EXHIBITS

LIST OF EXHIBITS TO APPLICANT'S RESPONSES TO APRIL 4, 2023 COMPLETENESS QUESTIONS

Exhibit Number	Title
17	CON Tables Sources and Assumptions
18	MHCC Psychiatric Services Work Group Survey
19	MHCC Psychiatric Services Work Group Additional Handouts
20	Fulton Bank Discussion Sheet
21	Migdole Contract
22	Construction Impact Information
23	Amendment to Lease
24	Financial Assistance Policy
25	MVS Analysis
26	Admissions Policy and Procedure
27	2021 Audited Financial Statements
28	Missing Subsections from Need Analysis
29	HHPH Program Description
30	Letter of Support from Local Advisory Council

EXHIBIT 17

Sources / Assumptions by Application Table	
1	Drive Time Source: https://www.smappen.com/app/ Population Source: 2020 American Community Survey
2	https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/counties/asrh/
3	https://planning.maryland. gov/MSDC/Pages/s3projection.aspx https://data.census.gov/cedsci/ To estimate the patient population, HHS reviewed the Maryland Department of Planning's estimated trends for po between 2020 -2030, and amended the data to reflect 2021 – 2027, which mirror the tables and analysis provided 1. HHS identified that the change in estimated population was in keeping with the Census Bureau trends in populat therefore utilized the state-based data projections. However, since the state-based data project age categories did not align with the child and adolescent patient popı age ranges, HHS assumed the ages were equally distributed throughout each age range. The state age ranges were 10-14, 15-19. HHS removed 40% of the 15-19 total to reflect the adolescent cut off at age 17. HHS also shifted 60% 14 age range to the children analysis to reflect the state child age range of 0-12 . The total for each column reflects analysis.
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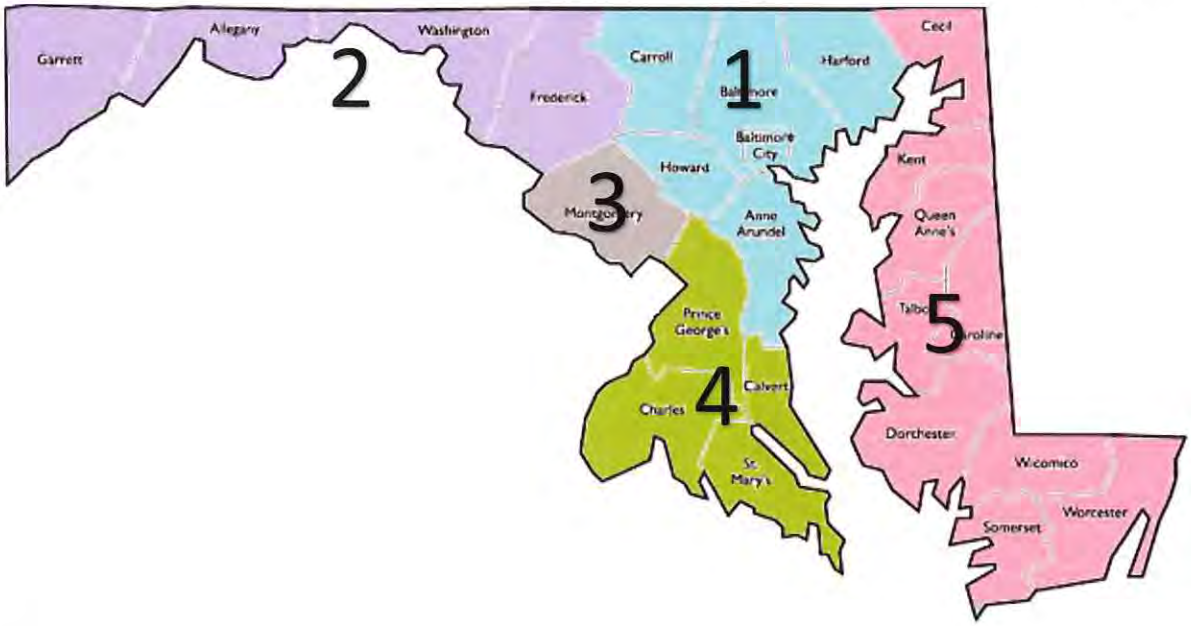
6	Utilization: Data from HSCRC through September 2022, and CY 2022 was annualized. Patient origin = 45 min dive time zip codes Principal and Secondary codes = F01-F099 Population: https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/counties/asrh/ 2019, 2020 and 2021 figures calculated using 2020 estimate as base period and using 2021-2027 annual growth rat

7	2019, 2020 and 2021 figures calculated using 2020 estimate as base period and using 2021-2027 annual growth rat https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/counties/asrh/
8	Use Rate per 100k calculated by deviding the Table 7 population figure by 100,000 and then dividing the utilization
9	Data is pulled directly from the HSCRC Experience Report for FY 2023. https://hscrc.maryland.gov/Pages/hsp_Data
10	The table is based on HSCRC data with the following parameters: Source: HSCRC Hospital Casemix Data Data from HSCRC through Sep 2022 (CY22 ananualized) Patient origin = 45 min dive time zip codes Principal and Secondary codes = F01-F099 The remaining assumptions/data parameters are noted within the table itself.
11	Table directly pulled from the following source: Maryland Health Care Commission: "White Paper: Maryland Acute
12	Data is based upon HSRC data purchased by the applicant for CY 2017-2019. Data parameters include: Primary Diagnosis = ICD-10 F01-F99 (Age 0-12) (Age 13-17) The population used to forecast the per 100,000 result is based on Table 4.
13	As per the notes within the application, the table is based upon the following assumptions: 1: Population based on estimates from Section II (Population Estimates) in the orignial application "need" response 2: Discharge Rate based on 2019 discharge rates reported for age group from HSCRC data 3: ALOS based on CY 2019 ALOS reported for age group from H5CRC data 4. Staffed bed totals based on MHCC Psychiatric Services work group survey & "single occupancy" equates to all pri rooms. There is no more recent public reporting on staffed beds. Please see the MHCC work group survey docume
14	Population based on estimates from Section II (Population Estimates) in the orignial application "need" response. Staffed bed totals based on MHCC Psychiatric Services work group survey (Exhibit 18) & "single occupancy" equate private rooms. There is no more recent public reporting on staffed beds.
15	Data is pulled directly from the HSCRC Experience Report for FY 2023. https://hscrc.maryland.gov/Pages/hsp_Data
16	Table is taken directly from the Maryland State Health Plan. https://dsd.maryland.gov/regulations/artwork/10242
17	Source: HSCRC Casemix data; Psych Dx codes; Age= <18; *2022 ytd Q3 annualized
18	Source: HSCRC Casemix data; Psych Dx codes; Age= <18; HHS service area zips *2022 ytd Q3 annualized
19	Please see the "Additional Handouts" document attached as Exhibit 19 from 11/06/2019 produced by the MHCC Ps Services Work Group. The online web links previously available to the public no longer appear on the MHCC websit
20	Source: HSCRC hospital submission data for children & adolescents in service area CY 2022 annualized on 9 months of data

	Admissions from ED: The LOS reduction in hours for patients shifted from hospital EDs assumes that delays in admitting are related to in capacity, thus patients that are subsequently admitted spend more time in the ED. If throughput was increased, we that LOS for admitted patients may be more similar to that of non-admitted patients. The difference in ED LOS (hou admitted patients vs non-admitted patients is .70 hours. This gives us: Hours saved: 203 (ED patients shifted to HHS) x .70 (difference between IP ED patients and OP ED Patients) =142 ho Cost Savings: 142 (hours saved) x 126.96 (RY23 statewide average charge per ED hour) =$18,084 We believe this is a conservative estimate, considering easing throughput in Maryland's hospital emergency depart would favorably impact ED wait times and crowding for other, non-shifted cases as well. Admissions from Observation: The LOS reduction in hours for patients shifted from hospital observation units assumes that the average number o some of these patients spend in observation is a result of inadequate capacity, thus these hours would be a savings increased capacity to better meet demand. This gives us: Hours saved: 41 (OBV patients shifted to HHS) x 35 (average # of hours spent in OBV for patients admitted from OB hours Cost Savings: 1,468 (hours saved) x 92.19 (RY23 statewide average charge per OBV hour) = $135,292 Admissions from Observation > 24 Hours: The cost savings from patients shifted from hospital observation stays greater than 24 hours assumes that a portion patients are in fact needing inpatient care, and with increased capacity, these patients can be served in an appropr setting and their observation hours would be eliminated from their total cost of care.
21	
22	Rate data is taken from the FY 2023 rates for the referenced providers, as published by HSCRC. The Table further d
23	The Applicant forecasted the stated inflationary assumptions based on its internal expectations given the current n
24	The data is taken directly from the public cost reports for the providers for FY 21 under the "RE" tab.
	Data is based upon HSRC data purchased by the applicant for CY 2017-2019. Data parameters include: Primary Diagnosis = ICD-10 F01-F99 (Age 0-12) (Age 13-17)
25	(Medicare/Medicaid/Commericial/Total Patient Days)
	Data is based upon HSRC data purchased by the applicant for CY 2017-2019. Data parameters include: Primary Diagnosis = ICD-10 F01-F99 (Age 0-12) (Age 13-17)
26	(Medicare/Medicaid/Commericial/Total Patient Days)
	The data is taken directly from the public cost reports for the providers for FY 21 and then adjusted the per patient upward by 120% to adjust for inflation to the first year
27	of operations and possible inefficiencies in size and scale for the smaller proposed location.
28	The Applicant forecasted the stated inflationary assumptions based on its internal expectations given the current n
	The Applicant forecasted the stated growth assumptions based on its internal expectations given the proposed ina
29	hospital operation and its existing forecasts for its outpatient volumes.
	The Applicant forecasted the stated expense growth assumptions based on its internal expectations given its assun
30	growth and a conservative marginal expense increase.
31	The Applicant forecasted the stated inflationary assumptions based on its internal expectations given the current n
32	See the "Source" and "Assumptions" notes from the "Missing Application Pages" provided with this completeness r
33	See the "Source" and "Assumptions" notes from the "Missing Application Pages" provided with this completeness r
34	See the "Source" and "Assumptions" notes from the "Missing Application Pages" provided with this completeness r

EXHIBIT 18

Current Health Planning Regions for Acute Psychiatric Services and Hospitals in Each Region



1. Central

BON SECOURS HOSPITAL
CARROLL HOSPITAL
HOWARD COUNTY GENERAL
JOHNS HOPKINS BAYVIEW
MEDSTAR FRANKLIN SQUARE
MEDSTAR HARBOR HOSPITAL
NORTHWEST HOSPITAL
SHEPPARD AND ENOCH PRATT
SHEPPARD PRATT AT ELLICOTT CITY
SINAI HOSPITAL OF BALTIMORE
THE JOHNS HOPKINS HOSPITAL
UM BALTIMORE WASHINGTON
UM MEDICAL CENTER MIDTOWN
UM SAINT JOSEPH
UM HARFORD MEMORIAL
UM MEDICAL CENTER

2. Western

BROOK LANE
FREDERICK MEMORIAL HOSPITAL
MERITUS MEDICAL CENTER
WESTERN MARYLAND REGIONAL

3. Montgomery

ADVENTIST HEALTHCARE SHADY GROVE^
ADVENTIST HEALTHCARE WHITE OAK*
HOLY CROSS GERMANTOWN HOSPITAL
MEDSTAR MONTGOMERY
SUBURBAN HOSPITAL

4. Southern

CALVERTHEALTH MEDICAL CENTER
MEDSTAR ST. MARY'S HOSPITAL
MEDSTAR SOUTHERN MARYLAND
UM PRINCE GEORGES HOSPITAL

5. Eastern Shore

PENINSULA REGIONAL MEDICAL CENTER
UM SHORE MEDICAL CENTER AT DORCHESTER
UNION HOSPITAL OF CECIL COUNTY

Notes: UM Laurel Regional Hospital's inpatient psychiatric program closed and is not included in these data.
State psychiatric programs are not included (i.e. Clifton T. Perkins Hospital Center, Eastern Shore Hospital Center).
*Adventist Healthcare White Oak was known as Adventist Healthcare Washington Adventist in FY2019
^Adventist Behavioral Health became part of Adventist Shady Grove in early FY2019; the data in this report only includes data reported by Adventist Shady Grove Hospital.

Table 1: Fiscal Year 2019 Capacity by Region (Preliminary Analyses)

	Central	Western	Montgomery	Southern	E. Shore
Total Number of Programs	16	4	5	4	3
Adult	16	4	4	4	3
Geriatric	3	0	2	0	0
Adolescent	4	1	2	0	0
Child	3	1	1	0	0
Partial Hospitalization/Outpatient	10 (63%)	4 (100%)	4 (80%)	4 (100%)	2 (67%)
State Hospitals/Forensic	1	0	0	0	1
Total Licensed Beds (FY 2019)	871	121	187	77	44
Private Rooms	291	93	31	7	8
Adult	218	56	26	7	8
Geriatric^	25	0	8	0	0
Adolescent	21	21	5	0	0
Child	32	16	0	0	0
Semi-Private Rooms	282	11	108	40	22
Adult	232	11	90	40	22
Geriatric^	20	0	5	0	0
Adolescent	41	0	12	0	0
Child	9	0	6	0	0
Greater Than 2 Beds Per Room	9	0	0	0	0
Adult	7	0	0	0	0
Adolescent	2	0	0	0	0
Child	0	0	0	0	0
Average Daily Census	640.4	82.6	116.4	55	27.5
Total Staffed Beds	775	113	162	72	36
Adult	624	76	136	72	36
Geriatric^	54	0	15	0	0
Adolescent	114	16	20	0	0
Child	37	21	6	7	0
Average Daily Occupancy Of Staffed Beds	82.6%	73.1%	71.9%	76.9%	76.4%
Number of Programs that Accept Involuntary Admissions (%)	14 (88%)	4 (100%)	2 (40%)	4 (100%)	3 (100%)
Number of Staffed Beds Available to Involuntary Patients (%)	736 (95%)	113 (100%)	118 (73%)	118 (100%)	36 (100%)

Sources: MHCC FY 2020 Survey, MHCC FY 2019 Survey, Program Staff
^Geriatric beds are a subset of adult beds, designated for older adults.

EXHIBIT 19

Table 1: Number of Psychiatric ED Visits by Diagnosis Category and Year, CY 2010- CY 2018

Psychiatric Diagnosis Category	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Other	31,303	33,935	37,468	36,763	38,412	37,367	25,980	27,880	28,035
Affective psychoses	13,457	13,592	13,939	14,465	14,223	16,758	26,044	25,754	25,016
Schizophrenic psychoses	3,297	3,651	3,790	3,807	4,254	4,877	5,929	6,348	6,725
Disturbance of conduct, not elsewhere classified	1,206	1,385	1,606	1,453	1,309	1,528	1,832	1,821	1,992
Specific nonpsychotic MH secondary to organic brain damage	1,185	1,276	1,344	1,374	1,478	1,425	1,457	1,291	1,049
Disturbance of emotions - childhood and adolescence	378	470	471	444	446	550	561	665	603
Personality disorders	411	413	456	534	685	529	272	282	251
Paranoid states	161	205	221	220	266	365	569	651	666
Psychoses with origin specific to childhood	166	180	197	213	270	358	399	444	481
Total	51,564	55,107	59,492	59,273	61,343	63,757	63,043	65,136	64,818

Source: MHCC staff analysis of HSCRC outpatient hospital data, CY 2010- CY 2018.
Notes: Psychiatric visits are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis.

Table 2: Number of Psychiatric ED Visits by Estimated Time in ED and Year, CY 2010- CY 2018

Estimated Time in ED	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	50,296	53,636	57,875	57,417	58,966	60,602	59,280	61,044	60,234
Between 24 and 48 hours	890	1,087	1,195	1,266	1,727	2,120	2,376	2,475	2,609
2-3 days	190	195	235	275	350	536	700	791	940
4-8 days	139	154	149	231	250	429	592	715	870
9-20 days	33	19	21	62	32	49	75	83	130
20+ days	16	16	17	22	18	21	20	28	35
Total	51,564	55,107	59,492	59,273	61,343	63,757	63,043	65,136	64,818

Source: MHCC staff analysis of HSCRC outpatient hospital data, CY 2010- CY 2018.
Notes: Psychiatric visits are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis.

Table 3: Number of Psychiatric Emergency Department (ED) Visits for Children By Estimated Time in ED and Year, CY 2010- CY 2018

Estimated Time in ED	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	2,963	3,285	3,595	3,476	3,510	3,460	3,342	3,500	3,781
Between 24 and 48 hours	31	44	33	54	67	67	103	107	148
2-3 days	7	11	8	12	13	16	24	35	77
4-8 days	3	8	5	8	14	17	30	47	83
9-20 days	2	2	1	1	0	2	4	7	15
20+ days	0	0	2	1	2	0	0	1	2
Total	3,006	3,350	3,644	3,552	3,606	3,562	3,503	3,697	4,106

Source: MHCC staff analysis of HSCRC outpatient data, CY 2010- CY 2018.
Notes: Psychiatric visits are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis. Children are defined as age zero to 12 years of age.

Table 4: Number of Psychiatric Emergency Department (ED) Visits for Adolescents By Estimated Time in ED and Year, CY 2010- CY 2018

Estimated Time in ED	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	6,765	7,046	7,584	7,909	8,276	8,460	7,431	7,431	7,360
Between 24 and 48 hours	142	197	215	221	278	360	330	419	420
2-3 days	26	40	43	53	78	94	121	173	186
4-8 days	17	35	41	61	55	110	148	222	199
9-20 days	3	1	5	13	3	3	16	34	30
20+ days	1	0	1	1	0	2	0	7	3
Total	6,954	7,319	7,889	8,258	8,690	9,029	8,046	8,286	8,198

Source: MHCC staff analysis of HSCRC outpatient data, CY 2010- CY 2018.
Notes: Psychiatric visits are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis. Adolescents are those age 13 to 17 years.

Table 5: Number of Psychiatric Emergency Department (ED) Visits for Adults By Estimated Time in ED and Year, CY 2010- CY 2018

Estimated Time in ED	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	40,568	43,305	46,696	46,032	47,180	48,682	48,507	50,113	49,093
Between 24 and 48 hours	717	846	947	991	1,382	1,693	1,943	1,949	2,041
2-3 days	157	144	184	210	259	426	555	583	677
4-8 days	119	111	103	162	181	302	414	446	588
9-20 days	28	16	15	48	29	44	55	42	85
20+ days	15	16	14	20	16	19	20	20	30
Total	41,604	44,438	47,959	47,463	49,047	51,166	51,494	53,153	52,514

Source: MHCC staff analysis of HSCRC outpatient data, CY 2010- CY 2018.
Notes: Psychiatric visits are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis. Adults are those age 18 years and older.

Table 6: Number of Psychiatric Emergency Department Visits Resulting in Admission by Length of Stay and Year, CY 2010- CY 2018

Length of Stay	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
1 day	2,658	2,313	2,046	1,924	1,787	1,436	1,297	1,138	984
2 days	3,579	3,391	3,265	3,087	2,940	2,502	2,216	2,186	2,075
3 days	4,229	4,174	4,133	4,111	3,956	3,502	2,901	3,034	2,996
4- 8 days	10,499	10,778	10,485	10,498	10,409	9,804	8,760	8,459	8,588
9-20 days	2,294	2,336	2,306	2,276	2,346	2,346	2,393	2,324	2,484
20+ days	317	327	350	354	375	490	527	529	668
Total	23,576	23,319	22,585	22,250	21,813	20,080	18,094	17,670	17,795

Source: MHCC staff analysis of Health Services Cost Review Commission discharge data for acute care general hospitals, CY 2010- CY 2018.
Notes: Discharges with emergency charges greater than zero are counted. Psychiatric discharges are defined as records with major diagnosis category coded as 19. Developmental Delay is defined as ICD-9 codes: "317" "3180" "3181" "3182" "319" "29900" "29901" "29910" "29980" "29981" "29990"; or ICD-10 codes: F70 "F71" "F72" "F73" "F78" "F79" "F840" "F843" "F845" "F848" "F849".

Table 7: Number of Psychistric Emergency Department Visits Resulting in Admission by Secondary Diagnosis for a Developmental Disability, CY 2010- CY 2018

Developmental Disability	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
No	22,848	22,683	21,949	21,550	21,160	19,471	17,525	17,083	17,102
Yes	728	636	636	700	653	609	569	587	693
Total	23,576	23,319	22,585	22,250	21,813	20,080	18,094	17,670	17,795

Source: MHCC staff analysis of Health Services Cost Review Commission discharge data for acute care general hospitals, CY 2010- CY 2018.
Notes: Discharges with emergency charges greater than zero are counted. Psychiatric discharges are defined as records with major diagnosis category coded as 19. Developmental Delay is defined as ICD-9 codes: "317" "3180" "3181" "3182" "319" "29900" "29901" "29910" "29980" "29981" "29990"; or ICD-10 codes: F70 "F71" "F72" "F73" "F78" "F79" "F840" "F843" "F845" "F848" "F849".

Table 8: Number of Psychiatric Emergency Department Visits Resulting in Admission Without a Secondary Diagnosis for a Developmental Delay by LOS and Year, CY 2010 - CY 2018

Length of Stay (LOS)	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
1 day	2,603	2,276	2,001	1,888	1,759	1,412	1,271	1,109	962
2 days	3,490	3,312	3,194	3,017	2,866	2,444	2,159	2,129	2,011
3 days	4,101	4,084	4,032	3,988	3,854	3,431	2,833	2,952	2,908
4-8 days	10,167	10,448	10,160	10,147	10,072	9,480	8,480	8,185	8,239
9-20 days	2,187	2,257	2,229	2,172	2,263	2,240	2,292	2,222	2,358
20+days	300	306	333	338	346	464	490	486	624
Total	22,848	22,683	21,949	21,550	21,160	19,471	17,525	17,083	17,102

Source: MHCC staff analysis of Health Services Cost Review Commission (HSCRC) discharge data for CY 2010- CY 2018.
Notes: Discharges with emergency charges greater than zero are counted. Psychiatric discharges are defined as records with major diagnosis category coded as 19. Developmental Delay is defined as ICD-9 codes: "317" "3180" "3181" "3182" "319" "29900" "29901" "29910" "29980" "29981" "29990"; or ICD-10 codes: F70 "F71" "F72" "F73" "F78" "F79" "F840" "F843" "F845" "F848" "F849".

Table 9: Number of Psychiatric Emergency Department Visits Resulting in Admission With a Secondary Diagnosis for a Developmental Delay by LOS and Year, CY 2010 - CY 2018

Length of Stay (LOS)	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
1 day	55	37	45	36	28	24	26	29	22
2 days	89	79	71	70	74	58	57	57	64
3 days	128	90	101	123	102	71	68	82	88
4-8 days	332	330	325	351	337	324	280	274	349
9-20 days	107	79	77	104	83	106	101	102	126
20+days	17	21	17	16	29	26	37	43	44
Total	728	636	636	700	653	609	569	587	693

Source: MHCC staff analysis of Health Services Cost Review Commission (HSCRC) discharge data for CY 2010- CY 2018.
Notes: Discharges with emergency charges greater than zero are counted. Psychiatric discharges are defined as records with major diagnosis category coded as 19. Developmental Delay is defined as ICD-9 codes: "317" "3180" "3181" "3182" "319" "29900" "29901" "29910" "29980" "29981" "29990"; or ICD-10 codes: F70 "F71" "F72" "F73" "F78" "F79" "F840" "F843" "F845" "F848" "F849".

Table 10: Number of Psychiatric Emergency Department (ED) Visits by Homeless Status and Year, CY 2010- CY 2018

Homeless Status	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
No	50,258	53,796	57,987	57,705	59,639	61,609	60,597	62,302	61,716
Yes	1,306	1,311	1,505	1,568	1,704	2,148	2,446	2,834	3,102
Total	51,564	55,107	59,492	59,273	61,343	63,757	63,043	65,136	64,818

Source: MHCC staff analysis of Health Services Cost Review Commission outpatient hospital data, CY 2010- CY 2018.
Note: Psychiatric patients are defined by records with a primary diagnosis with an ICD-9 code in the following ranges: 293-302 and 306-319 or a corresponding ICD-10 code. Homeless patients are defined as records with the code V600 or Z590.

Table 11: Number of Psychiatric Emergency Department (ED) Visits by Estimated Time in ED for Patients Who Are Not Homeless by Year, CY 2010- CY 2018

Estimated Time in ED	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	49,073	52,394	56,430	55,917	57,357	58,591	56,999	58,353	57,396
Between 24 hours and 48 hours	823	1,029	1,150	1,213	1,650	2,018	2,262	2,372	2,450
More than 48 Hours	362	373	407	575	632	1,000	1,336	1,577	1,870
Total	50,258	53,796	57,987	57,705	59,639	61,609	60,597	62,302	61,716

Source: MHCC staff analysis of Health Services Cost Review Commission outpatient hospital data.
Note: Estimated time is based on subtracting the date of admission and the end date for each visit. Psychiatric patients are defined by records with an ICD-9 code in the following ranges: 293-302 and 306-319 or a corresponding ICD-10 code. