

APPLICATION FOR CERTIFICATE OF NEED



Applicant: Integrated Community Services (ICS), Inc.

Submitted to The Maryland Health Care Commission

January 9, 2026

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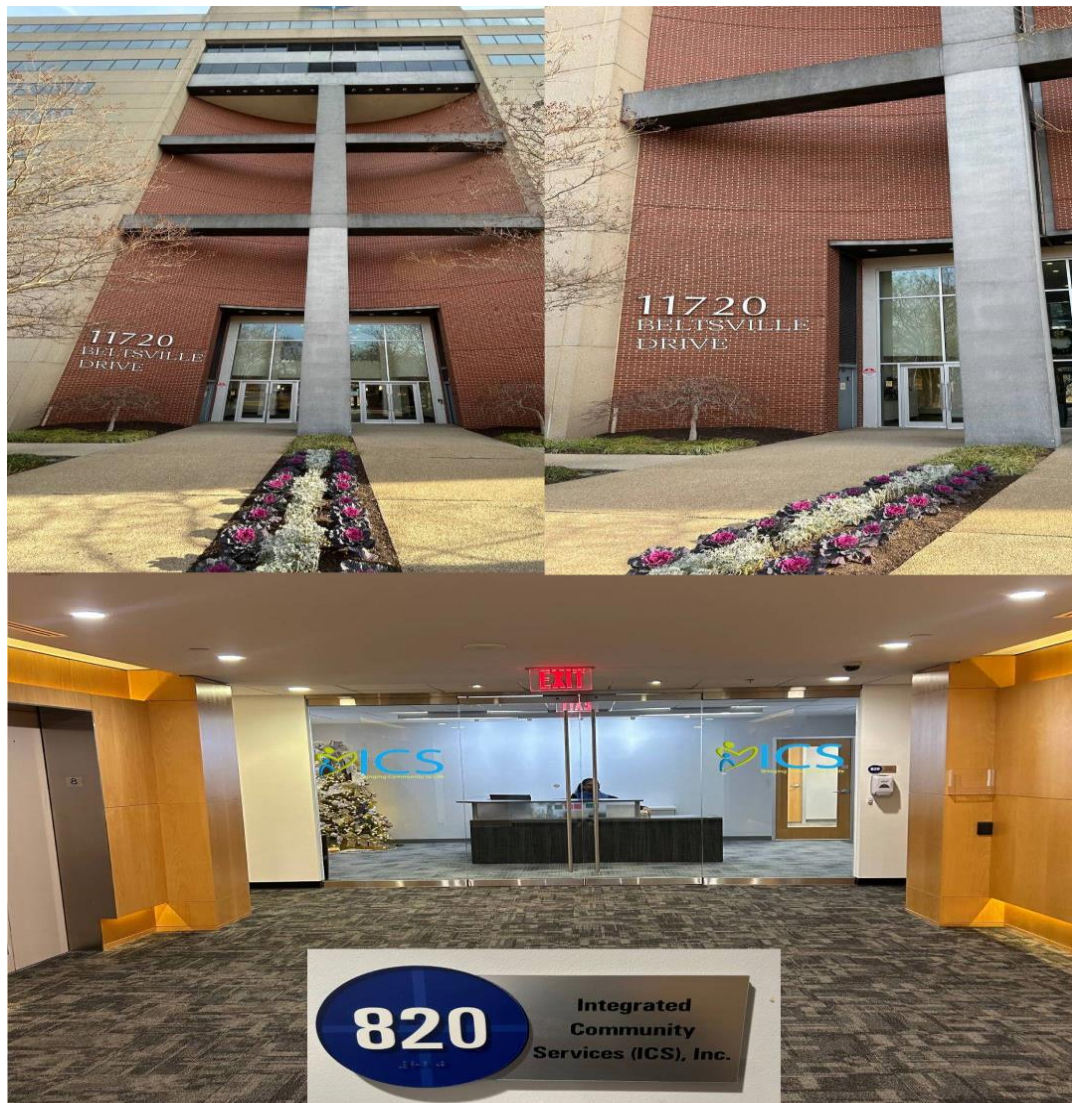
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INTRODUCTION TO ICS



Integrated Community Services (ICS) was established and incorporated in the State of Maryland in 2003 and obtained a license to provide speech/language services in the District of Columbia for recipients enrolled in the Developmental Disability Administration (DDA) program. In 2008, ICS expanded its services to include residential and behavioral supports services.

In 2010, youth served by the District of Columbia Child and Family Services Agency (CFSA) who had been placed in Maryland were found to be receiving inadequate residential and community-based support, resulting in the closure of those programs. In response, ICS was

entrusted with transitioning and supporting these youth, based on its well-established record of excellence in service delivery within the District of Columbia. Today, the majority of these individuals—now adults—remain connected to ICS and continue to receive supported living and related residential services through the agency’s adult home and community-based programs.

In 2014, the District of Columbia Department of Health Care Finance (DHCF), in collaboration with the DC Government, uncovered widespread fraud across multiple home health agencies, leading to a significant disruption in services for vulnerable Medicaid beneficiaries. To address this critical gap in care, DC Medicaid called upon ICS to help stabilize the system and restore access to high-quality home health services for individuals affected by the closure of noncompliant providers.

From April 2014 through March 2017, ICS worked closely with DHCF leadership to ensure continuity of care, delivering compliant, high-quality, and person-centered services to patients displaced by these agency closures.

Following this partnership, ICS formally applied for and successfully completed the rigorous Certificate of Need (CON) approval process in the District of Columbia. As a result, ICS was authorized and licensed as a Home Health Agency under both Medicare and DC Medicaid. Since obtaining licensure, ICS has consistently delivered high-quality, reliable healthcare services and currently maintains a patient census exceeding 600 individuals.

All patients served by ICS reside within the District of Columbia and receive Personal Care Aide (PCA) and Home Health Aide (HHA) services in their homes, tailored to their individualized care plans. Service hours vary based on each patient’s assessed needs and level of required support, ensuring appropriate, person-centered care delivery.

ICS remains steadfast in its commitment to excellence, integrity, and patient-centered outcomes. The agency’s strong compliance history, exemplary audit results, and consistently high satisfaction ratings reflect the confidence and trust placed in ICS by the individuals it serves, as well as by its regulatory and government partners.



Chairman

Randolph S. Sergent Esq,

Ben Steffen, Executive Director

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 of 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

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

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.

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): **Integrated Community Services**

Address:

**11720 Beltsville Drive Beltsville 20705 MD Prince Georges
Suite 820**

Street	City	Zip	State	County
		301-434-3503		

Telephone: _____

Name of Owner/Chief Executive:

Rose Oma

2. Name of Owner: Rose Oma

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.

3. FACILITY

Name of HHA
provider:

Integrated Community Services

Address:

11720 Beltsville Drive Suite 820 **Beltsville** **20705** **Prince Georges**

Street City Zip County

Name of Owner
(if differs from
applicant):

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:

Name and Title: Joseph Morris, Administrator

Mailing Address:

820 First Street NE Suite 425 Washington 20002 DC

Street City Zip State

Telephone: 202-751-5028

E-mail Address (required): jmorris@icsprograms.com

Fax: 202-506-1396

B. Additional or alternate contact:

Daja Chapman, Administrative Manager			
Mailing Address:			
11720 Beltsville Drive Suite 820	Beltsville	20705	MD
Street	City	Zip	State
Telephone:	202-250-9051		
E-mail Address (required):	dchapman@icsprograms.com		
Fax:	202-506-1396		

B. Additional or alternate contact:

Name and Title: Rose Oma, CEO	
Integrated Community Services, Inc	
Company Name	

Mailing Address:			
11720 Beltsville Drive, Suite 820	Beltsville	20705	MD
Street	City	Zip	State
Telephone: 202-431-2366			
E-mail Address (required): roma@icsprograms.com			
Fax: 202-506-1396			

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
- g. Other

(Please Specify.)__Home Health
 Agency_____

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	✓	✓
Home Health Aide	✓	✓
Occupational Therapy	✓	✓
Speech, Language Therapy	✓	✓
Physical Therapy	✓	✓
Medical Social Services	✓	✓

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

9. Offices

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

	Street	City	County	State	Zip Code	Telephone
Existing Main Office	820 First Street NE Suite 425	Washington	N/A	DC	20002	202-506-1209
Existing Branch Offices						
Locations of Proposed	11720 Beltsville Drive Suite	Beltsville	Prince Georges County	MD	20705	301-434-3503

HHA Main Office	820					
Locations of Proposed Branch Office						

10. Project Implementation Schedule for an HHA

An application for a CON or other Commission approval shall propose a schedule for implementation of the project in accordance with COMAR 10.24.01.12A(1) that specifies the estimated time for, at a minimum, the following project implementation steps: Obligation of Capital Expenditure, Beginning Construction, Complete Construction and Full Operation.

In developing the schedule, please note that COMAR 10.24.01.12C requires a holder to obligate at least 51 percent of the approved capital expenditure for a project involving building construction, renovation, or both, as documented by a binding construction contract or equipment purchase order, within the following specified time periods:

- (a) An approved new hospital has up to 36 months
- (b) A project involving an approved new non-hospital health care facility or involving a building addition or replacement of building space of a health care facility has up to 24 months
- (c) A project limited to renovation of existing building space of a health care facility has up to 18 months
- (d) A project that does not involve construction or renovation shall document that the approved project is complete and operational within 18 months.

In a multiphase plan of construction with more than one construction contract approved for an existing health care facility, a holder has:

- (a) Up to 12 months after approval to obligate 51 percent of the capital expenditure for the first phase of construction
- (b) Up to 12 months after completion of the immediately preceding phase of construction to obligate 51 percent of the capital expenditure for any subsequent approved phase

For Home Health projects, please also provide:

- A. Licensure: 3 months from CON approval date.

B. Medicare Certification N/A(Already certified) 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.

Agency Purpose:

The purpose of Integrated Community Services, Inc. is to provide exceptional, person-centered home health care and skilled nursing services. We are committed to improving quality of life through compassionate, individualized care that empowers clients to live independently, achieve personal growth, and maintain optimal well-being.

Services Overview:

ICS will offer a full spectrum of home health services, including:

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Worker
- Wound Care and Medication Management

Target Population:

ICS will serve adults across Maryland, with a focus on Anne Arundel, Montgomery, and Prince George's Counties, providing skilled nursing and supportive care tailored to meet the unique needs of each client.

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

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). “The State Health Plan” Review Criterion

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 documentation as 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
- (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.

ICS Response:

Integrated Community Services (ICS), Inc. proposes to establish a new Maryland Home Health Agency serving Anne Arundel County, Montgomery County, and Prince George’s County. This three-county area is contiguous and consistent with the service area of intent and jurisdictional requirements of COMAR 10.24.16.

ICS is a Maryland-incorporated healthcare organization founded in 2003 and currently operates a Medicare-certified Home Health Agency in Washington, DC, serving more than 600 patients annually. ICS’s demonstrated experience operating within a highly regulated environment, combined with its established administrative systems, clinical leadership structure, compliance oversight, and staffing model, supports its ability to deliver safe, timely, and effective home health services throughout the proposed service area.

10.24.16.08B. Populations and Services.

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

ICS Response:

Integrated Community Services, Inc. (ICS) will serve older adults, adults with physical disabilities, individuals with chronic and complex medical conditions, and medically underserved populations throughout the proposed service area. ICS will provide a comprehensive continuum of home health services, including skilled nursing; physical, occupational, speech therapy, medical social worker; home health aide services; medication management; chronic disease management; patient and caregiver education; post-acute and hospital discharge support; and care coordination.

Building on its proven, person-centered and clinically robust home health model currently operating in Washington, DC, ICS will expand services to meet the growing healthcare needs of Maryland residents. Target service areas include Anne Arundel, Montgomery, and Prince George’s Counties, Maryland.

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.

ICS Response:

ICS will seek and maintain Maryland licensure and certification to participate in Medicare and Medicaid, while also accepting commercial insurance and self-pay patients. ICS’s service

delivery model ensures access regardless of payor source and aligns with Maryland policy goals related to access, equity, and post-acute care system stability.

10.24.16.08D. Fees and Time Payment Plan.

An applicant shall make its fees known to prospective clients and their families at 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
- (3) 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.

ICS Response:

ICS maintains written policies governing fee disclosure and time payment plans. All applicable fees will be disclosed prior to the initiation of services, and individuals unable to pay at the time services are rendered may establish reasonable payment arrangements. These policies support transparency, access, and regulatory compliance and will be provided to patients and the Commission upon request.

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.
- (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 the client or clients' family concerns regarding payment for HHA services and provide individual notices regarding the HHA's charity care and sliding fee scale policies to the client and family.

- (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.

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

ICS Response:

ICS maintains a written Charity Care and Sliding Fee Scale Policy designed to ensure access to services regardless of ability to pay. Eligibility determinations are completed within two business days, and charity care is fully funded within the agency's financial projections. ICS commits to providing charity care equal to or exceeding county-level HHA averages, consistent with COMAR 10.24.16.08E.

10.24.16.08 F. 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;
- (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
- (4) 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.

ICS Response:

Integrated Community Services, Inc. (“ICS”) is submitting multi-year financial projections for the proposed project and provides the assumptions used to develop projected operating revenues and costs. The projections reflect a conservative ramp-up and demonstrate that the proposed project is financially feasible and sustainable.

ICS’s utilization projections reflect a conservative start-up volume and are consistent with typical home health episode patterns and expected demand for skilled home health services in the proposed service area. For Year 1, ICS assumes an average of 75 patients per month. Rather than projecting a specific distribution of referrals by county during the start-up period, ICS uses an overall monthly volume for the three-county service area to reflect a cautious and realistic ramp-up.

Utilization per patient is projected over a two-month service period and assumes, on average:

- 10 PT visits (5 visits per month per 60-day episode)
- 6 OT visits (3 visits per month per 60-day episode)
- 10 HHA visits (5(2 hours) visits per month per 60-day episode)

At the conclusion of the initial 60-day episode of care, ICS projects that approximately 80% of patients will be discharged from skilled physical therapy services based on documented goal attainment and clinical determination that continued skilled intervention is no longer medically necessary. The remaining 20% of patients are expected to require continued skilled PT services due to ongoing impairments, unresolved functional limitations, or incomplete progress toward established goals.

For these patients, ICS will continue services for an additional episode and provide approximately 10 additional PT visits at the same rate, contingent upon continued medical necessity. ICS will work collaboratively with the patient’s primary care provider (PCP) and the patient’s insurance carrier to obtain the required physician orders and any necessary authorization for the additional visits, consistent with the updated plan of care and payer requirements.

These utilization assumptions were selected to ensure that projected revenues reflect realistic reimbursement levels, and that staffing and expense projections remain directly aligned with projected service utilization throughout the forecast period.

Projected reimbursement rates for Skilled Nursing (SN), Physical Therapy (PT), Occupational Therapy (OT), and Home Health Aide (HHA) services were developed using the average Medicaid rates across Prince George’s County, Montgomery County, and Anne Arundel County. The projections incorporate standard revenue reductions and uncompensated care assumptions, including bad debt and charity care, consistent with prudent home health financial planning.

