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Via Electronic Mail

Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
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Re: Hope Health Systems, Inc.
Application for Certificate of Need
Docket No. 20-03-2444

Dear Ms. Potter:

Enclosed for filing in this review is the Applicant's Exceptions to Recommended Decision of the Reviewer.

Please let me know if you have any questions. Thank you for your attention to this matter.

Sincerely,

Marta Harting

Marta D. Harting

MDH/dll
Enclosure

cc: James C. Buck, Esquire
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IN THE MATTER OF	*	
	*	BEFORE THE
HOPE HEALTH SYSTEMS APPLICATION	*	
	*	MARYLAND HEALTH
	*	
Docket No. 20-03-2444	*	CARE COMMISSION
	*	

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APPLICANT'S EXCEPTIONS TO RECOMMENDED DECISION OF THE REVIEWER

In accordance with COMAR 10.24.01.09B, Hope Health Systems, Inc. ("HHS") submits these Exceptions to the Recommended Decision to deny HHS's certificate of need ("CON") application to establish a new 16-bed inpatient psychiatric special hospital to serve children and adolescents.

INTRODUCTION

HHS is a certified minority business enterprise that has provided culturally competent outpatient mental health care to underserved, predominantly minority communities for more than twenty years throughout Central Maryland and beyond. DI#4 (CON App. at 61). It filed this CON application so that it can provide a full continuum of behavioral health services to these communities, including inpatient care to children and adolescents. HHS explained that the hallmark of its mental health hospital will be to provide an "integrated, comprehensive, personalized mental health treatment facility to children and adolescents" with this project that will "provide improved access to care for patients, increase access for those who are publicly insured, provide high quality care through its step-down approach before discharging the patient to the community, diversify the provider market for inpatient mental health care, deliver culturally competent care, integrate the care continuum for patients, improve care coordination, and ultimately help reduce readmission rates." DI#4 (CON App. at 5).

HHS believes and demonstrated in this review that the number of inpatient beds in Maryland for children and adolescents is wholly inadequate with devastating consequences, particularly for the underserved population that HHS serves. As a minority business with extensive experience providing outpatient mental health services in these communities, HHS is uniquely well qualified to fill the void left by existing programs and meet the demonstrated need.

The project enjoys enormous community support, including from the local health departments in Baltimore County, Baltimore City and Prince George's County, and the State Department of Juvenile Services, as well as within the behavioral health provider community. DI#4, Exhibit 5. In his letter of support for the project from Dr. Ernest L. Carter, MD, Ph.D., the Prince George's County Health Officer, explains (DI#4, CON App. Ex. 5):

> Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. … The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs. …
>
> As a minority-owned business with minority medical leaders, such as their medical director, we are confident that HHS will continue to provide culturally sensitive care to meet the needs of our predominantly minority County. With the reinstitutionalization of those with behavioral health conditions in correctional settings and the nation's renewed focus on racial justice, we hope that having an additional facility to serve the behavioral health needs of high acuity youth will help to prevent unnecessary involvement in the criminal justice system for our at-risk residents as well.

The Reviewer determined (Recommended Decision at 15) that the project meets all applicable State Health Plan standards, policies and criteria. She further determined that HHS demonstrated the need for the project and met the other CON review criteria in COMAR 10.24.01.08G except for: (1) availability of more cost-effective alternatives, and (2) financial viability. For the reasons set forth below, the Reviewer erred in concluding that HHS did not

satisfy these requirements, and HHS excepts to the recommendation to deny the CON on these two grounds.[1]

EXCEPTIONS

1. COST EFFECTIVE ALTERNATIVES (COMAR 10.24.01.08G(3)(C)

Under this standard:

> The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a comparative application as part of a comparative review.

Since this review is not a comparative review, this standard requires a comparison of cost effectiveness of the project to providing the service through "alternative existing facilities." The instructions to this standard require consideration of providing the service through alternative existing facilities as well addressing the need through population health initiatives.

Consistent with the instructions and how this standard has been applied in previous CON reviews, HHS identified the primary objectives for the project: (1) to meet the demonstrated need for additional acute inpatient psychiatric bed capacity, particularly amongst underserved minority populations, and (2) to provide a complete and integrated continuum of behavioral care to underserved populations, building on the outpatient programs HHS has provided to underserved populations for more than twenty years. DI#4 (CON App.at 33, 68); DI# 13 (Applicant Response to Review Question #16). HHS explained that it explored the alternatives of establishing a more limited special psychiatric hospital that would serve only adolescents or children and rejected this alternative because it would not meet the demonstrated need within both of these populations.

[1] HHS recognizes that the Reviewer stated in the Conclusion that her recommendation is based primarily on financial viability (Recommended Decision at 40, 42), but because the Reviewer concluded that "I do not believe I have a definitive analysis in the record that would allow me to make a confident recommendation on this criterion", this finding is part of HHS's exceptions.

DI#4 (CON App. at 33). HHS explained that it considered and rejected the alternative not establishing the project in favor of continued reliance on existing inpatient facilities in the hope that they can meet the demonstrated need. As an experienced provider of outpatient behavioral health services, HHS explained that it regularly encounters the gaps left by existing programs in providing timely access to inpatient care for adolescents and children in underserved populations, so this alternative would not be effective in meeting the fundamental goal of the project. DI#4 (CON App. at 34).

Further, HHS explored the option of relying on population health initiatives and outpatient alternatives to meet the demonstrated need in lieu of establishing the project, but rejected this option explaining that population health and outpatient programming cannot meet the demonstrated need for inpatient care and that this project is "a necessary component of and effective care continuum for those patients that truly require acute inpatient treatment." HHS further explained that being able to offer a full continuum of behavioral health care services will enable HHS to better champion population health initiatives in the populations it serves. DI# 13 (Applicant Response to Review Question #16).

While recognizing that population health improvements have the potential to impact the demand for hospitalization and improve access to inpatient psychiatric care for young patients, the Reviewer found that the existing problems experienced by this population in accessing are related to a "mismatch between the demand for hospital resources and the supply of such resources." Recommended Decision at 26. Accordingly, consistent with her determination on need, the Reviewer explained that she approaches the issue of "cost effectiveness" from the perspective that expanding the bed inventory to the extent proposed by HHS is needed. Recommended Decision at 26.

The Reviewer found that the capital cost of the project is comparable to the cost of other recent inpatient psych projects approved by the Commission, and that the renovation of existing space is the "obvious lower cost choice among possible alternatives." She further found that the size of the program is in a reasonable range based on those other projects, although she characterized it as "minimal" since the other programs were in general hospitals with more existing ancillary and support space for inpatients and families than proposed by HHS. The Reviewer found that "when I compare Hope Health to alternative existing facilities, I find that the proposed project is a marginally 'cost effective' alternative for providing the needed psychiatric hospital service capacity in Maryland." Recommended Decision at 26-27.

Notwithstanding this conclusion, the Reviewer did not find that that HHS satisfied the cost-effective alternative criterion, concluding that "I do not believe I have a definitive analysis in the record that would allow me to make a confident recommendation on this criterion." This was due to the Reviewer's concern that the "low-cost alternative" proposed by HHS "may have a negative impact on the effectiveness of patient care, on the ability to have comprehensive programming, addressing a broad range of patient needs, on the feasibility of serving patients with specialized needs, and on patient and family satisfaction."[2] The Reviewer did not identify any specific component or attribute of the project proposed by HHS that caused concerns about the effectiveness of the project, but referred to unidentified "substantive comments" by the interested party Sheppard Pratt Health System ("Sheppard Pratt") on "important and still open questions in this review about the definition of how to define and measure cost effectiveness…" which she said made her question whether the project is the "best option" to meeting the identified need.

[2] HHS did not propose to serve specialized patients in its hospital. Accordingly, it was error to not find that HHS satisfied the standard because of concerns over whether the project would provide effective care to specialized patients.

Recommended Decision at 27. While the Recommended Decision does not identify these "substantive comments" by Sheppard Pratt in the Reviewer's Analysis and Findings, the description of Sheppard Pratt's comments refer to its March 1, 2021 Comments regarding "appropriate planning" in which it questions the project design and floor plans from a patient safety and quality of care perspective.[3] Recommended Decision at 25.

The Reviewer erred in not finding that HHS satisfied the cost-effective alternative criterion. It was applied to HHS's project in a way that is both contrary to the language of the regulation and to how it has previously been applied to other projects in the past, including recent psychiatric inpatient expansion projects. Consistent with its language, the Commission has consistently applied this regulation to require a comparison of the cost effectiveness of the proposed project to that of providing the services through alternative existing facilities or through population health initiatives. The Reviewer found that Hope Health Hospital is a "cost effective alternative for providing the needed psychiatric hospital service capacity in Maryland" but did not find the project to be in compliance with the regulation due to concern (for unspecified reasons) that the low-cost alternative being proposed by HHS would have a "negative impact" on the effectiveness of patient care and the ability to have comprehensive programming, among other program-related concerns. These issues are outside the scope of this regulation and HHS is aware of no other project as to which the Commission has applied the cost-effective alternative criterion (the criterion which is at issue here, which the Reviewer did not find HHS to have satisfied) to undertake a review of the proposed project's programmatic and clinical effectiveness.

The application of Recovery Centers of America – Upper Marlboro (Docket No. 15-16-2364) demonstrates the consistent interpretation of this criterion by the Commission that is

[3] As discussed further below, reliance on these comments (which were not tied to any project review standard or CON review criterion) was an error of law.

inconsistent with how it was applied here. In that review, the applicant sought to develop a new intermediate care facility for the treatment of alcoholism and drug abuse. In finding that RCA met this criterion, the Commission explained (Recommended Decision, at 33, emphasis supplied):

> The purpose of this regulation is to avoid issuing a CON to a facility that is cost-ineffective in light of alternatives. … RCA's perspective on this criterion is that adding detox (and residential treatment) capacity is the only alternative that would contribute to what it perceives as a serious undersupply of services…. Pathways argues that RCA did not adequately document that other facilities were turning people away or had lengthy waiting lists and wait times, but there is no need for RCA to make any such showing. The requirement that the Commission consider whether a facility is cost effective should not be read as a guarantee that current providers will be insulated from competition unless they have waiting lists.

The Commission concluded (Recommended Decision at 34, emphasis supplied):

> As discussed earlier in this report, the need for greater supply of detoxification services has been shown. The question here is simply whether the project proposed is cost-effective vis a vis other options, and specifically if the services could be provided more cost-effectively by other existing providers. The applicant has met this criterion by showing a need that surpasses the capacity of existing providers.

Here, the Reviewer found that HHS is a "cost effective alternative for providing the needed psychiatric hospital service capacity in Maryland." Further, HHS showed (and the Reviewer found) a need that surpasses the capacity of existing providers. Accordingly, the Reviewer erred in not finding that HHS had satisfied the standard.

Moreover, even if the cost effective alternative regulation was interpreted to allow consideration of a project's "effectiveness of patient care" and the other matters considered by the Reviewer, the Reviewer's Analysis and Findings does not identify (1) any specific components or attributes of the project causing the Reviewer's concerns, or (2) the specific "substantive comments" by Sheppard Pratt that gave rise to these concerns and prevented the Reviewer from finding that HHS satisfied this standard. In the absence of this information, HHS does not have a

meaningful opportunity to file exceptions to the Recommended Decision as to this criterion, to which HHS also takes exception.

As mentioned above, in its Interested Party Comments, Sheppard Pratt argued that HHS's floor plans for the facility do not demonstrate that it has planned appropriately for patient safety or other quality issues. Sheppard Pratt did not tie this argument to the cost-effective alternative standard or to any particular standard or review criteria, but asked the Reviewer to consider it because the State Health Plan Chapter under which this project must be reviewed is "out of date and does not directly address consideration of or compliance with modern standards for inpatient psychiatric units."[4] DI#22, at 22-23.

The Recommended Decision does not expressly mention these comments in the Reviewer's Analysis and Findings, but does refer to them in the description of Interested Party Comments suggesting that these comments were the "substantive comments" by Sheppard Pratt that gave rise to the concerns based on which the Reviewer determined that she could not find that HHS satisfied this review criterion. In addition to being contrary to the language of the regulation and how it has been applied in prior reviews as described above, reliance on these comments was an error of law. Under COMAR 10.24.01.08F(1)(c), an interested party is required to "state with particularity the State Health Plan standards or the review criteria in §G of this regulation that the person seeking interested party status believes have not been met by the applicant and the reasons why the applicant does not meet those standards or criteria." Sheppard Pratt failed to cite any standard or review criteria to which its comments on HHS's floor plans were at all germane.

[4]In fact, the new State Health Plan chapter does not contain any such standards either but reaffirms the importance of cost-effectiveness by requiring construction costs to be reasonable and consistent with Marshall Valuation Service guide, and providing that nursing units that exceed reasonable space standards per bed may not be recognized in a rate adjustment.

In any event, Sheppard Pratt's comments on HHS's floor plans and designs for patient safety and quality lack any merit because this project will meet FGI Design Standards and Guidelines (standards that the Commission recognizes and requires in other contexts) and the proposed inpatient hospital program will be accredited by The Joint Commission, just as its existing outpatient and partial hospitalization programs are accredited. DI# 27, at 14-17. Accordingly, the Reviewer erred in relying on these comments to determine that she could not find that HHS satisfied the cost-effective alternative criterion.

None of Sheppard Pratt's comments under the cost-effective alternative criterion described in the Recommended Decision are germane or have any merit. Indeed, its comments under this standard were based largely on its claim that HHS did not satisfy one of the project review standards (AP 11) -- an argument that the Reviewer rejected and found that HHS satisfied. Recommended Decision at 12; DI #22, at 8-9; DI# 30, at 9-10, and DI#47, at 11-12. Similarly, it claimed that the project is not cost effective as compared to existing providers because its charges will be higher than Sheppard Pratt's charges. A project's costs in comparison to other providers is germane to AP 11, which the Reviewer found that HHS satisfied. It is not germane to the cost-effective alternative requirement as it has been consistently applied in past reviews by the Commission as described above. In any event, HHS sufficiently demonstrated that its charges will not be higher than Sheppard Pratt's charges.[5] In its March 31, 2021 Interested Party Comments (DI#30, at 9), Sheppard Pratt reported an average inclusive per day rate for children and adolescents of $1,522 in FY20. HHS's projected rate of $1,585 was for CY 2022. Applying

[5] Although it argued that HHS projected a higher rate than Sheppard Pratt's approved rates, Sheppard Pratt was cryptic in its comments about what its rates actually are (and what is included in those rates) so it was difficult to respond to whether HHS's projected rate is higher. HHS's projected per-day rate is before its bad debt, charity care, and contractual adjustments (DI#35 at 5), while it is unclear whether Sheppard Pratt's self-reported rate includes adjustments or what such adjustments were.

the HSCRC's update factors since FY20, Sheppard Pratt's average rate would be higher (at $1,604.35) than the rate projected by HHS rate for CY2022. DI#50 at 13.

Sheppard Pratt also claimed that HHS did not meet the cost-effective alternative criterion because 84% of its admissions will come from existing providers, and because (according to Sheppard Pratt) HHS did not demonstrate how it would achieve the length of stay reductions assumed in its financial projections. DI# 47, at 12 Again, as described above, neither of these claims are germane to the cost-effective alternative criterion as it has consistently been applied by the Commission. Further, the Commission has found other new hospitals cost effective when (1) they projected to draw all of their admissions from other providers, and (2) projected reductions in length of stay based on early stage discharge planning and leveraging onsite outpatient programs and integrating closely with local community based support systems, just as HHS explained in its application and April 26, 2021 additional information filing it will do. DI#21, at 4. See, e.g., Anne Arundel Mental Health Hospital project (Docket No. 16-02-2375, CON Application at 54, 95). The Recommended Decision does not find that HHS's projection that 84% of its admissions will come from existing providers was unreasonable, let alone a ground to deny the application under any of the review criteria. Further, the Reviewer found that HHS's volume projections (which incorporate HHS's assumptions as to length of stay) were not unreasonable. Recommended Decision at 36.

Accordingly, the Reviewer erred in not finding that HHS satisfied the cost-effective alternative criterion after having found HHS's project to be a cost-effective alternative to meeting the demonstrated need for this bed capacity.

2. VIABILITY OF THE PROPOSAL (COMAR 10.24.01.08G(3)(D))

Under this CON review criterion:

> The Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

The Reviewer found that the volume assumptions on which HHS's financial projections were based were not unreasonable, and that HHS had demonstrated community support through "impressive letters of support for its project by persons who are familiar with behavior health services in Maryland." Recommended Decision at 36.

The Reviewer concluded, however, that HHS did not establish the availability of resources necessary to sustain the project due to the amount of operating margin that HHS projected in year five of operations, the final year of the projection period. The Reviewer stated that, following HHS's revisions to its financial projections during the review, its operating margin in year 5 was reduced to just over one-thousand dollars. While this projection still shows profitability, the Reviewer explained that "it would take only marginal changes in expenses and/or revenues anticipated by Hope Health to result in an unprofitable operation." In finding that HHS did not satisfy financial viability, the Reviewer also relied on the fact that the HSCRC was unable to endorse the viability of the project.

HHS submits that the Reviewer erred in finding that HHS did not demonstrate financial viability. HHS's original projections were based on publicly available data, which is more limited for freestanding special psychiatric hospitals than for psychiatric units in acute care general hospital. HHS modified its projections using information that was provided to it through Sheppard Pratt's interested party comments. This included adjustments to reduce the per diem reimbursement rate, reduce the annual percentage increase in revenues, increase staffing costs, and

increase from 20% to 25% the contractual costs that HHS would experience to reflect its smaller size in comparison to a larger psychiatric hospital. DI#28. It did so in order to be as conservative as reasonably possible and in the spirit of attempting to resolve issues presented by the interested party in order to facilitate the review of its application.[6] HHS does not believe that it is uncommon for CON applicants to make adjustments to their projections to respond to issues raised by staff or interested parties that show that the project continues to be viable even after addressing those issues.

These conservative adjustments kept the project profitable, but caused its projected margin in year five to decrease to just over one thousand dollars on an uninflated basis, and approximately $100,000 on an inflated basis. DI#35 (Exhibit 1, Table Replacements, Table K). However, this projection is based on an extremely conservative assumption as to bad debt in comparison to other providers, which provides a cushion to HHS, as shown in Table 1. DI#50, at page 6.

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TABLE 1

Filing	Year	Bad Debt Allowance	Contractual Allowance	Charity Care Allowance	Total Adjustments
Hope Health System	2021	11%	6%	4.11%	21%
University of Maryland Psych (Docket #18-24-2429)	2018	14.5%			14.5%
Brook Lane (FY 2019 Cost Report)	2019	3.71%	8.63%	2.05%	14.39%
Sheppard Pratt (FY 2019 Cost Report)	2019	0.12%	8.83%	3.27%	12.22%

[6] HHS also notes that it is a first time CON applicant. HHS retained Maryland CON counsel for this matter in September, 2021 following the issuance of the HSCRC memorandum. DI#41a.

The closest analogy to Hope Health Hospital is the recently approved University of Maryland psychiatric unit (Docket # 18-24-2429), which (like HHS) projected to serve 85% Medicaid in Table K of that Application. (Lower bad debt is to be expected with Medicaid than with commercial payors since there is no patient cost sharing.[7]). That project used a combined allowance of 14.5% (as stated in its Comprehensive Statement of Assumptions Used to Complete Tables F-L), as compared to HHS's total allowance of 21% incorporating an 11% bad debt allowance. Brook Lane's Medicaid percentage of net revenue in FY19 was 44.15%[8] and 47.44% in FY20[9] and it a bad debt allowance of only 3.71% in FY19 for regulated services according to its cost report. DI#50, at 7.

The Reviewer also based her decision on financial viability on the HSCRC's memorandum, which refers to need to reflect the real property tax pass through expense under HHS's lease and depreciation on HHS's major moveable equipment in HHS's financial projections. The real property tax pass through issue was identified by the HSCRC in its August 9, 2021 Memorandum (DI#42), but the Reviewer denied HHS's request to respond to the HSCRC and update its projections these Tables to include this information.[10] DI#43, 44. The amount of the real property tax pass through and depreciation on moveable equipment expense was noted in the HSCRC's August 9 Memorandum, totaling $97,475 annually. DI# 42 at 2. Including this amount with no other changes would put the project at nearly breakeven by the end of Year 5 on

[7] See COMAR 10.09.95.07 for payment regulations and the Maryland State Medicaid Plan documenting no cost sharing for inpatient services.

[8] https://hscrc.maryland.gov/Documents/Hospitals/ReportsFinancial/Audited/FY-2019/Brook%20Lane.pdf

[9] https://hscrc.maryland.gov/Documents/Hospitals/ReportsFinancial/Audited/FY%202020/Brook%20Lane%20Health%20Services%20Financial%20Statements%202020.pdf

[10] HHS submits that it was error to not allow it to respond to the HSCRC's memo. As explained in HHS's request to reconsider the denial of its request to respond to the HSCRC memo, applicants are consistently allowed to respond to concerns raised by the HSCRC, as shown in the examples cited by HHS in its letter. DI#45. The Reviewer denied HHS's request for reconsideration on grounds that HHS had previous opportunities to provide the information. Even if some of the issues were the subject of prior emails exchanges with staff, the applicants in the examples cited by HHS were not required to show that they did not have a prior opportunity to respond.

an inflated basis. DI#35, Exhibit 1 (Table Replacements, Table K). However, the HSCRC also noted in its Memorandum that principal repayment should be removed from the amortization expense (DI#42, at 2), a correction that would add to profitability. Further, if actual bad debt turns out to be below HHS's extremely conservative assumption of 11%, which is reasonable to expect given the Medicaid percentage and the experience of other providers discussed above, it would also counteract the additional $97,475 real property tax pass through expense.

HHS also submits that the record in this matter demonstrates the existence of a reasonable cushion in the event that expenses are higher or revenues are lower than projected. As referenced in the Recommended Decision (at page 29), HHS had $579,652 in cash and cash equivalents at the end of 2019. HHS's 2020 Audited Financial Statement shows approximately $600,000 in cash at the end of the year and net income of approximately $213,000 that year. DI#53, at 3, 4. As the Commission is aware and may take administrative notice of, the pandemic and related shut-downs during 2020 had a significant negative impact on health care providers and outpatient services revenue such as those provided by HHS. Accordingly, the reviewer erred in determining that HHS's audited financial statements to not demonstrate adequate resources if expenses are higher or revenues are lower than projected.

However, if the Commission determines that HHS did not demonstrate adequate resources to sustain the project in the record before it, HHS requests the Commission exercise its discretion to issue the CON subject to a condition that requires HHS to file with the Commission, within 60 days after the issuance of the CON, a binding commitment by Baltimore County government or agency thereof to provide working capital reserve funding to HHS to cover operating any operating losses during the first five years after project completion up to $500,000, with the repayment of advances being waived or deferred until such later time as repayment from HHS's

operating revenue can be made without adversely impacting the financial or operational viability of the hospital. The Commission has broad discretion to issue CONs with conditions that it determines to be appropriate under COMAR 10.24.01.13A.

In the Conclusion of the Recommended Decision (at 42-43), the Reviewer states that she would like to see more resources devoted to the provision of psychiatric hospital services to children and adolescents in Maryland, and expresses her hope that HHS will submit another CON application in the future based on a "stronger and more demonstrably viable project plan." HHS appreciates these comments by the Reviewer, but notes that under the new State Health Plan Chapter for Psychiatric Services that took effect August 9, 2021, if this CON is not issued, another CON to meet the need that has been demonstrated in this review is likely several years away. This is because the new Chapter requires Commission staff to publish regional utilization projections and a needs determination for historically underserved populations at least every two years (which the Chapter provides must be used in the review of future CON applications). See COMAR 10.24.21.05B. Accordingly, the Staff projections do not appear to be due to be first published for another year and a half (August 2023). With the Commission's CON review schedule for filing applications, and the time required for CON preparation and approval thereafter – which will be significantly longer if Sheppard Pratt were to again participate as an interested party – a CON to meet the need in the underserved populations that has been demonstrated in this review is likely to be delayed for several years.

CONCLUSION

For the reasons stated above, HHS's Application to for a Certificate of Need to establish Hope Health Hospital should be granted or should be granted with the condition described herein.

April 6, 2021

Respectfully submitted,

/s/ Marta D. Harting

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