	x			
Hope And Happiness Assisted Living	3120 Greenmead Road Baltimore	x			
House Of Victory Apostolic (The)	7824 Rolling Vista Court Baltimore	x			
Intervention Assisted Living Inc	702 Sturgis Place Pikesville	x			
J.L. Care Enterprises	601 Aldershot Road Baltimore	x			
Joy's Blessing I	3919 Innerdale Court Randallstown	x			
Joy's Blessing II	4122 Tiverton Road Randallstown	x			
Joyce's Home Of New Beginnings, Inc	4931 Old Court Road Randallstown	x			
Joyous Living, Inc	11130 Philadelphia Road White Marsh	x			
Lanie's Place	8705 Trumps Mill Road Baltimore	x			
Lifespring, LLC	2200 Pleasant Villa Avenue Catonsville	x			
Lisa's Place, Inc	3905 Nemo Road Randallstown	x			
Loving Care Home	3936 Tiverton Road Randallstown	x			
Loving Touch Personal Care, Inc	2229 Southland Road Baltimore	x			
Ma Maison I	9404 Belair Road Baltimore	x			
Ma Maison II	9402 Belair Road Baltimore	x			
Ma Maison III	9412 Belair Road Nottingham	x			
Mabel's House Asssted Living	4205 Liberty Heights Avenue Baltimore	x			
Magnolia Manor	900 South Rolling Road Catonsville	x			
Maplebrook Home (The)	8912 Maplebrook Road Randallstown	x			
Maples Of Towson (The)	7925 York Road Towson	x			
Marlyn Place Alf, LLC	951 North Marlyn Avenue Baltimore	x			
Martin's Wood LLC	1813 Old Eastern Avenue Essex	x			
Maryland Masonic Homes	300 International Circle Cockeysville	x			

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Rising Sun Assisted Living I	8419 Allenswood Road Randallstown	x			
Rising Sun Assisted Living II	7204 Barlow Court Windsor Mill	x			
Mayfield House	123 Fairfield Drive Catonsville	x			
Moms & Pops Place	3109 Putty Hill Avenue Parkville	x			
Morningside House At Satyr Hill	8800 Old Harford Road Parkville	x			
Mosley Care Provider Inc	3515 Melody Lane Baltimore	x			
My House 2	6612 Dalton Drive Baltimore	x			
Na's Place A Haven Of Rest	1604 Browns Road Essex	x			
New Horizons Alf	2726 Reisterstown Road Baltimore	x			
New Life Healthy Living, LLC	7600 Clays Lane Windsor Mill	x			
New Start #1	3917 Innerdale Court Randallstown	x			
New Start #2	2809 Diamond Ridge Road, Apt 102 Windsor Mill	x			
New Start #3	2809 Diamond Ridge Road, Apt. 101 Windsor Mill	x			
New Start #4	9802 Plowline Road Randallstown	x			
North Oaks Retirement Community	725 Mount Wilson Lane Baltimore	x			
Nottingham Place	3824 Deckerts Lane Baltimore	x			
Oak Crest Village, Inc	8830 Walther Boulevard Parkville	x			
Paradise Assisted Living LLC	6348 Frederick Road Catonsville	x			
Pat's Golden Girls Assisted Living & Respite Care	8529 Lucerne Road Randallstown	x			
Paulette's Assisted Living	210 Altamont Avenue Catonsville	x			
Pickersgill Retirement Community	615 Chestnut Avenue Towson	x			
Pima	3503 Flannery Lane Baltimore	x			
Pleasant Woods, LLC	5707 Gwynn Oak Avenue Baltimore	x			
Quail Run Assisted Living	9900 Walther Boulevard Baltimore	x			
Quail Run Assisted Living #2	9904 Walther Boulevard Baltimore	x			
Quail Run Assisted Living #4	9902 Walther Boulevard Baltimore	x			
Quality Care At Buckingham Manor Assisted Living	4012 Buckingham Road Gwynn Oak	x			
Retreat At Sheppard Pratt (The)	6501 North Charles Street Baltimore	x			
Saint Martin's Home	601 Maiden Choice Lane Catonsville	x			
Second Genesis	4003 Starbrook Road Randallstown	x			
Second Genesis II	4001 Starbrook Road Randallstown	x			
Second Genesis III	3737 Courtleigh Drive Randallstown	x			
Second Genesis IV	3617 Blair Avenue Randallstown	x			
Shining Moon Elder Care Alf	1310 Dulaney Valley Road Towson	x			
So Charm At Castlemoor	7300 Castlemoor Road Windsor Mill	x			
Splendid Home Care II	25 Greenapple Court Woodlawn	x			
Springhouse Of Pikesville	8911 Reisterstown Road Pikesville	x			
St. Stephen's Green @ Mercy Ridge	2525 Pot Spring Road Timonium	x			
Sunrise Of Pikesville	3800 Old Court Road Pikesville	x			
Sunshine Healthcare, LLC	4111 Hupa Place Randallstown	x			
T & E Cares, LLC	1724 Wycliffe Avenue Parkville	x			
Tenderness Love And Hope	3013 Wells Avenue Baltimore	x			
Touch Of Joy Assisted Living Svcs LLC (A)	8819 Liberty Road Randallstown	x			
Tranquility Assisted Living Home LLC	7500 Kelseys Lane Baltimore	x			
Trinity Care Of Love	3819 Collier Road Randallstown	x			
Tyrell's Housing, Llp	3425 Chapman Road Randallstown	x			
Villa At Campfield (The)	7117 Campfield Road Baltimore	x			
Vorizen Assisted Living	7425 Sudbrook Road Baltimore	x			
Vorizen Assisted Living II	825 Milford Mill Road Pikesville	x			
Windsor Crest Care Home	6951 Copperbend Lane Baltimore	x			
Wise Choice (A)	6504 Mount Vernon Avenue Baltimore	x			
Woodholme Gardens Assisted Living And Memory Care	1700 Woodholme Avenue Pikesville	x			
Woodholme Manor, LLC	101 Woodholme Avenue Pikesville	x			
Woodlands Assisted Living Community	1320 Windlass Drive Baltimore	x			
Your Family - My Family	26 Horseman Court Randallstown	x			
All The Best Care Assisted Living, Inc	6 Clarendon Avenue Pikesville	x			
Big O Assisted Living, LLC	8731 Meadow Heights Road Randallstown	x			
Griffin's Loving Care Assisted Living, LLC	204 Clyde Avenue Halethorpe	x			
Precious Jewels Assisted Living	3933 Chaffey Road Randallstown	x			

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Ok Family Care Assisted Living	6650 Belair Road Baltimore		x		
Gifted Hands Assisted Living, LLC (The)	2417 Resistertown Road Baltimore		x		
Care Blessings Assisted Living, LLC	3008 Glenmore Avenue Baltimore		x		
Howell's Care	3418 Piedmont Avenue Baltimore		x		
1 Stop Assisted Living	1804 Ruxton Avenue Baltimore		x		
1 Stop Assisted Living 2	1311 Luzerne Avenue Baltimore		x		
1 Stop Assisted Living 3	3226 Ravenwood Avenue Baltimore		x		
1 Stop Assisted Living 4	1824 Rayner Avenue Baltimore		x		
1 Stop Assisted Living 5	2306 West Lanvale Street Baltimore		x		
A And T Quality Care Assisted Living	4769 Melbourne Road Baltimore		x		
Acts Assisted Living	3923 Roland Avenue Baltimore		x		
Adal, Inc	2923 Woodland Avenue Baltimore		x		
Adassa Assisted Living	3908 Ridgecroft Road Baltimore		x		
Agape Assisted Living Home I	5706 Denwood Avenue Baltimore		x		
Agape Assisted Living Home II	4610 Eugene Avenue Baltimore		x		
Alhambra Assisted Living Facility	5503 Alhambra Avenue Baltimore		x		
All About Caring	2424 East Chase Street Baltimore		x		
All About You Assisted Living	5400 Daywalt Avenue Baltimore		x		
All In The Family	3505 Devonshire Drive Baltimore		x		
All Together Network Inc	643 Tunbridge Road Baltimore		x		
Allen House (The)	3607 Fairview Avenue Baltimore		x		
Almost Home II Assisted Living, Inc	4813 Gwynn Oak Avenue Baltimore		x		
Almost Like Home, Inc	4202 Maine Avenue Baltimore		x		
MDC Assisted Living, LLC	4806 Crenshaw Avenue Baltimore		x		
Amani Z Gifted Hands Assisted Living	3513 Parklawn Avenue Baltimore		x		
Ambrozean Assisted Living Care Center Inc	3800 West Rogers Avenue Baltimore		x		
American Home Care And Health Services Assisted	2914 East Federal Street Baltimore		x		
Angel Core Home Of Care	4719 Elison Avenue Baltimore		x		
Angel Core Home Of Care At Parkmont	4304 Parkmont Avenue Baltimore		x		
Angelic Hands Assisted Living	5801 Clover Road Baltimore		x		
Ann's Place	4101 Boarman Avenue Baltimore		x		
April Showers Assisted Living Facility Inc	3621 Gibbons Avenue Baltimore		x		
Aunt Shug's Assisted Living #2	4313 Belvieu Avenue Baltimore		x		
Aunt Shug's Assisted Living, Inc	4311 Belvieu Avenue Baltimore		x		
Aw Quality Care II	1625 North Rosedale Street Baltimore		x		
B-More Assisted Living	1933 West Lexington Street Baltimore		x		
Bea's Beautiful Blessing, LLC	3224 Woodring Avenue Baltimore		x		
Believe Homes, Inc	3404 Cardenas Avenue Baltimore		x		
Best Care	3524 Hayward Avenue Baltimore		x		
Better Ways Assisted Living	504 Beaumont Avenue Baltimore		x		
Betty's And Debbie's Family Place I	5411 Walther Avenue Baltimore		x		
Blessed Heart, LLC	1812 East 29Th Street Baltimore		x		
Brinkley Care Assisted Living	3053 Brighton Street Baltimore		x		
Burris Home Care	1436 Gittings Avenue Baltimore		x		
Butterfly Nest Assisted Living	5606 Todd Avenue Baltimore		x		
C & L Quality Home Care I	1001 Evesham Avenue Baltimore		x		
C & L Quality Home Care Ill	3901 Ridgecroft Road Baltimore		x		
Ca Assisted Living Home	1504 North Fulton Avenue Baltimore		x		
Calming Acres II	7205 Glenoak Avenue Baltimore		x		
Capital Assisted Living Program	4554 Derby Manor Road Baltimore		x		
Bea's Beautiful Blessings, LLC	6409 Moyer Avenue Baltimore		x		
Care Matters, LLC	3604 Grantley Road Baltimore		x		
Caring For You Assisted Living, LLC	10 South Gilmor Street Baltimore		x		
Caring For You II Alf	2928 Edison Highway Baltimore		x		
Caring For You Ill Assisted Living	2926 Edison Highway Baltimore		x		
Caring Hearts At Harford, LLC	4532 Harford Road Baltimore		x		
Caritas House Assisted Living	3308 Benson Avenue Baltimore		x		
Charles Jr House	2608 Roslyn Avenue Baltimore		x		
Charlie's Angels Assisted Living	2027 North Wolfe Street Baltimore		x		
Charlie's Angels Assisted Living II	2025 North Wolfe Street Baltimore		x		
Chelsea Manor, Inc	2309 Chelsea Terrace Baltimore		x		
Comfort City Assisted Living	1135 Myrtle Avenue Baltimore		x		
Concepts For Living	1331 Gittings Avenue Baltimore		x		

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Concord Meadows	1128 N Calhoun Street Baltimore		x		
Cozy House Adult Care	3905 Fleetwood Avenue Baltimore		x		
Cozy House Adult Care II	2910 Louise Avenue Baltimore		x		
Crystal Homes	2915 West Coldspring Lane Baltimore		x		
Unlimited Solutions Adult Care ll, LLC	1346 Kitmore Road Baltimore		x		
Daisy Group Inc (The)	5247 Reisterstown Road Baltimore		x		
Dee's House Of Care	5901 Lillyan Avenue Baltimore		x		
Destiny's Place	4603 Kernwood Avenue #2 Baltimore		x		
Easter Adult Care, Inc	3511 Alameda Circle Baltimore		x		
Ebenezer House, LLC	5008 Walther Avenue Baltimore		x		
Edna W. Cox Tranquil Pathway House (The)	838 Mount Holly Street Baltimore		x		
Elison Living	1730 Mckean Avenue Baltimore		x		
Emergency Care 24-7 Assisted Living, LLC	5702 Sefton Avenue Baltimore		x		
Empowering Lives	1716 Harlem Avenue Baltimore		x		
Erika And Eric Home Of Care II	2400 Roslyn Avenue Baltimore		x		
Esther's Place - Pinewood	2802 Pinewood Avenue Baltimore		x		
Esther's Place At Montebello	2831 Montebello Terrace Baltimore		x		
Esther's Place At Strathmore	2901 East Strathmore Avenue Baltimore		x		
Esthers Place, Inc	2926 Harford Road Baltimore		x		
Evergreen Valley Assisted Living	3009 Evergreen Avenue Baltimore		x		
Fruitful Love Christian Home Care I	6222 Northwood Drive Baltimore		x		
Fruitful Love Christian Home II	6215 Northwood Drive Baltimore		x		
Gaddy's Assisted Living Home	1130 West Lafayette Avenue Baltimore		x		
Gentleman's Club At Lakewood East Alf	515 North Lakewood Avenue Baltimore		x		
Georgie & Jetta Loving Care Home	720 East 35Th Street Baltimore		x		
Golden Age Inn Assisted Living	5934 Glennor Road Baltimore		x		
Habakkuk 2:3 Assisted Living	3817 Reisterstown Road Baltimore		x		
Habakkuk House	3833 Ferndale Avenue Baltimore		x		
Hanson Home Care II	1722 East 31St Street Baltimore		x		
Hanson's Home Care	1603 East 31St Street Baltimore		x		
Harmony House I	3511 Copley Road Baltimore		x		
Harmony Houses	2215 Baker Street Baltimore		x		
Harrison's Home Care	2935 North Edgecombe Circle Baltimore		x		
Haven Of Refuge Assisted Living, LLC	701 East 43Rd Street Baltimore		x		
Hawkin's Christian Care Home	802 Walnut Avenue Baltimore		x		
Hawkins House	3009 Northway Drive Baltimore		x		
He Ain't Heavy Assisted Living Facility, LLC	46 South Kossuth Street Baltimore		x		
Heart Of Angels	1215 North Curley Street Baltimore		x		
Heart Of The Phoenix	1522 West Fairmount Avenue Baltimore		x		
Heartfelt Care Providers, LLC	3505 Windsor Mill Road Baltimore		x		
Heavenly Grace Assisted Living #2	3201 Windsor Avenue Baltimore		x		
Heavenly Grace Assisted Living, Inc.	1210 Gittings Avenue Baltimore		x		
Hillcrest Manor	3602 Bayonne Avenue Baltimore		x		
Holbrock Estates At 809 N Rose Street	809 North Rose Street Baltimore		x		
Holbrock Estates At The Martin De Porres Center I	908 Valley Street, Apartment 1 Baltimore		x		
Holbrock Estates At The Martin De Porres Center II	908 Valley Street, Apartment 2 Baltimore		x		
Holbrock Estates At The Martin De Porres Center IV	908 Valley Street, Apartment 4 Baltimore		x		
Holbrock Estates At The Martin De Porres Center IX	908 Valley Street, Apartment 9 Baltimore		x		
Holbrock Estates At The Martin De Porres Center V	908 Valley Street, Apartment 5 Baltimore		x		
Holbrock Estates At The Martin De Porres Center Vl	908 Valley Street, Apartment 6 Baltimore		x		
Holbrock Estates At The Martin De Porres Center X	908 Valley Street, Apartment 10 Baltimore		x		
Holbrock Estates At The Martin De Porres Center XX	908 Valley Street, Apartment 11 Baltimore		x		
Holbrock Estates At The Martin De Porres Center Xll	908 Valley Street, Apartment 12 Baltimore		x		

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Holbrock Estates At The Martin De Porres Ctr III	908 Valley Street, Apartment 3 Baltimore		x		
Holbrock Estates At The Martin De Porres Ctr VII	908 Valley Street, Apartment 7 Baltimore		x		
Holbrock Estates At The Martin De Porres Ctr VIII	908 Valley Street, Apartment 8 Baltimore		x		
Home For The Blessed Ones Assisted Living (A), LLC	3604 Erdman Avenue Baltimore		x		
Home Of Tender Care, LLC	5315 Norwood Avenue Baltimore		x		
Honor & Cherish	3615 Gwynn Oak Avenue Baltimore		x		
Hope A Home Offers Opportunity For Each Other Inc	607 Woodbourne Avenue Baltimore		x		
Hoppe House, LLC	2418 West Lanvale Street Baltimore		x		
House Of Harmony, LLC	2848 Woodbrook Avenue Baltimore		x		
House Of Helping Hands (Alf), LLC	1804 Ashburton Street Baltimore		x		
House Of Loving Hands, Inc	1235 Ashburton Street Baltimore		x		
House Of Nobles, Inc	2518 Harford Road Baltimore		x		
House Of Peace	3725 Belle Avenue Baltimore		x		
House Of Tlc, Inc	3800 Parkside Drive Baltimore		x		
House Of Victory Apostolic Home Care	3001 Belair Road Baltimore		x		
Hummingbird Assisted Living, LLC	4102 West Forest Park Ave Baltimore		x		
Isaiah 43:19 Assisted Living	2631 Quantico Avenue Baltimore		x		
Jenny's Home Care II	1336 Meridene Drive Baltimore		x		
John 8:12 Assisted Living	2535 Park Heights Terrace Baltimore		x		
Joshua 14-15 Assisted Living	2533 Park Heights Terrace Baltimore		x		
Joy Assisted Living	5334 Gist Avenue Baltimore		x		
Julia's Place	618 Linnard Street Baltimore		x		
Just About Family	4222 Penhurst Avenue Baltimore		x		
Just Like Home Assisted Living II, LLC	6210 Walther Avenue Baltimore		x		
Justin's Assisted Living	4920 Gilray Drive Baltimore		x		
Karima's Place II	2431 Arunah Avenue Baltimore		x		
Keemer Kare	2814 Norfolk Avenue Baltimore		x		
Keeper Of All Hearts (A)	2442 West Baltimore Street Baltimore		x		
Keeping People Smiling	3903 Ridgecroft Road Baltimore		x		
Kenyon Springs, LLC	3000 Kenyon Avenue Baltimore		x		
Key To Heart	3032 Harlem Avenue Baltimore		x		
Kings Care, LLC	4216 Harford Terrace Baltimore		x		
Komfort & Kare, LLC	1525 Medford Road Baltimore		x		
Kps Assisted Living Homes II	1705 West Lombard Street Baltimore		x		
Lacy's Assisted Living	5117 Ardmore Way Baltimore		x		
Lashae Gloria Home Care	5624 Belle Avenue Baltimore		x		
Lily Ridge Assisted Living	720 Dryden Drive Baltimore		x		
We Care First, LLC	2902 Bayonne Avenue Baltimore		x		
Lin's Loving Care III	4215 Bayonne Avenue Baltimore		x		
Linz Assisted Living	4000 West Franklin Street Baltimore		x		
Live Well Assisted Living Springdale	4212 Springdale Avenue Baltimore		x		
Love & Faith Home Care	2112 West Saratoga Street Baltimore		x		
M & G's Total Tender Loving Care	1020 North Iris Avenue Baltimore		x		
Marie's Comfort & Care II, LLC	3925 Maine Avenue Baltimore		x		
Marlea Manor	4405 Raspe Avenue Baltimore		x		
Mary's Place	5621 Wayne Avenue Baltimore		x		
Maryland Living, Inc	4610 Springdale Avenue Baltimore		x		
Mccaskill's Assisted Living II	3420 Ramona Avenue Baltimore		x		
Men On The Move Assisted Living	3431 Piedmont Avenue Baltimore		x		
Milford Manor	3623 Milford Avenue Baltimore		x		
Millennium Assisted Living LLC (The)	1419 Kitmore Road Baltimore		x		
Mission Possible 2	4012 Springdale Avenue Baltimore		x		
Montford Assisted Living, LLC	920 Montford Avenue Baltimore		x		
Msc Family Care	4400 Belvieu Avenue Baltimore		x		
Mumsey's Assisted Living Facility	4008 Boarman Avenue, 1St Floor Baltimore		x		
Mumsey's Residential Care	3512 Devonshire Drive Baltimore		x		
My Caring Assisted Living	4008 Boarman Avenue, 2Nd Floor Baltimore		x		
My Second Home II	4519 Manorview Road Baltimore		x		

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
New Horizon (A)	5724 Onnen Road Baltimore		x		
Newton Manor Assisted Living	2424 West Rogers Ave Mount Washington		x		
Norma's House	502 North Linwood Avenue Baltimore		x		
Norma's Place 2, LLC	4601 1/2 Bowleys Lane Baltimore		x		
Ultimate Care Assisted Living	5005 Sipple Avenue Baltimore		x		
Open Arms Assisted Living, LLC	604 School Street Baltimore		x		
Open Heavens Assisted Living II	4223 Berger Avenue Baltimore		x		
P.J.'s House Of Care	2909 Woodland Avenue Baltimore		x		
Paige Place	3719 Chesmont Avenue Baltimore		x		
Palmer Home Care Facility, Inc	3820 West Coldspring Lane Baltimore		x		
Passionate Care	1934 West Baltimore Street Baltimore		x		
Patricia's Assisted Love Care Home	616 Mckewin Avenue Baltimore		x		
Peace And Serenity Assisted Living	4010 Southern Avenue Baltimore		x		
Peace Of Mind Assisted Living (A)	2606 Taney Road Baltimore		x		
Peachtree Manor Assisted Living	5402 Northwood Drive Baltimore		x		
Phil 4:13 Assisted Living	3825 Park Heights Avenue Baltimore		x		
Pho Assisted Living I	1200 North Bentalou Street Baltimore		x		
Pho Assisted Living II	3125 Gwynns Falls Parkway Baltimore		x		
Pho Assisted Living Ill	1116 North Bentalou Street Baltimore		x		
Phoenix Rising, LLC	6511 Rosemont Avenue Baltimore		x		
Pinkett's Assisted Living, LLC	1701 Lydonlea Way Baltimore		x		
Pleasant Care	4914 Belair Road Baltimore		x		
Pleasant Garden - Clover	5426 Clover Road Baltimore		x		
Pleasant Garden - Glenmore	3603 Glenmore Avenue Baltimore		x		
Pleasant Garden - Pinewood	3711 Pinewood Avenue Baltimore		x		
Pleasant Garden I	409 South Chapelgate Lane Baltimore		x		
Pleasant Garden II	411 South Chapelgate Lane Baltimore		x		
Pleasant Hope	5506 Cadillac Avenue Baltimore		x		
Prayer Changes Everything Assisted Living II	4305 Penhurst Avenue Baltimore		x		
Quindel's Home Of Assisted Living, LLC	1624 East Biddle Street Baltimore		x		
Ray Of Light (A)	933 Ellicott Drive Baltimore		x		
Renewed Ease-A Christian Home (R.E.A.C.H), LLC	712 Cator Avenue Baltimore		x		
Roland Park Place, Inc	830 West 40Th Street Baltimore		x		
Rose's Of Life	2711 Harlem Avenue Baltimore		x		
Rosemarie Manor - Ashburton	3809 Belle Avenue Baltimore		x		
Rosie's Assisted Living	2449-2451 Shirley Avenue Baltimore		x		
Royal Heart Assisted Living Facility	3604 White Avenue Baltimore		x		
Ruth's Comfort & Care Assisted Living	5808 Merville Avenue Baltimore		x		
Sabbath Place (The)	4847 Aberdeen Avenue Baltimore		x		
Sara's Christian Home	1516 Pentwood Road Baltimore		x		
Scotlands (The)	4859 Melbourne Road Baltimore		x		
Sefton Home Care	6007 Sefton Avenue Baltimore		x		
Sel's Place	2614 Greenmount Avenue Baltimore		x		
Seniority Living	3605 Hillsdale Road Baltimore		x		
Sensitive Hearts Assisted Living	2850 Kentucky Avenue Baltimore		x		
Serenity Care	4627 Marble Hall Road Baltimore		x		
Serenity Garden Manor Corporation	2311 Roslyn Avenue Baltimore		x		
Serenity Manor At Gwynn Oak	5216 Gwynn Oak Avenue Baltimore		x		
Serenity Manor, Inc	1802 Eutaw Place Baltimore		x		
Shelton Personal Care	3920 Mortimer Avenue Baltimore		x		
Skinner's Place, LLC	1501 Ellamont Street Baltimore		x		
Someone Always Watching Over You, LLC	5805 Bland Avenue Baltimore		x		
Springwell Senior Living	2211 West Rogers Avenue Baltimore		x		
St Paul Assisted Living	2128 Saint Paul Street Baltimore		x		
St. Charles Place, Inc.	5246 Saint Charles Avenue Baltimore		x		
Step From Home (A)	1637 Chilton Street Baltimore		x		
Sterling Hospitality, LLC	7015 Park Heights Avenue Baltimore		x		
Stump's Home, Inc	2301 Oswego Avenue Baltimore		x		
Su Casa	2615 Edison Highway Baltimore		x		
Sweet Rest And Care II	3010 Clifton Avenue Baltimore		x		
Symphony Manor Premier Assisted Living And Memory	4301 Roland Avenue Baltimore		x		

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
T & F Assistant Living	880 West Lombard Street Baltimore		x		
T & T Assisted Living	4309 Belvieu Avenue Baltimore		x		
Taylor Care, LLC	4119 Penhurst Avenue Baltimore		x		
Taylor Made Assisted Living Center II	1714 East 33Rd Street Baltimore		x		
Tender Care	1701 North Bentalou Street Baltimore		x		
Tender Love & Care	1629 East 31St Street Baltimore		x		
Tender Touch Assisted Living	5910 Ayleshire Road Baltimore		x		
Third Generation Care At Lake Walker	509 Walker Avenue Baltimore		x		
Third Generation Care, Inc	650 East 35Th Street Baltimore		x		
Timothy's Manor	4859 Bowland Avenue Baltimore		x		
Touch Of Class II (A)	3501 Powhattan Avenue Baltimore		x		
Touch Of Class III (A)	4300 Belvieu Drive Baltimore		x		
Touch Of Love	3818 Woodbine Avenue Baltimore		x		
Trinity Arms Assisted Living	4122 Duvall Avenue Baltimore		x		
Trinity Arms Assisted Living II	2800 Mosher Street Baltimore		x		
Two Charms, LLC	3702 Gwynn Oak Avenue Baltimore		x		
Uhh Wee, We Care, Inc	4726 Elison Avenue Baltimore		x		
Unity House Assisted Living, Inc	716 North Augusta Avenue Baltimore		x		
Victorian Inn, Inc.	3216 Taylor Avenue Baltimore		x		
Vision Care Assisted Living	2127 Mount Holly Street Baltimore		x		
Vision Of Glory	2235 Brookfield Avenue Baltimore		x		
Waltherville LLC (The)	3501 Echodale Avenue Baltimore		x		
Washington's Nest	3006 Beverly Road Baltimore		x		
We Care Assisted Living	1313 Kenhill Avenue Baltimore		x		
We Care Home Care	3001 Gwynns Falls Parkway Baltimore		x		
Weinberg Park Assisted Living	5829-5833 Park Heights Avenue Baltimore		x		
West Way Assisted Living	5252 Saint Charles Avenue Baltimore		x		
Whitelock Assisted Living	831 Whitelock Street Baltimore		x		
Yelverton Family Services	1149 North Calhoun Street Baltimore		x		
Helpful Hands, LLC	3403 Southern Avenue Baltimore		x		
Comfort Zone Assisted Living, LLC	1510 Kennewick Road Baltimore		x		
Divine Care Assisted Living, Inc	4603 Frankford Avenue Baltimore		x		
Kinfolk Assisted Living	644 East 36Th Street Baltimore		x		
Nu Direction Assisted Living	1125 Kevin Road Baltimore		x		
Together We Care Assisted Living	2416 Harlem Avenue Baltimore		x		
The Cottages of Perry Hall 9906	9906 Walther Blvd Baltimore		x		
At Ease and Renewed, LLC	4002 Glenmore Avenue Baltimore		x		
Gental Touch Assisted Living, LLC	3609 E Northern Pkwy Baltimore		x		
Assured Living	3012 Woodring Avenue Baltimore		x		
Westfield Assisted Living, LLC	2822 Louise Ave Baltimore		x		
Changing Times Assisted Living, LLC	5907 Arabia Avenue Baltimore		x		
Annie's Heart of Love	5410 Hamlet Avenue Baltimore		x		
Julie's Manor	2901 Gibbons Avenue Baltimore		x		
Romaine's Paradise Assisted Living	4709 Elsrode Avenue Baltimore		x		
Taylor & Jackie Assisted Living II	3503 Hamilton Avenue Baltimore		x		
Devine Hand, Inc.	4105 Century Road Baltimore		x		
Margaret's Manor, LLC	5801 Kavon Avenue Baltimore		x		
Friendly Brooke Home Care, LLC	5717 Seymour Avenue Baltimore		x		
My Caring Hands, LLC	4707 Renwick Ave Baltimore		x		
Irene's Manor at Glenarm	4602 Glenarm Avenue Baltimore		x		
Open Arms	5404 Belair Road Baltimore		x		
Desky Assisted Living, LLC	4307 Willshire Avenue Baltimore		x		
Millie's Personal Care	5479 Moores Run Drive Baltimore		x		
Heaven Sent Assisted Living, LLC	4411 Frankford Avenue Baltimore		x		
Golden View Assisted Living, LLC	4407 Frankford Avenue Baltimore		x		
Angel XI Assisted Living, INC	4731 Elison Avenue Baltimore		x		
Minnie Blessings	4229 Nicholas Avenue Baltimore		x		
A Home Full of Joy	4200 Stanwood Avenue Baltimore		x		
Awesome Quality Care, LLC	3624 Dudley Avenue Baltimore		x		
1 Stop Assisted Living 7	3857 Lyndale Avenue Baltimore		x		
Angelic Care Assisted Living, LLC	3781 Ravenwood Avenue Baltimore		x		
Sweet P's Joyceful	3745 Ravenwood Avenue Baltimore		x		
Latisha Thompson Assisted Living Care, LLC	3505 Erdman Avenue Baltimore		x		

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
My Family and Yours	2840 Pelham Avenue Baltimore		x		
Divine Enlargement I	3127 Cliftmont Avenue Baltimore		x		
Elaine's Home	3117 Cliftmont Ave Baltimore		x		
C & L Quality Home Care II	1312 Highland Drive Baltimore		x		
For Those Who Serve, LLC	1100 Sherwood Ave Baltimore		x		
Tamara Loving Care, LLC	1305 Sherwood Avenue Baltimore		x		
Passionate Assisted Living	5911 Loch Raven Baltimore		x		
Blessed Hands Assisted Living, LLC	1611 Ramblewood Road Baltimore		x		
Sweet P's Joyceful Assisted Living 3	914 Saint Dunstands Baltimore		x		
Because We Care, LLC	511 Rossiter Avenue Baltimore		x		
K And R'S Assisted Living, LLC	1660 Roundhill Road Baltimore		x		
Friendly Best (805)	805 Beaumont Avenue Baltimore		x		
Friendly Best Care	801 Beaumont Ave Baltimore		x		
Better Ways Assisted Living	504 Beaumont Avenue Baltimore		x		
Royal Star Assisted Living	1611 Chilton Street Baltimore		x		
Ednor Gardens Assisted Living	920 Chestnut Hill Avenue Baltimore		x		
Home Care Services, LLC	3509 Greenmount Avenue Baltimore		x		
Exalt, LLC	1703 Montpelier St Baltimore		x		
Strength to Love Assisted Living, LLC	2209 E North Avenue Baltimore		x		
Quality of Life Assisted Living Facility	2125 Homewood Avenue Baltimore		x		
Helping Hands Residential Care	1812 Guilford Avenue Baltimore		x		
Golden Gatz, LLC	3118 McElderry Street Baltimore		x		
Treasured Loved One's Home Care, LLC	1210 Edison Highway Baltimore		x		
My Daughter's Place	1326 North Linwood Street Baltimore		x		
Joshua 22-5 Assisted Living	1308 North Linwood Avenue Baltimore		x		
Matthew 6-14 Assisted Living	1510 North Ellwood Avenue Baltimore		x		
Phil 4:6-7 Assisted Living	1511 N Ellwood Avenue Baltimore		x		
Unlimited Blessings Foundation, Inc.	940 North Eden Street Baltimore		x		
Holley's Haven Assisted Living Facility, LLC	821 W Cross Street Baltimore		x		
Changing Places Assisted Living, LLC	338 South Bentalou Street Baltimore		x		
New Life Care, Inc.	2723 West Fairmount Ave Baltimore		x		
G II G Life Living Center	544 North Fulton Avenue Baltimore		x		
WAWG II Assisted Living, LLC	1116 Stockton Street Baltimore		x		
At Majestic Care	902 Wheeler Avenue Baltimore		x		
Golden Heart's Assisted Living	2542 West Lanvale Street Baltimore		x		
Emmanuel's House, LLC	3104 Windsor Avenue Baltimore		x		
Moreland Assisted Living	1628 Moreland Avenue Baltimore		x		
R Home	1562 Moreland Avenue Baltimore		x		
Key to Heart AL II	2942 Winchester Street Baltimore		x		
Poplar Grove Assisted Living	1107 Poplar Grove Street Baltimore		x		
RDA, LLC	2928 West Mosher Street Baltimore		x		
House of Helping Hands II	1800 Ashburton Street Baltimore		x		
Our House Is A Home	1029 Rockhill Avenue Baltimore		x		
Just Like My Family	4409 Eldone Road Baltimore		x		
Gneale Home Care, LLC	23 1/2 Cobber Lane Baltimore		x		
ABH Assisted Living	117 S Augusta Avenue Baltimore		x		
A Place for Me Assisted Living, LLC	830 Stamford Rd Baltimore		x		
Bridgecare Assisted Living, LLC	4405 Rokeby Road Baltimore		x		
Foster's Assisted Living	108 North Edgewood Street Baltimore		x		
A Ray of Light, LLC	11 South Abington Avenue Baltimore		x		
JE Lets Love Assisted Living, LLC	3228 Massachusetts Avenue Baltimore		x		
1 Stop Assisted Living	149 South Hilton Street Baltimore		x		
Cozy Cove Home Care, LLC	718 North Augusta Avenue Baltimore		x		
Lyla Haven South	925 Bridgeview Road Baltimore		x		
Homes With Care	5213 Windsor Mill Rd Baltimore		x		
My House Assisted Living Facilities	2817 Hillsdale Road Baltimore		x		
Heartfelt Care Providers at Wentworth 2	4413 Wentworth Road Baltimore		x		
Stepping Stone Assisted Living	3410 Woodbine Avenue Baltimore		x		
Jan's House	2709 Roslyn Avenue Baltimore		x		
Garrison Estates Assisted Living II, LLC	2702 Garrison Blvd Baltimore		x		
Garrison Estates Assisted Living, LLC	2700 Garrison Blvd Baltimore		x		
Rosemarie Manor - Longwood	3333 Alto Road Baltimore		x		
Loving Hands and Heart Assisted Living, LLC	2606 Denison Street Baltimore		x		

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Loving Care Home	3415 Cedardale Road Baltimore		x		
Peace and Love Assisted Living Center, LLC	3913 Fairview Avenue Baltimore		x		
Passionate Pursuits Assisted Living, LLC	4009 Norfolk Avenue Baltimore		x		
Embracing Change Assisted Living	3301 Oakfield Avenue Baltimore		x		
Maryland Living-A	4013 Kathland Ave Baltimore		x		
Gwynn Oak Assisted Living, LLC	4104 Ethland Ave Baltimore		x		
Beyond Loving Care, LLC	4134 West Forest Park Avenue Baltimore		x		
Grace & Mercy Home Care	4131 West Forest Park Avenue Baltimore		x		
Affluent Living	4106 Maine Avenue Baltimore		x		
A-Pal-At Bell-Care	4002 Belle Ave Baltimore		x		
A home Away From Home	4309 Liberty Heights Ave Baltimore		x		
Easy Like Sunday Morning	4402 Maine Avenue Baltimore		x		
Mohawk Manor	3616 Gwynn Oak Baltimore		x		
Love 2 Care	3810 Fernhill Avenue Baltimore		x		
Fernhill Assisted Living	4002 Fernhill Avenue Baltimore		x		
Taylor Care IV	4113 Penhurst Avenue Baltimore		x		
Taylor Care II	4115 Penhurst Avenue Baltimore		x		
Taylor Care III	4208 Penhurst Avenue Baltimore		x		
All Settled Inn, Inc.	4301 Belvieu Avenue Baltimore		x		
Peregrine's Landing at Tudor Heights	7218 Park Heights Avenue Baltimore		x		
Reliable Quality Care, LLC	6504 Hopeton Avenue Baltimore		x		
Peace of Mind II (A)	6111 Western Run Road Baltimore		x		
Lifetime Serenity Assisted Living	3304 Menlo Drive Baltimore		x		
A Blessing Away From Home, LLC	3512 Menlo Drive Baltimore		x		
Next of Kin Assisted Living	3325 West Northern Pkwy Baltimore		x		
His Goodness Assisted Living I	7109 Reno Road Baltimore		x		
At Last (Me) Home	2719 Woodland Avenue Baltimore		x		
Home Away From Home 2	2816 West Garrison Avenue Baltimore		x		
Lucille Assisted Living	3506 Lucille Ave Baltimore		x		
Litchfield Assisted Living	5000 Litchfield Ave Baltimore		x		
Sunshyne Homes Assisted Living, LLC	5256 Cordelia Ave Baltimore		x		
Lamplight Inn of Baltimore	3855 Greenspring Avenue Baltimore		x		
Jones-Williams Family Care	3716 Park Heights Avenue Baltimore		x		
Park Heights Assisted Living	3827 Park Heights Ave Baltimore		x		
Joy Villa	506 Cording Avenue Baltimore		x		
Caring Hearts Senior Living	620 Wildwood Parkway Baltimore		x		
Aastoria Home II	6636 Cedar Lane Columbia			x	
Abundant Life I	9966 Oaklea Court Ellicott City			x	
Abundant Life II	9950 Oaklea Court Ellicott City			x	
Agape Senior Home I	9420 Ridgeview Drive Columbia			x	
Alive, LLC	4994 Beaverbrook Road Columbia			x	
Always Caring, Inc	9534 Angelina Circle Columbia			x	
Angel's Touch I	12900 Frederick Road West Friendship			x	
Angel's Touch, Inc.	12799 Buttercup Court West Friendship			x	
Angels Alert III	6526 Greenmount Drive Elkridge			x	
Autumn Hill	12401 Lime Kiln Road Fulton			x	
Blooming Hearts Assisted Living, LLC	8107 Tide Rock Square Columbia			x	
Brighton Gardens Of Columbia	7110 Minstrel Way Columbia			x	
Chestnut Hill Manor Inc	8205 Tyson Road Ellicott City			x	
Clarksville Assisted Living LLC	7246 Guilford Road Clarksville			x	
Cooper's Senior Assisted Group Home, Inc	5615 Tricross Drive Columbia			x	
Country Gardens Assisted Living	12752 Scaggsville Road, Route 216 Highland			x	
Crcare Of Clarksville, LLC	5313 Broadwater Lane Clarksville			x	
Elternhaus, Inc.	4201 Linthicum Road Dayton			x	
Emmanuel Care Center I	2992 Mount Etna Circle Ellicott City			x	
Emmanuel Care II	2988 Mount Etna Circle Ellicott City			x	
Encore At Turf Valley	11150 Resort Road Ellicott City			x	
Evergreen Gardens Assisted Living LLC	10120 Stansfield Road Laurel			x	
Font Hill Assisted Living	3417 Font Hill Drive Ellicott City			x	
Forever Young, Inc	16440 Frederick Road Woodbine			x	
Friendship Assisted Living, Inc	3282 Rosemary Lane West Friendship			x	
Friendship Place	6348 Sunny Spring Columbia			x	

List of Continuum of Care PRoviders in the Primary Service Area FHC Relationships

Organation Name	Address	Jurisdiction Organization Located			FHC Established Link
		Baltimore County	Baltimore City	Howard County	
Glen Hill	14269 Triadelphia Mill Road Dayton			x	
Golden Time Inc	10705 Vista Road Columbia			x	
Grace Senior Homes, Inc	5612 Roundtree Lane Columbia			x	
Greenway Manor	2913 Greenway Drive Ellicott City			x	
Harmony Hall Retirement Community	6336 Cedar Lane Columbia			x	
Heartlands Senior Living Village At EIIIcott City	3004 North Ridge Road Ellicott City			x	
Howard County Assisted Living at Clarksville	5502 Harris Farm Lane Clarksville			x	
Ivy Manor Chestnut, Inc.	2817 Montclair Drive Ellicott City			x	
Ivy Manor Normandy II	2928 Normandy Drive Ellicott City			x	
Ivy Manor Normandy, Inc.	2942 Rosemar Drive Ellicott City			x	
La Casa De Rosa LLC	8433 Woodward Street Savage			x	
Lighthouse Senior Living At EIIIcott City	3100 North Ridge Road Ellicott City			x	
Livingspring Assisted Living	14831 Cemetery Road Cooksville			x	
Maple Hill	10711 Harding Road Laurel			x	
Maranatha House Of Columbia, Inc	6118 Sebring Drive Columbia			x	
Meadows Assisted Living	2289 Meadows Trail Lane West Friendship			x	
Montclaire Manor, Inc	11805 Wayne Ridge Street Fulton			x	
Morning Glory Assisted Living Inc	3030 Brookwood Road Ellicott City			x	
Morningside House Of EIIIcott City	5330 Dorsey Hall Drive Ellicott City			x	
New Life Assisted Living II	8313 Church Lane Ellicott City			x	
New Life Assisted Living Inc.	6901 Scarlet Oak Drive Elkridge			x	
Odilia's House II	7310 Wye Avenue Jessup			x	
Pearls Of Wisdom Assisted Living Centers, Inc	9359 Guilford Road Columbia			x	
Pfefferkorn Assisted Living	3320 Pfefferkorn Road West Friendship			x	
Pine Hill	8455 Murphy Road Laurel			x	
Royal Residential Services LLC	6379 Shadow Shape Place Columbia			x	
Sah - Rang - Bong Care I	10717 Hunting Lane Columbia			x	
Sah - Rang - Bong Care II	10804 Hunting Lane Columbia			x	
Shangri-La Assisted Living	4475 Montgomery Road Ellicott City			x	
Somerford Place - Columbia	8220 Snowden River Parkway Columbia			x	
Sunrise Of Columbia	6500 Freetown Road Columbia			x	
Total Assisted Living Home	12026 Scaggsville Road Fulton			x	
Vantage House	5400 Vantage Point Road Columbia			x	
We Care Too	6257 Tamar Drive Columbia			x	
Where We Live	8760 Mary Lane Jessup			x	
Winter Growth - Howard Center	5460 Ruth Keeton Way Columbia			x	
Winter Growth - Ruth Keeton House	5466 Ruth Keeton Way Columbia			x	
Woori Care	8549 Pineway Drive Laurel			x	
Yolanda's Home	13351 Triadelphia Mill Road Clarksville			x	
New Life Assisted Living IV	7924 Savage Guilford Road Jessup			x	
Trulife Meadows	11913 New Country Lane Columbia			x	
Delicate Hands Home Care, LLC	3952 Cooks Lane Ellicott City			x	
Chalet (The)	4211 Linthicum Road Dayton			x	
Ashleigh's Place	4914 Canvasback Court Columbia			x	
April Bloom Assisted Living	5037 Durham Road East Columbia			x	
Bredd Health Services, LLC	5984 Grand Banks Road Columbia			x	
Golden Oasis Senior Living, LLC	6905 Scarlet Oak Drive Elkridge			x	
Sand Cherry Manor	8367 Sand Cherry Lane Laurel			x	
Sincere Hands Home Care, LLC	8402 Ivy Drive Ellicott City			x	
Autumn Quest Assisted Living	8437 Jopenda Drive Ellicott City			x	
A Wise Choice Assisted Living, LLC	8732 Mary Lane Jessup			x	
Lutheran Village at Miller Grant (The)	9100 Fathers Legacy Ellicott City			x	
San Jose Care Home, LLP	9316 Pilar Court Columbia			x	

Exhibit 5

Quick Links

- Home
- Monthly Labor Review
- Employment Situation
- Local Area Unemployment Statistics (LAUS)
- Current Employment Statistics (CES)
- Press Release Schedule
- Area Explorer
- Growth Industry Tool
- Occupational Employment and Wage Statistics
- Projections Data
- Publications
- Employment and Wages (QCEW)
- A to Z Index
- Major Employer Lists
- Hot Jobs

WDAL Services

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

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

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

Maryland Seasonally Adjusted LAUS Data

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

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

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Maryland Not Seasonally Adjusted LAUS Data

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

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

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County Unemployment Rate

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

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

More Data:

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

Press Release Schedule

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

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Division of Workforce Development and Adult Learning
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Area Explorer - Baltimore County Workforce Development Area - Workforce Information & Performance

Local Area Unemployment Statistics (LAUS)

Baltimore County Workforce Development Area	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Unemployment Rate	3.8%	4.3%	4.4%	0.0%	4.7%	3.6%
Unemployment	17,168	19,073	19,357	0.0	20,889	16,001
Employment	433,794	427,521	425,383	0.0	423,652	425,876
Labor Force	450,962	446,594	444,740	0.0	444,541	441,877

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

Published by Division of Workforce Development and Adult Learning.

Powered by dataZoa

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

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

Local Area Unemployment Statistics (LAUS)

Howard Workforce Development Area	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Unemployment Rate	3.4%	3.8%	3.9%	0.0%	4.1%	3.1%
Unemployment	6,266	6,896	7,058	0.0	7,430	5,683
Employment	178,930	176,352	175,499	0.0	174,735	175,610
Labor Force	185,196	183,248	182,557	0.0	182,165	181,293

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

Published by Division of Workforce Development and Adult Learning.

Powered by dataZoa

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Exhibit 6

Focus Area	Measure	Description	Weight	Source	Year(s)	Top Performers	US Overall
POPULATION HEALTH AND WELL-BEING							
LENGTH OF LIFE							
Life span	Premature Death*	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	50%	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program	2020-2022	6,200	8,400
QUALITY OF LIFE							
Physical health	Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	10%	Behavioral Risk Factor Surveillance System	2022	3.6	3.9
	Low Birth Weight*	Percentage of live births with low birth weight (< 2,500 grams).	20%	National Center for Health Statistics - Natality Files	2017-2023	6%	8%
Mental health	Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	10%	Behavioral Risk Factor Surveillance System	2022	4.9	5.1
Life satisfaction	Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	10%	Behavioral Risk Factor Surveillance System	2022	14%	17%
COMMUNITY CONDITIONS							
HEALTH INFRASTRUCTURE							
Health promotion and harm reduction	Flu Vaccinations*	Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination.	4%	Mapping Medicare Disparities Tool	2022	54%	48%
	Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	4%	ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles	2024, 2022 & 2020	91%	84%
	Food Environment Index+	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	4%	USDA Food Environment Atlas; Map the Meal Gap from Feeding America	2019 & 2022	8.8	7.4
Clinical care	Primary Care Physicians	Ratio of population to primary care physicians.	2%	Area Health Resource File/American Medical Association	2021	1,030:1	1,330:1
	Mental Health Providers	Ratio of population to mental health providers.	1%	CMS, National Provider Identification	2024	220:1	300:1
	Dentists	Ratio of population to dentists.	1%	Area Health Resource File/National Provider Identifier Downloadable File	2022	1,180:1	1,360:1
	Preventable Hospital Stays*	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	4%	Mapping Medicare Disparities Tool	2022	1,596	2,666
	Mammography Screening*	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	1%	Mapping Medicare Disparities Tool	2022	53%	44%
	Uninsured	Percentage of population under age 65 without health insurance.	4%	Small Area Health Insurance Estimates	2022	6%	10%
PHYSICAL ENVIRONMENT							
Housing and transportation	Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	4%	Comprehensive Housing Affordability Strategy (CHAS) data	2017-2021	8%	17%
	Driving Alone to Work*	Percentage of the workforce that drives alone to work.	2%	American Community Survey, five-year estimates	2019-2023	69%	70%
	Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	1%	American Community Survey, five-year estimates	2019-2023	17%	37%
Air, water and land	Air Pollution: Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	8%	Environmental Public Health Tracking Network	2020	5.6	7.3
	Drinking Water Violations+	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	4%	Safe Drinking Water Information System	2023		
Civic and community resources	Broadband Access	Percentage of households with broadband internet connection.	4%	American Community Survey, five-year estimates	2019-2023	92%	90%
	Library Access	Library visits per person living within the library service area per year.	2%	Institute of Museum and Library Services	2022	5	2

SOCIAL AND ECONOMIC FACTORS							
Education	Some College	Percentage of adults ages 25-44 with some post-secondary education.	8%	American Community Survey, five-year estimates	2019-2023	74%	68%
	High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	8%	American Community Survey, five-year estimates	2019-2023	95%	89%
Income, employment and wealth	Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	8%	Bureau of Labor Statistics	2023	2.3%	3.6%
	Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	8%	American Community Survey, five-year estimates	2019-2023	3.7	4.9
	Children in Poverty*	Percentage of people under age 18 in poverty.	8%	Small Area Income and Poverty Estimates; American Community Survey, five-year estimates	2023 & 2019-2023	10%	16%
Safety and social support	Injury Deaths*	Number of deaths due to injury per 100,000 population.	4%	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2018-2022	67	84
	Social Associations	Number of membership associations per 10,000 population.	2%	County Business Patterns	2022	18.0	9.1
	Child Care Cost Burden	Child care costs for a household with two children as a percent of median household income.	4%	The Living Wage Institute; Small Area Income and Poverty Estimates	2024 & 2023	20%	28%

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

County	Premature Death Deaths	Years of Potential Life Lost Rate	Poor Physical Health Days Average Number of Physically Unhealthy Days	Low Birth Weight % Low Birth Weight	Poor Mental Health Days Average Number of Mentally Unhealthy Days
	83,019.0	8,091.1	3.4	8.7	4.8
Baltimore	12,492.0	8,667.5	3.6	9.3	5.3
Howard	2,441.0	4,573.3	3.0	8.4	4.4
Baltimore City	14,164.0	15,997.6	4.5	12.1	6.2

County	Poor or Fair Health % Fair or Poor Health	Flu Vaccinations % Vaccinated	Access to Exercise Opportunities % With Access to Exercise Opportunities	Food Environment Index Food Environment Index	Primary Care Physicians # Primary Care Physicians
	14.6	52.0	92.1	8.7	5,227.0
Baltimore	14.8	56.0	97.0	8.4	734.0
Howard	10.7	60.0	98.1	9.2	614.0
Baltimore City	19.8	50.0	98.8	7.9	668.0

County	Primary Care Physicians Rate	Primary Care Physicians Ratio	Mental Health Providers # Mental Health Providers	Mental Health Provider Rate	Mental Health Provider Ratio
	84.8	1179:1	22,601.0	365.7	273:1
Baltimore	86.4	1157:1	3,679.0	435.5	230:1
Howard	183.5	545:1	1,433.0	426.5	234:1
Baltimore City	115.9	863:1	3,779.0	668.6	150:1

	Dentists			Preventable Hospital Stays	Mammography Screening
County	# Dentists	Dentist Rate	Dentist Ratio	Preventable Hospitalization Rate	% with Annual Mammogram
	4,980.0	80.8	1238:1	2,527.0	45.0
Baltimore	669.0	79.1	1265:1	2,829.0	48.0
Howard	301.0	89.7	1114:1	1,728.0	50.0
Baltimore City	489.0	85.8	1166:1	3,899.0	44.0

	Uninsured		Severe Housing Problems	Driving Alone to Work	Long Commute - Driving Alone
County	# Uninsured	% Uninsured	% Severe Housing Problems	% Drive Alone to Work	# Workers who Drive Alone
	340,945.0	6.8	15.6	66.3	3,104,587.0
Baltimore	40,013.0	6.0	15.5	71.4	421,075.0
Howard	12,048.0	4.3	12.5	67.4	173,843.0
Baltimore City	30,030.0	6.6	21.5	56.8	268,543.0

	Air Pollution: Particulate Matter	Drinking Water Violations	Broadband Access		Library Access
County	Average Daily PM2.5	Presence of Water Violation	% Households with Broadband Access	# Households with Broadband Access	Visits per service area population
	6.3		91.5	2,139,911.0	2.1
Baltimore	7.5	No	90.5	298,811.0	2.4
Howard	7.0	No	96.2	115,446.0	3.2
Baltimore City	6.5	No	83.1	208,294.0	1.4

Some College

County	# Some College	Population	% Some College
	1,170,081.0	1,648,124.0	71.0
Baltimore	157,531.0	220,813.0	71.3
Howard	75,291.0	88,354.0	85.2
Baltimore City	123,206.0	184,356.0	66.8

High School Completion

County	# Completed High School	Population	% Completed High School
	3,890,112.0	4,272,813.0	91.0
Baltimore	539,254.0	588,072.0	91.7
Howard	216,545.0	227,341.0	95.3
Baltimore City	352,561.0	404,300.0	87.2

Unemployment

County	# Unemployed	Labor Force	% Unemployed
	67,600.0	3,184,870.0	2.1
Baltimore	9,755.0	445,794.0	2.2
Howard	3,216.0	188,575.0	1.7
Baltimore City	7,999.0	274,275.0	2.9

	Income Inequality			Child Care Cost Burden
County	80th Percentile Income	20th Percentile Income	Income Ratio	% Household Income Required for Child Care Expenses
	195,515.0	42,240.0	4.6	26.1
Baltimore	174,888.0	39,561.0	4.4	33.6
Howard				27.3
Baltimore City	129,006.0	19,963.0	6.5	42.1

	Children in Poverty		Injury Deaths		Social Associations	
County	% Children in Poverty	# Injury Deaths	Injury Death Rate	# Associations	Social Association Rate
	11.3	28,464.0	93.4	5,449.0	8.8
Baltimore	10.3	4,688.0	112.2	674.0	8.0
Howard	6.3	779.0	47.3	285.0	8.5
Baltimore City	26.2	6,625.0	226.2	608.0	10.7

Focus Area	Measure	Description	Source	Year(s)
POPULATION HEALTH AND WELL-BEING				
LENGTH OF LIFE				
Life span	Life Expectancy*	Average number of years people are expected to live.	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program	2020-2022
	Premature Age-Adjusted Mortality*	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program	2020-2022
	Child Mortality*	Number of deaths among residents under age 20 per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2019-2022
	Infant Mortality*	Number of infant deaths (within 1 year) per 1,000 live births.	National Center for Health Statistics - Natality and Mortality Files	2016-2022
QUALITY OF LIFE				
Physical health	Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	Diabetes Prevalence	Percentage of adults aged 18 and above with diagnosed diabetes (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	HIV Prevalence+	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2022
	Adult Obesity	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
Mental health	Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	Suicides*	Number of deaths due to suicide per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2018-2022
Life satisfaction	Feelings of Loneliness+	Percentage of adults reporting that they always, usually or sometimes feel lonely.	Behavioral Risk Factor Surveillance System	2022
COMMUNITY CONDITIONS				
HEALTH INFRASTRUCTURE				
Health promotion and harm reduction	Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	USDA Food Environment Atlas	2019
	Food Insecurity	Percentage of population who lack adequate access to food.	Map the Meal Gap	2022
	Insufficient Sleep	Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	Teen Births*	Number of births per 1,000 female population ages 15-19.	National Center for Health Statistics - Natality Files; Census Population Estimates Program	2017-2023
	Sexually Transmitted Infections+	Number of newly diagnosed chlamydia cases per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2022
	Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
	Alcohol-Impaired Driving Deaths	Percentage of driving deaths with alcohol involvement.	Fatality Analysis Reporting System	2018-2022
	Drug Overdose Deaths*	Number of drug poisoning deaths per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2020-2022
	Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	Behavioral Risk Factor Surveillance System	2022

	Physical Inactivity	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted).	Behavioral Risk Factor Surveillance System	2022
Clinical care	Uninsured Adults	Percentage of adults under age 65 without health insurance.	Small Area Health Insurance Estimates	2022
	Uninsured Children	Percentage of children under age 19 without health insurance.	Small Area Health Insurance Estimates	2022
	Other Primary Care Providers	Ratio of population to primary care providers other than physicians.	CMS, National Provider Identification	2024
PHYSICAL ENVIRONMENT				
Housing and transportation	Traffic Volume	Average traffic volume per meter of major roadways in the county.	EJSCREEN: Environmental Justice Screening and Mapping Tool	2020
	Homeownership	Percentage of owner-occupied housing units.	American Community Survey, five-year estimates	2019-2023
	Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	American Community Survey, five-year estimates	2019-2023
Air, water and land	Access to Parks	Percentage of the population living within a half mile of a park.	ArcGIS Online; US Census TIGER/Line Shapefiles	2024 & 2020
Climate	Adverse Climate Events*	Indicator of thresholds met for the following adverse climate and weather-related event categories: extreme heat (300 or more days above 90F), moderate or greater drought (65 or more weeks), and disaster (2 or more presidential disaster declarations) over the five-year period.	Environmental Public Health Tracking (EPHT) Network; U.S. Drought Monitor (USDM); OPEN FEMA Disaster Declaration Summaries	2019-2023
Civic and community resources	Census Participation	Percentage of all households that self-responded to the 2020 census (by internet, paper questionnaire or telephone).	Census Operational Quality Metrics	2020
	Voter Turnout+	Percentage of citizen population aged 18 or older who voted in the 2020 U.S. Presidential election.	MIT Election Data and Science Lab; American Community Survey, five-year estimates	2020 & 2016-2020
SOCIAL AND ECONOMIC FACTORS				
Education	High School Graduation+	Percentage of ninth-grade cohort that graduates in four years.	EDFacts	2021-2022
	Reading Scores*+	Average grade level performance for 3rd graders on English Language Arts standardized tests.	Stanford Education Data Archive	2019
	Math Scores*+	Average grade level performance for 3rd graders on math standardized tests.	Stanford Education Data Archive	2019
	School Segregation	The extent to which students within different race and ethnicity groups are unevenly distributed across schools when compared with the racial and ethnic composition of the local population. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation.	National Center for Education Statistics	2023-2024
	School Funding Adequacy+	The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district.	School Finance Indicators Database	2022

Income, employment and wealth	Children Eligible for Free or Reduced Price Lunch+	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	National Center for Education Statistics	2022-2023
	Gender Pay Gap	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar."	American Community Survey, five-year estimates	2019-2023
	Median Household Income*	The income where half of households in a county earn more and half of households earn less.	Small Area Income and Poverty Estimates; American Community Survey, five-year estimates	2023 & 2019-2023
	Living Wage	The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children.	The Living Wage Institute	2024
Safety and social support	Child Care Centers	Number of child care centers per 1,000 population under 5 years old.	Homeland Infrastructure Foundation-Level Data (HIFLD)	2010-2022
	Residential Segregation - Black/White	Index of dissimilarity where higher values indicate greater residential segregation between Black and White county residents.	American Community Survey, five-year estimates	2019-2023
	Homicides*	Number of deaths due to homicide per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2016-2022
	Motor Vehicle Crash Deaths*	Number of motor vehicle crash deaths per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2016-2022
	Firearm Fatalities*	Number of deaths due to firearms per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2018-2022
	Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	American Community Survey, five-year estimates	2019-2023
	Lack of Social and Emotional Support+	Percentage of adults reporting that they sometimes, rarely, or never get the social and emotional support they need.	Behavioral Risk Factor Surveillance System	2022
DEMOGRAPHICS				
All	% Below 18 Years of Age	Percentage of population below 18 years of age.	Census Population Estimates Program	2023
	% 65 and Older	Percentage of population ages 65 and older.	Census Population Estimates Program	2023
	% Female	Percentage of population identifying as female.	Census Population Estimates Program	2023
	% American Indian or Alaska Native	Percentage of population identifying as American Indian or Alaska Native.	Census Population Estimates Program	2023
	% Asian	Percentage of population identifying as Asian.	Census Population Estimates Program	2023
	% Hispanic	Percentage of population identifying as Hispanic.	Census Population Estimates Program	2023
	% Native Hawaiian or Other Pacific Islander	Percentage of population identifying as Native Hawaiian or Other Pacific Islander.	Census Population Estimates Program	2023
	% Non-Hispanic Black	Percentage of population identifying as non-Hispanic Black or African American.	Census Population Estimates Program	2023
	% Non-Hispanic White	Percentage of population identifying as non-Hispanic white.	Census Population Estimates Program	2023
	% Disability: Functional Limitations	Percentage of adults reporting any of six specific functional limitations	Behavioral Risk Factor Surveillance System	2022
	% Not Proficient in English	Percentage of population aged 5 and over who reported speaking English less than well.	American Community Survey, five-year estimates	2019-2023
	Children in Single-Parent Households	Percentage of children that live in a household headed by a single parent.	American Community Survey, five-year estimates	2019-2023
	% Rural	Percentage of population living in a census-defined rural area.	Decennial Census Demographic and Housing Characteristics File	2020

	Population	Resident population.	Census Population Estimates Program	2023

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

	Life Expectancy	Premature Age-Adjusted Mortality		Child Mortality		Infant Mortality		Frequent Physical Distress
County	Life Expectancy	# Deaths	Age-Adjusted Death Rate	# Deaths	Child Mortality Rate	# Deaths	Infant Mortality Rate	% Frequent Physical Distress
	77.8	83,019.0	383.2	3,084.0	51.5	3,013.0	6.1	9.8
Baltimore	76.9	12,492.0	413.4	447.0	54.8	426.0	6.3	10.3
Howard	82.5	2,441.0	214.8	127.0	36.5	123.0	5.2	8.2
Baltimore City	70.6	14,164.0	735.3	497.0	93.2	479.0	8.9	13.3

	Diabetes Prevalence	HIV Prevalence		Adult Obesity	Frequent Mental Distress	Suicides		Feelings of Loneliness
County	% Adults with Diabetes	# HIV Cases	HIV Prevalence Rate	% Adults with Obesity	% Frequent Mental Distress	# Deaths	Suicide Rate (Age-Adjusted)	% feeling lonely
	10.5	33,580.0	643.8	33.5	15.2	3,120.0	9.8	35.9
Baltimore	10.6	3,624.0	504.4	33.2	16.1	454.0	10.3	36.0
Howard	8.8	745.0	265.0	26.9	13.7	123.0	7.4	34.5
Baltimore City	13.8	10,252.0	2,110.3	38.5	19.8	288.0	9.6	38.0

	Limited Access to Healthy Foods		Food Insecurity		Insufficient Sleep	Teen Births	Sexually Transmitted Infections	
County	# Limited Access to Healthy Foods	% Limited Access to Healthy Foods	# Food Insecure	% Food Insecure	% Insufficient Sleep	Teen Birth Rate	# Chlamydia Cases	Chlamydia Rate
	205,285.7	3.6	749,260.0	12.2	38.7	12.6	31,234.0	506.7
Baltimore	35,615.2	4.4	102,630.0	12.1	37.2	11.5	4,057.0	479.5
Howard	5,427.1	1.9	32,130.0	9.7	37.4	4.7	958.0	285.6
Baltimore City	11,246.3	1.8	90,750.0	15.5	42.1	26.3	8,074.0	1,416.7

	Excessive Drinking	Alcohol-Impaired Driving Deaths			Drug Overdose Deaths		Adult Smoking	Physical Inactivity
County	% Excessive Drinking	# Alcohol-Impaired Driving Deaths	# Driving Deaths	% Driving Deaths with Alcohol Involvement	# Drug Overdose Deaths	Drug Overdose Mortality Rate	% Adults Reporting Currently Smoking	% Physically Inactive
	15.8	801.0	2,714.0	29.5	8,081.0	44.0	9.8	20.5
Baltimore	17.4	103.0	353.0	29.2	1,284.0	50.9	12.2	21.6
Howard	16.1	40.0	134.0	29.9	152.0	15.2	8.1	17.9
Baltimore City	18.8	49.0	234.0	20.9	2,496.0	144.1	16.6	27.2

	Uninsured Adults		Uninsured Children		Other Primary Care Providers		Traffic Volume	Homeownership
County	# Uninsured Adults	% Uninsured Adults	# Uninsured Children	% Uninsured Children	Other Primary Care Provider Rate	Other Primary Care Provider Ratio	Traffic Volume	# Homeowners
	292,218.0	7.9	53,199.0	3.8	145.7	686:1	162.6	1,578,702.0
Baltimore	33,422.0	6.8	7,173.0	3.9	144.4	692:1	180.8	218,994.0
Howard	9,902.0	4.9	2,347.0	2.9	138.7	721:1	139.9	86,100.0
Baltimore City	26,091.0	7.5	4,306.0	3.7	366.0	273:1	373.1	119,077.0

		Severe Housing Cost Burden		Access to Parks	Adverse Climate Events			
County	% Homeowners	# Households with Severe Cost Burden	% Households with Severe Cost Burden	% with access to parks	Adverse Climate Events	Days above 90F	Weeks in moderate or greater drought	Disaster declarations
	67.5	328,777.0	14.4	66.2				
Baltimore	66.3	48,142.0	14.9	64.9	-	80.0	28.0	-
Howard	71.7	13,693.0	11.6	67.3	-	95.0	34.0	-
Baltimore City	47.5	51,320.0	21.3	85.2	-	88.0	25.0	-

	Census Participation	Voter Turnout	High School Graduation		Reading Scores	Math Scores	School Segregation	
County	% Census Participation	% Voter Turnout	Cohort Size	High School Graduation Rate	Average Grade Performance	Average Grade Performance	Segregation Index	
		70.4	67,045.0	86.4	3.0	3.0	0.3	
Baltimore	72.2	68.0	8,440.0	85.0	2.9	2.9	0.2	
Howard	78.2	82.8	4,662.0	95.0	3.4	3.4	0.1	
Baltimore City	55.6	52.4	5,296.0	69.2	2.2	2.2	0.3	

	School Funding Adequacy		Children Eligible for Free or Reduced Price Lunch	Gender Pay Gap			Median Household Income	
County	Spending per Pupil	School Funding Adequacy	% Enrolled in Free or Reduced Lunch	Women's Median Earnings	Men's Median Earnings	Gender Pay Gap	Median Household Income	
	17,752.9	1,542.2	50.7	68,044.0	78,655.0	0.9	98,568.0	
Baltimore	16,538.0	(156.9)	53.1	63,023.0	73,543.0	0.9	86,807.0	
Howard	17,971.0	6,651.8	27.6	88,067.0	110,957.0	0.8	140,113.0	
Baltimore City	18,272.0	(10,330.9)	71.4	58,444.0	61,140.0	1.0	58,616.0	

	Child Care Centers		Residential Segregation - Black/White	Homicides	Motor Vehicle Crash Deaths		Firearm Fatalities
County	# Child Care Centers	Child Care Centers per 1,000 Children	Segregation Index	Homicide Rate	# Motor Vehicle Deaths	Motor Vehicle Mortality Rate	# Firearm Fatalities
	6.2	63.0	10.0	4,041.0	9.5	3,995.0	
Baltimore	265.0	5.3	59.8	10.0	533.0	9.1	575.0
Howard	137.0	7.2	38.9	3.2	148.0	6.5	94.0
Baltimore City	237.0	6.5	67.6	45.5	414.0	10.0	1,314.0

	Disconnected Youth	Lack of Social and Emotional Support	% Below 18 Years of Age	% 65 and Older	% Female
County	% Disconnected Youth	% lacking support	% Below 18 Years of Age	% 65 and Over	% Female
	6.1	27.4	22.0	17.3	51.4
Baltimore	6.4	27.7	21.7	18.7	52.5
Howard	4.1	27.4	23.5	15.9	50.7
Baltimore City	8.6	31.0	20.8	15.8	53.6

	% American Indian or Alaska Native		% Asian		% Hispanic		% Native Hawaiian or Other Pacific Islander	
County	# American Indian or Alaska Native	% American Indian or Alaska Native	# Asian	% Asian	# Hispanic	% Hispanic	# Native Hawaiian or Other Pacific Islander	% Native Hawaiian or Other Pacific Islander
	47,993.0	0.8	437,702.0	7.1	781,273.0	12.6	8,096.0	0.1
Baltimore	5,080.0	0.6	55,289.0	6.5	67,159.0	8.0	946.0	0.1
Howard	1,827.0	0.5	68,754.0	20.5	29,751.0	8.9	278.0	0.1
Baltimore City	3,501.0	0.6	16,152.0	2.9	46,375.0	8.2	739.0	0.1

	% Non-Hispanic Black		% Non-Hispanic White		% Disability: Functional Limitations	% Not Proficient in English	
County	# Non-Hispanic Black	% Non-Hispanic Black	# Non-Hispanic White	% Non-Hispanic White	% with disability	# Not Proficient in English	% Not Proficient in English
	1,865,398.0	30.2	2,921,370.0	47.3	24.0	210,070.0	3.6
Baltimore	262,780.0	31.1	435,707.0	51.6	24.4	16,430.0	2.1
Howard	69,762.0	20.8	155,846.0	46.4	20.2	11,592.0	3.7
Baltimore City	338,772.0	59.9	150,346.0	26.6	30.6	10,623.0	2.0

	Children in Single-Parent Households			% Rural		Population
County	# Children in Single-Parent Households	# Children in Households	% Children in Single-Parent Households	# Rural Residents	% Rural	Population
	352,458.0	1,374,017.0	25.7	888,464.0	14.4	6,180,253.0
Baltimore	51,683.0	185,999.0	27.8	60,921.0	7.1	844,703.0
Howard	13,553.0	80,197.0	16.9	39,471.0	11.9	336,001.0
Baltimore City	59,799.0	120,167.0	49.8	-	-	565,239.0

Exhibit 7

Demographic Summary of the FHC PSA Counties, 2025

US Census Bureau, American Community Survey, DP02 and DP03

Metric	Maryland	Baltimore	Baltimore City	Howard	Total PSA Percentage	Total PSA Population	Sources
2025 Total Pop	6,244,960	838,558	599,995	344,148		1,782,701	Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Percent Distribution		47.0%	33.7%	19.3%	100.0%		
FHC PSA Demographic Data							
Female	51.8%	53.0%	52.0%	51.2%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Male	48.2%	47.0%	48.0%	48.8%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Under 18 Years	24.0%	19.6%	21.4%	23.2%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
18 to 64 Years	57.7%	63.8%	56.5%	56.8%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
65 and Older	18.2%	16.5%	22.1%	20.0%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
Non-Hispanic Other	10.6%	10.6%	5.1%	26.6%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Non-Hispanic Black	30.7%	32.9%	60.5%	21.7%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Non-Hispanic White	47.3%	49.8%	29.2%	43.6%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Hispanic	11.4%	6.7%	5.2%	8.1%			Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025
Veterans	6.8%	4.9%	5.5%	6.1%			US Census Bureau American Community Survey 5-Year Estimates Selected Social Characteristics Table DP02
English as a Second Language	21.80%	16.30%	12.40%	30.60%			US Census Bureau American Community Survey 5-Year Estimates Selected Social Characteristics Table DP02
Less then High School Degree	8.60%	7.60%	11.10%	6.20%			US Census Bureau American Community Survey 5-Year Estimates Selected Social Characteristics Table DP02
Disability	12.30%	13.20%	17.70%	8.70%			US Census Bureau American Community Survey 5-Year Estimates Selected Social Characteristics Table DP02
Drove to work (alone + carpool)	66.40%	70.80%	56.50%	66.20%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
Uninsured	6.30%	5.60%	6.60%	4.50%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
Poverty	9.10%	9.20%	17.70%	5.10%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
Household Median Income							
<$10,000 - $34,999	16.00%	18.40%	28.40%	8.90%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
$35,000 - $74,999	20.60%	24.40%	27.30%	13.30%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
$75,000 - $149,000	30.00%	30.90%	26.60%	26.90%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024
$150,000 - $200,000+	33.30%	26.30%	17.70%	50.90%			US Census Bureau American Community Survey 5-Year Estimates Selected Economic Characteristics Table DP03, 2024

Demographic Summary of the FHC PSA Counties, 2025

US Census Bureau, American Community Survey, DP02 and DP03

Metric	Maryland	Baltimore	Baltimore City	Howard	Total PSA Percentage	Total PSA Population	Sources
Weighted Average of FHC PSA Demographic Data							
Female		24.9%	17.5%	9.9%	52.3%	932,637	
Male		22.1%	16.2%	9.4%	47.7%	850,064	
Under 18 Years		9.2%	7.2%	4.5%	20.9%	372,599	
18 to 64 Years		30.0%	19.0%	11.0%	60.0%	1,069,473	
65 and Older		7.8%	7.4%	3.9%	19.1%	339,791	
Non-Hispanic Other		5.0%	1.7%	5.1%	11.8%	211,030	
Non-Hispanic Black		15.5%	20.4%	4.2%	40.0%	713,563	
Non-Hispanic White		23.4%	9.8%	8.4%	41.7%	742,849	
Hispanic		3.2%	1.8%	1.6%	6.5%	115,259	
Veterans		2.3%	1.9%	1.2%	5.3%	95,082	
English as a Second Language		7.7%	4.2%	5.9%	17.7%	316,394	
Less then High School Degree		3.6%	3.7%	1.2%	8.5%	151,667	
Disability		6.2%	6.0%	1.7%	13.8%	246,830	
Drove to work (alone + carpool)		33.3%	19.0%	12.8%	65.1%	1,160,522	
Uninsured		2.6%	2.2%	0.9%	5.7%	102,046	
Poverty		4.3%	6.0%	1.0%	11.3%	200,898	
Household Median Income							
<$10,000 - $34,999		8.7%	9.6%	1.7%	19.9%	355,322	
$35,000 - $74,999		11.5%	9.2%	2.6%	23.2%	414,178	
$75,000 - $149,000		14.5%	9.0%	5.2%	28.7%	511,289	
$150,000 - $200,000+		12.4%	6.0%	9.8%	28.2%	501,911	

Estimated Medicare and Medicaid Enrollment in FHC PSA, 2025 Data

Metric	Medicare	Medicaid
a. Total Baltimore County Population	838,558	838,558
b. Total Baltimore City Population	599,995	599,995
c. Total Howard County Population	344,148	344,148
d. Total Population FHC PSA	**1,782,701**	**1,782,701**
e. Total Baltimore County Enrollees	172,869	27,769
f. Total Baltimore City Enrollees	102,742	249,281
g. Total Howard County Enrollees	57,999	52,552
h. Total Enrollees FHC PSA	**333,610**	**329,602**
i. Percent Baltimore County Enrolled	20.6%	3.3%
j. Percent Baltimore City Enrolled	17.1%	41.5%
k. Percent Howard County Enrolled	16.9%	15.3%
l. Percent FHC PSA Enrolled	**18.7%**	**18.5%**

a - c. Maryland Department of Planning, 2020 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender, 2025

d. sum of a through c

e-g. Medicare Enrollment Dashboard, November 2025 *https://data.cms.gov/tools/medicare-enrollment-dashboard*

Mayland Medicaid Enrollment by County, March 2025 https://health.maryland.gov/newsroom/SiteAssets/Pages/Impact-of-Potential-Medicaid-Proposals-to-Maryland-Medicaid/Maryland%20Medicaid%20Fact'

h. sum of e through g

i-l. Total enrollees by jurisdiction / total population by jurisdiction

Exhibit 8

Charity Care and Discount Policy

I. PURPOSE

First Healthcare Consultants LTD("FHC") is committed to ensuring that all individuals, regardless of their financial circumstances, have access to medically necessary home health services. The purpose of this policy is to clearly define how FHC provides charity care, discounted services, and interest-free payment plans to eligible patients who are uninsured, underinsured, or otherwise unable to pay.

This policy aligns with FHC's mission of serving underserved and medically complex populations and complies with all applicable federal and state regulations, including **COMAR 10.24.16.08E**, **COMAR 10.24.01.08G(3)(f)**, COMAR 10.24.01.09 and CMS Conditions of Participation as well as all applicable federal and state regulations.

FHC will not deny, delay, or discontinue medically necessary care based on a patient's inability to pay.

II. POLICY STATEMENT

FHC ensures equitable access to care through the following commitments:

1. Provide **charity care (free care)** to patients with household income at or below **100% of the Federal Poverty Level (FPL)**.
2. Provide **discounted care** on a sliding scale to patients with income up to **200% of FPL**, at minimum, and up to 300% FPL based on financial hardship.
3. Offer **interest-free payment plans** to patients who do not qualify for full charity care.
4. Never charge interest, late fees, or use aggressive collection practices.
5. Not refuse, limit, or discontinue services based on inability to pay.
6. Inform all patients of the availability of charity care and discounts, both verbally and in writing, in English and Spanish and other languages as needed.
7. Make this policy publicly available in physical locations and on the agency's website.
8. Report charity care annually to the Maryland Health Care Commission (MHCC) as required.

III. DEFINITIONS

Charity Care:

Medically necessary services provided **at no cost** to eligible patients with income ≤100% FPL or those who demonstrate financial hardship.

Discounted Care:

Reduced charges based on a sliding fee scale for patients with income between 101%–300% FPL.

Financial Hardship:

A situation in which medical expenses, loss of income, or extraordinary circumstances prevent a patient from paying for necessary care, even if income exceeds standard thresholds.

Uninsured Patient:

An individual without any third-party health insurance coverage.

Underinsured Patient:

A patient whose insurance does not cover all medically necessary services or who faces high deductibles, coinsurance, or copayments.

Household Income:

Combined gross income of all household members, as defined by federal guidelines.

Family Size:

As defined by current Federal Poverty Level (FPL) guidelines.

Medically Necessary Services:

Skilled home health services ordered by a physician and delivered under a plan of care.

IV. ELIGIBILITY CRITERIA

A patient may qualify for charity care or discounted services if they meet **any** of the following:

1. Family Size or household income at or below 300% of FPL (with sliding scale applied)
2. High out-of-pocket medical expenses, exceptional medical hardship or extraordinary medical expenses relative to income
3. Significant change in financial circumstances (job loss, divorce, death in family, disability, etc.)
4. Participation in needs-based government assistance programs (e.g., Medicaid, SNAP, SSI)
5. Uninsured/Underinsured status – Status does not automatically disqualify patient

Patients with insurance may still qualify if they have high out-of-pocket responsibility or financial hardship.

V. SLIDING FEE SCALE (By % of Federal Poverty Level)

FHC uses the current Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services and updates the scale annually.

Household Income (% of FPL)	Patient Responsibility	Discount Applied
0–100%	0%	100% (Full Charity Care – No Charge)
101–150%	25% of charges	75% Discount
151–200%	50% of charges	50% Discount
201–250%	75% of charges	25% Discount
251–300%	Case-by-case (up to 25% discount)	Hardship Discount
>300%	May qualify for hardship discount or payment plan	Determined individually

Note: *The sliding fee scale will be updated annually based on the current Federal Poverty Guidelines published by the U.S. Department of Health and Human Services.*

FHC may provide additional discounts beyond the minimum requirements in cases of verified financial hardship, extraordinary medical expenses or exceptional circumstances.

Application Process

Patients may request charity care or discounted services at any time, including before, during, or after care.

How to Apply:

1. Complete the Financial Assistance Application form
2. Provide proof of income (e.g., tax return, pay stub, W-2, benefits statement)
3. Provide proof of household size
4. Provide documentation of medical expenses or hardship if requested

FHC Responsibilities:

1. Provide the application in English, Spanish, and other languages as needed
2. Assist patients in completing the application
3. Make reasonable efforts to verify information when documents are unavailable
4. Make a probable eligibility determination within two (2) business days of a client's request

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

Important: Care will not be denied or delayed while an application is pending. No medically necessary services will be denied, delayed, or discontinued while a probable eligibility determination or final financial assistance review is pending.

Failure to provide documentation may result in denial; however, FHC will make reasonable efforts to verify eligibility through alternative means.

Payment Plans

Patients who do not qualify for full charity care may set up an **interest-free payment plan** based on their ability to pay. Monthly payments will not exceed a reasonable percentage of household income.

What to Expect:

1. Affordable monthly payments
2. Flexible terms
3. No interest or late fees
4. May be extended or adjusted for hardship
5. No aggressive collections

Communication Of Policy

FHC will make this policy available:

1. At admission or referral
2. During financial counseling
3. In patient handbooks or welcome packets
4. On the agency website
5. In publicly accessible office areas
6. In English, Spanish, and other languages appropriate to the service area or as needed.

Staff will verbally inform patients of the availability of charity care and assist them in applying. Interpreter services for other languages are available at no cost to the patient.

Non-Discrimination

FHC does not discriminate in the provision of charity care, discounted services, or payment plans based on:

1. Race or ethnicity
2. Color
3. National origin
4. Religion
5. Sex, gender identity, or sexual orientation
6. Age
7. Disability
8. Marital or family status
9. Veteran status
10. Immigration status
11. Insurance status
12. Any other protected characteristic

Eligibility is based solely on financial need and medical necessity.

Confidentiality

All financial and personal information submitted by the patient is:

1. Kept confidential
2. Used only for determining eligibility
3. Protected under HIPAA and other privacy laws
4. Never shared with external entities except as required by law

Reporting And Compliance

FHC will:

- Track all charity care and discount services
- Maintain documentation for auditing purposes
- Report charity care annually to the Maryland Health Care Commission (MHCC) and other agencies as required
- Comply with **COMAR 10.24.16.08E**

Quality And Performance Monitoring

As part of FHC's **Quality Assurance and Performance Improvement (QAPI)** program:

- Utilization of charity care will be reviewed to ensure access
- Barriers to care will be identified and addressed
- Trends in service needs will inform resource planning
- Policy effectiveness will be reviewed annually

Governance And Policy Review

- This policy will be reviewed and updated at least **annually**
- Sliding fee scale will be updated annually according to the latest FPL guidelines
- Significant changes will be approved by senior leadership or governing body
- Staff will receive training on any revisions

No Delay Or Denial Of Service

FHC will **not delay, deny, or discontinue** medically necessary services due to a patient's inability to pay or due to charity/discount application status.

No patient will be referred to collections or incur negative action while an application is pending.

SLIDING FEE SCALE TABLES

Effective Date: 2025

Based on the Federal Poverty Guidelines (FPG)

This Sliding Fee Scale is used to determine the level of financial assistance available to eligible clients of First Healthcare Consultants LTD(FHC). Discount levels are determined by household income and size, as verified through the FHC Financial Assistance Application.

INCOME ELIGIBILITY & DISCOUNT TABLE

All percentages refer to Federal Poverty Guideline (FPG) thresholds.

Household Income as % of FPG	Discount Level	Client Responsibility
0% – 200% of FPG	100% Discount (Full Charity Care)	$0 owed
201% – 300% of FPG	75% Discount	25% of charges
301% – 350% of FPG	50% Discount	50% of charges
351% – 400% of FPG	25% Discount	75% of charges
Above 400% of FPG	Standard Charges Apply – Unless Financial Hardship is documented	May qualify for Time-Payment Plan or Special Hardship Review

HOUSEHOLD INCOME TABLE – 2025 FEDERAL POVERTY GUIDELINES

(Effective January 2025 — official HHS values)

Household Size	100% FPG	200% FPG	300% FPG	400% FPG
1	$15,650	$31,300	$46,950	$62,600
2	$21,150	$42,300	$63,450	$84,600
3	$26,650	$53,300	$79,950	$106,600
4	$32,150	$64,300	$96,450	$128,600
5	$37,650	$75,300	$112,950	$150,600
6	$43,150	$86,300	$129,450	$172,600
7	$48,650	$97,300	$145,950	$194,600
8	$54,150	$108,300	$162,450	$216,600

For households larger than eight (8), add $5,500 for each additional person at the 100% FPG level, then multiply accordingly for higher percentages. larger than 8, add $5,140 per additional person (100% FPG baseline). Values are updated each year when HHS issues new guidelines.

PROGRAM NOTES

- Determinations are based on **gross household income** and documentation submitted.
- Clients with **special financial hardship** may request individualized review.
- Discounts apply only to medically necessary home health services.
- Probable eligibility is determined within **two business days**, as required by Maryland law.

POSTING REQUIREMENT

This chart must be posted:

- In the FHC main office
- On the official website
- In all service intake areas
- Included in client admission packets

*For questions or assistance, call FHC at **301.725.1800** or **info@fheconsultantsus.com***

HEALTH EQUITY & CHARITY CARE COMPLIANCE WORKSHEET

Applicant: First Healthcare Consultants LTD (FHC)

Project Type: Establishment of a Home Health Agency (HHA)

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

Regulatory Reference: COMAR 10.24.16.08E – Charity Care and Sliding Fee Scale: Each applicant for home health agency services shall have **a written policy** for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual's ability to pay and shall provide home health agency services on a charitable basis to qualified indigent and low-income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

COMAR STANDARDS	Quote from the policy	Section citation
1.Determination of Eligibility for Charity Care and Reduced Fees. Within **two business days following a client's initial request for charity care services**, **application for medical assistance, or both, the home health agency shall make a determination of probable eligibility** for medical assistance, charity care, and reduced fees, and **communicate** this probable eligibility determination to the client.	"FHC will make a **probable eligibility determination within two business days** of: (1) A request for charity care, (2) Submission of a financial assistance application, or (3) Submission of a Medical Assistance (Medicaid) application." During the first contact or upon referral, FHC will assess family size, insurance status, household income, and financial resources to determine probable eligibility." "Care will **not be denied or delayed** while an application is pending."	FHC Charity Care Assessment & Financial Assistance Policy — **Section V: Determination of Probable Eligibility** FHC Charity Care & Discount Policy — **Section VI: Application Process**

COMAR STANDARDS	Quote from the policy	Section citation
2.Notice of Charity Care and Sliding Fee Scale Policies. Public notice and information regarding the home health agency's **charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA's service area, and in a format understandable by the service area** population. Notices regarding the HHA's charity care and sliding fee scale policies shall be **posted in the business office of the HHA and on the HHA's website, if such a site is maintained. Prior to the provision of HHA services, a HHA shall address clients' or clients' families concerns with payment for HHA services** and **provide individual notice regarding the HHA's charity care and sliding fee scale policies to the client and family.**	**Public Notice Statement:** "First Healthcare Consultants LTD(FHC) will make home health care available to all adult residents… Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. **Probable eligibility will be determined within two business days**." "FHC will make this policy available: at admission, during financial counseling, in patient packets, on the website, and in publicly accessible office areas, in English, Spanish, and other languages."	FHC Charity Care Public Notice — **Public Notice Statement** FHC Charity Care & Discount Policy — **Section VIII: Communication of Policy** FHC Sliding Fee Scale Tables — **Posting Requirement Section**
3.Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each HHA's charity care policy shall **include provisions for a sliding fee scale and time payment plans for low-income clients who do not qualify for full charity care but are unable to bear the full cost of services.**	**Sliding Fee Scale:** "0–200% FPG — 100% Discount (Full Charity Care) 201–300% FPG — 75% Discount 301–350% FPG — 50% Discount 351–400% FPG — 25% Discount Above 400% FPG — hardship review or time-payment plan." "FHC provides charity care to patients with income at or below 100% FPL and discounted care up to 300% FPL."	FHC Sliding Fee Scale Tables — **Income Eligibility & Discount Table** FHC Charity Care & Discount Policy — **Section V: Sliding Fee Scale** FHC Time Payment Plan Policy — **Payment Plan Terms**

COMAR STANDARDS	Quote from the policy	Section citation
4. Policy Provisions. An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, **provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve** during the most recent year for which data is available. The applicant shall demonstrate that: **Its track record** in the provision of charity care services, if any, supports the credibility of its commitment; and **It has a specific plan** for achieving the level of charity care to which it is committed.	"FHC will **not deny, delay, or discontinue** medically necessary care based on inability to pay." "FHC does not discriminate in the provision of charity care… based on race, ethnicity, national origin, gender, age, disability, immigration status, insurance status, or any protected characteristic." "FHC provides charity care (free care) to patients ≤100% FPL and discounted care up to 300% FPL." "Probable eligibility will be determined within two business days… Discounts may be applied retroactively for up to 90 days." "Utilization of charity care will be reviewed to ensure access… Policy effectiveness will be reviewed annually."	FHC Charity Care & Discount Policy — **Sections II, IX & XII** FHC Charity Care Assessment & Financial Assistance Policy — **Section V**

Charity Care Assessment & Financial Assistance Policy

I. PURPOSE

First Healthcare Consultants LTD("FHC") or "FHC") is committed to ensuring that all individuals, regardless of their financial circumstances, have access to medically necessary home health services.

The purpose of this policy is to establish clear, compliant, and equitable policies for assessing and providing financial assistance, including charity care, sliding fee scale discounts, and time-payment arrangements, to eligible clients of FHC.

This policy aligns with FHC's mission of serving underserved and medically complex populations and complies with all applicable federal and state regulations, including **COMAR 10.24.16.08E**, **COMAR 10.24.01.08G(3)(f)**, COMAR 10.24.01.09 and CMS Conditions of Participation as well as all applicable federal and state regulations.

FHC will not deny, delay, or discontinue medically necessary care based on a patient's inability to pay.

II. POLICY STATEMENT

First Healthcare Consultants LTD(FHC) is committed to ensuring access to high-quality home health services for all adult residents of its licensed service area, including individuals who are uninsured, underinsured, or experiencing financial hardship. FHC does not discriminate based on race, color, creed, gender, age, sexual orientation, gender identity, national origin, disability, or financial status.

Clients who lack adequate insurance coverage and demonstrate inability to pay may qualify for:

- Charity care (free or reduced-cost services)
- Sliding fee scale discounts based on Federal Poverty Guidelines
- Time-payment plans allowing extended, affordable repayment options

FHC will make timely determinations of probable eligibility in accordance with MHCC regulations.

III. PUBLIC NOTIFICATION

In compliance with Maryland regulations, FHC will publicly communicate its Charity Care and Financial Assistance policies through:

- Notices posted prominently in FHC business offices,
- Information published on FHC's official website,
- Annual newspaper publication within the service region.

Required Notice Language:

"First Healthcare Consultants LTD will make home health care available to all adult residents of its service area regardless of race, creed, gender, age, sexual orientation, national origin, or financial status. If insurance coverage is not available for reimbursement, patients or guarantors are responsible for payment. Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. Probable eligibility will be determined within two business days of a request for assistance or an application for Medical Assistance. Assistance amounts are based on Federal Income Poverty Guidelines. For information or applications, call 301.725.1800."

IV. PAYMENT EXPECTATIONS & TIME-PAYMENT PLANS

Clients who do not qualify for Medicaid, insurance reimbursement, or charity care are responsible for payment of services rendered. FHC will:

- Issue billing statements over a three-month cycle,
- Provide follow-up communication after the second billing notice,
- Offer time-payment plans with minimum monthly payments as low as $10,
- Allow repayment periods up to 18 months based on financial circumstances.

V. DETERMINATION OF PROBABLE ELIGIBILITY

FHC will make a **probable eligibility determination within two business days** of:

- A request for charity care,
- Submission of a financial assistance application,
- Submission of a Medical Assistance (Medicaid) application.

During the first contact or upon referral, FHC will assess:

- Family size,
- Insurance status,
- Household income and available financial resources.

Probable Eligibility Guidance:

1. If the client has applied for Medicaid, FHC will treat the client as Medicaid-pending unless a denial occurs.
2. If the client:
    a. Lacks insurance,
    b. Is not eligible for Medicaid, and
    c. Demonstrates insufficient income or resources, the client will be considered probably eligible for charity care or sliding-scale discounts.

Clients will receive written communication of probable eligibility determination.

VI. FINAL ELIGIBILITY DETERMINATION

1. Final charity care eligibility must be determined by FHC. A client's self-declaration of inability to pay is not considered adequate proof.
2. Clients who have applied for Community Medicaid and completed required documentation may be accepted as "Medicaid Pending." In these cases, no FHC charity form is required, but FHC will monitor Medicaid application progress.
3. FHC will assess total financial resources, including disposable income, assets, and ordinary living expenses.
4. FHC must confirm that no other party is legally responsible for the patient's medical expenses.

VII. SLIDING FEE SCALE

FHC will apply sliding-scale discounts based on the most current **Federal Poverty Level (FPL)** guidelines (See Exhibit on Federal and State FPL Guidelines). Eligibility and discount tiers will be published annually and included in the client information packet.

VIII. DOCUMENTATION REQUIREMENTS

Clients applying for charity care, sliding-scale discounts, or time-payment arrangements may be required to provide:

- Proof of income (pay stubs, tax return, benefits statements),
- Household size verification,
- Medicaid denial letter (if applicable),
- Documentation of financial hardship or catastrophic events.

FHC will maintain confidentiality and handle all documentation in compliance with HIPAA and state privacy laws.

IX. STAFF RESPONSIBILITIES & TRAINING

FHC staff responsible for intake, billing, and financial assistance review shall be trained annually in:

- Eligibility determination procedures,
- Federal and state regulatory requirements,
- Communication of patient rights and available financial options.

X. RECORDKEEPING & COMPLIANCE

FHC will maintain records of:

- All applications received,
- Probable and final eligibility determinations,
- Correspondence with clients regarding financial assistance,
- Annual publication notices.

Records will be retained in accordance with MHCC, Medicare Conditions of Participation, and state recordkeeping requirements.

XI. POLICY REVIEW

This policy will be reviewed annually and updated to reflect FHC operational updates, regulatory changes, and changes to Federal Poverty Guidelines.

XII. REGULATORY AUTHORITY

This policy is established in accordance with the following Maryland laws and regulations:

- **COMAR 10.24.16** – Home Health Agency Regulations
- **COMAR 10.24.10** – Certificate of Need Procedures
- **COMAR 10.24.01.08G** – Charity Care Standards
- **Maryland Health–General §19-214.1** – Billing & Financial Assistance Notice Requirements

XIII. DEFINITIONS

Charity Care: Free or discounted services provided to eligible clients based on financial hardship.
Sliding Fee Scale: A structured discount schedule tied to Federal Poverty Level (FPL) income brackets.

Probable Eligibility: A preliminary determination made within two business days based on available information.

Financial Hardship: A circumstance in which a client lacks sufficient income or assets to pay for medically necessary care.

Medicaid Pending: Status given to a client who has applied for Medical Assistance but has not yet received a determination.

XIV. SLIDING FEE SCALE

FHC applies a transparent, annually updated sliding fee scale based on Federal Poverty Guidelines:

- **0–200% FPL:** 100% discount (free care)
- **200–300% FPL:** 75% discount
- **300–350% FPL:** 50% discount
- **350–400% FPL:** 25% discount
- **Above 400% FPL:** May be eligible for time-payment plans or special hardship review.

A full version of the Sliding Fee Schedule will be included in the FHC client information packet and posted publicly.

XV. PATIENT RIGHTS

All clients receiving services from FHC have the right to:

- Apply for charity care, sliding-scale discounts, or time-payment arrangements.
- Receive a probable eligibility determination within two business days.
- Receive written notification of approval, denial, or need for additional documentation.
- Appeal any denial of financial assistance.
- Receive medically necessary services without discrimination, delay, or retaliation.

Applying for financial assistance **will not** affect the quality, timeliness, or availability of services.

XVI. APPEALS AND RECONSIDERATION

Clients may request reconsideration of any denial within **15 days** of notification. Appeals must be submitted in writing and may include new or updated financial information.
FHC will review and respond to appeals within **10 business days** of receipt.

XVII. DOCUMENTATION & RETENTION REQUIREMENTS

FHC will retain all charity care applications, probable eligibility determinations, final eligibility decisions, appeals and associated outcomes, and all financial documentation used in determining eligibility for a minimum of seven (7) years. These records will be securely maintained in compliance with HIPAA requirements and all applicable Maryland state privacy regulations.

XVIII. ANNUAL REVIEW & APPROVAL AUTHORITY

This policy will be reviewed annually, and all revisions must be approved by the FHC Administrator and the FHC Compliance Officer. Updates will reflect regulatory changes, MHCC CON requirements, and modifications to operational practices.

XIX. NON-RETALIATION ASSURANCE

FHC strictly prohibits retaliation or any adverse action against clients who request financial assistance, apply for charity care or sliding-scale discounts, or appeal a financial determination. Medical services will not be delayed or denied while a charity care application is being processed.

FHC Charity Care Public Notice

First Healthcare Consultants LTD(FHC) will make home health care available to all adult residents of its service area regardless of race, creed, gender, age, sexual orientation, national origin, or financial status. If insurance coverage is not available for reimbursement, patients or guarantors are responsible for payment. Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. Probable eligibility will be determined within two business days of a request for assistance or an application for Medical Assistance. Assistance amounts are based on Federal Income Poverty Guidelines. For information or applications, call 301.725.1800.

Please complete the attached application. Once completed submit the application and all required supporting documentation to:

First Healthcare Consultants LTD
RE: Client Financial Services Department
Address: 12906 North Point Lane, Unit A, Laurel, MD 20708
Phone: 301.725.1800
Fax: 1.800.275.0157
Email: info@fheconsultantsus.com

CHARITY CARE & FINANCIAL ASSISTANCE APPLICATION FORM

This application is used to determine eligibility for Charity Care, Sliding-Scale Discounts, or Time-Payment Arrangements under the First Healthcare Consultants LTD(FHC) Charity Care and Financial Assistance Program.

Applicants must complete all sections and provide required documentation. Incomplete applications may delay processing.

SECTION 1. APPLICANT INFORMATION

Name

Date of Birth / /

Social Security Number - -

Address

City **State** **ZIP**

Phone **Email**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

U.S. Citizen: ☐ Yes ☐ No

Permanent Resident: ☐ Yes ☐ No

Employer

Employer Address

City **State** **ZIP**

SECTION 2. HOUSEHOLD MEMBERS

List all members of your household, including yourself.

Name	Age	Relationship	Monthly Income

SECTION 3. MEDICAL ASSISTANCE / INSURANCE STATUS

Have you applied for Medicaid/Medical Assistance? ☐ Yes ☐ No

If YES, Date Applied" **/** **/**

Status: ☐ Pending ☐ Approved ☐ Denied

Do you receive any state or county assistance? ☐ Yes ☐ No

If Yes, Describe:

SECTION 4. MONTHLY INCOME

List gross monthly income for all sources. Attach documentation for each applicable item.

Income Source	Monthly Amount
Employment	
Retirement / Pension	
Social Security	
Disability	
Public Assistance	
Unemployment	
Veterans Benefits	
Alimony	
Rental Income	
Self-Employment	
Other:	
TOTAL	

SECTION 5. ASSETS

LIQUID ASSETS

Asset Type	Current Balance
Checking Account	
Savings Account	
CD/Bonds/Money Market	
Other	
TOTAL	

OTHER ASSETS

Asset Type	Make / Year	Approximate Value / Loan Balance
Home		
Primary Vehicle		
Other		
TOTAL		

SECTION 6. MONTHLY EXPENSES

Expense Type	Monthly Amount
Rent / Mortgage	
Utilities	
Car Payment(s)	
Credit Card(s)	
Insurance (Car)	
Insurance (Health)	
Medical Expenses	
Food	
Other:	
TOTAL	

Do you have unpaid medical bills? ☐ Yes ☐ No
If yes, for what service(s)?

If you already have a payment plan, **monthly payment amount:** _____

SECTION 7. DOCUMENTATION CHECKLIST

Please attach copies (not originals) of the following, when applicable:

- ☐ Last 3 months of pay stubs
- ☐ Employer income verification letter
- ☐ Last year's tax return (if self-employed)
- ☐ 3 months of bank statements
- ☐ Social Security / pension award letters
- ☐ Public assistance or benefit letters
- ☐ Letter of support (if another person provides housing/food)
- ☐ Medicaid denial or approval letter (if applicable)

SECTION 8. CERTIFICATION & SIGNATURE

I certify that the information provided in this application is accurate and complete. I understand that First Healthcare Consultants LTD may request additional information to determine eligibility. I agree to notify FHC of any changes to my financial situation within 10 days.

Applicant Signature

Date: **Relationship to Patient:**

Exhibit 9

March 3, 2026

Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215

Re: First Healthcare Consultants Ltd Funds Availability

Dear Commissioners and Staff:

Please accept this letter as our acknowledgement that, as of the date of this letter, First Healthcare Consultants Ltd has cash available in excess of $500,000 to fund its proposed home health agency expansion project. These funds are unrestricted and are immediately available for the start-up of a new business.

This letter is issued solely for the benefit of First Healthcare Consultants Ltd, and Atlantic Union Bank assumes no liability whatsoever in connection with this letter.

Please contact me directly with any questions.

Sincerely,

Cynthia Long

Cynthia Long
Assistant Vice President | Branch Manager
Laurel Main Branch | 319 Main Street | Laurel, MD 20707
(240) 264-5422 | cindy.long@atlanticunionbank.com

Exhibit 10

2.17 DISCHARGE/TRANSFER POLICY

1. The Agency will maintain a process for the ongoing assessment of each patient/client's continuing care and discharge planning needs. This is required to ensure that patient/client discharges are adequately planned to terminate services when the patient/client no longer has a need or desire for care, and to ensure that the patient/client's continuing care needs are met and that the patient/client participates in the discharge planning process. The reason for discharge is discussed and charted.

2. Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, care, all physicians issuing orders for the agency plan of care, and the patient's primary care practitioner or other healthcare professional who will be responsible for providing care and services to the patient after discharge for the agency (if any).

3. Patients/clients may be discharged for various reasons including the patient expires, the client/patient's condition improves and therefore the client/patient no longer needs the care provided, the physician discontinues the order for home care services, the patient moves out the Agency geographic service area or the client/patient refuses the care and requests discontinuation of services.

4. Discharge planning shall begin at the time of admission with patients/clients included in the process and being advised as to the expected duration of treatment. Re-evaluation by the RN and additional planning with the patient/client shall occur throughout the course of care and shall include documentation of specific plans and the expected date of discharge.

5. Discharge plans will be coordinated with other care/service providers, as applicable.

6. All discharged patients will have required documentation to ensure appropriate communication is provided to the physician, as requested.

7. Patients may require transfer from the Agency. Reasons for transfer include the patient moves out of the Agency geographic area, the patient requires care/service not provided by the Agency or the Agency is not a preferred provided by the patient's insurance company.

8. All transferred patients will have required documentation to ensure appropriate communication is provided to the receiving agency.

Discharge/Transfer Procedure:

1. The Agency will develop and implement an effective transfer and discharge planning process for patients who are transferred to another agency or who are discharged to a Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), or Long Term Care Hospital (LTCH).

2. The Agency will assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The Agency must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

3. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.

4. This broad, flexible requirement allows home health agencies to tailor the exchange of information to the exact circumstances and needs of the care transition in order to support the patient's post-discharge goals.

5. Continue to send Discharge summary to post-discharge provider.

6. Agencies will be required to provide data to the patient and caregiver on quality and resource use measures that are relevant to the patient's goals of care and treatment preferences. This applies for patients discharged to a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF) or long-term care hospital (LTCH). **Transfers to hospitals are not included in the requirement for home health agencies.**

    a. Instead of a specified list, the Agency will send necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences to the receiving facility of health care practitioner to ensure the safe and effective transition of care.

    b. The Agency is required to comply with requests for additional necessary clinical information made by the receiving facility or health care practitioner,

which may include items such as a copy of the patient's current plan of care or latest physicians' orders.

c. Information you have to share outcomes with:

    a. Home Health Agencies

    b. Skilled Nursing Facilities

    c. Inpatient Rehabilitation Facilities

    d. Long Term Acute Care Hospital

7. Quality measures and data on resource-use measures relevant to patient goals and treatment preferences; see below:
    a. https://www.medicare.gov/homehealthcompare/search.html

    b. https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

    c. https://www.medicare.gov/nursinghomecompare/search.html

    d. https://www.medicare.gov/longtermcarehospitalcompare/

8. The patient will be transferred or discharged when:
    a. It is necessary for the patient's welfare because the agency and the physician agree the agency can no longer meet the patient's needs.
    b. The patient or payor will no longer pay for services.
    c. The goals of the patient have been met.
    d. Patient choice.
    e. Patient dies.
    f. The agency ceases to operate.

9. At least 2 days before the discharge (final) visit, the Medicare beneficiary patient will receive the notice to discharge with instructions on the purpose of the form. The patient will be required to sign the Notice of Medicare Non-Coverage (NOMNC). Included on the NOMNC form will be the name and phone number of the local QIO for the patient to contact in the effect the patient wishes to appeal the discharge. If any of the following reasons are present the Notice of Non-Coverage form should not be used:

    a. because the Medicare benefit is exhausted;
    b. for denial of Medicare admission;
    c. for denial of non-Medicare covered services; or
    d. due to a reduction or termination of Medicare services that do not end the skilled Medicare services.

In these cases, the patient will receive the CMS form 1003-Notice of Denial of Medical Coverage (NDMC).

10. When the patient/client is transferred to another organization or facility, the patient/client is informed in a timely manner of the need for transfer and/or level of care and of the alternatives. The patient/client and family have input into these decisions. They are notified of any financial benefit to the referring home care. Relevant information regarding the patient/client's condition and care requirements will be provided verbally and in writing to the facility with the Agency becoming aware of the transfer.

11. A transfer does not need to be completed for patients who are temporarily at a facility for the purposes of observation and diagnostic testing if it is expected that home care will be resumed following the non-admission stay. However, an Agency representative will communicate with hospital personnel regarding the patient's care. The patient's clinical record will reflect the need for facility care with a communication note. Missed visit paperwork will be completed accordingly, if applicable.

12. All patients/clients will receive discharge instructions regarding his/her ongoing care needs prior to the final visit.

13. Prior to discharging the patient, the attending physician shall be notified. A written discharge summary will be sent to the physician within 5 business days of discharge with a copy maintained in the clinical record. The discharge summary will include:
    a. Patient identifying information
    b. Patient's physician and phone number
    c. The reason for discharge
    d. The date of discharge
    e. The patient's physical and psychosocial status at the time of discharge
    f. The patient's diagnosis
    g. A summary of the care and services provided
    h. Patient progress toward desired goals
    i. Instructions and referrals provided to the patient

14. Agency staff will be responsible for assisting the patient /family to identify and provide for anticipated care needs after discharge from the Agency.

15. Patient/family will be informed of the discharge, orally and in writing, at least five (5) days prior to discharge. The following will be discussed:

a. The date of the discharge
b. The reason for the discharge
c. Contact information for the receiving facility if the patient is to be transferred.
d. Expectation that they will participate in their discharge planning process.

16. OASIS data sets are completed when a patient is transferred or discharged.

17. Patients are discharged from the Agency for cause in the following situations:

a. The treatment goals are attained or are no longer attainable
b. A change in the patient/client's condition requires care or services other than those that can be safely provided by the Agency
c. Another person (i.e., family member) is able and willing to provide the required service
d. The patient refuses to obtain needed medical supervision
e. The patient and/or family consistently refuse to cooperate in attaining treatment goals
f. The home setting is not suitable
g. The patient moves from the geographic area served by the Agency
h. The patient is receiving the same services from another Agency
i. The physician consistently fails to sign the plan of treatment in the required time period or does not renew the Plan of Care at the 60-day interval or gives orders that are not consistent with the stated diagnosis
j. The Agency is closing out a particular service or all of its services; in such instances appropriate referral will be made
k. The patient is institutionalized
l. The patient expires
m. The patient, family, or physician requests discharge
n. Payment sources are exhausted, and the Agency is fiscally unable to provide free or reduced-fee care. In such instance appropriate referral will be made with the patient's participation in the discharge/transfer process
o. Behavior of patient or caregiver interferes with the agency's ability to provide care. The patient is non-compliant or continuously abusive to staff and all interventions have failed; appropriate referral will be made
p. The situation is unsafe for the staff
q. The patient requires continuous care in the home, over and above the intermittent care provided by the Agency

r. The patient is no longer homebound by Medicare definition (when applicable).

Discharge of Patients in Unsafe Situations

The safety of field staff is of primary importance. If in any way this safety would be compromised, the case (after all efforts to resolve the issues have been exhausted) will be closed and the patient and/or responsible caregivers will be notified.

1. In any situation where a field staff person feels immediate danger and/or a threat to safety, the home or area should be left at once and the supervisor notified.

2. If there are ongoing unsafe situations in the home or area, which the field staff observes, this should be brought to the attention of the supervisor as soon as possible. Examples of unsafe situations include:

    a. Drug dealing

    b. Firearms which are visible and available

    c. Persons in the home or proximity who exhibit violent or agitated, threatening behavior

    d. Environmental issues, e.g., vermin, open flames near oxygen cylinders, animal droppings, etc.

    e. Animals that are not locked away. If injury occurs involving an animal attacking a patient/client or employee, the following procedure will be implemented:

        i. The employee will alert his/her supervisor immediately regarding the injury

        ii. Report the incident to the county animal control office

        iii. Notify the patient's physician (if the patient is injured) and carry out orders, if any

        iv. Document the incident in the patient/client's clinical record (if patient is injured)

        v. Complete an Incident/Accident Report form and submit it to the Administrator

        vi. If the employee is injured, the employee is sent to the emergency room of the hospital of choice for treatment.

3. A patient care conference, with the participation of all appropriate disciplines will be held to discuss the situation and any appropriate actions which could be taken.

4. Documentation will include a description of the situation, any discussions and communications with the patient, caregiver, organizational staff, community resources, etc., and any actions to be taken.

5. If the decision is made to discharge the patient/client, the following steps will be taken:
    a. The patient/client or representative will be notified by administration of the decision to discharge, the reason and the date of the last visit by certified mail. Whenever possible, the patient/client will be given time to secure other modes of care or placement.

    b. The agency will provide the patient or representative with contact information of other agencies that may be able to provide care.

    c. The physician involved and any appropriate referral source or community resources will also be informed by telephone and certified mail.

    d. A summary of the situation, attempts to resolve it, and the action taken, will be documented and placed in the chart.

Completion of Discharged Records

In order to verify closure of inactive records, all clinical records will be completed and audited within thirty days of discharge as follows:

1. The clinical record of a discharged patient/client is fully completed, including a discharge summary that is sent to the physician within five (5) business days of the discharge.

2. Each clinical record is audited within ten working days and returned to the secretary for filing.

Interruption of Services

When an interruption of services occurs during a patient/client's certification period, a form is to be completed and placed in the clinical record with previous progress notes to clarify why visits have not occurred. This will apply to instances in which the patient/client has been admitted to the hospital or to any other situation that creates the need for a brief, temporary hold on Agency services. It does not apply to a one-time missed visit occurrence.

1. When an interruption of services occurs, the following procedure should be followed:

a. Complete the Interruption of Services/Transfer Summary form which includes an explanation as to why services must be temporarily halted and anticipated length of hold, if known.

    i. The Interruption of Services/ Transfer Summary must include:

        1. Date
        2. Patient identifying information and emergency contact
        3. Destination of patient transferred
        4. Contact person receiving report and date and time report given
        5. Patient's physician and phone number
        6. Diagnosis related to the transfer
        7. Significant health history
        8. Transfer orders and instructions
        9. A brief description of services/care provided and ongoing needs that cannot be met
        10. Patient progress toward desired goals
        11. Instructions and referrals provided to the patient
        12. Status of patient at the time of transfer

    The transfer form is required for patients who are temporarily admitted to the hospital for exacerbation of illnesses if it is expected that a home care will be resumed after hospitalization.

b. The Transfer Summary is sent within 2 business days of planned transfer or 2 business days of becoming aware of unplanned transfer if patient is still receiving healthcare services.

c. The Agency will maintain a log of hospitalized patients/clients.

d. Request notification of patient/client discharge from the hospital in order to resume home care if appropriate.

2. Once the patient/client has been released from the hospital and home health services have resumed, the form is completed, and an interim nursing assessment is performed by an RN to determine whether or not there has been a significant change in the patient/client’s needs.

3. If the patient/client is in the hospital at the time of recertification, the patient/client will be discharged from home health services and then readmitted to home health when discharged from the hospital in order to continue home care services.

4. If the patient/client expires while in the hospital, the discharge will be completed to reflect this occurrence and the clinical record will be closed.

Notice Delivery to Representatives

CMS requires that notification of changes in coverage for a beneficiary who is not competent be made to a representative acting on behalf of the beneficiary. Notification to the representative may be problematic because he or she may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary is incapable or incompetent, and the provider cannot obtain the signature of the beneficiary's representative through direct personal contact.

1. If the provider is unable to personally deliver a notice of non-coverage to a person legally acting on behalf of a beneficiary, then the provider should telephone the representative to advise him or her when the beneficiary's services are no longer covered.

2. The beneficiary's appeal rights will be explained to the representative, and the name and telephone number of the appropriate quality improvement organization (QIO) should be provided.

The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date.

1. Place a dated copy of the notice in the beneficiary's medical file and document the telephone contact to include name of person initiating the contact, name of the representative contacted, date and time of the contact and the telephone number called.

2. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested.

3. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt.

4. When notices are returned by the post office, with no indication of a refusal date, then the beneficiary's liability starts on the second working day after the provider's mailing date.

Exhibit 11

Quality Assurance and Performance Improvement (QAPI) Program & Policy

I. PURPOSE

The purpose of the Quality Assurance & Performance Improvement ("QAPI") Program is to ensure that First Healthcare Consultants LTD ("FHC") consistently delivers safe, effective, patient-centered, high-quality home health services and continuously improves clinical outcomes, patient experience, and operational performance across all service areas and patient populations.

This QAPI Program is designed to:

- Fully comply with CMS Conditions of Participation (42 CFR §484.65)
- Meet the Maryland State Health Plan standards (COMAR 10.24.16.08 – Quality)
- Satisfy COMAR 10.24.01.08G(3)(f) – Quality Review Criteria
- Align with Joint Commission Home Care Accreditation Standards
- Support FHC's mission to provide evidence-based, high-performing, equitable care

FHC is committed to serving **adult and pediatric patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay.

II. POLICY STATEMENT

FHC maintains an agency-wide, data-driven QAPI Program that is:

- Ongoing and proactive
- Led by administrative and clinical leadership
- Supported by all staff and disciplines
- Focused on measurable quality indicators and patient outcomes
- Linked to strategic goals, regulatory standards, and patient needs
- Driven by data, patient feedback, staff input, and regulatory requirements
- Designed to continuously improve performance, prevent problems and sustain excellence

III. SCOPE

This QAPI Program applies to:

- All departments and disciplines
- All clinical programs (skilled nursing, therapy, high-acuity care, pediatric care, chronic

disease programs, etc.)

- All service lines and locations (existing and new)
- All payor types (Medicare, Medicaid, commercial, private pay, etc.)
- All patient populations (adult, pediatric, medically complex, underserved)
- All aspects of operations that impact care quality and patient experience

IV. GOVERNANCE & RESPONSIBILITY

Governing Body

The Governing Body (or Administrator/Executive Leadership) holds ultimate responsibility for:

- QAPI design, implementation, and results
- Allocating adequate resources (staff, time, data systems, training)
- Approving QAPI goals and Performance Improvement Projects (PIPs)
- Reviewing QAPI quarterly and annual reports
- Holding leadership accountable for outcomes
- Ensuring QAPI aligns with strategic priorities and regulatory obligations

QAPI Committee

The QAPI Committee meets **at least quarterly** and includes:

- Administrator / Executive Director
- Director of Nursing / Clinical Director
- Therapy Supervisor(s)
- Quality Improvement Coordinator / QAPI Nurse
- Medical Director or physician advisor (as needed)
- Representatives from nursing, therapy, MSW, and home health aides
- Representatives from intake/scheduling/billing as appropriate

Responsibilities:

- Analyze quality data and trends
- Review patient outcomes and satisfaction
- Evaluate compliance with clinical standards and regulatory measures
- Identify opportunities for improvement
- Select and monitor PIPs
- Develop and track corrective action plans

- Report findings to the Governing Body

Management & Supervisors

Department leaders are responsible for:

- Monitoring discipline-specific quality indicators
- Educating and supervising staff
- Ensuring protocol compliance
- Implementing corrective actions
- Reporting issues to the QAPI Committee

All Staff Members

All employees participate in QAPI by:

- Delivering high-quality care
- Reporting incidents, near misses, and concerns
- Following policies and best practices
- Participating in training and improvement projects
- Supporting a culture of safety, accountability, and excellence

QAPI is embedded in daily operations — not a separate function.

V. QAPI PROGRAM STRUCTURE

FHC's QAPI Program includes four required components as defined by CMS:

Performance Measurement

Systematic collection and analysis of data in:

- Clinical outcomes
- Patient safety events
- Operational efficiency
- Patient experience & satisfaction
- Staff competency and retention
- Regulatory compliance

Performance Improvement Activities

When opportunities or problems are identified, FHC:

- Conducts root cause analysis (RCA)
- Develops and implements corrective actions
- Re-measures performance
- Ensures sustained improvement

Performance Improvement Projects (PIPs)

Data-driven, interdisciplinary projects that focus on:

- High-risk, high-volume, or problem-prone processes
- Critical quality concerns or strategic priorities
- Patient safety, access, or outcome improvements

Continuous Feedback & Integration

QAPI activities lead to:

- Policy and procedure updates
- Staff training
- Operational changes
- Technology enhancements
- Resource allocation
- Long-term strategic planning

VI. QUALITY INDICATORS & DATA SOURCES

FHC collects both quantitative and qualitative data, including:

Clinical Outcomes (examples):

- Wound healing rates
- Improvement in functional ability
- Pain management effectiveness
- Medication reconciliation accuracy
- CHF/COPD/diabetes outcomes
- OASIS outcome measures
- High-acuity case success metrics (vent/trach/IV)

Patient Safety:

- Falls and fall-related injuries

- Infection rates (wound, line sepsis, etc.)
- Adverse events or medical errors
- Hospitalizations and ED visits (especially 30-day readmissions)
- Timeliness of interventions and follow-up

Operational Performance:

- Time from referral to admission (48-hour standard)
- Same-day or next-day start of care rate
- Visit frequency compliance
- Missed or canceled visits
- Staff productivity and caseload
- Scheduling efficiency

Patient Experience:

- Patient satisfaction surveys (98% historical performance)
- Family/caregiver feedback
- Complaint/grievance tracking
- Net promoter scores (if used)

Staff & Workforce:

- Staff retention and turnover
- Competency validation results
- Training completion rates
- Staff satisfaction and culture assessments

Regulatory Compliance:

- CMS process measures (e.g., timely initiation of care)
- State requirements (COMAR)
- Joint Commission standards
- Documentation audit results

VII. HEALTH EQUITY & ACCESS MONITORING

FHC actively monitors access and outcomes to ensure care is **equitable and effective** across:

- Geographic areas

- Age groups (including pediatric vs adult)
- Disability or functional status
- Socioeconomic status / payor type
- Race / ethnicity / language
- Medically underserved or rural populations

When disparities are identified, FHC implements targeted interventions (e.g., outreach, staff education, telehealth expansion, partnerships with local providers).

VIII. USE OF TECHNOLOGY & DATA ANALYTICS

FHC leverages technology to enhance quality:

- **Electronic Health Record (EHR)** with integrated clinical alerts, documentation audits, and outcomes tracking
- **Clinical dashboards** to monitor real-time performance
- **Telehealth and remote monitoring** to support high-acuity, rural, and chronic care populations
- **Data analytics tools** to identify trends, predict risks, and support early intervention
- **Secure communication platforms** to coordinate interdisciplinary care and reduce delays Technology supports **faster decisions, better coordination, and improved patient safety.**

IX. PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

Purpose of PIPs

Performance Improvement Projects are **targeted, data-driven initiatives** aimed at improving specific aspects of care with the greatest impact on:

- Patient outcomes
- Safety
- Access
- Satisfaction
- Regulatory compliance
- Strategic goals

Criteria for Selecting PIPs

PIPs are initiated when:

- Quality data reveals below-target performance

- A process is high-risk or high-volume
- A problem is persistent or trending negatively
- Regulatory requirements indicate focus
- Staff, patient, or caregiver feedback identifies issues
- Strategic priorities or innovation opportunities arise

Examples of PIPs FHC May Conduct:

- Reduce 30-day hospital readmission rates (CHF, COPD, wound infections)
- Improve admission timeliness (48-hour or same-day starts)
- Strengthen medication reconciliation accuracy
- Improve caregiver education and competency in high-acuity cases
- Increase wound healing rates
- Decrease missed or canceled visits
- Enhance pediatric tracheostomy or ventilator care outcomes
- Improve documentation completeness and timeliness
- Increase patient satisfaction scores beyond 98%

PIP Methodology

Each PIP follows a structured improvement model:

- Define the problem with data
- Establish measurable goals/outcomes
- Form an interdisciplinary PIP team
- Conduct root cause analysis (e.g., fishbone, 5 Whys)
- Develop and implement interventions
- Measure progress regularly
- Modify interventions as needed
- Sustain successful improvements
- Report to QAPI Committee and Governing Body

Minimum Requirement

At least **one PIP at all times**, as required by CMS. FHC typically conducts **multiple PIPs simultaneously** to drive improvement across key areas.

X. USE OF QAPI TO DRIVE RESOURCES & STAFFING

FHC uses QAPI findings to inform:

- Staffing levels and caseload distribution
- Specialized clinical training needs
- Recruitment of high-acuity and pediatric specialists
- Investment in telehealth, remote monitoring, and data systems
- Scheduling and workflow optimization
- Budget allocation for quality initiatives
- Development or expansion of specialty programs

Quality drives operational decision-making at FHC.

XI. VALUE-BASED CARE & INNOVATION

FHC aligns QAPI with Home Health Value-Based Purchasing (HHVBP) measures, including:

- Improvement in ambulation
- Improvement in self-care
- Medication management
- Hospital readmission reduction
- Patient experience (satisfaction and communication)
- Timely initiation of care
- Adopt evidence-based best practices
- Pilot new care models (e.g., advanced chronic care programs)
- Scale successful initiatives across all service areas
- Drive efficiency without sacrificing care quality

XII. PATIENT SAFETY & RISK MANAGEMENT

FHC uses a comprehensive safety program that includes:

- Incident and near-miss reporting (non-punitive culture)
- Investigation and root cause analysis (RCA)
- Corrective action implementation
- Regular safety rounds (field observations, case reviews)
- Fall and injury prevention strategies
- Medication safety protocols

- Infection surveillance and control
- Emergency preparedness drills
- Staff safety training and reporting mechanisms

High-risk events are reported to the Governing Body and monitored for trends.

XIII. STAFF EDUCATION & COMPETENCY

QAPI findings directly inform staff training, including:

- Orientation and annual competencies
- High-acuity skills (vent/trach, wound, IV, pediatric)
- Documentation accuracy
- Cultural competence and health equity
- Emergency preparedness
- Ethics and patient rights
- Regulatory changes and best practices

FHC ensures:

- Competency checklists are validated
- Staff receive ongoing education
- Performance issues lead to targeted retraining or coaching
- High performers are recognized and used as preceptors/mentors

XIV. DOCUMENTATION & REPORTING

FHC maintains comprehensive records of:

- QAPI Committee meetings
- Quarterly performance dashboards
- Data trend reports and analysis
- Identified issues and improvement actions
- PIP charters, interventions, and outcomes
- RCA findings and action plans
- Staff training related to QAPI
- Annual QAPI Program evaluation

Documentation is maintained in a secure, organized manner and is available to CMS, state surveyors, and accrediting bodies.

XV. ANNUAL QAPI PROGRAM EVALUATION

Every year, FHC conducts a formal QAPI Program Evaluation that includes:

- Review of quality indicators and trends
- Summary of PIPs conducted and outcomes
- Analysis of goals met and unmet
- Identification of emerging risks or gaps
- Assessment of resource sufficiency
- Staff competency and training needs
- New priorities for the next year
- Recommendations for policy or operational changes
- Approval by Governing Body

XVI. CULTURE OF QUALITY & CONTINUOUS IMPROVEMENT

FHC promotes a culture where:

- Quality is everyone's responsibility
- Data drives decisions
- Patient safety is non-negotiable
- Transparency is expected
- Improvement is continuous
- Success is celebrated
- Innovation is encouraged
- Patients, families, and staff are heard

FHC strives to be a leader in clinical excellence, patient satisfaction, and operational performance.

XVII. POLICY REVIEW & APPROVAL

This QAPI Program and Policy is reviewed at least annually and updated to ensure continued alignment with:

- CMS Conditions of Participation (42 CFR 484.65)
- COMAR 10.24.16.08 Quality standards & Best practices in home health care
- Community Health Accreditation Partner (CHAPs)

Hand Hygiene Technique Compliance

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

Instructions: This survey is designed to evaluate the understanding and application of proper hand hygiene practices among clients and their family members. Please complete each item by checking the appropriate box. Your participation helps us improve the quality of care provided.

1. Education & Understanding

- ☐ I received verbal and/or written instruction on proper handwashing techniques.
- ☐ I understand when handwashing is required (e.g., before/after care, meals, restroom use).
- ☐ I was educated on the differences between handwashing with soap and using hand sanitizer.
- ☐ I understand how hand hygiene helps prevent infections and protects my loved one.

2. Skill Demonstration (To Be Completed with Staff Observation)

- ☐ I demonstrated how to wash hands using soap and water, covering all hand surfaces for at least 20 seconds.
- ☐ I demonstrated how to use alcohol-based hand sanitizer appropriately when soap and water are not available.
- ☐ I performed hand hygiene before and after participating in patient care activities during the observation.
- ☐ Observed and Verified by Staff

3. Application and Compliance

- ☐ I am able to demonstrate proper hand washing technique.
- ☐ I have access to clean water, soap, and paper towels at home.
- ☐ I use hand hygiene consistently during daily routines and caregiving.
- ☐ I encourage other caregivers/family members to follow hand hygiene protocols.

4. Feedback

- ☐ I feel confident in my ability to maintain good hand hygiene.
- ☐ I would benefit from additional training or materials on hand hygiene.

☐ I am satisfied with the training provided by the agency.

5. Additional Comments (Optional)

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
This survey is confidential and used solely to evaluate and improve our educational services. Your feedback helps us ensure safety and compliance.

Tracheostomy Suctioning Techniques

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

Instructions: Please review the following items with the client or family caregiver. Check each box that applies. This form should be completed during initial training and reviewed annually or as needed.

1. Understanding of Suctioning Equipment Use

- ☐ Able to identify suction machine and its parts
- ☐ Can assemble suction equipment correctly
- ☐ Demonstrates knowledge of appropriate suction pressure settings
- ☐ Understands when and how often to suction

2. Demonstration of Proper Technique

- ☐ Performs hand hygiene before and after suctioning
- ☐ Uses appropriate Personal Protective Equipment (PPE)
- ☐ Measures catheter insertion depth accurately
- ☐ Suctions tracheostomy tube correctly (using circular motion, ≤ 10 seconds per pass)
- ☐ Allows sufficient recovery time between suction passes

3. Safety and Emergency Readiness

- ☐ Recognizes signs of respiratory distress
- ☐ Knows when to stop suctioning and call for medical help
- ☐ Keeps spare tracheostomy supplies readily available
- ☐ Able to describe steps for accidental decannulation

4. Post-Suctioning Care

- ☐ Cleans suction catheter or uses disposable appropriately
- ☐ Properly discards waste and used supplies
- ☐ Ensures tracheostomy ties are secure
- ☐ Monitors for secretions, bleeding, or skin breakdown around the stoma

5. Client/Family Confidence

- ☐ Verbalizes understanding of procedure
- ☐ Demonstrates confidence in performing suctioning independently
- ☐ Agrees to contact nurse if unsure or if changes are noticed

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Medication Management Education

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

1. Medication Education

a. Were you educated on how to take your medications safely?

☐ Yes ☐ No ☐ Not Sure

b. Do you understand the purpose of each medication you are currently taking?

☐ Yes, completely ☐ Somewhat ☐ No

c. Were written instructions (e.g., medication list or schedule) provided to you?

☐ Yes ☐ No ☐ Not Sure

d. Were you informed about potential side effects of your medications?

☐ Yes ☐ No ☐ Not Applicable

e. Do you know what to do or who to contact if you experience side effects?

☐ Yes ☐ No ☐ Not Sure

2. Medication Management Support

a. Do you use a pill organizer or reminder system (e.g., phone alert, caregiver)?

☐ Yes ☐ No ☐ Not Applicable

b. Did someone assist you with medication setup (sorting pills, creating schedule, etc.)?

☐ Yes ☐ No ☐ Not Applicable

c. Have your nurses or caregivers reviewed your medication list with you regularly?

☐ Yes, every visit ☐ Sometimes ☐ No

d. Do you feel confident managing your medications independently or with help?

☐ Yes ☐ No ☐ I need more training

e. How satisfied are you with the medication education provided?

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied

f. Would you like additional support or follow-up regarding your medications?

☐ Yes ☐ No

3. Feedback and Suggestions

How would you rate the clarity and usefulness of the medication management education you received?

- ☐ Very clear and helpful
- ☐ Somewhat helpful
- ☐ Not helpful
- ☐ I did not receive education

Do you have any suggestions on how we can improve our medication management education and support?

_____

_____

_____

_____

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Home Oxygen Safety

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

1. Oxygen Safety Training Completion

a. Did you (or your caregiver) receive education from a nurse or respiratory therapist on how to safely use and store oxygen at home?

☐ Yes ☐ No ☐ Not Sure

b. Was this training provided at the start of care or during your first oxygen setup visit?

☐ Yes ☐ No ☐ Don't Remember

c. Were written materials (handouts, checklists, or posters) provided to you on oxygen safety?

☐ Yes ☐ No ☐ Not Sure

d. Were you educated on the importance of avoiding smoking or open flames near oxygen?

☐ Yes ☐ No ☐ Don't Remember

e. Did the staff check where and how the oxygen tanks were stored in your home?

☐ Yes ☐ No ☐ Not Applicable

2. Confidence and Knowledge Retention

a. On a scale of 1 to 5, how confident do you feel about safely using and storing oxygen in your home?

☐ 1 – Not Confident

☐ 2 – Somewhat Confident

☐ 3 – Neutral

☐ 4 – Confident

☐ 5 – Very confident

b. Do you know what to do in case of an oxygen-related emergency or equipment failure?

☐ Yes ☐ No ☐ Not Sure

c. Do you know how to clean and maintain your oxygen equipment (if applicable)?

☐ Yes ☐ No ☐ Not Applicable (Maintenance handled by provider)

3. Feedback and Suggestions

Do you believe the training you received was:

- ☐ Easy to understand
- ☐ Too basic
- ☐ Too complicated
- ☐ Not applicable to your situation

Do you have any suggestions for improving how we provide oxygen safety training?

_____

_____

_____

_____

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Fall Prevention

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

1. Fall Prevention Education Completion

a. Did you receive education from a nurse or therapist on how to prevent falls at home?

☐ Yes ☐ No ☐ Not Sure

b. Was this training provided during your admission or within the first few days of service?

☐ Yes ☐ No ☐ Don't Remember

c. Were you given written materials (handouts or visual aids) on fall prevention?

☐ Yes ☐ No ☐ Not Sure

d. Did the staff discuss common household hazards that increase fall risk (e.g., loose rugs, poor lighting, uneven surfaces)?

☐ Yes ☐ No ☐ Not Sure

e. Did the nurse or staff make recommendations for home modifications (e.g., grab bars, non-slip mats, clutter removal)?

☐ Yes ☐ No ☐ Not Applicable

2. Confidence and Fall History

a. Have you or your caregiver made changes to your home environment to reduce fall risks?

☐ Yes ☐ No ☐ Not Applicable ☐ In Progress

b. On a scale of 1 to 5, how confident do you feel about avoiding falls in your home?

☐ 1 – Not Confident

☐ 2 – Somewhat Confident

☐ 3 – Neutral

☐ 4 – Confident

☐ 5 – Very confident

c. Since beginning care with our agency, have you experienced any falls?

☐ No falls ☐ One fall ☐ More than one fall ☐ Prefer not to say

3. Feedback and Suggestions

How would you rate the clarity and usefulness of the fall prevention education you received?

- ☐ Very clear and helpful
- ☐ Somewhat helpful
- ☐ Not helpful
- ☐ I did not receive education

Do you have any suggestions on how we can improve our fall prevention education and support?

_____

_____

_____

_____

_____ _____

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Feeding Tube Insertion Demonstration

Client Name: _____ Date _____

Staff Name: _____ _____

Survey Completed by ☐ Client ☐ Family Member ☐ Other (Specify) _____

Instructions: This survey is designed to assess your understanding and ability to demonstrate safe and accurate feeding tube insertion. Please complete the checklist below. Your feedback helps us maintain and improve our quality of care.

1. Feeding Tube Insertion Demonstration

Please check the box for each step that you or your caregiver feel confident in performing correctly after receiving education/training:

- ☐ Washed hands thoroughly before the procedure
- ☐ Verified the correct placement of the tube before use
- ☐ Flushed the tube with the appropriate solution prior to feeding
- ☐ Administered the correct formula and volume as directed
- ☐ Maintained proper positioning during and after the feeding
- ☐ Recognized signs of tube displacement or complications
- ☐ Cleaned the insertion site and equipment properly
- ☐ Documented feedings or reported to the nurse as instructed
- ☐ Felt comfortable asking questions or requesting help
- ☐ Understood the emergency steps in case of aspiration or blockage

2. Overall Understanding and Confidence

Please check the box that best represents your experience:

- ☐ I feel very confident performing this task independently
- ☐ I feel somewhat confident but may need occasional help
- ☐ I do not feel confident and need additional training

3. Additional Comments (Optional)

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Home Equipment Maintenance/Cleaning Compliance

Client Name: _____ Date: _____

Staff Completing Audit: _____

Instructions: This form should be completed by field staff conducting home visits. Please review each applicable equipment item for maintenance, cleanliness, and functionality. Select all that apply. Signature required at the end.

1. Equipment Inventory (Check all present in the home)

- ☐ Oxygen Concentrator
- ☐ Nebulizer
- ☐ Suction Machine
- ☐ Feeding Pump
- ☐ Pulse Oximeter
- ☐ Wheelchair / Walker
- ☐ Bed Rails / Hospital Bed
- ☐ Other (Specify): _____

2. Maintenance Compliance (Check all that apply)

- ☐ All equipment is clean and free of visible dust, mold, or residue.
- ☐ Equipment is stored in a safe, accessible location.
- ☐ Power cords and tubing are free from damage or frays.
- ☐ Disposable parts (filters, masks, tubes) have been replaced on schedule.
- ☐ Manufacturer's guidelines for cleaning/maintenance are being followed.
- ☐ No foul odors, rust, or leakage detected.
- ☐ Client/family was reminded about routine equipment checks.

3. Corrective Actions (if applicable)

- ☐ Client/family was educated on cleaning schedule
- ☐ Malfunctioning equipment was reported to agency or DME vendor
- ☐ Maintenance issue resolved during visit
- ☐ Follow-up visit scheduled
- ☐ Not applicable

4. Comments / Observations

Staff Auditor Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Hazard Vulnerability Assessment Completion

Client Name: _____ Date: _____

Staff Completing Audit: _____

1. Hazard Identification (Check all that apply in the client's home environment)

- ☐ Fire hazards (e.g., faulty wiring, unattended candles, overloaded outlets)
- ☐ Slip/trip hazards (e.g., loose rugs, cluttered walkways, wet floors)
- ☐ Inadequate lighting (especially near stairways or bathrooms)
- ☐ Unsecured medical equipment or tubing
- ☐ Poor ventilation or exposure to smoke/allergens
- ☐ Hazardous chemicals or substances accessible to children/vulnerable adults
- ☐ Pets that may pose fall risks or cause allergic reactions
- ☐ Lack of functioning smoke or carbon monoxide detectors
- ☐ Unsafe storage of medication or sharp objects
- ☐ Unclear emergency exits or blocked paths
- ☐ Other (Specify): _____

2. Client Education Topics Reviewed (Check all completed)

- ☐ Emergency preparedness (fire, medical, evacuation plan)
- ☐ Proper use and storage of medical equipment
- ☐ Fall prevention strategies
- ☐ Safe medication handling and disposal
- ☐ Environmental safety and cleanliness
- ☐ When and how to call emergency services
- ☐ Infection control measures (e.g., hand hygiene, disinfection)
- ☐ Other (Specify): _____

3. Client/Family Understanding

- ☐ Client/family understood hazard risks
- ☐ Client/family verbalized understanding of mitigation strategies
- ☐ Client/family demonstrated safe practices

4. Recommendations Made

Staff Auditor Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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Client Satisfaction

Client Name: _____ Date _____

Staff Name: _____

Survey Completed by: ☐ Client ☐ Family Member ☐ Other (Specify) _____

Instructions: Please review each statement below and circle the number that best reflects your level of satisfaction. Your feedback is confidential and helps us improve our services.

How do you feel?	Very Satisfied	Satisfied	Neutral	Dis-satisfied	Very Dis-satisfied
Staff are respectful and professional	1	2	3	4	5
Staff arrive on time for scheduled visits	1	2	3	4	5
Communication with the agency is easy and responsive	1	2	3	4	5
My care plan is explained clearly and updated as needed	1	2	3	4	5
I feel safe and cared for by the staff	1	2	3	4	5
My needs are met in a timely and respectful manner	1	2	3	4	5
I am informed about my medications and treatments	1	2	3	4	5
The agency addresses my complaints or concerns promptly	1	2	3	4	5
Agency and staff are knowledgeable and professional	1	2	3	4	5
I am satisfied with the overall quality of services received	1	2	3	4	5

1. What do you like most about our services?

_____

_____

_____

_____

2. What could we do to improve our care services?

3. Additional comments or suggestions

Client / Family Member Signature: _____ Date: _____

Staff Reviewer Signature: _____ Date: _____

Confidentiality Notice:
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HAND HYGIENE / GLOVE USE

Staff Name / Title: _____ Location: ☐ Home ☐ Lab ☐ Office

MONTH	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Number of Nurses Observed												
Hand Hygiene (use of alcohol foam hand rub or washing hands with soap and water for at least 15 seconds)												
Before touching a patient	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Before clean and aseptic procedures, including medication suction, G-tube care, tracheostomy care, personal care, wound care,etc.	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
After touching the patient	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Before and after contacting equipment	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
After removing gloves or other personal protective equipment (PPE)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Proper donning and removing glove	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
After equipment contact upon exiting patient's room**	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Glove Use												
Whenever potential for hand contact with blood/body substance	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y N	☐ Y ☐ N	☐ Y ☐ N
Gloves removed right after use	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Total Score (total count of "Y")												
Compliance Score (total score / 9 * 100)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**

Annual Average Compliance Score: % National Average: % State Average: % Agency Goal: %

OXYGEN CYLINDER STORAGE COMPLIANCE

Staff Name / Title: _____ Location: ☐ Home ☐ Lab ☐ Office

MONTH	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Staff Position Observed	RN / LPN	HHA / CNA / PCA	RN / LPN	HHA / CNA / PCA	RN / LPN	HHA / CNA / PCA	RN / LPN	HHA / CNA / PCA
Cylinder stored in well-ventilated area	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Cylinder placed in the stander	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Cylinder stored in a manner to prevent hazard by tipping, falling or rolling.	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Cylinder stored upright	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Cylinders are 20 feet away from combustible or flammable substance	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Total Score (total count of "Y")								
Compliance Score (total score / 5 * 100)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**

Annual Average Compliance Score: **%** **National Average:** **%** **State Average:** **%** **Agency Goal:** **%**

OXYGEN SAFETY

Client Name: _____ Date of Birth: _____

Staff Name: _____ Training Date: _____

O2 Related Diagnosis: _____ Code Status: _____

Allergies: _____

1. Training Type:

- ☐ Initial Teaching
- ☐ Reassessment

2. Oxygen Type (used at home):

- ☐ Compressed oxygen cylinders, or "green tanks
- ☐ Oxygen concentrators
- ☐ Liquid oxygen systems

3. Means of Delivery:

- ☐ Nasal cannula
- ☐ Ventilator
- ☐ Mask
- ☐ Trach collar

4. Training Provided:

- ☐ Placing “No Smoking Oxygen in Use” signs
- ☐ Handling and storage of oxygen cylinders
- ☐ Hazards of smoking with oxygen in use
- ☐ Importance of securing electric devices to prevent short-circuit sparks.
- ☐ Danger of using volatile, flammable materials near the patient using oxygen

5. Trainees:

- ☐ Patient
- ☐ Mother
- ☐ Father
- ☐ Other:_____

6. Type of Training:

- ☐ Instructed
- ☐ Supervised
- ☐ Independent
- ☐ Return demonstration

7. Training Tools:

- ☐ Verbal
- ☐ Video
- ☐ Demonstration
- ☐ Printed material
- ☐ Other: _____

8. Response to Training:

☐ Good ☐ Fair ☐ Poor ☐ Anxious ☐ Unable to Cope

☐ Clear indication of understanding ☐ Needs further instruction

Plan for next training:

Equipment Cleaning Log

Client Name: _____ DOB: _____

EQUIPMENT TO CLEAN /CHANGE	HOW OFTEN	DATE CLEANED	PROPER CLEANSER USED	EQUIPMENT CHECKED	EQUIPMENT FUNCTIONS WELL	INITIALS
Suction machine	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Suction canister	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Suction Tubing	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Ventilator	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Ventilator Tubing	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
Vent. Water Chamber	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
CPAP/BIPAP	Weekly		☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	☐Y ☐N	

EQUIPMENT TO CLEAN /CHANGE	HOW OFTEN	DATE CLEANED	PROPER CLEANSER USED	EQUIPMENT CHECKED	EQUIPMENT FUNCTIONS WELL	INITIALS
CPAP/BIPAP tubing	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Monitors	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Nebulizer	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Aerosol Tubing	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Oxygen Tank	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Oxygen Tubing	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Oxygen Concentrator	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Tracheostomy Tube	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	

EQUIPMENT TO CLEAN /CHANGE	HOW OFTEN	DATE CLEANED	PROPER CLEANSER USED	EQUIPMENT CHECKED	EQUIPMENT FUNCTIONS WELL	INITIALS
Feeding Pump	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
IV infusion pump	Weekly		□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
			□Y □N	□Y □N	□Y □N	
Wheelchair	Monthly		□Y □N	□Y □N	□Y □N	
Patient bed &furniture	Monthly		□Y □N	□Y □N	□Y □N	
Hoyer lift	Monthly		□Y □N	□Y □N	□Y □N	
Refrigerator	Monthly		□Y □N	□Y □N	□Y □N	
Medication cart	Monthly		□Y □N	□Y □N	□Y □N	
Toys	Monthly		□Y □N	□Y □N	□Y □N	

Staff Name (Print)	Initials

FALL REDUCTION PROGRAM EVALUATION

Reducing the risk of patient harm from falls is one of the National Patient Safety Goals established by the Joint Commission. FHC has implemented a fall-reduction program that provides guidelines for staff caring for patients at the agency. The program not only reduces the number of falls but also minimizes fall-related injuries.

Key components include:

- Fall Risk Assessment for each patient
- Environmental Assessment
- Staff education and training
- Education for patient & family
- Review of patient medications
- Individualized patient care plan
- Post-Fall Assessments
- Evaluation

FHC will measure the effectiveness of the program quarterly

The agency's comprehensive fall reduction program includes restraint-free tools to:

- Identify high fall risk patients
- Alert caregivers of a potential fall
- Hip protectors and floor cushions to reduce the risk of fall-related injuries
- Patient Safety tools to reduce the hazards within the patient's environment

Fall Risk Assessment Evaluation

Staff Name: _____ Date: _____

RISK CONTROL MEASURES	YES / NO	CORRECTIVE ACTION
Risk Assessment Process		
1. Is every client evaluated for risk of falling, utilizing a fall-assessment tool that considers the following factors, among others: a. Previous fall history and associated injuries? b. Gait and balance disturbances? c. Foot and leg problems? d. Reduced vision? e. Medical conditions and disabilities? f. Cognitive impairment? g. Bowel and bladder dysfunction? h. Special toileting requirements? i. Use of multiple prescription and over-the-counter medications? j. Need for mechanical and/or human assistance? k. Environmental hazards?		
2. Are higher-risk clients identified, including those who experience recurrent falls or have multiple risk factors?		
3. Are higher-risk clients referred to their physician for a more thorough assessment?		
4. Is a home safety check conducted before the commencement of services?		
5. If safety problems are detected in the home, are corrective actions recommended to the client as part of the service agreement?		
6. Are direct care staff members involved in the initial client assessment and ongoing reassessment?		
7. Are services regularly assessed and modified in response to changes in the client's condition?		
8. Are clients and families informed of key risk factors and basic safety strategies?		
9. Are all assessment findings documented and incorporated into the client's plan of care?		

RISK CONTROL MEASURES	YES / NO	CORRECTIVE ACTION
Staff Education		
1. Are educational in-service programs offered to direct care staff on a regular basis, and are attendance records kept?		
2. Do staff educational programs focus on skills training, such as how to use gait belts and assist with transfers?		
3. Do educational offerings examine the root causes of falls, as well as their prevention?		
4. Are staff members instructed to assess and document the client's condition at each visit, and also to: a. Report any changes to the supervisor and family in a clear and timely manner? b. Perform frequent home safety checks? c. Reinforce fall-reduction tactics with clients and family? d. Encourage clients to ask for assistance with risky tasks? e. Keep accurate, detailed records of client encounters		
Post Fall Analysis		
1. Are all clients fall reviewed for quality assurance purposes, including analysis of root causes and tracking of trends?		
2. Does the post-fall analysis require caregivers to describe the circumstances of the fall, and also to: a. Identify major causal factors, both personal and environmental? b. Indicate the client's functional status before and after the fall? c. Suggest interventions to prevent or mitigate future falls?		
3. Is the post-fall analysis thoroughly documented, and are findings incorporated into quality assurance and/or incident reporting programs		

FALL RISK ASSESSMENT

The fall risk assessment serves as the basis for care planning. The agency will conduct the fall risk assessment on each patient at the start of care, when there is a change in the patient's condition, and at re-certification.

The Morse Fall Risk Assessment is an official fall-risk assessment scale used by FHC. It is made up of six subscales: History of falls, secondary diagnosis, ambulatory aid, iv or heparin lock, gait, and mental status.

I. EDUCATION:

In order to promote patient and family participation in the fall reduction and safety plan, the Fall Risk and Prevention procedure is introduced upon admission. Using the Morse Fall Scoring system. Besides admission, patients are reassessed based on a change of status, transfer, or after a fall occurs.

The identified fall risk factors and interventions are reviewed with the patient and family. This is to help them understand why they are at risk for falls and increase their compliance with key interventions.
The goal of the agency is to assess and improve patients' knowledge of risks for falls, and how to prevent falls. The agency will use different teaching methods and tools that are appropriate to the patient/family level of understanding.

The education is documented and revised as patient status changes Education Topics include the following:

- Impaired balance and gait
- Vision
- Medications
- Environment
- Chronic conditions

II. ENVIRONMENTAL ASSESSMENT

FHC understands that environmental assessment is effective in falls reduction. On initial assessment, the agency examines the physical environment to determine whether the home is safe for the patients. The agency will educate its nursing staff the importance of maintaining a safe environment for all its patients; assist with identifying patients who are high risk for fall; provide the tools to educate patient/families of the potential risk for falls and outline strategies to develop individualized plan of care to reduce fall. Often, some modifications are necessary to accommodate the functional abilities of the patients.

All patients are considered at risk of falling and simple prevention strategies have been put in place to ensure the risk of fall is minimized. A safe environment will be maintained for all patients. Standard safety measures have been put place for all patients regardless of identified

risk, these include:

- Patients are nursed in an appropriate bed
- Orientate all patients and parents to room
- Keep beds with brakes on
- Side rails are raised for appropriate age and patient groups
- Appropriate non slip footwear for ambulating patients
- Maintain adequate lighting in child's room; low level lighting at night.
- Keep floors clear of clutter including equipment and toys
- Secure and supervise all children with a safety belt or harness in wheelchairs, highchairs, strollers, infant seats and any specialist seating)
- Bathroom assist unsteady patients with ambulation
- Place necessary items a patient may need within reach (drinking water, phone, etc)
- Ensure equipment is well maintained and serviced appropriately (such as wheelchairs and commodes)

POST-FALL ASSESSMENT

A post-fall assessment is a structured way to collect information after a fall. The patient will be carefully and systematically assessed for injuries. All findings will be documented in the nursing record, and an incident report will be filled.

The post-fall assessment focuses on immediate risk of injury or complications and will begins as soon as possible after the fall. It includes:

- General information about the fall
- Patient Assessment---vital signs; visible signs of injury (type & pain scores); Glucometer (if diabetic); Glasgow Scale (if suspected brain injury and Morse Falls scale
- Interventions based on Morse Falls scale
- Notification of RN supervisor
- Activation of EMS response team for emergency situation

The desired outcome of the post-fall assessment is to:

- Specify root cause Specify type of fall
- Identify actions to prevent reoccurrence Change plan of care
- Involve patient/family in learning about the fall occurrence Prevent repeat fall

I. PLAN OF CARE

POLICY

An individualized plan of care tailored to the client's risk factors will be developed by FHC. This is done after completion of the fall risk assessment and will be based on the assessment of the client's needs, strengths, limitations and goals.

PROCEDURE

The plan of care will match the identified client's risk factors such as mobility challenges, medication, mental status, and continence needs.

The plan of care identifies particular kinds of risks specific to a client and interventions to mitigate those risks.

The plan of care guides staff on how to reduce falls. Fall reduction care planning is a process by which the client's risk assessment information is translated into an action plan to address the client's needs. It is an active document that ensures continuity of care and changes as the client's condition changes.

The DON/RN (Director of Nursing, Registered Nurse) develops a Plan of Care for each client following completion of the risk assessment.

The individualized plan of care is developed for patients with any of the following:

- Patient has risk factors for falling (found on the risk assessment form)
- Patient has fallen since admission
- Patient or family are anxious about falls

Based on the results and the provisions of the Plan of Care, the DON will select the appropriate staff that meet the skills and experience qualification needed to provide the specific needs of the client. To maintain full compliance with the requirements of this policy, the following is addressed as applicable to each client:

1. The client's plan of care is based on assessments of the client's health, function, and psychosocial condition.
2. The assessment of a client is provided:
    a. Before the client receives services from the agency
    b. When there is a change in client's condition
    c. At recertification
3. The agency shall ensure that the care plan developed for the client at a minimum addresses:
    a. The services to be provided to the client, which are based on the
    b. assessment of the client
    c. When and how often the services are to be provided
    d. How and by whom the services are to be provided
    e. Long-range and short-range goals for the client
    f. Physical needs, including safety measures to protect against fall and injuries
4. The client's plan of Care shall be reviewed by a registered nurse.

REVIEW OF MEDICATION

The agency reviews and evaluates medication-related fall risk on admission and at regular intervals. FHC has identified common ways medications contribute to falls. Such as:

- Sedation
- Impaired balance/coordination/reaction time
- Orthostatic hypotension
- Parkinsonism
- Cognitive changes

SCREENING MEDICATION FALL RISK

The agency has developed a screening tool to help identify the reactions of medication, and a medication related risk factors for falls

Drug	Reaction
Ant diabetic agents	Hypoglycemia
Cardiovascular agents	Orthostatic hypotension, dizziness, syncope, bradycardia
Psychotropic agents	Psychomotor impairment, sedation, orthostatic hypotension, confusion
Analgesics	Sedation, Confusion
Metoclopramide	Psychomotor impairment, sedation
Anticonvulsants	Sedation, psychomotor impairment, confusion
Antihistamines	Sedation, confusion, blurred vision

MEDICATION FALL RISK SCORE

The agency has also developed a Medication Fall Risk Scoring to determine if a patient is at risk for falls and plan care accordingly.

Point Value (Risk Level)	Class Of Medication	Reaction
3 (High)	Analgesics, antipsychotics, anticonvulsants, benzodiazepines	Sedation, dizziness, postural disturbances, altered gait and balance, impaired cognition
2 (Medium)	Antihypertensive, cardiac drugs, antiarrhythmic, antidepressant,	Induced orthostatic, impaired Cerebral perfusion, poor health status
1 (Low)	Diuretics	Increased ambulation, induced orthostatic
Scores >/= 6		Higher risk for fall; evaluate patient

To calculate the score, the staff member completing the assessment will sum the point values (risk levels) for each medication the patient is taking. If the patient is taking more than one medication in a particular risk category, the score should be calculated by (risk level score) x (number of medications in that risk level category). For a patient at risk, the agency will use evaluation tools to determine whether medications may be tapered, discontinued, or replaced with a safer alternative.

FALL REDUCTION PROGRAM EVALUATION

On evaluation, the interventions on the plan of care are noted to be effective and accurate. The agency licensed staff are providing adequate supervision and are committed to the reducing falls. Staff training on reduction of falls and identifying patients that are high risk for falls was noted to be effective. Standard safety measures have been maintained.

The program appears to have had a protective effect. No fall or injury has been reported. Patient and patient family appears to be knowledgeable about the risk for fall and the prevention of falls.

STAFF TRAINING AND EDUCATION

The agency staff will be trained and educated on fall reduction and fall-related injuries**.** Reducing falls requires leadership commitment and a systematic approach.

The training/education will entail the following:

- Informing staff of the need to reduce falls/fall-related injuries by: Communicating safety information to staff Incorporating fall/safety precaution into the patient care
- Training staff on the standardized, validated tool used by the agency to identify risk factors for falls. (Morse Fall Scale is used by the agency)
- Training is provided to staff on using the tool to ensure inter-rater reliability.
- Informing staff of the interventions in the individualized plan of care based on identified fall and injury risks.
- Training on implementation of the interventions
- Training on assessment and continued reassessment of the patient
- Training on environmental safety
- Training on post-fall assessment and how to accurately fill the post-fall form

Fall Risk Assessment Tool

Client Name: _____ Date of Birth: _____

Staff Name: _____ Date: _____

1. Background

Patient Fall risk factors (check all that apply):

- ☐ Impaired mobility
- ☐ Impaired mentation
- ☐ Impaired / altered elimination patterns (nocturia, urgency, frequency, diarrhea, incontinence, laxative, bowel prep)
- ☐ Impaired communication / sensory (vision, hearing, neuropathy)
- ☐ Impaired vital signs (fever, slow or fast heart rate, low blood pressure)
- ☐ Prior fall history
- ☐ Medication NOTE: If pertinent, attach copy of MAR for previous 12-hours
  - ☐ Anticonvulsant
  - ☐ Anti-anxiety agent
  - ☐ Psychotropic
  - ☐ Hypnotic/Sleep aid
  - ☐ Pain Medication
  - ☐ Diuretic
  - ☐ Notable medication change within the past 2 days
  - ☐ Other _____
- ☐ Diagnosis-related
  - ☐ Hypotension
  - ☐ Hypoglycemia
  - ☐ TIA/Syncope
  - ☐ Parkinson's
  - ☐ History of CVA or paralysis
  - ☐ Orthopedic condition
  - ☐ Other _____

2. Assessment

Vital Signs: T: P: R: B/P: O2:

Neurochecks if evidence / suspicion of head injury:

If diabetic, Glucometer result: Pain Level (1-10)

Describe any NEW onset pain:

Injury (describe findings):

- ☐ None
- ☐ Minor
- ☐ Major
- ☐ Death

3. Recommendation

What can we do to prevent this from happening again? Care plan recommendations:

- ☐ High-Fall Risk Precautions
- ☐ Clear path to Bathroom
- ☐ Frequent monitoring
- ☐ Remove clutter
- ☐ Every 2hrsToileting
- ☐ Non-slip footwear
- ☐ Oxygen/IV tubing mgmt
- ☐ Hip protectors
- ☐ Patient/family education
- ☐ PT Evaluation
- ☐ Improved positioning
- ☐ Review of meds
- ☐ Other: _____

Additional Notes

4. Post Fall Checklist

- ☐ Notify physician
- ☐ Notify RN supervisor
- ☐ Assess patient for injury and document assessment findings in the nursing record
- ☐ Revise plan of care to include reduction strategies
- ☐ Fill out incident report

First Healthcare Consultants Patient Satisfaction Survey

We were privileged to participate in the care of the above patient. We are interested in rendering quality care to our patients and would appreciate your input by answering the following questions. Your evaluation will allow us to be more responsive to future patient/family needs.

* Indicates required question

- ◯ Option 1

What service(s) did you receive from the agency? (select all that apply) *

- ☐ Nursing
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Home health aide
- ☐ Home making/chore service
- ☐ Medical social worker

Were you satisfied with the care you received? *

- ◯ Yes
- ◯ No

If you answered no to the above question, please explain why not.

Your answer

Did you participate in your plan of care? *

- Yes
- No

Did you receive and understand your “Bill of Rights” including the toll-free “hotline”number that you could call if any problems were not resolved by the agency or if you were dissatisfied with the services provided? *

- Yes
- No

Did the staff visit as frequently as they stated they would? *

- Yes
- No

Did you feel comfortable asking staff questions regarding your health? *

- Yes
- No

Did the staff person visit at a mutually agreeable time? *

- Yes
- No

If you had therapy, were exercise instructions given to you in a clear, written manner that you could easily understand? *

- Yes
- No
- Not Applicable

Did you feel that you were discharged appropriately? *

- ◯ Yes
- ◯ No

Would you use the services of the agency in the future? *

- ◯ Yes
- ◯ No

Please provide any suggestions for improvement

Your answer

Patient Name *

Your answer

Date *

Your answer

Submit Clear form

Exhibit 12

Estimated Annual HHA Use Rates by Resident Age Group and County / Jurisdiction, FY19-FY23

Baltimore City

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CY31	CY32	CY33	CY34	CY35	CAGR CY20-CY25	CAGR CY25-CY30	CAGR CY30-CY35
0 to 4	33,620	34,145	34,670	35,204	35,746	36,296	36,854	36,798	36,743	36,688	36,632	36,577	36,578	36,579	36,581	36,582	36,583	1.5%	-0.2%	0.0%
5 to 14	67,015	66,242	65,469	64,705	63,950	63,204	62,467	62,476	62,485	62,493	62,502	62,511	63,050	63,593	64,141	64,694	65,251	-1.2%	0.0%	0.9%
15 to 24	74,405	75,387	76,369	77,363	78,371	79,391	80,425	80,373	80,321	80,269	80,218	80,166	79,995	79,825	79,656	79,486	79,317	1.3%	-0.1%	-0.2%
25 to 44	198,489	197,756	197,023	196,293	195,566	194,842	194,120	193,064	192,014	190,969	189,930	188,897	186,914	184,952	183,011	181,090	179,189	-0.4%	-0.5%	-1.0%
45 to 64	143,063	142,133	141,203	140,280	139,362	138,451	137,545	138,562	139,587	140,619	141,659	142,706	145,266	147,871	150,523	153,223	155,971	-0.7%	0.7%	1.8%
65 to 74	47,769	48,792	49,815	50,860	51,926	53,015	54,127	54,329	54,532	54,735	54,939	55,144	54,168	53,209	52,267	51,342	50,433	2.1%	0.4%	-1.8%
75 to 84	20,465	21,252	22,039	22,855	23,701	24,578	25,488	26,396	27,337	28,311	29,319	30,364	31,197	32,053	32,932	33,835	34,763	3.7%	3.6%	2.7%
85+	9,389	9,318	9,247	9,177	9,107	9,038	8,969	9,079	9,191	9,304	9,419	9,535	9,849	10,174	10,510	10,856	11,214	-0.8%	1.2%	3.3%
Total	594,214	595,025	595,836	596,737	597,729	598,815	599,995	601,078	602,209	603,388	604,618	605,900	607,017	608,256	609,619	611,107	612,721	0.2%	0.2%	0.2%

TABLE 15

Unduplicated Clients	ACTUAL					*ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP*											
Age Group	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**	**CY24**	**CY25**	**CY26**	**CY27**	**CY28**	**CY29**	**CY30**	**CY31**	**CY32**	**CY33**	**CY34**	**CY35**
0 to 4	346	326	348	276	294	299	303	303	302	302	301	301	301	301	301	301	301
5 to 14	34	37	50	47	54	53	53	53	53	53	53	53	53	54	54	55	55
15 to 24	89	75	79	78	76	77	78	78	78	78	78	78	78	77	77	77	77
25 to 44	595	583	565	583	443	441	440	437	435	433	430	428	423	419	415	410	406
45 to 64	3,135	3,221	2,804	2,799	2,206	2,192	2,177	2,193	2,210	2,226	2,242	2,259	2,299	2,341	2,383	2,425	2,469
65 to 74	3,472	3,690	3,785	3,867	3,768	3,847	3,928	3,942	3,957	3,972	3,987	4,001	3,931	3,861	3,793	3,726	3,660
75 to 84	3,019	3,000	3,129	3,545	3,334	3,457	3,585	3,713	3,845	3,982	4,124	4,271	4,388	4,509	4,633	4,760	4,890
85+	2,072	2,096	2,144	2,413	2,330	2,312	2,295	2,323	2,352	2,381	2,410	2,440	2,520	2,603	2,689	2,777	2,869
Total	12,762	13,028	12,904	13,610	12,511	12,679	12,859	13,042	13,231	13,426	13,625	13,831	13,994	14,165	14,344	14,531	14,727

Estimated Use Rate per 1,000 ***population*** *(unduplicated clients by age group by year / population by age group by year * 1,000)*

Age Group	CY19	CY20	CY21	CY22	CY23
0 to 4	10.3	9.5	10.0	7.8	8.2
5 to 14	0.5	0.6	0.8	0.7	0.8
15 to 24	1.2	1.0	1.0	1.0	1.0
25 to 44	3.0	2.9	2.9	3.0	2.3
45 to 64	21.9	22.7	19.9	20.0	15.8
65 to 74	72.7	75.6	76.0	76.0	72.6
75 to 84	147.5	141.2	142.0	155.1	140.7
85+	220.7	224.9	231.9	262.9	255.8
Total	21.5	21.9	21.7	22.8	20.9

Baltimore Coutny

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CY31	CY32	CY33	CY34	CY35	CAGR CY20-CY25	CAGR CY25-CY30	CAGR CY30-CY35
0 to 4	45,567	45,738	45,909	46,081	46,253	46,426	46,600	46,796	46,993	47,190	47,389	47,588	47,962	48,339	48,720	49,103	49,489	0.4%	0.4%	0.8%
5 to 14	102,189	101,668	101,147	100,630	100,114	99,602	99,092	98,672	98,255	97,839	97,424	97,012	97,415	97,819	98,226	98,633	99,043	-0.5%	-0.4%	0.4%
15 to 24	106,879	107,170	107,461	107,753	108,046	108,340	108,634	109,094	109,555	110,019	110,484	110,952	110,641	110,331	110,022	109,713	109,406	0.3%	0.4%	-0.3%
25 to 44	211,372	211,585	211,798	212,012	212,226	212,440	212,654	212,111	211,570	211,030	210,491	209,954	210,069	210,184	210,299	210,415	210,530	0.1%	-0.3%	0.1%
45 to 64	218,660	216,292	213,924	211,581	209,265	206,973	204,707	203,510	202,321	201,138	199,963	198,794	198,989	199,184	199,380	199,575	199,771	-1.1%	-0.6%	0.1%
65 to 74	82,484	84,174	85,864	87,589	89,348	91,142	92,972	93,745	94,525	95,311	96,104	96,903	96,004	95,114	94,232	93,358	92,492	2.0%	0.8%	-0.9%
75 to 84	38,336	40,161	41,986	43,893	45,887	47,972	50,151	51,887	53,682	55,540	57,462	59,451	60,904	62,392	63,916	65,478	67,078	4.5%	3.5%	2.4%
85+	23,477	23,522	23,567	23,612	23,657	23,703	23,748	24,170	24,601	25,038	25,484	25,937	26,897	27,893	28,926	29,996	31,107	0.2%	1.8%	3.7%
Total	828,963	830,310	831,657	833,151	834,796	836,597	838,558	839,986	841,501	843,106	844,801	846,591	848,881	851,257	853,720	856,272	858,916	0.2%	0.2%	0.3%

TABLE 15

Unduplicated Clients	**ACTUAL**					***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***											
Age Group	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**	**CY24**	**CY25**	**CY26**	**CY27**	**CY28**	**CY29**	**CY30**	**CY31**	**CY32**	**CY33**	**CY34**	**CY35**
0 to 4	501	536	368	333	404	406	407	409	410	412	414	416	419	422	426	429	432
5 to 14	61	53	54	49	87	87	86	86	85	85	85	84	85	85	85	86	86
15 to 24	118	97	97	96	104	104	105	105	105	106	106	107	106	106	106	106	105
25 to 44	726	694	576	520	486	486	487	486	484	483	482	481	481	481	482	482	482
45 to 64	3,752	3,551	3,413	3,171	2,884	2,852	2,821	2,805	2,788	2,772	2,756	2,740	2,742	2,745	2,748	2,750	2,753
65 to 74	4,964	4,981	5,326	5,636	5,262	5,368	5,475	5,521	5,567	5,613	5,660	5,707	5,654	5,602	5,550	5,498	5,447
75 to 84	5,441	5,568	5,766	6,680	6,628	6,929	7,244	7,495	7,754	8,022	8,300	8,587	8,797	9,012	9,232	9,458	9,689
85+	5,121	5,522	5,533	5,680	5,593	5,604	5,614	5,714	5,816	5,919	6,025	6,132	6,359	6,594	6,839	7,092	7,354
Total	20,684	21,002	21,133	22,165	21,448	21,836	22,240	22,620	23,011	23,413	23,827	24,253	24,644	25,048	25,467	25,900	26,349

Estimated Use Rate per 1,000 ***population*** *(unduplicated clients by age group by year / population by age group by year * 1,000)*

Age Group	CY19	CY20	CY21	CY22	CY23
0 to 4	11.0	11.7	8.0	7.2	8.7
5 to 14	0.6	0.5	0.5	0.5	0.9
15 to 24	1.1	0.9	0.9	0.9	1.0
25 to 44	3.4	3.3	2.7	2.5	2.3
45 to 64	17.2	16.4	16.0	15.0	13.8
65 to 74	60.2	59.2	62.0	64.3	58.9
75 to 84	141.9	138.6	137.3	152.2	144.4
85+	218.1	234.8	234.8	240.6	236.4
Total	25.0	25.3	25.4	26.6	25.7

Howard Coutny

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CY31	CY32	CY33	CY34	CY35	CAGR CY20-CY25	CAGR CY25-CY30	CAGR CY30-CY35
0 to 4	19,157	19,428	19,699	19,973	20,252	20,534	20,820	20,885	20,951	21,017	21,083	21,149	21,038	20,927	20,817	20,708	20,599	1.4%	0.3%	-0.5%
5 to 14	43,268	43,671	44,074	44,480	44,890	45,304	45,722	45,854	45,987	46,120	46,253	46,387	46,412	46,436	46,461	46,485	46,510	0.9%	0.3%	0.1%
15 to 24	39,167	39,053	38,939	38,824	38,711	38,597	38,484	38,856	39,231	39,610	39,993	40,379	40,673	40,970	41,269	41,570	41,873	-0.3%	1.0%	0.7%
25 to 44	85,201	86,278	87,355	88,446	89,550	90,668	91,800	92,050	92,301	92,552	92,804	93,057	92,917	92,778	92,639	92,500	92,361	1.2%	0.3%	-0.2%
45 to 64	90,473	89,864	89,255	88,650	88,049	87,452	86,859	86,443	86,030	85,618	85,209	84,801	84,938	85,076	85,214	85,352	85,490	-0.7%	-0.5%	0.2%
65 to 74	29,366	30,153	30,940	31,748	32,577	33,428	34,301	35,076	35,868	36,679	37,508	38,355	38,376	38,397	38,417	38,438	38,459	2.6%	2.3%	0.1%
75 to 84	13,745	14,697	15,649	16,663	17,742	18,891	20,115	20,925	21,768	22,645	23,557	24,506	25,168	25,849	26,547	27,265	28,002	6.5%	4.0%	2.7%
85+	4,628	4,847	5,066	5,295	5,535	5,785	6,047	6,431	6,839	7,273	7,735	8,226	8,772	9,354	9,974	10,636	11,342	4.5%	6.3%	6.6%
Total	325,005	327,991	330,977	334,080	337,306	340,660	344,148	346,521	348,975	351,514	354,141	356,860	358,295	359,787	361,339	362,954	364,636	1.0%	0.7%	0.4%

TABLE 15

Unduplicated Clients	**ACTUAL**					***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***											
Age Group	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**	**CY24**	**CY25**	**CY26**	**CY27**	**CY28**	**CY29**	**CY30**	**CY31**	**CY32**	**CY33**	**CY34**	**CY35**
0 to 4	165	88	79	85	65	66	67	67	67	67	68	68	68	67	67	66	66
5 to 14	23	15	14	12	18	18	18	18	18	18	19	19	19	19	19	19	19
15 to 24	51	29	38	36	30	30	30	30	30	31	31	31	32	32	32	32	32
25 to 44	252	159	129	124	106	107	109	109	109	110	110	110	110	110	110	109	109
45 to 64	1,255	840	859	697	649	645	640	637	634	631	628	625	626	627	628	629	630
65 to 74	1,624	1,276	1,303	1,387	1,249	1,282	1,315	1,345	1,375	1,406	1,438	1,471	1,471	1,472	1,473	1,474	1,474
75 to 84	1,681	1,539	1,783	1,987	2,089	2,224	2,368	2,464	2,563	2,666	2,774	2,885	2,963	3,044	3,126	3,210	3,297
85+	1,238	1,262	1,442	1,542	1,603	1,676	1,751	1,862	1,981	2,106	2,240	2,382	2,540	2,709	2,889	3,080	3,285
Total	6,289	5,208	5,647	5,870	5,809	6,047	6,299	6,533	6,778	7,036	7,307	7,591	7,829	8,079	8,343	8,620	8,913

Estimated Use Rate per 1,000 ***population*** *(unduplicated clients by age group by year / population by age group by year * 1,000)*

Age Group	CY19	CY20	CY21	CY22	CY23
0 to 4	8.6	4.5	4.0	4.3	3.2
5 to 14	0.5	0.3	0.3	0.3	0.4
15 to 24	1.3	0.7	1.0	0.9	0.8
25 to 44	3.0	1.8	1.5	1.4	1.2
45 to 64	13.9	9.3	9.6	7.9	7.4
65 to 74	55.3	42.3	42.1	43.7	38.3
75 to 84	122.3	104.7	113.9	119.2	117.7
85+	267.5	260.4	284.6	291.2	289.6
Total	19.4	15.9	17.1	17.6	17.2

Baltimore City, Baltimore County, and Howard County Summed

Population

Age Group	CY19	CY20	CY21	CY22	CY23	CY24	CY25	CY26	CY27	CY28	CY29	CY30	CY31	CY32	CY33	CY34	CY35	CAGR CY20-CY25	CAGR CY25-CY30	CAGR CY30-CY35
0 to 4	98,338	99,311	100,284	101,267	102,260	103,262	104,274	104,481	104,689	104,897	105,105	105,314	105,584	105,855	106,126	106,398	106,671	1.0%	0.2%	0.3%
5 to 14	212,448	211,581	210,714	209,850	208,990	208,134	207,281	207,006	206,732	206,457	206,183	205,910	206,880	207,854	208,833	209,816	210,804	-0.4%	-0.1%	0.5%
15 to 24	220,436	221,610	222,784	223,964	225,151	226,344	227,543	228,328	229,116	229,907	230,701	231,497	231,317	231,136	230,956	230,776	230,596	0.5%	0.3%	-0.1%
25 to 44	495,029	495,619	496,209	496,799	497,390	497,982	498,574	497,234	495,897	494,564	493,234	491,908	489,927	487,953	485,987	484,030	482,080	0.1%	-0.3%	-0.4%
45 to 64	452,192	448,289	444,386	440,517	436,682	432,880	429,111	428,548	427,985	427,423	426,862	426,301	429,246	432,212	435,198	438,205	441,232	-0.9%	-0.1%	0.7%
65 to 74	159,616	163,119	166,622	170,199	173,854	177,587	181,400	183,166	184,949	186,749	188,567	190,402	188,563	186,742	184,939	183,153	181,384	2.1%	1.0%	-1.0%
75 to 84	72,533	76,110	79,687	83,431	87,352	91,456	95,754	99,209	102,789	106,497	110,340	114,321	117,269	120,294	123,396	126,579	129,843	4.7%	3.6%	2.6%
85+	37,474	37,687	37,900	38,114	38,330	38,546	38,764	39,704	40,667	41,653	42,663	43,698	45,531	47,440	49,430	51,503	53,663	0.6%	2.4%	4.2%
Total	1,748,067	1,753,326	1,758,585	1,764,142	1,770,008	1,776,190	1,782,701	1,787,675	1,792,822	1,798,147	1,803,655	1,809,351	1,814,316	1,819,486	1,824,865	1,830,459	1,836,273	0.3%	0.3%	0.3%

TABLE 15

Unduplicated Clients	**ACTUAL**					***ESTIMATED UNDUP CLIENTS at 5 YEAR AVG USE RATE BY AGE GROUP***											
Age Group	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**	**CY24**	**CY25**	**CY26**	**CY27**	**CY28**	**CY29**	**CY30**	**CY31**	**CY32**	**CY33**	**CY34**	**CY35**
0 to 4	1,012	950	795	694	763	770	777	778	780	781	783	784	787	790	793	796	799
5 to 14	118	105	118	108	159	158	157	157	157	156	156	156	157	157	158	159	160
15 to 24	258	201	214	210	210	211	212	213	214	214	215	216	216	215	215	215	215
25 to 44	1,573	1,436	1,270	1,227	1,035	1,035	1,035	1,032	1,029	1,025	1,022	1,019	1,014	1,010	1,006	1,002	997
45 to 64	8,142	7,612	7,076	6,667	5,739	5,689	5,639	5,635	5,632	5,629	5,626	5,624	5,668	5,713	5,759	5,805	5,852
65 to 74	10,060	9,947	10,414	10,890	10,279	10,496	10,718	10,808	10,899	10,991	11,085	11,179	11,056	10,935	10,815	10,697	10,581
75 to 84	10,141	10,107	10,678	12,212	12,051	12,611	13,198	13,672	14,162	14,671	15,198	15,744	16,149	16,564	16,990	17,428	17,876
85+	8,431	8,880	9,119	9,635	9,526	9,591	9,660	9,900	10,148	10,406	10,675	10,954	11,419	11,906	12,416	12,950	13,508
Total	39,735	39,238	39,684	41,643	39,762	40,562	41,397	42,195	43,021	43,875	44,760	45,675	46,466	47,291	48,153	49,051	49,989

Estimated Use Rate per 1,000 ***population*** *(unduplicated clients by age group by year / population by age group by year * 1,000)*

Age Group	CY19	CY20	CY21	CY22	CY23
0 to 4	10.3	9.6	7.9	6.9	7.5
5 to 14	0.6	0.5	0.6	0.5	0.8
15 to 24	1.2	0.9	1.0	0.9	0.9
25 to 44	3.2	2.9	2.6	2.5	2.1
45 to 64	18.0	17.0	15.9	15.1	13.1
65 to 74	63.0	61.0	62.5	64.0	59.1
75 to 84	139.8	132.8	134.0	146.4	138.0
85+	225.0	235.6	240.6	252.8	248.5
Total	22.7	22.4	22.6	23.6	22.5

Sources:

Population Data

Maryland Department of Planning
Total population projections by age, sex, and race
Updated June 2025
https://planning.maryland.gov/MSDC/Pages/default.aspx

HHA Utilization Data

Table 15: Total Number of Home Health Clients (Unduplicated Count) by Jurisdictionof Residence, Age Group, and Agency: Maryland FY2019-FY2023
https://mhcc.maryland.gov/public_use_files/index.aspx

Exhibit 13

MD Historical HHA Service in FHC Jurisdictions

Total Number of Unduplicated Clients by Client Residence County / Jurisdiction, 2019-2023 (TABLE 13)

County / Jurisdiction	FY19	FY20	FY21	FY22	FY23		5 Yr CAGR	3Yr CAGR
Baltimore City	12,762	13,028	12,904	13,610	12,511		-0.4%	-1.0%
Baltimore County	20,684	21,002	21,133	22,165	21,448		0.7%	0.5%
Howard	6,289	5,208	5,647	5,870	5,809		-1.6%	0.9%
Total SA	39,735	39,238	39,684	41,645	39,768		0.0%	0.1%
					30.7%			

Total Number of Visits Based on Unduplicated Client County by Client Residence County / Jurisdiction, 2019-2023 (TABLE 14)

County / Jurisdiction	FY19	FY20	FY21	FY22	FY23		5Yr AGR	3Yr CAGR
Baltimore City	203,082	192,340	194,294	191,637	179,005		-2.5%	-2.7%
Baltimore County	359,756	329,881	328,977	322,688	315,476		-2.6%	-1.4%
Howard	85,327	76,872	89,593	83,815	83,372		-0.5%	-2.4%
Total SA	648,165	599,093	612,864	598,140	577,853		-2.3%	-1.9%

Estimated Visits per Unduplicated Client, 2019-2023

County / Jurisdiction	FY19	FY20	FY21	FY22	FY23
Baltimore City	15.9	14.8	15.1	14.1	14.3
Baltimore County	17.4	15.7	15.6	14.6	14.7
Howard	13.6	14.8	15.9	14.3	14.4
Total SA	16.3	15.3	15.4	14.4	14.5

Maryland Estimated Visits by Non / Billable and Discipline, 2019-2023 (TABLES 6 & 9)

***not available at jurisdiction level*

Metric	FY19	FY20	FY21	FY22	FY23	5Yr Average
Billable	2,225,550	2,046,969	2,018,232	1,887,847	1,892,291	10,070,889
Non Billable	55,788	70,191	53,525	63,477	49,279	292,260
Total Visits	2,281,338	2,117,160	2,071,757	1,951,324	1,941,570	10,363,149
Skilled Nursing	903,651	859,620	783,877	735,934	704,925	3,988,007
Home Health Aide	109,652	89,073	92,046	74,331	63,991	429,093
OT	306,781	255,720	259,476	257,480	272,966	1,352,423
PT	883,479	786,197	833,790	770,820	819,666	4,093,952
SLT	56,662	50,044	52,750	50,545	46,448	256,449
Med Soc Work	18,568	13,483	11,403	12,342	10,011	65,807
Total Visits	2,278,793	2,054,137	2,033,342	1,901,452	1,918,007	10,185,731

Estimated Visits per Unduplicated Client by Non / Billable and Discipline, 2019-2023

Metric	FY19	FY20	FY21	FY22	FY23	5Yr Avgerage
*Total MD Unduplicated Clients**Table 13*	*123,033*	*125,769*	*129,774*	*134,194*	*129,733*	642,503
Billable	18.1	16.3	15.6	14.1	14.6	15.7
Non Billable	0.5	0.6	0.4	0.5	0.4	0.5
Total	18.5	16.8	16.0	14.5	15.0	16.1
Skilled Nursing	7.3	6.8	6.0	5.5	5.4	6.2
Home Health Aide	0.9	0.7	0.7	0.6	0.5	0.7
OT	2.5	2.0	2.0	1.9	2.1	2.1
PT	7.2	6.3	6.4	5.7	6.3	6.4
SLT	0.5	0.4	0.4	0.4	0.4	0.4
Med Soc Work	0.2	0.1	0.1	0.1	0.1	0.1

Exhibit 14

Date: 2/19/2026

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Letter of Support for First Healthcare Consultants' Proposed Medicare-Certified Home Health Agency

Ms. Shaw-Taylor,

I am writing to express my support for First Healthcare Consultants' ("FHC") proposal to establish a Medicare-certified home health agency in our community. My family and/or I have firsthand experience with the care provided by FHC through its current in-home services.

The staff at FHC have consistently demonstrated professionalism, compassion, and respect, and have played an important role in helping us manage our health needs at home. Their services have allowed greater independence, reduced stress for caregivers, and improved overall quality of life.

FHC's ability to offer Medicare-certified home health services is especially important for families like ours. Access to Medicare-covered home health care will make it easier for patients to receive skilled services without unnecessary delays, financial strain, or hospital visits.

Based on our positive experience with FHC as a Residential Service Agency, I am confident that the same level of quality and dedication will carry over to its home health agency. I strongly support approval of this application and believe it will benefit patients and families throughout the service area.

Sincerely,

Signature: Barbara Dixon

Name: Barbara Dixon

Address: 5000 Oaklyn Ave, Balto., Md. 21207

Phone 443-691-1535 Email

I am familiar with FHC's services through: *(e.g., former patient, family caregiver, etc.)*

Date: 02/19/26

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Letter of Support for First Healthcare Consultants' Proposed Medicare-Certified Home Health Agency

Ms. Shaw-Taylor,

I am writing to express my support for First Healthcare Consultants' ("FHC") proposal to establish a Medicare-certified home health agency in our community. My family and/or I have firsthand experience with the care provided by FHC through its current in-home services.

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FHC's ability to offer Medicare-certified home health services is especially important for families like ours. Access to Medicare-covered home health care will make it easier for patients to receive skilled services without unnecessary delays, financial strain, or hospital visits.

Based on our positive experience with FHC as a Residential Service Agency, I am confident that the same level of quality and dedication will carry over to its home health agency. I strongly support approval of this application and believe it will benefit patients and families throughout the service area.

Sincerely,

Signature: Prince Hawkins

Name: Prince Hawkins

Address: 1619 Bluffdale Rd Apt A, Windsor Mill, MD 21244

Phone 443-431-0641 Email

I am familiar with FHC's services through: *(e.g., former patient, family caregiver, etc.)*

Date: 2/20/2026

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Letter of Support for First Healthcare Consultants' Proposed Medicare-Certified Home Health Agency

Ms. Shaw-Taylor,

I am writing to express my support for First Healthcare Consultants' ("FHC") proposal to establish a Medicare-certified home health agency in our community. My family and/or I have firsthand experience with the care provided by FHC through its current in-home services.

The staff at FHC have consistently demonstrated professionalism, compassion, and respect, and have played an important role in helping us manage our health needs at home. Their services have allowed greater independence, reduced stress for caregivers, and improved overall quality of life.

FHC's ability to offer Medicare-certified home health services is especially important for families like ours. Access to Medicare-covered home health care will make it easier for patients to receive skilled services without unnecessary delays, financial strain, or hospital visits.

Based on our positive experience with FHC as a Residential Service Agency, I am confident that the same level of quality and dedication will carry over to its home health agency. I strongly support approval of this application and believe it will benefit patients and families throughout the service area.

Sincerely,

Signature: [signature]

Name: Michael Snape

Address: 3421 Gateshead Manor Way #104
Silver Spring, MD. 20904

Phone 202-455-2521 Email

I am familiar with FHC's services through: *(e.g., former patient, family caregiver, etc.)*

Exhibit 15

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

Qualifying Jurisdictions

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

Types of Applicants

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

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

Qualifications for All Applicants

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

Performance-Related Qualifications by Type of Applicant

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

Exhibit 16

FHC MD HHA Batch 1 Startup and Working Capital		1	2	3	4	5	6	7	8	9	10	11	12	13
	Startup Period	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27	Jul-27	Aug-27	Sep-27	Oct-27	Nov-27	Dec-27	Jan-28
Net Revenue		$ 5,437	$ 5,437	$ 5,437	$ 5,437	$ 5,437	$ 99,873	$ 99,873	$ 99,873	$ 99,873	$ 99,873	$ 99,873	$ 99,873	$ 86,203
Non-CMS revenue spread over 12 months													$ 726,296	batch 2 start
CMS revenue spread ofver six months (June-Dec)														
	Startup Period	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27	Jul-27	Aug-27	Sep-27	Oct-27	Nov-27	Dec-27	Jan-28
Cash Inflow/Receipts		-	2,719	5,437	5,437	5,437	5,437	52,655	99,873	99,873	99,873	99,873	99,873	99,873
Assuming 45 days in A/R														
Operating Costs	**Startup Period**	**Jan-27**	**Feb-27**	**Mar-27**	**Apr-27**	**May-27**	**Jun-27**	**Jul-27**	**Aug-27**	**Sep-27**	**Oct-27**	**Nov-27**	**Dec-27**	**Jan-28**
These variable expenses are ramped with visits														
Salaries	$ 2,198	$ 4,395	$ 4,395	$ 4,395	$ 50,781	$ 50,781	$ 50,781	$ 50,781	$ 50,781	$ 50,781	$ 50,781	$ 50,781	$ 50,781	$ 52,832
Benefits	$ 330	$ 659	$ 659	$ 659	$ 7,617	$ 7,617	$ 7,617	$ 7,617	$ 7,617	$ 7,617	$ 7,617	$ 7,617	$ 7,617	$ 7,925
Payroll Taxes	$ 168	$ 336	$ 336	$ 336	$ 3,885	$ 3,885	$ 3,885	$ 3,885	$ 3,885	$ 3,885	$ 3,885	$ 3,885	$ 3,885	$ 4,042
Marketing	$ 10,000	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 183	$ 285
Travel	$ 175	$ 175	$ 175	$ 175	$ 2,025	$ 2,025	$ 2,025	$ 2,025	$ 2,025	$ 2,025	$ 2,025	$ 2,025	$ 2,025	$ 2,222
Medical Supplies	$ 136	$ 136	$ 136	$ 136	$ 1,572	$ 1,572	$ 1,572	$ 1,572	$ 1,572	$ 1,572	$ 1,572	$ 1,572	$ 1,572	$ 1,726
Bad Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
IT	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 1,734	$ 2,699
Training	$ 46	$ 46	$ 46	$ 46	$ 531	$ 531	$ 531	$ 531	$ 531	$ 531	$ 531	$ 531	$ 531	$ 410
Contractor	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 2,117	$ 3,296
Interest	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 69	$ 108
Professional Fees	$ -	$ 403	$ 403	$ 403	$ 4,651	$ 4,651	$ 4,651	$ 4,651	$ 4,651	$ 4,651	$ 4,651	$ 4,651	$ 4,651	$ 3,589
Rent	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 499	$ 776
Repairs	$ -	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21	$ 21
Taxes	$ -	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86	$ 86
Telecom	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 318	$ 496
Utilities	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 39	$ 60
Payroll Processing		$ 24	$ 24	$ 24	$ 278	$ 278	$ 278	$ 278	$ 278	$ 278	$ 278	$ 278	$ 278	$ 289
Other Indirect	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,192	$ 1,698
Cash Outflows by Month	**$ 19,020**	**$ 12,432**	**$ 12,432**	**$ 12,432**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 77,597**	**$ 82,559**
Total Cash Inflows		$ -	$ 2,719	$ 5,437	$ 5,437	$ 5,437	$ 5,437	$ 52,655	$ 99,873	$ 99,873	$ 99,873	$ 99,873	$ 99,873	$ 99,873
Total Cash Outflows	$ (19,020)	$ (12,432)	$ (12,432)	$ (12,432)	$ (77,597)	$ (77,597)	$ (77,597)	$ (77,597)	$ (77,597)	$ (77,597)	$ (77,597)	$ (77,597)	$ (77,597)	$ (82,559)
Principal Payment Outflow														
Net Cash Flow before WC interest	$ (19,020)	$ (12,432)	$ (9,714)	$ (6,995)	$ (72,160)	$ (72,160)	$ (72,160)	$ (24,942)	$ 22,275	$ 22,275	$ 22,275	$ 22,275	$ 22,275	$ 17,314
Monthly Interest on WC Outflow	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Net Monthly Cash Flow	$ (19,020)	$ (12,432)	$ (9,714)	$ (6,995)	$ (72,160)	$ (72,160)	$ (72,160)	$ (24,942)	$ 22,275	$ 22,275	$ 22,275	$ 22,275	$ 22,275	$ 17,314
Cumulative Cash Flow	$ (19,020)	$ (31,452)	$ (41,166)	$ (48,161)	$ (120,321)	$ (192,481)	$ (264,642)	$ (289,584)	$ (267,308)	$ (245,033)	$ (222,757)	$ (200,482)	$ (178,206)	$ (160,893)
		1	2	3	4	5	6	7	8	9	10	11	12	13
													cash flow generated from batch 1 operations prior to batch 2 starting	$ 111,377

Start up Costs & Pre-opening	**$ 19,020**	
Total Working Capital	**$ 289,584**	Maximum amount borrowed (max cumulative cash flow deficit)
Fixed Capital Cost (from Table 1)	**$ 20,000**	
Financing Cost & Other Cash Requirements	**$ 55,000**	
Total Capital Cost and Working Capital	**$ 364,584**	**$ 400,000** **$ 35,416**
Max Money Available		
Months to positive cash flow	8	