Based on the submitted projections, gross patient service revenue and net patient services revenue are as follows:

Fiscal Year	Gross Patient Service Revenue	Revenue Reductions (13%)	Net Patient Services Revenue	Total Operating Expenses	Income from Operations
2026	\$1,441,188	\$187,354	\$1,253,834	\$948,478	\$305,356
2027	\$3,602,970	\$456,376	\$3,134,583.90	\$2,321,730	\$812,854
2028	\$3,855,178	\$5011,173	\$3,354,004.77	\$2,402,029	\$951,975
2029	\$4,125,040.35	\$536,255.00	\$3,588,785	\$2,485,270	\$1,103,515

Revenue Reductions / Uncompensated Care Assumptions

- Bad debt allowance: 6% of gross patient service revenue
- Charity care: 7% of gross patient service revenue

(3) Staffing and Expense Projections

Staffing and overall expense projections are tied to utilization of assumptions and reflect reasonable expenditure levels for a new home health agency operating under Maryland requirements. Expenses include direct care compensation, contract clinical resources during ramp-up, and administrative and operating costs necessary to support oversight, compliance, documentation, and quality improvement.

Position	2026 FTEs	2027 FTEs	2028 FTEs	2029 FTEs
Registered Nurses (RNs)	6.0	6.5	7.0	7.5
Physical Therapists (PTs)	4.0	4.5	5.0	5.5
Occupational Therapists (OTs)	2.0	2.5	3.0	3.5
Home Health Aides (HHAs)	8.0	9.0	10.0	11.0
Clinical Supervisor / Director	1.0	1.0	1.0	1.0
QA / Compliance / Case Management	1.0	1.0	1.5	1.5
Administrative / Billing / Intake Staff	2.0	2.5	3.0	3.5
Total FTEs	24.0	28.0	30.5	33.0

- Staffing levels are directly tied to projected patient volume and visit utilization.
- Initial staffing includes a mix of employed and contract clinicians during ramp-up, with a gradual transition to permanent FTEs.
- Clinical supervision and administrative staffing remain stable to ensure regulatory compliance, care coordination, documentation oversight, and quality assurance.
- Incremental FTE growth reflects anticipated increases in census and service intensity over the projection period.

Financial Feasibility Conclusion The projections demonstrate that the proposed project is financially feasible, with positive operating performance in every projected year, and that staffing and expense assumptions remain aligned with conservative utilization expectations.

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 in each jurisdiction or regional service area affected by the proposed project. This shall include impact on existing HHAs caseloads, staffing and payor mix.

ICS Response:

ICS concludes that its entry into the proposed service area will not adversely impact existing home health agencies and will instead strengthen the local post-acute care continuum. Prince George's County, Montgomery County, and Anne Arundel County continue to demonstrate unmet demand for timely skilled home health services, driven by population growth, staffing shortages, and discharge delays. Accordingly, the proposed project will increase skilled home health capacity, expand consumer choice, and improve start-of-care timeliness, while having minimal impact on existing providers' caseloads, staffing, and payer mix and without materially displacing current providers.

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.

ICS Response:

ICS documents the availability of financial resources necessary to sustain the proposed project and demonstrates the ability to comply with CMS capital reserve and solvency expectations for a Medicare-certified home health agency.

The submitted projections demonstrate positive operating income in each forecast year and include conservative assumptions for bad debt (6%) and charity care (7%). The projected income from operations supports sustainability and the ability to maintain appropriate reserves, staffing infrastructure, compliance oversight, and continuity of care.

Operating income remains positive across the forecast period:

- 2026: \$187,293.70
- 2027: \$466,741.19
- 2028: \$567,674.63
- 2029: \$678,370.88

Solvency Conclusion: Based on projected operating performance, conservative revenue reductions, and aligned staffing/expense assumptions, ICS demonstrates the financial resources necessary to sustain the project and maintain compliance with Medicare-certified home health solvency requirements. ICS ended strong on net assets in 2024 (\$5.1M) and is projecting a \$7.5M net assets for 2025. We ended 2024 with a cash ratio of 4:1 and are projecting a 7:1 ratio for 2025.

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.

ICS Response:

ICS maintains active and developing relationships with hospitals, assisted living facilities, nursing facilities, hospice providers, community-based organizations, social workers, and faith-based organizations. These linkages support coordinated referrals, culturally and linguistically appropriate outreach, and continuity of care for underserved populations. Documentation of linkages will be submitted at first use approval.

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.

ICS Response:

ICS maintains a formal discharge planning policy to ensure safe, timely, and coordinated transitions of care. Discharge planning incorporates patient goals, clinical criteria, and referrals to appropriate providers or community resources. Secure records management is maintained through Iron Mountain, ensuring continuity and compliance with all regulatory requirements. (Please see Exhibit 5 for Discharge policies enclosed with this package)

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 (HHAHPS).

ICS Response:

ICS will comply with all State and federal data collection and reporting requirements, including MHCC Home Health Agency Annual Survey reporting, CMS OASIS submissions, and HHAHPS measures. ICS utilizes Axxess and CurisTech CRM systems to track start-of-care timeliness, health equity metrics, clinical outcomes, and quality indicators, supporting accurate reporting, continuous quality improvement, and regulatory compliance.

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.

ICS Response:

Integrated Community Services, Inc. acknowledges the preference criteria set forth in COMAR 10.24.16.09, which apply only in the event of a comparative review. ICS understands that these preferences are used solely to differentiate among fully compliant applications when approval of all qualified proposals would exceed the number of additional HHAs permitted in a jurisdiction or region.

Although ICS has not previously operated a Maryland-licensed home health agency or been issued a Maryland Certificate of Need, the organization has a demonstrated and transferable record of performance through its long-standing operation of a Medicare-certified home health agency in Washington, DC. That program provides relevant, verifiable data addressing each of the preference areas identified in COMAR 10.24.16.09.

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.

ICS Response:

ICS's DC home health program has maintained strong compliance and quality outcomes over multiple reporting periods, supported by an established QAPI program, routine clinical monitoring, and corrective action process. These systems and performance management practices will be implemented without modification in Maryland.

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.

ICS Response:

ICS has a proven track record serving patients across a broad range of payor types, including Medicare, Medicaid, managed care, and low-income populations, consistent with the organization's mission and charity care policies.

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

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

ICS Response:

ICS provides a comprehensive array of home health services, including skilled nursing, therapy services, and care coordination, demonstrating operational capacity and clinical breadth that directly translates to the proposed Maryland program.

ICS submits that its demonstrated experience, quality infrastructure, and service history satisfy the intent of the preference criteria, even as a new Maryland applicant. Regardless of whether a comparative review is conducted, ICS fully complies with all applicable review standards set forth in COMAR 10.24.16.08.

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.

ICS Response:

Integrated Community Services, Inc. acknowledges that the preference criteria set forth in COMAR 10.24.16.09A through D are applied only in the context of a comparative review, and only when approval of all applications that fully comply with the review standards in COMAR 10.24.16.08 would exceed the number of additional Home Health Agencies permitted within a jurisdiction or multi-jurisdictional region pursuant to COMAR 10.24.16.10.

ICS submits that its application independently satisfies all applicable review standards under COMAR 10.24.16.08. To the extent that a comparative review is conducted, ICS has demonstrated that it can meet the intent of the preference criteria through its established operational experience, quality infrastructure, and service history

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.

ICS Response:

ICS is uniquely positioned to fulfill the documented need for additional high-quality home health agency services in Anne Arundel, Montgomery, and Prince George’s Counties. These jurisdictions currently exhibit high HHA concentration ratios and limited meaningful consumer choice, resulting in gaps in access to timely, culturally competent, and person-centered care. ICS’s expansion leverages its established Medicare-certified home health program in Washington, DC, serving over 600 patients annually, to bring proven clinical expertise, bilingual staff, and rapid start-of-care capabilities to Maryland residents. By providing skilled nursing, therapy, and comprehensive care management, ICS will address unmet demand, improve post-acute care transitions, and enhance access for underserved populations, including low-income, Limited English- speaking and non-English-speaking residents.

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.

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.

ICS Response:

Integrated Community Services (ICS) has designed this proposed project to fully align with the objectives of Maryland's State Health Plan (SHP). The initiative is focused on ensuring timely access to high-quality health care services, strengthening continuity of care across settings, reducing avoidable utilization, and promoting the efficient and responsible development of resources.

The proposed project will expand skilled home health capacity in Prince George's County, Montgomery County, and Anne Arundel County and is intended to improve timely access to skilled nursing and interdisciplinary home health services for individuals who currently

experience start-of-care delays, limited provider availability, and disruptions in post-acute transitions. If approved, ICS will establish a Maryland home health agency serving these counties, that is operationally prepared and clinically equipped to deliver high-quality services from day one, supported by experienced leadership, established systems, and proven performance in regulated environments.

This proposed project aligns with SHP goals related to quality and system efficiency through a deliberate focus on:

- Preventing avoidable hospital readmissions
- Supporting timely Start of Care (SOC) and Resumption of Care (ROC)
- Appropriate utilization of authorized hours and services • Strong care coordination with clinical and payer partners
- Building a stable workforce capable of delivering consistent services

ICS has a documented history of delivering home health services under regulatory oversight and performance expectations. Notably, ICS is the only home health agency invited by UnitedHealthcare to participate in its pilot Value-Based Initiative, which includes performance-based monitoring and incentives tied to hospital readmissions, hours utilization, SOC, and ROC performance. This participation reflects payer confidence in ICS's clinical performance and operational readiness and supports the need for the proposed expansion in Maryland.

B. INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project.

ICS used a structured planning process designed to ensure the proposed project is feasible, sustainable, and aligned with SHP goals. The planning process includes the following components:

B.1. Assessment of Need and Service Gaps:

If approved, this will be the first time ICS will be providing services in Maryland. ICS evaluated the proposed service area and identified key factors impacting access to skilled home health services, including:

- Increasing demand for skilled services associated with chronic illness and an aging population.
- Workforce shortages and capacity limitations that contributed to delayed initiation of care.

Poor clinical outcomes for patients when skilled services are delayed, including increased risk of readmissions.

- The need for improved continuity of care after transitions from hospitals and other in-patient facilities.

ICS also considered feedback from current referral partners, as well as clinical and payer partners, confirming ongoing demand for timely skilled nursing capacity and the need for agencies prepared to deliver high-quality care immediately upon licensure.

B.2. Internal Capacity and Readiness Assessment:

ICS assessed internal readiness to scale services without compromising quality. ICS has existing operational and clinical infrastructure to support expansion, including:

- Over 1000 home health aides
- Over 30 Registered Nurses
- Multiple clinicians in Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy
- Established QA and compliance systems, clinical supervision, and documentation standards

B.3. Workforce Strategy:

ICS's workforce strategy is a core part of project planning and feasibility. Over 80% ICS clinicians and Aides currently reside in Maryland and commute to DC to provide care. ICS intends to optimize workforce deployment by increasing Maryland-based service delivery while maintaining stability in our DC operations.

ICS is also involved in workforce initiatives with the DC government and UnitedHealthcare, supporting recruitment and licensing of DC residents to work with DC agencies. This strategy will strengthen DC staffing capacity and allow most Maryland-based employees to return to serving Maryland residents, improving retention, responsiveness, and long-term workforce sustainability.

B.4. Growth Planning and Utilization Targets:

ICS developed phased growth targets to ensure controlled expansion and quality from day one:

- Year 1: Average 75 skilled nursing patients per month
- Year 2: Average 125 skilled nursing patients per month
- Year 3: Average 125–150 skilled nursing patients per month

These volume targets are aligned with ICS's demonstrated staffing capacity, payer access readiness, and operational oversight capabilities. ICS currently supports an average monthly census exceeding 380 patients, with each patient receiving Personal Care Aide services at an average rate of 14 to 16 hours per day, seven days per week. ICS maintains the administrative infrastructure, clinical supervision model, and quality oversight systems necessary to manage this level of service delivery and is prepared to implement comparable capacity across Prince

George's County, Montgomery County, and Anne Arundel County. ICS is further prepared to scale operations beyond projected volumes, should demand exceed initial projections

. B.5. Payer and Partner Readiness:

ICS has established payer relationships and a credentialing foundation that supports rapid implementation upon licensure. ICS is currently credentialed with select private insurance partners and has relationships with key payers that also operate in Maryland, including UnitedHealthcare, and existing relationships with Kaiser Permanente, Humana, Cigna and CareFirst/Blue Cross Blue Shield. These relationships support project feasibility and access once licensure is obtained.

C. This should include a full explanation of the primary goals or objectives of the project, or the problem(s) being addressed by the project.

C.1. Primary Problems / Needs Being Addressed:

The proposed project addresses:

1. Insufficient or delayed access to skilled home health services resulting from provider capacity limitations and workforce shortages.
2. Gaps in continuity of care during post-acute transitions and service initiation.
3. Increased risk of avoidable hospital readmissions when timely skilled services are not available.
4. A need for provider capacity capable of operating under quality and value-based performance expectations (SOC/ROC) timeliness, and readmission prevention.

C.2. Primary Goals and Objectives:

ICS proposes to:

1. Increase access to skilled home health services in Prince George's, Montgomery, and Anne Arundel Counties.
2. Deliver excellent care from day one, supported by proven clinical oversight and QA infrastructure.
3. Improve continuity of care and care transition support, ensuring timely SOC/ROC. Implement a sustainable workforce approach leveraging Maryland- and DC-based clinicians, supporting retention and stable staffing.
4. Align service delivery with payer quality expectations through a focus on outcomes consistent with value-based performance.

D. Identify the alternative approaches to achieving these goals or objectives or solving these problem(s) that were considered during the project planning process, including alternatives to the services being provided by existing facilities.

ICS considered multiple alternative approaches during project planning:

D.1. Alternative 1 – Do Not Expand: ICS considered maintaining current operations without the Maryland expansion.

D.2. Alternative 2 – Rely on Existing Facilities/Providers: ICS considered whether existing skilled home health agencies in the proposed counties could sufficiently meet the service demand.

D.3. Alternative 3 – Subcontract Services through Existing Agencies: ICS considered meeting demand through subcontracting or partnership arrangements with existing providers.

D.4. Alternative 4 – Develop an Entirely New Entity or Separate Infrastructure: ICS considered whether launching a separate organization or duplicating infrastructure would be necessary instead of leveraging existing systems.

E. For all alternative approaches, provide information on the level of effectiveness and the costs of each alternative, including life-cycle costs. Clearly convey analytical findings and reasoning and why the proposed project is the most effective solution for the level of cost required, compared to alternatives.

E.1. Alternative 1 – Do Not Expand Effectiveness: Not effective. This alternative does not address access barriers, workforce challenges, or readmission-prevention objectives in Maryland.

Costs (Lifecycle): Lower direct cost to ICS, but higher system-level life-cycle costs due to ongoing service gaps, and delayed SOC.

Conclusion: Not effective for Maryland State Health Plan Goals.

E.2. Alternative 2 – Rely on Existing Facilities/Providers Effectiveness: Moderately effective, but existing provider capacity and workforce limitations may continue to result in service delays and gaps. This alternative does not ensure improved timeliness, staffing stability, or consistent performance under value-based care expectations.

Costs (Life-Cycle): No expansion cost

Conclusion:

Not effective for Maryland State Health Plan Goals.

E.3. Alternative 3 – Subcontract Services Effectiveness: Subcontracting would reduce ICS's control over clinical oversight, staffing reliability, documentation standards, and quality assurance performance measures, and it could expose ICS to liability resulting from the contractor's acts or omissions. ICS has not historically partnered with outside entities to operate

or deliver core services under the ICS model, and ICS does not intend to use subcontracting arrangements for this proposed project.

Costs (Life-Cycle): May appear lower initially but typically increases life-cycle costs through administrative burden, reduced quality control, and compliance risk.

Conclusion: Not an effective long-term solution.

E.4. Alternative 4 – Create a Separate Entity / Duplicate Infrastructure Effectiveness: Effective but unnecessarily complex; slower implementation and not required, given ICS has an established infrastructure.

Costs (Life-Cycle): Highest cost alternative due to duplication of leadership, compliance systems, technology, policies, and administrative overhead.

Conclusion: Less cost-effective than the proposed project.

E.5. Why the Proposed Project is the Most Effective Choice for the Level of Cost Required. ICS selected the proposed project because it provides the strongest combination of effectiveness and cost efficiency:

- Improves access and timeliness of skilled services
- Delivers high-quality care from day one using existing clinical and QA systems
- Supports value-based priorities (SOC/ROC, and readmissions), validated by participation in UnitedHealthcare’s pilot initiative
- Leverages an existing Maryland-based workforce currently commuting to DC
- Avoids unnecessary duplication of infrastructure, reducing life-cycle costs
- Provides controlled, phased growth consistent with staffing and oversight capacity

Conclusion: Compared to the alternatives, the proposed project offers the highest likelihood of achieving

SHP-aligned goals at a lower life-cycle cost, while strengthening quality outcomes and continuity of care.

F. Project Feasibility / Timetable (Implementation Planning Statement)

Upon approval of the Certificate of Need (CON), ICS will immediately initiate the Maryland licensure process. ICS has reviewed Maryland home health agency licensing requirements and has the operational infrastructure, policies, clinical oversight structure, and staffing plan in place to submit a complete application.

ICS anticipates submitting its application to the Maryland Board of Nursing within two (2) weeks of CON approval. Based on Board processing timelines, ICS expects to be fully licensed

and positioned to begin providing services in Maryland within three (3) to six (6) months of CON approval.

Upon receipt of a Maryland license, ICS will promptly expand payer credentialing and contracting to ensure broad access and reimbursement readiness, including extending existing relationships with UnitedHealthcare, Kaiser Permanente, CareFirst/Blue Cross Blue Shield, Cigna, and other third-party insurance partners currently credentialed with ICS in DC.

ICS's phased implementation approach ensures service expansion occurs responsibly, with quality assurance, clinical supervision, and staffing capacity fully aligned with projected patient volumes

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).**

ICS Response:

ICS will operate the proposed Maryland Home Health Agency from an existing administrative office location. No new construction or major renovations are required. All necessary State licensure, local approvals, and compliance requirements will be obtained prior to the planned start of operations in August 2026. Staffing, training, and operational workflows are planned to ensure the agency can begin services promptly and operate in compliance with Maryland regulatory requirements.

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 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.

ICS Response:

Integrated Community Services, Inc. has not previously been issued a Certificate of Need in the State of Maryland. Neither ICS, nor any parent entity, affiliate, or subsidiary, has received a Maryland Certificate of Need within the past 15 years.

Accordingly, there are no prior Maryland CON terms or conditions applicable to the applicant, and there is no history of noncompliance associated with prior Maryland CON approvals.

ICS notes that it has successfully implemented and operated health care programs in other jurisdictions, including a Medicare-certified home health agency in Washington, DC, in full compliance with all applicable licensure, certification, and regulatory requirements. This operational history demonstrates ICS’s capacity to implement approved projects in accordance with regulatory expectations.

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.**

ICS Response:

COMAR 10.24.01.08G(3)(f)(a) Impact on Volume of Service Provided by Other Existing Providers

In accordance with COMAR 10.24.01.08G(3)(f), ICS has analyzed the likely impact of the proposed project on the volume of services provided by other existing home health providers in the proposed service area.

ICS anticipates that the proposed project will result in minimal to no adverse impact on the volume of home health services provided by existing HHAs in the service area. This conclusion is supported by (1) strong and continuing demand for home health services, (2) persistent

workforce constraints that limit provider capacity, and (3) the modest scale of ICS's projected start-up volumes relative to overall market need.

Projected Volumes Support Minimal Market Impact: ICS's projections reflect a conservative and phased ramp-up. Based on ICS's planning assumptions, the proposed agency anticipates serving approximately:

- Year 1: 975 skilled nursing admissions
- Year 2: 1,500 skilled nursing admissions
- Year 3: 1,750 skilled nursing admissions

These volumes represent a limited portion of total home health utilization across the proposed service area and are not of a scale that would reasonably be expected to materially reduce existing agencies' patient volumes or market share.

Need for High-Performing Providers and Expected Sources of Referrals: ICS's decision to expand into Maryland is further supported by documentation and planning guidance indicating that Maryland continues to require high-performing home health providers to strengthen access and quality across the continuum of care. ICS anticipates that its growth in the proposed service area will be driven primarily by referrals from patients, hospital discharge planners, social workers, and community partners seeking agencies that consistently deliver timely, complete, and high-quality services. ICS expects that positive patient experience and demonstrated clinical performance will generate ongoing referrals through established professional networks and word-of-mouth, consistent with ICS's experience operating a Medicare-certified home health agency in Washington, DC.

Unmet Demand and Capacity Constraints Reduce Displacement Risk: Home health referrals in the proposed service area are frequently affected by provider limitations related to staffing availability, geographic coverage, language needs, and patient acuity. As a result, ICS expects that many of the referrals it accepts will be those that are currently delayed, redirected, or unfilled due to capacity limitations among existing providers, rather than patients actively being served by other agencies.

ICS's operational model designed to support timely admissions, consistent staffing, and strong care coordination will primarily increase system capacity and improve access, rather than displace existing provider volume.

Sources of Information: This impact analysis is informed by:

- The Maryland Health Care Commission home health CON review framework and requirements under COMAR 10.24.16;
- CMS home health utilization trends and national demand patterns for home-based post-acute care; and

- Maryland demographic and aging population trends that drive increased demand for home health services.

Assumptions:

ICS's analysis is based on the following assumptions:

- 1) Demand for home health services in the proposed service area will remain strong due to an aging population and discharge transition needs.
- 2) Existing HHAs will continue to face workforce constraints that limit their ability to accept all referrals.
- 3) ICS's projected patient volumes reflect conservative start-up operations and a gradual ramp-up rather than rapid market capture.
- 4) The proposed project will not rely on pricing strategies or exclusive payer arrangements that would materially shift market share from existing providers.

Conclusion: Based on these market conditions, assumptions, and projected volumes, ICS concludes that the proposed project will have minimal impact on the volume of service provided by existing home health agencies, while contributing positively to access and system capacity in the proposed service area.

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.

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)² 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.

ICS Response: Integrated Community Services, Inc. ("ICS") respectfully submits that its demonstrated experience serving a culturally diverse, medically underserved, and linguistically diverse populations in Washington, DC positions the organization as an excellent candidate to expand high-performing home health services into Maryland. ICS's service delivery model is grounded in health equity principles ensuring that individuals, regardless of income, language, disability, or neighborhood, have timely access to high-quality care and the support necessary to achieve the highest possible level of health.

1) Organizational Experience Serving Medically Underserved Populations: ICS has provided home- and community-based services in Washington, DC since 2003 and has delivered home health services across all wards of the District of Columbia, including communities with high poverty rates, high chronic disease burden, and limited access to primary and specialty care. ICS's experience in these environments has required the development of practical systems to address access barriers, improve continuity of care, and support high-risk patients in the home setting.

Importantly, since 2014, more than 95% of ICS's census has consisted of Medicaid beneficiaries, reflecting long-term experience serving populations most at risk for healthcare disparities and poor outcomes. ICS has operated successfully under these conditions by building strong care

coordination, documentation, compliance, and staffing systems that prioritize timely service delivery and patient stability

2) Linguistic Access and Cultural Responsiveness: ICS has extensive experience serving culturally and linguistically diverse communities. More than 10% of ICS's census includes individuals for whom English is not the primary language. ICS actively recruits and retains bilingual/multilingual aides and staff who can communicate effectively with patients and families, support understanding of care plans, and strengthen patient comfort and trust.

ICS uses targeted recruitment and staffing practices to match patients with caregivers who share the patient's language whenever feasible. Where direct language matching is not possible, ICS employs alternative strategies including professional interpretation support, culturally competent care training, and enhanced care coordination to prevent gaps in communication that can compromise care and diminish outcomes.

This proven approach will be directly applied to Maryland's diverse service areas, particularly in communities where language barriers and cultural differences contribute to delays in care, limited participation in treatment, and avoidable utilization of services.

3) Identifying Underserved Areas/Groups and Addressing Unique Needs Within Anne Arundel County, Montgomery County, and Prince George's County; ICS recognizes that disparities in access and quality are often experienced by persons that identify as:

- Low-income and Medicaid populations
- Older adults with complex chronic conditions and functional limitations
- Individuals with disabilities requiring coordinated skilled services
- Patients with limited English proficiency (LEP)
- Communities with transportation barriers, unstable housing, or limited caregiver support
- Individuals with fragmented access to primary care and specialty follow-up

ICS will address these disparities through an operational model designed to reduce common barriers to access and quality, including:

- Timely start-of-care processes to prevent delays after inpatient hospital discharge or referral.
- Consistent staffing and continuity strategies to reduce missed visits and gaps in care.

- Strong documentation and care coordination with the Care Team to improve plan-of-care execution
- Patient-centered and cultural competency training that fosters good communication practices to account for language and health literacy.
- A structured intake process that identifies Social Determinants of Health (SDOH) barriers and triggers referrals and support linkages.

4) SDOH and Disparities in Care Delivery: ICS acknowledges that social determinants of health including poverty, limited transportation, language barriers, caregiver instability, food insecurity, and limited access to outpatient care contribute directly to disparities in service access, quality, and health outcomes.

ICS's service model is designed to reduce the impact of these barriers through:

- Rapid care initiation when clinically appropriate
- Care coordination with community partners and referring providers
- Continuity-focused staffing and performance monitoring
- Escalation and intervention processes when patients experience instability or unmet needs
- Ongoing communication with patients and families to support adherence and patient engagement.

5) Cultural Competency and Implicit Bias Training: ICS currently integrates cultural competency and implicit bias training into its onboarding and ongoing staff development and monthly retraining.

Training addresses:

- Respectful and patient-centered communication
- Cultural and language considerations in home-based care
- Disability sensitivity and trauma-informed practices
- Recognition of implicit bias and strategies to reduce it in care delivery
- Patient rights, dignity, and grievance procedures

Training includes field-based reinforcement by supervisory registered nurses who monitor quality, PCA/HHA performance, and patient experience during monthly PCA/ HHA supervisory visit.

ICS will extend our current community engagement through:

- Regular collaboration with referral partners and community organizations
- Participation in care coordination initiatives and transition-of-care programs
- Patient and caregiver feedback mechanisms to strengthen quality and responsiveness
- Ongoing outreach to organizations serving LEP, immigrant, and underserved populations

6) Potential Unintended Barriers and Mitigation Strategies: ICS recognizes that any expansion effort can unintentionally create barriers if not proactively addressed. Potential barriers may include:

- Workforce limitations affecting service start timelines
- Challenges staffing specialized or language-specific cases
- Transportation/geographic scheduling barriers in certain neighborhoods

ICS will mitigate these risks through:

- Strategic Recruitment and Retention Planning: Integrated Community Services, Inc. (ICS) currently employs approximately 1,000 active employees, the majority of whom reside in Maryland. Upon award of the CON, ICS will immediately implement a targeted recruitment and retention initiative. This initiative will commence following submission of the licensure application to the Maryland Board of Nursing and will be designed to ensure timely staffing in alignment with projected service demand.
- Flexible staffing models and team-based scheduling: We plan to use the same staffing model that has been very successful in DC. We will modify and adapt to Maryland as needed.
- Priority staffing protocols for high-risk and underserved patients: We plan to use the staffing model that has been very successful in our service in Washington DC. We will implement this staffing and modify and adapt to align with Maryland requirements as needed.
- Escalation workflows to prevent unresolved service gaps: Again, we will use our existing service model that has a high rate of success.
- Continuous performance tracking and quality improvement through QAPI

Conclusion ICS's long-standing experience serving Medicaid-dominant, culturally diverse, and Medically underserved communities in all wards of Washington, DC demonstrates proven organizational capacity to reduce disparities and deliver high-quality care in high-need environments. Through its proposed Maryland home health agency, ICS will apply this equity-focused model to expand availability, improve accessibility, strengthen quality, and directly

address social determinants of health impacting residents of Anne Arundel, Montgomery, and Prince George's Counties.

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 III 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

ICS Response:

Integrated Community Services (ICS), Inc. respectfully submits that its history of service delivery, performance in highly regulated environments, and long-standing partnerships with the District of Columbia government agencies demonstrate strong character and competence to operate a Maryland Home Health Agency. ICS’s record reflects consistent compliance, crisis-response capability, and repeated selection by public agencies to stabilize services for vulnerable populations during high-risk transitions.

1) Demonstrated Government Trust and Crisis-Response Performance (DHCF, 2014–2017): In 2014, the District of Columbia Department of Health Care Finance (“DHCF”) and the DC Government uncovered widespread Medicaid fraud among multiple home health agencies, resulting in agency closures and immediate disruption of services for vulnerable Medicaid beneficiaries. To protect continuity of care and stabilize access to services, DHCF selected ICS as one of only four DC agencies equipped alongside them and assist with identifying, locating, and rapidly staffing patients impacted by the closures.

It is important to note that during this period, ICS did not yet operate as a Medicare-certified home health agency and had no experience providing Home Health Aide services. However, ICS was entrusted with this work because of its established reputation for operational integrity, ethical performance, and high-quality service delivery within the District of Columbia.

From April 2014 through March 2017, ICS worked closely with DHCF leadership to ensure continuity of care for displaced patients and to support safe, compliant transitions into stable service arrangements. DHCF ultimately established a temporary DHCF-operated Home Health Agency to manage and stabilize the transition process for a large number of displaced beneficiaries.

In 2016, ICS's Director of Operations and current Administrator was appointed as the Administrator of DHCF's temporary Home Health Agency, reflecting DHCF's confidence in ICS's leadership and compliance capability. ICS leadership maintained this role until DHCF successfully transitioned more than 700 patients from the temporary DHCF program into self-standing home health agencies, restoring stable access to services for individuals who had been placed at risk by prior agency closures.

This experience reflects ICS's ability to perform under urgent conditions, maintain compliance standards, and protect vulnerable populations when system instability occurs.

2) Trusted Provider for Youth and Residential Transitions (CFSA / Maryland Program Closures)
ICS has also been entrusted to support vulnerable youth impacted by service disruptions in the region. Specifically, youth served through CFSA and placed in Maryland residential and community support programs were found to be receiving insufficient residential and community support, which resulted in program closures. ICS was entrusted to transition and support these youth based on the organization's established history of excellence, accountability, and consistent service delivery in the District of Columbia.

At present, many of these individuals now in adulthood remain connected to ICS and continue to receive supported living and related residential services through ICS's adult home and community-based programs. This outcome reflects long-term service continuity, stability, and sustained trust by individuals and public partners.

3) Recognized Community Leadership and External Validation (UnitedHealthcare)
ICS leadership has also been recognized through direct engagement with managed care and community health partners. ICS's Administrator was invited to serve as a UnitedHealthcare Ambassador for the Community, participating in a Board-level initiative led by respected community and healthcare leaders, including former DC Mayor and Councilmember Vincent Gray, aimed at strengthening health outcomes and building an ecosystem responsive to the needs of Dual Special Needs Plan (D-SNP) populations and communities of color.

ICS leadership served in this capacity from 2022 through 2024, contributing to community-driven solutions and workforce-focused discussions to strengthen health equity and access.

Following this service, ICS leadership was also invited to participate in UnitedHealthcare's Community Action Council, which brings together healthcare leaders to:

- Develop community-driven and sustainable solutions;
- Address workforce challenges from multiple perspectives; and
- Improve outcomes through collaboration and strategic partnership.

4) Evidence of Competence Across Multiple Licensure Types

During the COVID-19 period, ICS was approached by the DC Department of Behavior Health and encouraged to apply for licensure as a Behavioral Health Agency. This licensure is highly regulated and sought after within the District of Columbia. ICS applied and was granted the license, further demonstrating compliance readiness, organizational maturity, and the ability to meet demanding regulatory requirements.

5) Compliance Record and Organizational Integrity

ICS have consistently emphasized regulatory compliance, quality oversight, and ethical operations. ICS maintains structured processes for training, supervision, documentation integrity, patient rights, complaints and grievance handling, and quality improvement. The organization's continued selection by government partners during crisis-response periods and transitions reflects confidence in ICS's capability, integrity, and stability.

Conclusion:

ICS's record reflects strong character and competence demonstrated through:

- Selection by DHCF to stabilize care during widespread home health agency closures;
- Leadership of a DHCF temporary Home Health Agency and successful transition of 600+ patients;
- Successful execution of complex youth and residential transitions with sustained continuity into adulthood;
- Recognition and leadership participation within UnitedHealthcare community health initiatives; and
- Successful attainment of multiple licenses under rigorous regulatory standards.

Collectively, this history demonstrates that ICS is prepared to deliver high-quality, compliant home health services in Maryland and to meet all State and Federal requirements governing home health agency operations.

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

**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.

Integrated Community Services, INC

Rose Oma- 100% ownership

16672 Bridle Ridge Lane

Olney,MD 20832

May 2003

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.

No _____

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.

No _____

1. 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.

No

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).

No

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.

1/9/2026

Date

Rose Oma

Signature of Owner

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

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 JURSDICTIONS

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): N/A	
a. New Construction	
1) Building	\$0
2) Fixed Equipment (not included in construction)	\$0
3) Architect/Engineering Fees	\$0
4) Permits, (Building, Utilities, Etc.)	\$0
a. SUBTOTAL New Construction	\$0
b. Renovations	
1) Building	\$0
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc.)	
b. SUBTOTAL Renovations	\$0
c. Other Capital Costs	
1) Movable Equipment	
2) Contingency Allowance	
3) Gross Interest During Construction	
4) Other (Specify)	
c. SUBTOTAL Other Capital Cost	\$0
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	\$0
Non-Current Capital Cost	

d. Land Purchase Cost or Value of Donated Land	\$0
e. Inflation (state all assumptions, including time period and rate	\$0
TOTAL PROPOSED CAPITAL COSTS (sum of a - e)	\$0
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	\$0
b. Bond Discount	\$0
c. CON Application Assistance	\$0
c1. Legal Fees	\$0
c2 Other (Specify and add lines as needed)	\$0
d. Non-CON Consulting Fees	\$0
d1. Legal Fees	\$0
d2. Other (Specify and add lines as needed)	\$0
e. Debt Service Reserve Fund	\$0
f. Other (Specify)	\$0
TOTAL (a - e)	\$0
3. WORKING CAPITAL STARTUP COSTS	\$0
TOTAL USES OF FUNDS (sum of 1 - 3)	\$0
B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	
2. Pledges: Gross _____, less allowance for uncollectable _____ = Net	
3. Gifts, bequests	

4. Authorized Bonds	\$0
5. Interest income (gross)	\$0
6. Mortgage	\$0
7. Working capital loans	\$0
8. Grants or Appropriation	\$0
a. Federal	\$0
b. State	\$0
c. Local	\$0
9. Other (Specify)	\$0
TOTAL SOURCES OF FUNDS (sum of 1-9)	\$0
ANNUAL LEASE COSTS (if applicable)	N/A
• Land	
• Building	
• Moveable equipment	
• Other (specify)	

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).

	Two Most Current Actual Years		Projected years – ending with first year at full utilization				
	CY or FY (circle)	2024	2025	2026__	2027__	2028__	2029__
Client Visits		N/A	N/A	N/A	N/A	N/A	N/A
Billable		N/A	N/A	N/A	N/A	N/A	N/A
Non-Billable		N/A	N/A	N/A	N/A	N/A	N/A
TOTAL		N/A	N/A	N/A	N/A	N/A	N/A
# of Clients and Visits by Discipline							
Total Clients (Unduplicated Count)		N/A	N/A	N/A	N/A	N/A	N/A
Skilled Nursing Visits		N/A	N/A	N/A	N/A	N/A	N/A
Home Health Aide Visits		N/A	N/A	N/A	N/A	N/A	N/A
Physical Therapy Visits		N/A	N/A	N/A	N/A	N/A	N/A
Occupational Therapy Visits		N/A	N/A	N/A	N/A	N/A	N/A
Speech Therapy Visits		N/A	N/A	N/A	N/A	N/A	N/A

Medical Social Services Visits	N/A	N/A	N/A	N/A	N/A	N/A
Other Visits (Please Specify)	N/A	N/A	N/A	N/A	N/A	N/A

Table 2A- is not applicable. Integrated Community Services, Inc. has not previously operated as a licensed home health agency in the State of Maryland and has not provided home health services in Maryland during any prior reporting period. Accordingly, there is no historic Maryland utilization data to report.

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).

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2026__	2027__	2028__	2029__
Client Visits				
Billable	12,000	28,800	30,2040	31,752
Non-Billable	600	1,440	1,512	1,588
TOTAL	12,600	30,240	31,752	33,340
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	375	900	945	992
Skilled Nursing Visits	2,250	5,400	5,670	5,954
Home Health Aide Visits	3,750	9,000	9,450	9,920
Physical Therapy Visits	3,750	9,000	9,450	9,920
Occupational Therapy Visits	2,250	5,400	5,670	5,954
Speech Therapy Visits	—	—	—	—
Medical Social Services Visits	—	—	—	—
Other Visits (Please Specify)	—	—	—	—

Table 2B- The utilization projections for ICS are presented on a Calendar Year (CY) basis and reflect a phased start-up beginning in August 2026 (approximately five months

of operations). ICS anticipates an average monthly census of 75 patients, resulting in 375 unduplicated clients in CY 2026. Services are projected based on a standard 60-day episode of care, with each episode including, on average, six skilled nursing visits, ten physical therapy visits, six occupational therapy visits, and ten home health aide visits. Non-billable visits, such as care coordination, supervision, and documentation, are estimated at 5% of total billable visits, and speech therapy and medical social services are not included in initial projections. These assumptions support the volumes in Table 2B and align with revenue and expense projections in Table 4, demonstrating the operational and financial feasibility of ICS.

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).

	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__	20__	20__	20__	20__	20__
CY or FY (Circle)							
1. Revenue							
Gross Patient Service Revenue	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Allowance for Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contractual Allowance	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Charity Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Net Patient Services Revenue	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Operating	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Revenues (Specify)							
Net Operating Revenue	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2. Expenses							
Salaries, Wages, and Professional Fees, (including fringe benefits)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contractual Services (please specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Interest on Current Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Interest on Project Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Current Depreciation	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Project Depreciation	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Current Amortization	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Project Amortization	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Supplies	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Expenses (Specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Total Operating Expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3. Income							
Income from Operation	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Non-Operating Income	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Subtotal	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Income Taxes	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Net Income (Loss)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
4A. - Payor Mix as Percent of Total Revenue							
Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare Advantage	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid MCO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blue Cross	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Commercial Insurance	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Self-Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other (Specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL REVENUE	100%	100%	100%	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits							
Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare Advantage	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid MCO	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blue Cross	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Commercial Insurance	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Self-Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other (Specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL VISITS	100%	100%	100%	100%	100%	100%	100%

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

Table 3 – Not Applicable.

Integrated Community Services, Inc. (ICS) is not an existing Maryland home health agency and has no historic Maryland revenues or expenses to report. Accordingly, Table 3 is not applicable to this application.

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 on the basis of Medicaid rates and ceilings in effect at the time of submission of this application.

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

	Projected Years			
	(ending with first full year at full utilization)			
CY or FY (Circle)	2026__	2027__	2028__	2029__
1. Revenue				
Gross Patient Service Revenue	1,441,188.00	3,431,400.00	3,671,598.00	3,928,609.86
Allowance for Bad Debt	(86,471.28)	(205,884.00)	(220,295.88)	(235,716.59)
Contractual Allowance				
Charity Care	(100,883.16)	(240,198.00)	(257,011.86)	(275,002.69)
Net Patient Services Revenue	1,253,833.56	2,985,318.00	3,194,290.26	3,417,890.58
Other Operating Revenues (Specify)				
Net Operating Revenue	1,253,833.56	2,985,318.00	3,194,290.26	3,417,890.58
2. Expenses				
Salaries, Wages, and Professional Fees, (including fringe benefits)	295,819.16	704,331.34	735,461.28	747,225.12
Contractual Services	500,976.00	1,192,800.00	1,252,440.00	1,315,062.00
Interest on Current Debt				
Interest on Project Debt				

Current Depreciation	13,000.00	26,000.00	27,300.00	28,665.00
Project Depreciation				
Current Amortization				
Project Amortization				
Supplies	30,000.00	60,000.00	63,000.00	66,150.00
Other Expenses (Specify)	226,744.69	535,445.46	558,414.35	582,417.57
Total Operating Expenses	1,066,539.86	2,518,576.81	2,626,615.63	2,739,519.70
3. Income				
Income from Operation	187,293.70	466,741.19	567,674.63	678,370.88
Non-Operating Income				
Subtotal				
Income Taxes				
Net Income (Loss)				

Table 4 Cont.	Projected Years			
	(ending with first full year at full utilization)			
CY or FY (Circle)	2026	2027	2028	2029
4A. - Payor Mix as Percent of Total Revenue				
Medicare				
Medicare Advantage	65%	65%	65%	65%
Medicaid	30%	30%	30%	30%
Medicaid MCO	3%	3%	3%	3%
Blue Cross	2%	2%	2%	2%
Other Commercial Insurance				

Other (Specify)				
TOTAL	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits				
Medicare				
Medicare Advantage				
Medicaid	70%	70%	70%	70%
Medicaid MCO	25%	25%	25%	25%
Blue Cross	3%	3%	3%	3%
Other Commercial Insurance	2%	2%	2%	2%
Self-Pay				
Other (Specify)				
TOTAL	100%	100%	100%	100%

Table 4- reflects projected revenues and expenses for ICS’s proposed Maryland Home Health Agency, serving Anne Arundel, Montgomery, and Prince George’s Counties. ICS’s projections are based on a phased start-up model with conservative census assumptions, planned staffing, and expected referral patterns. Revenue estimates include anticipated Medicare, Medicaid, and private payor income. Expense estimates include salaries, benefits, operational costs, and administrative overhead. Non-operating income is based on ICS’s internal reserves. All projections are presented in current dollars on a Calendar Year (CY) basis

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.**

ICS Response: Please see exhibit 7

* Indicate method of calculating benefits cost

Integrated Community Services CON Application

List of Exhibits

TAB 1/Exhibit 1. Integrated Community Services Organization Chart

TAB 2/Exhibit 2. Integrated Community Services Finance Policy Charity Care Policy

TAB 3/Exhibit 3. Integrated Community Services Emergency Preparedness Policy

TAB 4/Exhibit 4. Integrated Community Services Quality Assurance & Performance Improvement (QAPI) Program

TAB 5/Exhibit 5. Integrated Community Services: Discharge Planning Policy

TAB 6/ Exhibit 6. Letters of Support

TAB 7/Exhibit 7. Part IV Tables

TAB 8/Exhibit 8. Integrated Community Services. DC DOH Annual Licensure Survey August 2025

**EXHIBIT 1- Integrated Community Services
Organization Chart**



**EXHIBIT 2- Integrated Community Services Finance
Policy Charity Care & Emergency Preparedness
Policy**



Integrated Community Services, Inc
820 First Street NE Suite 425 Washington DC 20002
Phone: 202-506-1209 Fax: 202-506-1396

Date:

Address:

Notice of Availability of Charity Care/ Discounted Fee Care

Dear Beneficiary,

Thank you for contacting Integrated Community Services, Inc for your home Care needs.

In accordance with COMAR 10.24.16.08C -E Integrated Community Services, Inc. is committed to providing home health services to all clients in the communities it serves. Home health care is available for all patients regardless of their race, color, religion, national origin, gender, marital status, personal appearance, sexual orientation, family responsibilities, political affiliation, physical handicap, source of income or place of residence or business or the ability to pay for services.

Integrated Community Services provides services at no cost to patients who do not have the means of payment either by the patient or an Insurer.

Discounted fee care is available to patients whose income is at or below 125% of the Federal Poverty Income Guidelines for the patient's family size.

Discounted fee care is provided by Integrated Community Services for patients of limited means, or whose income is below 125% of the Federal Poverty Guidelines, who are not eligible for charity care but are unable to pay the full cost of home health care. A sliding scale is used to determine the amount of the discount that the patient is eligible for based on income within that range.

After an initial assessment, a determination will be made within two business days of probable eligibility for medical assistance, charity care and or discounted fee service. Integrated Community Services will make a final determination of eligibility for charity care and or discounted fee care based on income verification and supporting documentation received from the patient. A time payment plan will be provided for patients who are eligible for discounted care which will allow for payment to be made over time.

A request for Charity care can/ discounted fee care be made by writing to Integrated Community Services, Inc at 820 First Street, NE Washington DC 20002 or contacting the office Monday to Friday at 202-506-1209.

Regards,

Administrator

Integrated Community Services, Inc.

Integrated Community Services, Inc Charity Care Policy

Date Developed:	Title: Maryland Charity Care Policy- Eligibility Criteria
Date Approved:	Revision Date:
Version Number: 001	Approved By:

Purpose:

The purpose of this Charity Care Policy is to ensure that Integrated Community Services, Inc (ICS) provides financially accessible home health services to individuals residing in Anne Arundel, Montgomery and Prince George’s Counties who lack adequate financial resources can access medically necessary home health services. This policy establishes:

- Criteria for determining Charity Care and discounted fee care eligibility.
- A Sliding Fee Scale based on Federal Poverty Level (FPL).
- Optional time-payment plans for patients who cannot pay in full.

Policy Statement:

ICS will provide charity care and discounted fee care, to eligible individuals based on income, household size, and documented financial hardship. Patients may be uninsured, underinsured, or cannot reasonably pay their share of the cost.

ICS does not discriminate based on race, color, national origin, language, disability, age, gender, sexual orientation, religion or socioeconomic status.

ICS will provide guidelines to determine a patient’s eligibility for charity care and discounted fee care and establish a framework by which patients can request charity care and discounted fee care and the process by which approval for these services are met.

ICS will meet the jurisdictional average level of charity care for home health agencies operating in its service area as required by the Maryland Health Care Commission (MHCC).

Eligibility Criteria:

Charity care or discounted fee care are available for patients who are at or below 125% of the Federal Poverty Guidelines and are based on the patient’s income and family size.

Federal Poverty Guidelines:

Household Size	100%FPL	200%FPL	250%FPL	300%FPL
1	\$15,060	\$30,120	\$37,650	\$45,180
2	\$20,440	\$40,880	\$51,100	\$61,320

3	\$25,820	\$51,640	\$64,550	\$77,460
4	\$31,200	\$62,400	\$78,000	\$93,600
5	\$36,580	\$73,160	\$91,450	\$109,740
6	\$41,960	\$83,920	\$104,900	\$125,880

Discounted fee care is provided for patients above 125% and up to 400% of the Federal Poverty Guidelines for the patient’s family size, and the following Sliding Fee Scale will be utilized.

A. Charity Care - free service.

Household Income	Discount	
0 – 150% FPL	100% Discount	Full Charity Case

B. Sliding Fee Discounts

Household Income Level	Discount Applied	Patient Pays
151 – 200% FPL	75% discount	25% of charges
201 – 250% FPL	50% discount	50% of charges
251 – 300% FPL	25% discount	75% of charges
> 300%FPL	Not Eligible	Full Charges

Patients who are insured and meet the above noted income criteria are eligible for charity care or discounted fee care when services are provided more than benefits under their insurance coverage.

Time-Payment Plan Option

A patient who qualifies for discounted fee care based on this policy and is unable to pay their assessed amount in full may request a monthly payment plan. The terms of the plan include a minimum payment of \$25 or 2% of the balance, whichever is greater, and a maximum payment period of 24 months. No interest will be charged on the balance. Missed payments of greater than 60 days will require financial reassessment.

Eligibility Determination:

- When a patient or their representative makes a request for charity care/ discounted fee care or medical assistance, ICSs **Care Coordinator** will conduct an interview with the patient or their representative, and a determination will be provided to the patient/ representative within two business days.

- To make the determination for probable eligibility, the care Coordinator will interview the patient/ representative on the following: proof of household size, Insurance coverage/ Insurance denial or explanation of benefits (EOB), proof of income – pay stubs, tax returns, W-2 form, Medicaid card.
- The final determination of eligibility for charity care/ discounted fee care or medical assistance will be made based on a completed income verification form and the supporting documents provided by the patient/representative.
- In the event the patient is unable to provide proof of income, the **Clinical Director** is authorized to decide that the patient is eligible for charity care or discounted fee care based on all the information provided by the patient.
- Patients requesting medical assistance will apply for financial assistance. Eligibility for charity care or discounted fee care will be granted on a provisional basis pending the approval of the application for medical assistance. Full cooperation is required from the patient/ representative in obtaining the required information to make a determination for charity care or discounted fee care.
- Under the Time Payment Plan, any patient who qualifies for the discounted fee care, may request to pay billed services over a period. Under this policy, ICS requests a minimum payment of \$25 or 2% of the balance (whichever is greater) and a maximum payment period of 24 months.

Internal Auditing of Charity Care / Discounted Fee Care

- The **Clinical Director** may approve charity care or discounted care up to **\$1,000**.
- Approval must be granted by the **Chief Financial Officer (CFO)** if the amount of charity care / discounted fee care **exceeds \$4,000**.
- Finance will maintain a log of all pre-approved charity care and discounted fee care patients.
- ICS will use for all Charity care patients the unique payer code of **ICSP**, these visits will be non-billable visits.
- Discounted fee care patients who are in default of payments, will have a reassessment of income and may be moved to a charity care case if their income level qualifies them for charity care.

PUBLIC DISCLOSURE OF THE AVAILABILITY OF HOME HEALTH CHARITY CARE, DISCOUNTED FEE CARE AND TIME PAYMENT PLAN.

Integrated Community Services, Inc. (ICS) provides care for the residents of Anne Arundel, Montgomery and Prince Georges County. ICS is committed to providing home health care to residents of the communities they serve regardless of race, color, national origin, language, disability, age, gender, sexual orientation, religion or socioeconomic status.

ICS provides charity care at no cost to the patient for those patients who do not have the means to pay, do not have an insurer or those whose income is at or below 125% of the Federal Poverty Guidelines based on the patient’s family size.

ICS provides discounted fee care to patients with limited means whose income is above 125% of the Federal Poverty Guidelines, who are not eligible for charity care, but are not able to pay the full cost for home health services.

Discounted care is based on the federal Poverty Guidelines, household size and documented income:

Household Size 100% FPL 200% FPL 250% FPL 300% FPL

1	\$15,060	\$30,120	\$37,650	\$45,180
2	\$20,440	\$40,880	\$51,100	\$61,320
3	\$25,820	\$51,640	\$64,550	\$77,460
4	\$31,200	\$62,400	\$78,000	\$93,600
5	\$36,580	\$73,160	\$91,450	\$109,740
6	\$41,960	\$83,920	\$104,900	\$125,880

A sliding scale is used to determine the discount that the patient is eligible for based on their income level.

Sliding Fee Discounts

Household Income level Discount Applied Patient pays

0 – 150%FPL	100%	No charges
151 – 200%FPL	75% discount	25% of charges
201 – 250%FPL	50% discount	50% of charges
251 – 300%FPL	25% discount	75% of charges

301 – 400%FPL

Not eligible

Full charges (may request time-payment plan)

ICS, within two business days, will make a determination of eligibility for charity care and reduced fees following a patient's initial request for charity care services, application for medical services, or both. ICS will make a determination of probable eligibility for medical assistance, charity care and reduced fees and will communicate this determination to the patient. A final determination will be made based on a completed income verification form and other supporting documentation.

ICS offers a Time-Payment Plan option for patients who are eligible for discounted fee care, which will allow them to pay discounted fees over a specified time.

Time-Payment Plan Option

Patients who are unable to pay their assessed amount in full may utilize a monthly payment plan:

Terms of the Time-Payment Plan

- Minimum monthly payment: **\$25 or 2% of balance**, whichever is greater
- Maximum repayment period: **24 months**
- No interest charged



Integrated Community Services, Inc

820 First Street NE Suite 425 Washington DC 20002

Phone 202-506-1209 Fax: 202-506-1396

ICS - Emergency Preparedness Program

Formal Regulatory Program Document

Applicable to ICS Operations in Maryland and the District of Columbia.

Purpose & Regulatory Authority

ICS maintains a comprehensive Emergency Preparedness Program (§484.102) which was developed to meet all applicable Federal, State and local emergency preparedness requirements.

The Emergency Plan (§484.102) (a)

The ICS Emergency Preparedness Program includes an Emergency Preparedness Plan that is reviewed and updated at least every two (2) years.

- (1) This plan utilizes a framework which evaluates risks through a structured Hazard Vulnerability Assessment which addresses patient needs, the ability of the agency to provide support during the actual emergency and its ability to collaborate with local emergency preparedness officials.
- (2) The agency's "all-hazard" approach considers the area where care is provided, the hazards likely to affect the service area, the likely duration of interruption of services and the timeframes for the reinitiation of services during and after the end of the emergency, collaboration with local and State agencies and the agency's capacity and ability to function based on a wide range of emergencies.
- (3) The emergency plan outlines the patient population with emphasis on patients with limited mobility and oxygen usage and specifies the services that the agency is able to provide during the emergency. Essential staff roles and functions are outlined in the emergency plan with succession planning identifying personnel to fill key positions in the absence or unavailability of some key personnel.
- (4) The agency includes in its emergency plan a process for collaboration with local, tribal, State and Federal emergency officials to allow for a greater integrated response and to review and address broader community needs.

The Emergency Plan

(b) Policies and Procedures

The agency has developed emergency preparedness policies and procedures based on the emergency plan, risk assessment, and communication plan of this section. These policies and procedures are updated at least every two (2) years.

1. An individual emergency preparedness plan is completed at the time of the comprehensive assessments for all patients (§484.55). Discussions are held with the patient, caregiver on emergencies that may occur in the home or natural disasters, and education is provided on steps to be taken and when to contact local emergency officials. A copy of the individualized emergency plan is provided to the patient, and a copy placed in the patient's file.
2. State and local emergency officials are notified of patients requiring evacuation during an emergency. Information should include mobility issues, lifesaving equipment used (battery or electrically operated), the patient's ability to express their needs clearly, or do they have communication, language or intellectual barriers to communication. The agency will ensure that all patient information is communicated in a HIPAA compliant manner.
3. ICS has included in its policies and procedures, the emergency plan for making transfer arrangements for patients to neighboring hospitals or nursing facility with whom it has a transfer arrangement. In the event the disruption of services is anticipated to last for a short duration of one or two days and does not pose a threat to the patient's safety or well-being, services can be rearranged. For disasters of longer duration, lasting over a week or more, immediate transfer of the patient is initiated. In the event the agency is unable to make contact with patients or staff, designated staff will notify the local and State emergency officials.
4. The agency will maintain the electronic medical record system throughout any disaster; patient records will remain secure and available to ensure continuity of care in a HIPAA compliant manner.
5. In the event the agency needs to utilize the services of volunteers in an emergency, State laws, State scope of practice and the agency's policies will be utilized. Non – medical volunteers will only perform non-medical tasks. The staff call trees will be utilized to call out staff who are not working at the time of an emergency.

(c) Communication Plans

ICS will maintain an emergency preparedness communication plan in compliance with State, Federal and local laws which will be reviewed at least every two years.

1. ICS maintains a multi-layer emergency communication plan that includes all staff, anyone providing services to patients, the patient physicians and volunteers. While data is stored electronically, the agency has its data backed up and has access to data during an emergency and access to contact lists.
2. ICS maintains contact information for Federal, State, tribal, regional and local emergency preparedness staff. This information is stored in an electronic format but can be retrieved in an emergency situation.
3. The agency's primary means of communicating with staff, Federal, State, tribal, regional and local emergency management agencies is via landlines, cellular phones, EMR – based alerts, and email. Alternate means utilized radio transceivers, landline and cellular redundancy.
4. ICS will maintain its method of sharing clinical documentation for patients through its EMR system, e-fax. Hard copies of clinical documentation will be utilized in the event electronic means are not available during an emergency.
5. HIPAA compliance will be maintained while hard copy clinical documentation is being utilized to provide information regarding patient condition and location of patients.
6. ICS will utilize its Incident command center to disseminate information to local, State, Federal emergency management personnel.

(d) Training and testing

ICS has developed and maintained an emergency preparedness training and testing program based on the emergency plan, risk assessment, policies and procedures and the communication plan.

1. Training program.

- I. Emergency preparedness training is completed for all new and existing staff. Initial training is done at on boarding and annually for all other staff. Documented evidence of training is maintained in the training records.
- II. All staff must demonstrate knowledge of emergency procedures either through self-learning and testing or through question and answers after the training which method is utilized. New training courses are scheduled for all staff when there is a significant update to the policies and procedures.

2. Testing

- I. The agency will conduct a facility-based functional exercise or a tabletop exercise. This is done to evaluate the effectiveness of the training as well as the overall

emergency preparedness program. Testing includes conducting drills and exercises to test the emergency plan and to identify gaps and areas for improvement.

- II. Review of the agency's response to all drills is completed, and the emergency plan is revised as appropriate.

EXHIBIT 3- Integrated Community Services Quality Assurance & Performance Improvement (QAPI) Program

ICS - Quality Assurance & Performance Improvement (QAPI) Program

Integrated Community Services, Inc. (ICS)

Formal Regulatory Program Document

CMS Survey Version – Compliant with 42 CFR §484.65

Applicable to ICS Operations in Maryland & the District of Columbia

1. Purpose & Regulatory Authority

Integrated Community Services, Inc. (ICS) establishes this Quality Assurance & Performance Improvement (QAPI) Program in compliance with:

- **Medicare Conditions of Participation for Home Health Agencies (42 CFR §484.65)**
- **CMS Quality Reporting Program Requirements**
- **Maryland MHCC Home Health Agency Standards**
- **District of Columbia Home Health Licensing Regulations (DCMR Title 22-B, Chapter 39)**

This QAPI Program applies to all ICS staff, contractors, and services provided to Medicare, Medicaid, and commercial patients in **Maryland and the District of Columbia**.

The purpose of the program is to ensure ongoing, agency-wide, data-driven improvement in clinical care, patient safety, and organizational operations.

2. Program Scope (42 CFR §484.65(a))

The scope of the ICS QAPI Program includes:

Clinical Services:

- Skilled Nursing
- Physical, Occupational, and Speech Therapy
- Medical Social Work
- Home Health Aide services
- Interdisciplinary care coordination
- OASIS requirements (MD & DC)

Administrative & Operational Functions:

- Documentation compliance
- Timeliness of Start of Care (SOC)

- Billing and coding accuracy
- Privacy and confidentiality protections
- Patient experience and communication standards
- Infection prevention and control (MD & DC requirements)

Patient Safety & Risk Management:

- Incident reporting, including near-miss events
- Emergency preparedness-related risks
- Falls, medication events, equipment-related hazards

The program covers **all locations** where care is provided in Maryland and the District of Columbia.

3. Governance & Responsibility (42 CFR §484.65(a)(2))

The Administrator and Clinical Director (CD) are responsible for ensuring active involvement in QAPI operations and meeting all regulatory expectations.

QAPI Committee Membership:

- Administrator (Chair)
- Clinical Director
- Skilled Services Manager
- Quality Manager
- QAPI/Compliance Nurse (Coordinator)
- Nursing Supervisors
- Therapy Department Leads
- Home Health Aide Supervisor
- Medical Director (as consultant, when appropriate)
- Administrative/QA Support

The Committee meets **monthly**, with special meetings convened for high-risk events.

4. Data-Driven Quality Indicators (42 CFR §484.65(b))

ICS gathers and analyzes performance data specific to Maryland and DC operations.

4.1 Clinical Outcome Indicators

- Hospitalization & 30-day readmission rates
- Wound healing, infection rates, and complication tracking
- Functional improvement (therapy outcome measures)
- High-risk disease management outcomes (CHF, COPD, diabetes, hypertension)
- Medication reconciliation accuracy and adherence

4.2 Patient Safety Indicators

- Fall incidents and fall-prevention adherence
- Medication errors and near-miss reporting
- Adverse reactions and emergency events
- Documentation of home environment hazards

4.3 Infection Control Indicators

(Aligned with 42 CFR §484.70; Maryland & DC infection standards)

- Infection transmission events
- Compliance with hand hygiene and PPE
- Aseptic and sterile technique audit results
- Environmental safety concerns in the home

4.4 Documentation & Compliance Metrics

- OASIS accuracy (MD & DC submissions)
- Visit note timeliness
- Plan of Care completeness and timely order processing
- Intake and referral processing accuracy

4.5 Patient Experience Metrics

- HHCAHPS survey results
- ICS internal satisfaction surveys
- Complaint and grievance trending

5. Performance Monitoring Process

ICS uses the following monitoring structure:

1. **Monthly KPI Dashboards** reviewed by the QAPI Committee
2. **Quarterly trend reviews** of high-risk, high-volume areas
3. **Annual Program Evaluation** capturing MD and DC data separately
4. **High-risk event review** within 48–72 hours of notification

Maryland and DC jurisdictional differences are tracked separately and comparatively.

6. Chart Audits & OASIS Quality Review

The QA/Compliance Nurse conducts structured audits monthly, including:

- Skilled nursing visit documentation review
- Therapy plan-of-care compliance and goal attainment
- OASIS item accuracy validation
- Medication profile and reconciliation audits
- Home Health Aide supervision documentation

Findings from Maryland and DC charts are evaluated separately to assess jurisdictional differences.

Corrective actions may include retraining, competency testing, or workflow revisions.

7. Incident Reporting, Near-Miss Tracking & Risk Management

ICS maintains a multi-level incident management system, including:

Events Requiring Review:

- Patient falls
- Medication errors or omissions
- Infections or complications
- Equipment failures or hazards
- Clinician safety risks
- Behavioral or environmental threats

Near-Miss Tracking

ICS formally logs near-miss events to:

- Identify risk patterns

- Prevent future harm
- Improve processes through root cause analysis (RCA)
- Support staff education

All incidents are reviewed by QAPI within the month of identification.

8. Root Cause Analysis (RCA) Framework

RCA is initiated for:

- Sentinel or high-risk events
- Repeat occurrences or negative trends
- Any event required by MD or DC reporting rules

RCA steps include:

1. Event fact gathering
2. Cause mapping
3. Identification of contributing factors
4. Development of corrective actions
5. Verification of sustained improvement

Results are reported to leadership within 30 days.

9. Performance Improvement Projects (PIPs) (42 CFR §484.65(d))

ICS always maintains at least one PIP.

PIP Selection Criteria:

- High-risk, high-volume, or problem-prone
- CMS-identified priority areas
- Patient-safety events
- Jurisdiction-specific needs (Maryland vs. DC)

Examples of ICS PIPs:

- Chronic disease management enhancement
- Wound infection reduction program
- Start of Care timeliness project

- OASIS accuracy improvement initiative
- Reduction in fall incidence during first 14 days of care

PIP results are documented, trended, and incorporated into the annual evaluation.

10. Staff Training & Competency Programs

Training and competency assessments reflect:

- QAPI findings and annual priorities
- Maryland & DC regulatory requirements
- Evidence-based practice changes
- Audit or incident-driven corrective actions

Competencies include:

- Clinical skills validation
- Documentation standards
- Infection prevention practices
- Emergency preparedness
- Cultural competence
- Device and equipment use

Annual and ad hoc retraining is conducted based on QAPI findings.

11. Patient Feedback Systems

ICS collects and analyzes:

- HHCAHPS survey data
- Internal satisfaction surveys
- Complaints and grievances
- Real-time service feedback

Maryland and DC results are analyzed separately for targeted improvement.

HHCAHPS data are incorporated into the **Annual QAPI Evaluation**.

12. Annual QAPI Program Evaluation (42 CFR §484.65(e))

ICS produces a comprehensive Annual QAPI Evaluation including:

- Review of all QAPI activities
- Performance data for MD and DC
- PIP outcomes
- Audit trends
- Incident and near-miss analysis
- Patient satisfaction trends (HHCAHPS)
- Infection control outcomes

The Administrator and CD approve the evaluation and ensure accessibility for CMS surveyors and state inspectors.

13. Recordkeeping & Document Retention

ICS maintains:

- QAPI meeting minutes
- KPI dashboards and audit tools
- PIP documentation
- RCA reports
- Staff competency and training files
- Annual evaluations

Records comply with:

- **CMS retention requirements**
- **Maryland COMAR standards**
- **DCMR Title 22-B retention rules**

Documentation is securely stored within the EMR and administrative systems.

14. Program Integration & Organizational Culture

ICS fosters a quality-focused environment by:

- Sharing QAPI findings with staff
- Encouraging safety event and near-miss reporting

- Empowering staff participation in improvement activities
- Maintaining openness, accountability, and transparency

Quality is treated as a shared responsibility across Maryland and DC operations.

15. Board & Leadership Oversight

The ICS Board and senior leadership:

- Review QAPI reports quarterly
 - Approve annual evaluations
 - Allocate resources for quality initiatives
 - Ensure compliance with MD & DC regulatory obligations
-

End of Formal QAPI Program Document

EXHIBIT 4- Integrated Community Services Discharge Planning Policy

Facility Team: ICS Administration	SOP Title: Discharge Planning
Effective Date:	Version No.: 001
Approved By:	Revision Date:

Purpose:

To establish a structured, comprehensive discharge planning process that ensures continuity of care, supports patient safety, and complies with Maryland’s Certificate of Need (CON) standards for home health agencies.

Policy Statement:

ICS maintains a formal, person-centered discharge planning process designed to ensure that all patients receive coordinated, safe, and appropriate transitions of care. ICS will provide timely referrals and facilitate communication with all relevant providers to maintain continuity of care. All discharges and transfers will occur only for valid, clearly defined reasons.

Scope:

This policy applies to all ICS clinical and administrative personnel involved in patient care coordination and the Skilled Services Team including RNs, LPNs, therapists, social workers, clinical supervisors, and Quality Review Nurses.

Discharge Planning Process:

- 1. Initiation of Discharge Planning**
 - Begins at admission and is updated throughout care.
 - Conducted by the RN Case Manager or admitting therapist (e.g., Physical Therapist) with support from interdisciplinary staff.
- 2. Patient and Caregiver Involvement**
 - Patients and caregivers participate in planning, goal setting, and education.
 - All preferences, needs, and identified risks are incorporated into the plan.
- 3. Coordination and Communication**
 - ICS communicates with the patient’s primary care provider, specialists, hospital discharge planners, and other involved entities.
 - Prior to discharge, the RN or therapist verifies the completion of goals or determines that the patient requires transition to a different level of care.
- 4. Referrals and Continuity of Care**

- ICS makes referrals to appropriate community resources, including primary and specialty care, hospice, palliative care, community based programs, DME providers, social services, outpatient therapy, or skilled rehabilitation or nursing facilities.
- All referrals are documented in the electronic health record.

5. Patient Education Prior to Discharge

- Disease specific education
- Medication reconciliation and instructions
- Follow-up appointment scheduling and instructions
- Emergency contact information
- Written discharge summary

6. Documentation

- An OASIS Discharge Summary is completed within 5 calendar days of the last discipline visit.
- All communications, referrals, goals met/unmet, and rationale for discharge are documented.

Reasons for Discharge or Transfer

ICS may discharge or transfer a patient only for the following legitimate reasons:

- **Goals met** or no further skilled services required.
- **Patient relocation** outside the licensed service area.
- **Change in medical condition** requires a higher or different level of care.
- **Safety concerns**, including threatening or unsafe behaviors that place staff at risk.
- **Repeated missed visits** after documented attempts to coordinate care.
- **Non-compliance** that makes care ineffective or unsafe, after all interventions are attempted.
- **Insurance or payer issues**, such as lack of authorization, or when the patient declines self pay.
- **Patient requests** to discontinue services.
- **Admission to hospice, hospital, or facility** requiring termination of home health services.

Facility Team: ICS Administration	SOP Title: Data Collection & Submission
Effective Date:	Version No.: 001
Approved By:	Revision Date:

Purpose:

To ensure that ICS collects, maintains, and reports all required State and federal home health data in compliance with COMAR, CMS, and Maryland Health Care Commission (MHCC) requirements.

Policy Statement:

ICS is committed to accurate, timely, and complete data reporting in adherence with all applicable Maryland and federal regulations, including the Maryland Home Health Agency Annual Survey, Outcome and Assessment Information Set (OASIS), and the Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

Scope:

This policy applies to all ICS clinical and administrative personnel responsible for documentation, data quality, reporting, and regulatory compliance.

Data Collection Requirements

1. OASIS Data (CMS Requirement)

- Collected by trained clinicians.
- Completed at required time points: Start of Care, Recertification, Resumption of Care, Transfer, Discharge.
- Reviewed for accuracy prior to transmission.
- Submitted electronically via CMS approved systems.

2. HCAHPS Surveys

- ICS will contract with a CMS approved survey vendor.
- Patient information will be securely transmitted to the vendor in strict compliance with HIPAA, state law (like Health-General Article, §4-302.5), and MHCC guidance.
- Reports are reviewed quarterly to identify opportunities for quality improvement.

3. Maryland Home Health Agency Annual Survey (MHCC), COMAR 10.07.10.12

- ICS will complete and submit the annual survey by the established deadlines.
- Submit it directly to the Maryland Health Care Commission (MHCC).

- Data elements include Agency-level data such as patient/service volume, financial data, staffing, utilization patterns, quality indicators, and demographics. Data elements include Agency-level data such as patient/service volume, financial data, staffing, utilization patterns, quality indicators, and demographics.
- Patient information will be securely transmitted to MHCC in strict compliance with HIPAA, state law (like Health-General Article, §4-302.5), and MHCC guidance.
- The Skilled Services Manager will verify accuracy prior to submission.

Internal Data Quality Assurance

- ICS uses an electronic health record (Axxess) with built-in validation tools.
- Monthly audits are performed to ensure accuracy and completeness.
- Staff receive annual training on documentation standards and updates to reporting requirements.
- Corrective action plans will be implemented when audit findings identify trends of non-compliance.

Record Retention

- All records supporting data submissions will be retained for a minimum of 5 years or longer when required by law.

Compliance Monitoring

- The Skilled Services Manager oversees compliance with all State and federal data reporting programs.
- ICS leadership reviews reporting compliance quarterly.
- Any reporting errors, delays, or discrepancies are addressed immediately.

EXHIBIT 5- Letters of Support

December 16th, 2025

Joe Morris

Administrator, HHA Services

Integrated Community Services

820 First Street, NE, Suite 425

Washington, DC 20002

Dear Mr. Morris:

This correspondence serves as a formal letter of recommendation in support of Integrated Community Services, Incorporated, and its demonstrated ability to operate as a fully compliant, high-performing Home Health Care Agency in accordance with applicable federal, state, and regulatory standards governing home- and community-based healthcare services.

I currently serve as a Director within the Veterans Benefits Administration, and I formerly served as a Director at the U.S. Department of Health and Human Services, Food and Drug Administration. In both roles, I have been responsible for oversight functions that require a rigorous understanding of regulatory compliance, quality assurance, risk management, internal controls, and performance accountability within federally regulated environments. This professional background informs my assessment of healthcare organizations operating under licensure and compliance requirements.

Over a ten-year period, I worked closely with multiple home health agencies that provided primary care services for my mother, Diana Gray, whose medical condition involved complex care needs and limited ability to communicate. Throughout this time, Integrated Community Services, Incorporated consistently demonstrated superior performance, distinguishing itself through clinical accuracy, operational reliability, caregiver competency, and adherence to patient-centered care principles. Their services were instrumental in maintaining my mother safely within her home environment, consistent with best practices under home- and community-based care models.

From a regulatory and compliance perspective, the agency's commitment to continuity of care and staff consistency is particularly noteworthy. Integrated Community Services, Incorporated, made deliberate and proactive efforts to ensure that assigned nursing attendants were appropriately trained, fully credentialed, and well-versed in my mother's individualized care plan. This approach reflects strong internal controls and alignment with regulatory expectations related to care coordination, staff competency validation, and individualized service delivery.

Equally significant is the agency's detail-oriented and transparent operational approach, which demonstrates a clear understanding of compliance obligations related to documentation accuracy, ethical service delivery, patient rights, and risk mitigation. Their healthcare representatives consistently executed their responsibilities with professionalism and accountability, establishing a standard of performance that compares favorably with—and in many respects exceed—peer organizations within the region.

Integrated Community Services, Incorporated exemplifies an organization that successfully integrates regulatory compliance, quality assurance, and compassionate care into daily operations. Their demonstrated ability to sustain high performance while meeting regulatory expectations is the basis for this strong and unqualified recommendation.

Should additional information be required regarding the agency's operational integrity, compliance posture, or overall performance, I would be pleased to provide further clarification. I may be contacted at 469-337-3266 or gr4510@aol.com.

Thank you for your consideration and for your careful review of this recommendation.

Respectfully,

Andre L. Gray

Director, Veterans Benefits Administration

Former Director, U.S. Department of Health, and Human Services

Food and Drug Administration

Andre' L. Gray,

Director, Human Resources Center – Des Moines

Office of Human Capital Services (HCS)

U.S. Department of Veterans Affairs

515-323-7400 X 43059 (Office), 515-462-7791 (Cell),



December 12, 2025

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

To Whom It May Concern:

I am writing to offer my recommendation for Integrated Community Services, Inc. ("ICS") as they seek to expand their skilled home health services to residents of Prince George's, Montgomery, Howard, and Anne Arundel counties in Maryland. Based on my family's nearly decade-long experience with ICS, I can confidently attest to their exceptional quality of care and unwavering commitment to their clients.

From April 2014 until my mother's passing in December 2023, ICS provided personal care assistance services that exceeded every expectation. My mother faced significant health challenges, including Parkinsonism, Lewy-Body Dementia, and speech aphasia—conditions that required not only clinical competence but also extraordinary patience, compassion, and dedication.

The ICS caregivers consistently demonstrated these qualities and more. Despite the considerable communication barriers posed by my mother's speech aphasia, her caregivers showed remarkable patience and creativity in understanding her needs and ensuring her comfort and dignity each day. They kept her clean, comfortable, and—most importantly—happy during a very difficult period of her life. Throughout our time with ICS, I made numerous unannounced visits to check on my mother's care. Without exception, I found her in excellent hands, receiving attentive and compassionate service. This consistency gave me invaluable peace of mind during a challenging time for our family.

ICS also distinguished itself through responsive and professional communication. The management team was consistently approachable, addressing my questions and concerns promptly and thoroughly. This level of organizational support complemented the outstanding care delivered by their staff.

The residents of Prince George's, Montgomery, Howard, and Anne Arundel counties would be fortunate to have access to ICS's services. Families facing similar circumstances to ours deserve the same exceptional level of care that my mother received, and I am confident that ICS has the expertise, compassion, and organizational excellence to serve this expanded community effectively.

Please feel free to reach out if you have any questions.

Sincerely,



Aziza Farooki
Tel: 202.445.6776



MICHAEL S. STEELE

December 31, 2025

LT. GOVERNOR OF MARYLAND
2003-2007

Maryland Healthcare Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Integrated Community Services, Inc.

Dear Sir/Madam:

I am pleased to write on behalf of Integrated Community Services, Inc. ("ICS") in support of their application to provide skilled home health services to residents of Maryland.

ICS has played an enormously important role in the lives of residents of the District of Columbia, providing high quality care, sound clinical support along with professional caregivers who demonstrate not just competency, but compassion. I know this well as ICS provided that very same care for my mother for ten years!

As Lt. Governor, I remember well the efforts of so many in our Maryland healthcare system who sought improvements and made them; reimagined care creatively and did it; and shared their expertise and compassion selflessly for the benefit of families and communities across the state. As a son concerned with the wellbeing of his mother, I watched ICS deliver the care my mother needed responsibly and always with the necessary outreach to the family. So, when informed of the opportunity for ICS to expand their caregiving services to Marylanders in need of quality care and individual attention, I wanted to express how much I believe ICS will not only contribute to but uphold the standards that have defined excellence in caregiving here in Maryland.

Marylanders deserve the best in quality healthcare and patient services. ICS stands ready to be such a provider. I hope you will agree and approve their application.

Thank you for your attention and consideration. Should you have any questions, please contact me at your convenience.

Sincerely,


Michael Steele

EXHIBIT 6- Part IV Tables

Table 2B

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2026__	2027__	2028__	2029__
Client Visits				
Billable	12,000	28,800	30,2040	31,752
Non-Billable	600	1,440	1,512	1,588
TOTAL	12,600	30,240	31,752	33,340
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	375	900	945	992
Skilled Nursing Visits	2,250	5,400	5,670	5,954
Home Health Aide Visits	3,750	9,000	9,450	9,920
Physical Therapy Visits	3,750	9,000	9,450	9,920
Occupational Therapy Visits	2,250	5,400	5,670	5,954
Speech Therapy Visits	—	—	—	—
Medical Social Services Visits	—	—	—	—
Other Visits (Please Specify)	—	—	—	—

Table 2B- The utilization projections for ICS are presented on a Calendar Year (CY) basis and reflect a phased start-up beginning in August 2026 (approximately five months of operations). ICS anticipates an average monthly census of 75 patients, resulting in 375 unduplicated clients in CY 2026. Services are projected based on a standard 60-day episode of care, with each episode including, on average, six skilled nursing visits, ten physical therapy visits, six occupational therapy visits, and ten home health aide visits. Non-billable visits, such as care coordination, supervision, and documentation, are estimated at 5% of total billable visits, and speech therapy and medical social services are not included in initial projections. These assumptions support the

volumes in Table 2B and align with revenue and expense projections in Table 4, demonstrating the operational and financial feasibility of ICS.

Table 4B

	Projected Years			
	(ending with first full year at full utilization)			
CY or FY (Circle)	2026__	2027__	2028__	2029__
1. Revenue				
Gross Patient Service Revenue	1,441,188.00	3,431,400.00	3,671,598.00	3,928,609.86
Allowance for Bad Debt	(86,471.28)	(205,884.00)	(220,295.88)	(235,716.59)
Contractual Allowance				
Charity Care	(100,883.16)	(240,198.00)	(257,011.86)	(275,002.69)
Net Patient Services Revenue	1,253,833.56	2,985,318.00	3,194,290.26	3,417,890.58
Other Operating Revenues (Specify)				
Net Operating Revenue	1,253,833.56	2,985,318.00	3,194,290.26	3,417,890.58
2. Expenses				
Salaries, Wages, and Professional Fees, (including fringe benefits)	295,819.16	704,331.34	735,461.28	747,225.12
Contractual Services	500,976.00	1,192,800.00	1,252,440.00	1,315,062.00
Interest on Current Debt				
Interest on Project Debt				
Current Depreciation	13,000.00	26,000.00	27,300.00	28,665.00
Project Depreciation				
Current Amortization				
Project Amortization				
Supplies	30,000.00	60,000.00	63,000.00	66,150.00
Other Expenses (Specify)	226,744.69	535,445.46	558,414.35	582,417.57

Total Operating Expenses	1,066,539.86	2,518,576.81	2,626,615.63	2,739,519.70
3. Income				
Income from Operation	187,293.70	466,741.19	567,674.63	678,370.88
Non-Operating Income				
Subtotal				
Income Taxes				
Net Income (Loss)				

Table 4 Cont.	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2026	2027	2028	2029
4A. - Payor Mix as Percent of Total Revenue				
Medicare				
Medicare Advantage	65%	65%	65%	65%
Medicaid	30%	30%	30%	30%
Medicaid MCO	3%	3%	3%	3%
Blue Cross	2%	2%	2%	2%
Other Commercial Insurance				
Other (Specify)				
TOTAL	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits				
Medicare				
Medicare Advantage				
Medicaid	70%	70%	70%	70%

Medicaid MCO	25%	25%	25%	25%
Blue Cross	3%	3%	3%	3%
Other Commercial Insurance	2%	2%	2%	2%
Self-Pay				
Other (Specify)				
TOTAL	100%	100%	100%	100%

Table 4- reflects projected revenues and expenses for ICS’s proposed Maryland Home Health Agency, serving Anne Arundel, Montgomery, and Prince George’s Counties. ICS’s projections are based on a phased start-up model with conservative census assumptions, planned staffing, and expected referral patterns. Revenue estimates include anticipated Medicare, Medicaid, and private payor income. Expense estimates include salaries, benefits, operational costs, and administrative overhead. Non-operating income is based on ICS’s internal reserves. All projections are presented in current dollars on a Calendar Year (CY) basis

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.**

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	19	-	-	-	62,750.19	-	1,192,253.66	-
Registered Nurse	11	9	-	-	105,278.25	66,000.00	1,158,060.80	594,000.00
Licensed Practical Nurse	-	-	-	-	-	-	-	-
Physical Therapist	-	3	-	-	-	196,000.00	-	588,000.00
Occupational Therapist	-	5	-	-	-	70,560.00	-	352,800.00
Speech Therapist	-	-	-	-	-	-	-	-
Home Health Aide	830	-	-	-	29,500.52	-	24,485,432.40	-
Medical Social Worker	1	-	-	-	75,350.08	-	75,350.08	-
Other (Please specify.)	-	-	-	-	-	-	-	-
Benefits							4,305,775.51	-
TOTAL							31,216,872.45	1,534,800.00

2026

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	19	-	1.00	-	62,750.19	-	1,255,003.85	-
Registered Nurse	11	9	2.00	-	105,278.25	66,000.00	1,368,617.31	594,000.00
Licensed Practical Nurse	-	-	-	-	-	-	-	-
Physical Therapist	-	3	-	1.00	-	196,000.00	-	784,000.00
Occupational Therapist	-	5	-	1.00	-	70,560.00	-	423,360.00
Speech Therapist	-	-	-	-	-	-	-	-
Home Health Aide	830	-	8.00	-	29,500.52	-	24,721,436.57	-
Medical Social Worker	1	-	-	-	75,350.08	-	75,350.08	-
Other (Please specify.)	-	-	-	-	-	-	-	-
Benefits							4,387,265.25	-
TOTAL							31,807,673.06	1,801,360.00

2027

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	20.00	-	-	-	62,750.19	-	1,255,003.85	-
Registered Nurse	13.00	9.00	-	-	105,278.25	66,000.00	1,368,617.31	594,000.00
Licensed Practical Nurse	-	-	-	-	-	-	-	-
Physical Therapist	-	4.00	-	-	-	196,000.00	-	784,000.00
Occupational Therapist	-	6.00	-	-	-	70,560.00	-	423,360.00
Speech Therapist	-	-	-	-	-	-	-	-
Home Health Aide	838.00	-	-	-	29,500.52	-	24,721,436.57	-
Medical Social Worker	1.00	-	-	-	75,350.08	-	75,350.08	-
Other (Please specify.)	-	-	-	-	-	-	-	-
Benefits							4,387,265.25	-
TOTAL							31,807,673.06	1,801,360.00

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	20.00	-	-	-	62,750.19	-	1,255,003.85	-
Registered Nurse	13.00	9.00	-	1.00	105,278.25	66,000.00	1,368,617.31	660,000.00
Licensed Practical Nurse	-	-	-	-	-	-	-	-
Physical Therapist	-	4.00	-	1.00	-	196,000.00	-	980,000.00
Occupational Therapist	-	6.00	-	1.00	-	70,560.00	-	493,920.00
Speech Therapist	-	-	-	-	-	-	-	-
Home Health Aide	838.00	-	2.00	-	29,500.52	-	24,780,437.61	-
Medical Social Worker	1.00	-	-	-	75,350.08	-	75,350.08	-
Other (Please specify.)	-	-	-	-	-	-	-	-
Benefits							4,396,705.42	-
TOTAL							31,876,114.27	2,133,920.00

Table 5-reflects ICS’s staffing projections for the proposed Maryland Home Health Agency, including planned additions of RNs, HHAs, therapists, and administrative staff. FTEs are calculated at 2,080 hours/year. Staffing increases are phased to match anticipated patient volume and referral patterns.”

**EXHIBIT 7- Integrated Community Services DC DOH Annual
Licensure Survey August 2025**

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER INTEGRATED COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 820 FIRST ST NE #LL110 WASHINGTON, DC 20002		
(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
H 000	<p>INITIAL COMMENTS</p> <p>An annual licensure survey was conducted on 07/24/2025 through 08/04/2025 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services for 374 patients and employed 800 staff. The findings of the survey were based on the review of 26 active patient records, four discharged patient records, two home visits, 18 personnel records, administrative records, and a review of the agency's response to complaints and incidents received.</p> <p>Listed below are abbreviations used throughout this report:</p> <p>HCA - Home Care Agency POC - Plan of Care RN- Registered Nurse SN -Skilled Nurse SOC- Start of Care</p>	H 000	<p>The deficiencies identified during the annual Licensure survey which started on 7/24/2025 through 8/4/2025 were reviewed with the ICS team and the following Plan of Correction was developed to address the deficiencies.</p> <p>1. What corrective action will be accomplished to address this deficient practice.</p> <p>a.) ICS requires care coordination to be completed for all patients who are receiving services from external agencies; this includes patients receiving care from Dialysis centers. The Plans of Care and 62 Day Summaries for patient #1 and #7 were updated to reflect care coordination. ICS policy on care coordination with external agencies was discussed with the clinical team on 10/15/2025.</p>	12/10/2025
H 433	<p>3916.2(c) SKILLED SERVICES GENERALLY</p> <p>Each home care agency shall develop written policies for documenting the coordination of the provision of different services. Written policies shall include, at a minimum, the following:</p> <p>(c) Coordinating services with other agencies actively involved in the patient's care, through written communication and/or interdisciplinary conferences, in accordance with the patient's needs; and...</p>	H 433		

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ingrid Dore

TITLE

Clinical Manager

(X6) DATE

10/20/2025

STATE FORM

9DG011

If continuation sheet 1 of 3

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER INTEGRATED COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 820 FIRST ST NE #LL110 WASHINGTON, DC 20002		
(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
H 433	Continued From page 1 This Statute is not met as evidenced by: Based on clinical record review and staff interview, the home care agency (HCA) failed to ensure nurses coordinated services with other agencies actively involved in the patient's care for two of 16 active patients in the survey, (Patient's #1, and #7). Findings included. 1. Clinical record review on 07/24/2025 at 2:30 PM for Patient #1 showed a start of care (SOC) date of 09/24/2024, with a duration of 09/24/2024 through 09/30/2025. Diagnoses included end-stage renal disease, dialysis dependence, hypertension, pain, and spondylosis of the lumbar region. The clinical record showed that Patient #1 received dialysis treatments 3x/week; however, the record lacked documented evidence of coordination with the dialysis treatment provider to ensure safety and continuity of care. A telephone interview was conducted on 07/24/2025 at 3:00 PM with Skilled Nurse (SN) Employee #14, a Registered Nurse (RN), who stated, "I forgot to document the discussions with the dialysis center about ongoing care and treatment for the patient. There have been no changes in the POC [plan of care]." 2. On 07/25/2025 at 11:00 AM, review of Patient #7's record showed a SOC date of 11/17/2022, with a duration of 11/01/2024 through 10/31/2025. Diagnoses included heart failure, hypertension, osteoarthritis, chronic respiratory failure on supplemental oxygen, and obesity. The clinical record showed that Patient #7 received dialysis treatments 3x/week; however, the record lacked documented evidence of coordination with the dialysis treatment provider to ensure safety	H 433	b) The Skilled Registered Nurse and the Nursing Coordinator were instructed to coordinate care with all external agencies providing care to our patients along with the Case Manager as appropriate. c)Retraining was completed with the Nursing Coordinator and Skilled Nurse #14 regarding scheduling care coordination for all patients receiving services from external agencies. Retraining was completed on 10/13/2025. (Attachment #1). d) Nursing In Service was completed for ICS Skilled Nurses and Clinical office staff on 10/15/2025. (Attachment #2 – In Service Agenda and sign in sheet). A makeup session is scheduled for 10/23/2025 for Skilled RNs who did not attend the In Service. 2. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur. a) The Skilled Nurses and the Nursing Coordinator will discuss the scheduling of care coordination meetings for all patients receiving services from external agencies. b) Care coordination will be completed quarterly and more often as appropriate.	12/10/2025

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER INTEGRATED COMMUNITY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 820 FIRST ST NE #LL110 WASHINGTON, DC 20002		
(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
H 433	Continued From page 2 and continuity of care. A telephone interview was conducted on 08/01/2025 at 10:00 AM with SN Employee #14, who acknowledged the findings.	H 433	3.How the corrective action will be monitored to ensure the deficient practice does not recur. a) During the quality review of the clinical documents, the QA team will ensure that care coordination is documented in the Skilled nurse monthly note, the 62 Day Summary and the Nursing Coordinators notes, for all patients receiving services from external agencies. b) Continuous monitoring with a goal of 80% compliance at the end of 60 Days. Monitoring will be ongoing.	12/10/2025

ATTACHMENT #1



Integrated Community Services, Inc. (ICS)
Bringing Community to Life

Date developed: 9/2/2025	Policy Title: Coordination of Care with External Agencies
Date Approved: 9/25/2025	Revision Date:
Version Number: 001	Approved By: ICS Administrator

Purpose:

To ensure effective coordination and continuity of care for patients receiving services from multiple healthcare providers or external agencies (e.g., dialysis centers, wound care centers, hospice providers, therapy services). This policy aims to promote safe, efficient, and patient-centered care by facilitating timely communication and collaboration among all care providers.

Policy Statement:

It is the policy of the Agency to actively coordinate care with all external agencies or providers involved in the patient's treatment to ensure comprehensive, integrated, and non-duplicative care. Care Coordination activities must be documented in the patient's clinical record and communicated to all relevant staff, including the beneficiary's Physician.

Scope:

This policy applies to all agency staff involved in patient care, including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Home Health Aides (HHAs), Therapists, Care Coordinators, and Administrative Staff responsible for patient communication and care planning.

Definitions

- **External Agency:** Any healthcare organization or provider outside the Home Care Agency that is actively providing care to the same patient (e.g., dialysis center, hospice agency, outpatient therapy clinic, primary care physician).
- **Care Coordination:** A deliberate process of organizing and sharing patient care information among participants involved in a patient's care to achieve safer and more effective outcomes.



Responsibilities

1. Clinical Manager/Director of Nursing (DON):

- Ensures implementation of this policy and monitors compliance.
- Facilitates communication with external providers as needed for complex cases.

2. Nursing Coordinator/Supervisory Nurse:

- Identifies external providers involved in the patient's care during admission/ Annual Recertification/ change in status and updates the Plan of Care accordingly.
- Communicates regularly with external agencies regarding changes in condition, treatment plans, or services provided.
- Documents all care coordination activities in the patient's clinical record.

3. Field Staff (Nurses, Therapists, HHAs):

- Reports any observed changes in patient condition or conflicting care instructions to the Case Manager/ Nursing Coordinator/Skilled Nurse Supervisor/QA Manager/ Clinical Manager as appropriate.
- Reinforces care coordination activities as directed.

Procedures

1. Identification and Consent:

- Upon admission and annual recertification, the Supervisory identifies all external agencies involved in the patient's care.

2. Initial Coordination:

- Contact each external provider to confirm their scope of services, frequency of visits, and contact information for key contact personnel.
- Request and share necessary documentation (e.g., dialysis schedule, treatment plan, physician orders).



**Integrated Community Services, Inc. (ICS)
Bringing Community to Life**

- Care coordination must be done for patients receiving skilled services from ICS skilled team for wound care, physical therapy, occupational therapy and speech language pathology.
- 3. Ongoing Communication:**
- Maintain regular communication with external providers regarding:
 - Changes in patient condition or treatment needs.
 - Medication adjustments or potential conflicts.
 - Safety concerns or infection control issues.
 - Hospitalizations or readmissions.
 - Status of wounds, including wound measurements and treatment.
- Communication may occur via phone call, email, or EMR messaging and DCCC in compliance with HIPAA.
- 4. Case Conferences:**
- Schedule interdisciplinary case conferences as needed, including representatives from all involved agencies.
- Document all discussions, decisions, and care plan updates.
- 5. Documentation:**
- Document all care coordination activities in the patient's clinical record, including date, time, person contacted, and summary of information exchanged.
- Update the patient's **Plan of Care** to reflect collaboration with external agencies.
- 6. Problem Resolution:**
- In cases of conflicting care instructions or duplication of services, the Case Manager consults with the patient's physician and collaborating agencies to reconcile the care plan.
- Escalate unresolved issues to the Clinical Manager for review and intervention.



Integrated Community Services, Inc. (ICS)
Bringing Community to Life

Quality Assurance

The Agency's Quality Assurance and Performance Improvement (QAPI) Committee will review care coordination activities quarterly to identify trends, gaps, and improvement opportunities.

References

- CMS Conditions of Participation for Home Health Agencies (42 CFR §484.60)
- HIPAA Privacy Rule, 45 CFR Part 164

Employee Signature: _____ Date: _____



Integrated Community Services, Inc.

Bringing Community to Life
820 First Street Ste. 425 Washington DC 20002

ICS RETRAINING Form

DATE: 10/13/2025

TIME: 11:00AM

NAME OF Employee: Edith Tengen

The Employee received retraining in the following areas:

- a. Review of ICS Care Coordination Policy.
- b. Care Coordination for patients receiving services from external agencies.

Retraining completed by: Ismael Rix Date: 10/13/2025⁻

Signature of Employee: Edith Tengen Date: 10/13/2025

11/13/2020



Integrated Community Services, Inc.

Bringing Community to Life
820 First Street Ste. 425 Washington DC 20002

ICS RETRAINING Form

DATE: 10/13/2025

TIME: 11:00AM

NAME OF Employee: Victor Fomba

The Employee received retraining in the following areas:

- a. Review of ICS Care Coordination Policy.
- b. Care Coordination for patients receiving services from external agencies.

Retraining completed by: ISovee Rix Date: 10/13/2025
Signature of Employee: Victor Fomba, RN Date: 10/13/25

11/13/2020

ATTACHMENT #2



Integrated Community Services, Inc.

Bringing Community to Life

6323 Georgia Avenue NW Suite 106, Washington DC 20011

HHA IN-Sheet RN IN-SERVICE

DATE: 10/15/2025

Print Your Name Clearly

	NAME	SIGNATURE	Material Received
1	Victor Fomba	Victor Fomba RN	
2	Temidayo Akin Selina	Temidayo Akin Selina RN	
3	Gadisa Gize	Gadisa Gize	
4	Ekeoma Okoroqfir	Ekeoma Okoroqfir RN	
5	Paul Appiah	Paul Appiah	
6	Benedicta Langwa	Benedicta Langwa RN	
7	Edith Teugen	Edith Teugen	
8	Samuel Abungwi	Samuel Abungwi	
9	Beatrice Esapa	Beatrice Esapa RN	
10	Patience Nkama	Patience Nkama	
11	Ingrid Dquer	Ingrid Dquer	
12	Alford Sali	Alford Sali RN	
13	EDDIE Amuro	EDDIE Amuro	

Agenda



- ❖ Welcome to August In Service.
- ❖ Care of the Patient with Congestive Heart Failure (CHF).
- ❖ Annual training – Emergency Preparedness.
- ❖ COVID 19 and Flu season.
- ❖ Clinical documentation expectations.
- Documenting dietary teaching based on patient's diagnosis.
- Review of the PCA timesheet during the supervisory visit.
- Content of the 62 Day Summary.
- New: Invoices for Field Staff.
- ❖ Distribution of POCs for October..

The 62 Day Summary



- ❖ The 62 Day Summary summarizes all activities and interventions during the last 62 Days.
- ❖ The RN must document – (see handout).
- ❖ Current Clinical Status
- ❖ Progress towards goals.
- ❖ Response towards care.
- ❖ Coordination of Care with external agencies/ Communication.
- ❖ Safety & Risk Factors.
- ❖ Summary Statement.

EXHIBIT 8- Integrated Community Services Financial Audit



INTGRATED COMMUNITY SERVICES INC.

Financial Statements

AND

Independent Auditors Audit Report

For the Year Ended 2024

INTGRATED COMMUNITY SERVICES INC.

December 31, 2024

Table of Contents

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Statement of cash-flows	6
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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors

Integrated Community Services Inc.

Washington, DC

We have audited the accompanying financial statements of Integrated Community Services Inc (company), which comprise of the balance sheet as of December 31, 2024, and, the related statements of income, and retained earnings for the twelve months ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility


Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement. These financial statements were prepared based on "other comprehensive basis of accounting" (OCBOA)

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position Integrated Community Services Inc.as of December 31, 2024, and the results of its operations and its cash flow for the years ended in accordance with accounting principles generally accepted in the United States of America.


Suraj Navrothi, CPA T&S CPA Services LLC
12/2/2025

INTEGRATED COMMUNITY SERVICES INC
BALANCE SHEET
December 31, 2024

ASSETS	2024	2023
Current Assets		
Cash and Cash Equivalents	\$ 3,653,640	\$ 5,244,562
Total Current Assets	3,653,640	5,244,562
Accounts Receivable	436,832	
Other Current Assets		51,182
Prepaid	26,509	31,089
Other Receivables	3,446	4,672
DC Tax Asset	223,750	
Employee Advances	6,895	
Total Other Current Assets	697,432	86,943
Fixed Assets		
Automobile	432,677	380,329
Office Equipment	80,912	67,179
Furniture & Fixtures	79,965	76,798
Total	593,555	524,307
Less Accumulated Depreciation	(327,626)	(279,823)
Net Fixed Assets	265,929	244,484
Other Assets		
Life Insurance CSV	682,146	798,947
Property	274,412	274,412
ROI Asset	2,895,339	3,053,667
Security Deposits	60,066	59,843
Total Other Assets	3,911,962	4,186,869
Total Assets	8,528,963	9,762,858
LIABILITIES AND SHAREHOLDER'S EQUITY		
Current Liabilities		
Account Payables	137,736	40,936
Security Deposits		10,267
Accrued Expenses	8,943	60,277
Wages Payables	133,322	890
Current Operating Lease Liability	515,387	808,400
Capitalized Leases Current	55,176	51,727
Total Other Liabilities	712,827	931,561
Total Current Liabilities	850,564	972,497
Long Term Debt		
Term Loan		24,088
Noncurrent Operating Lease Liability	2,443,413	2,231,109
Capitalized Leases long term	128,743	120,695
Other Loans	13,688	
Total Long Term Debt	2,585,845	2,375,893
Total Liabilities	3,436,408	3,348,390
Shareholder's Equity		
Capital Stock	500	500
Retained Earnings	5,092,055	6,413,968
Net Assets	5,092,555	6,414,468
Total Liabilities and Shareholder's equity	8,528,963	9,762,858

INTEGRATED COMMUNITY SERVICES INC
STATEMENT OF OPERATIONS
YEAR ENDED DECEMBER 31, 2024

	2024	2023
Income-Fees for Services	\$ 36,837,693	\$ 39,771,401
Other Program Income	5,607,875	3,068,774
Total Income	42,445,568	42,840,174
Expenses		
Salaries & Wages	35,005,510	33,143,872
Taxes- Employment	3,027,095	2,764,360
Payroll Fees	254,169	228,828
Rent Expense	880,459	620,144
Utilities	84,400	85,992
Employee Benefits	926,583	726,256
Service Fees	5,699	2,446
Life Insurance Premium Expense	144,833	154,000
Legal Expenses	15,420	611
Insurance Expense	597,341	544,009
Food	134,550	121,652
Medical Supplies	34,100	6,702
Nursing Services	451,488	198,157
Household Expenses	48,594	36,572
Professional Fees	497,971	807,907
Office Related	85,895	106,404
Dues & Subscription	7,557	14,405
Donations	18,365	45,648
Telephone & Communications	100,876	92,058
Computer & Equipment	153,848	107,361
Depreciation Expense	114,842	89,731
Automobile Expense	3,594	11,269
Repairs and Maintenance	67,837	138,553
Meals, Entertainment & Travel	42,207	50,309
Interest Expense	17,258	15,467
Licensing & Permits	1,674	3,307
Taxes- Other	3,757	3,886
DC Ball Park Taxes	16,500	18,926
Furniture & Equipment- Client	7,592	11,539
Bank Charges	2,633	2,778
Taxes- Property	4,884	2,431
Client Expenses	18,369	31,316
Bad Debt	12,057	-
Transportation Expenses	219,333	122,959
Equipment Lease	126,241	137,048
Accounting Expenses	44,100	15,000
IT Services	30,000	40,584
Total Expenses	43,207,632	40,502,484
Operating Income	(762,064)	2,337,690
Other Income and expenses		
Gain/Loss on Disposal of Assets	(9,210)	(40,436)
Grants		34,726
Life Insurance Income Account	242,184	96,862
Other Income	9,824	200,364
Interest Income	85,316	45,211
Net Other Income	328,114	336,726
Income (loss) before income taxes	(433,950)	2,674,416
DC Franchise Fees	1,000	223,668
Net Income (Loss)	(434,950)	2,450,748

INTEGRATED COMMUNITY SERVICES INC
STATEMENT OF CHANGES IN RETAINED EARNINGS
YEAR ENDED DECEMBER 31, 2024

	<u>2024</u>
Balance, beginning of year	\$ 6,414,468
Distributions	<u>(886,963)</u>
Net Income	(434,950)
Balance, year end	<u>5,092,555</u>

INTEGRATED COMMUNITY SERVICES INC
STATEMENT OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2024

	2024
<u>Cash flows from operating activities</u>	
Change in net assets	\$ (434,950)
Adjustments to reconcile change in net assets to net cash used in operating activities:	
(Increase)/Decrease in operating assets:	
Receivables	(384,424)
Security Deposits	(10,490)
Employee Advances	(6,895)
Prepaid Expenses	4,580
DC Franchise Tax Asset	(223,750)
Depreciation and amortization	47,803
Accrued Expenses	(51,335)
Amortization of operating lease right to use asset	158,329
Payment of operating lease liability	(80,709)
Accounts Payable	229,232
Increase/(Decrease) in operating liabilities:	(317,659)
Accounts Payable and Accrued Expenses	
Net cash provided by operating activities	(752,608)
 <u>Cash flows from investing activities</u>	
Adjustments to reconcile change in net assets to net cash used in investing activities:	
Life Insurance CSV	116,801
Net cash flows provided by investing activities	116,801
 <u>Cash flows from financing activities</u>	
Adjustments to reconcile change in net assets to net cash flows provided by financing activities	(10,400)
Asset Purchases	(69,248)
Payment on Debt	11,497
Owner Distributions	(886,963)
	(955,115)
Net Decrease in Cash and Cash Equivalents	(1,590,922)
Cash and cash equivalents, beginning of the year	5,244,562
Cash and cash equivalents, end of year	3,653,640

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Integrated Community Services Inc. NOTES TO FINANCIAL STATEMENTS

YEAR ENDED DECEMBER 31, 2024

1. Organization and summary of significant accounting policies

Organization

Integrated Community Services Inc. (the "Company") was incorporated on May 7, 2003, under the laws of the state of Maryland. The Company provides home health care in a patient's home, assisted living facility or retirement centers in the District of Columbia and in the state of Maryland.

Company Philosophy

- Provide compassionate care to each person served to achieve the best and most favorable outcomes
- Use a holistic approach that focuses on individualized care
- Take pride in selecting highly qualified staff
- ICS team works hard to provide excellent, person-centered care planning services that meet the needs of each person served
- To provide comprehensive, high quality, multi-disciplinary and compassionate care to the acutely or chronically ill client in the comfort of their own home
- Is driven by the philosophy of commitment to our patients, leadership and excellence in the provision of quality services
- We recognize the unique physical, emotional and spiritual needs of each person, and strive to extend the highest level of courtesy and service to patients, families and caregivers

Company Services

- HOME HEALTH AIDE
- PERSONAL CARE AIDE
- SKILLED NURSING (R.N., L.P.N.)
- PHYSICAL THERAPY
- OCCUPATIONAL THERAPY
- SPEECH THERAPY
- HOME HEALTH AIDE
- PERSONAL CARE AIDE

In 2020, The company applied and received approval to be licensed as a core service agency in the District of Columbia under the Department of Health (DBH) in 2020. The company intends to provide the following services under this program in the future.

- Comprehensive mental health services including.
 - Assessment of needs and life domains
 - Individualized treatment planning
 - Community support services
 - In home and /or office-based counselling
 - Community based interventions

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- Provide trauma-focused cognitive behavioral therapy
- HEART (Healing, Empowering, and Recovering together program) offers family therapy and care coordination for adult and child behavioral health services.

Method of Accounting

The company prepares its financial statements on an "other comprehensive basis of accounting" (OCBOA), Income Tax Cash Basis. Under this method revenue is recognized when received rather than when earned, and expenses are recognized when paid rather than when related obligation is incurred. Modification to the cash basis of accounting results from management's decision to record property and equipment and related depreciation, notes payable, prepaid expenses and advances to employees in the accompanying assets, liabilities and net assets.

Economic Concentration

During the twelve months ending December 31, 2024, the Company received 100% of its patient care revenue from the District of Columbia Medical Assistance Program (Medicaid). The Company does not consider this to be a significant risk.

Cash and Cash Equivalents

The company considers all cash and highly liquid investments with initial maturities of three months or less to be cash equivalents. As of December 31, 2024, the company holds no such investments.

Concentration of Credit Risk

The company maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The funds are insured by Federal Deposit Insurance Corporation (FDIC) up to \$250,000 for all accounts. For the year ended December 31, 2024 \$2,902,340 was in excess of the federal insured limits. The company has not experienced any losses and does not consider this to be a significant risk.

Accounts Receivable

The company prepares its financial statements on the Income Tax Cash Basis. As such accounts receivable is not recorded.

Property and Equipment

Property and equipment are stated at cost. The Company capitalizes additions of property and equipment in excess of \$1,000. Property and equipment are depreciated over a range of 5 to 27.5 years, using straight-line depreciation methods over their estimated useful lives.

Maintenance and repairs, which neither materially add to the value of the property nor appreciably prolong its life, are charged to expense as incurred.

Property and equipment consist of the following for the year ended December 31, 2024;

Automobile	\$ 432,677
Office Equipment	80,912
Furniture & Fixtures	<u>79,965</u>
	593,555
Less: accumulated depreciation	<u>(327,626)</u>
Net property and equipment	\$ <u>265,929</u>

Finance Lease Obligations

The company acquired 6 vehicles under a non-cancellable lease agreements that expires through the next five years. One of the leases was paid off in 2023 and another lease was paid off in 2024 without any prepayment penalties. The liabilities under finance leases are recorded at present value of the minimum lease payments. The financed lease asset is depreciated over finance lease length.

Automobile	\$ 432,677
Less: accumulated depreciation	<u>(207,226)</u>
Finance lease asset, net	\$ <u>225,451</u>

Revenue Recognition

Patient care revenue is reported when cash is received from third-party payers for services rendered.

Related Party Transactions

The company owner Ms. Rose Oma has operating lease agreements with the company for the following leased properties which are owned by Ms. Oma

- 1036 45th NE LLC
- 836 48th NE LLC
- 840 48th NE LLC
- 123 57TH SE LLC
- 4860 Queens Chapel LLC
- 33 rd SE LLC

Income Taxes

The Company has elected to be treated as a S Corporation for Federal and state tax purposes. As such, the Company generally pays no federal income tax and pays district income taxes in District of Columbia as a C corporation. The Company's taxable income is passed through to the shareholder, where it is reported and taxed on the shareholder's individual federal and state income tax returns. The company reports its income under the modified cash method for income tax reporting purposes and financial reporting purposes.

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Operating Lease Commitments

The Company leases residential homes and office space under operating leases requiring monthly payments ranging from \$1,379 to \$19,273 in Maryland and DC metro area. These leases expire various dates through 2031 and are non-cancelable. For the twelve months ending December 31, 2024, rental expenses were \$713,448.

The company is subleasing space at 3730 10TH street NE, to PETIT Scholars. The sublease agreement commenced on July 11, 2018. The term is seven years ending June 30, 2024. The monthly sublease amount is \$10,266.67 with a rent escalation.

Future minimum lease payments under the operating leases on December 31, 2024, are as follows:

Year ended December 2024	\$ 880,459
2025	613,968
2026	506,098
Thereafter	\$1,949,081

Life insurance cash value

The company offers a cash value life insurance policy paid by the company for key employees of the company. The cash surrender value of these policies at December 31, 2024 is \$682,146.

Capital Leases Payable

The company entered into five capital lease agreements for five vehicles at various times. Each lease commences on the delivery date of the respective vehicle and end in 60 months after the full monthly rental payment date. The balance of capital lease obligations at December 31, 2024, is \$183,919. of which \$55,176 is short term and \$128,743 is classified as long term.

Subsequent Events

Management of the company has evaluated events and transactions that occurred after the balance sheet date through December 2, 2025, the date the financial statements were available to be issued and has determined that no subsequent events have occurred that require recognition or disclosure in the financial statements.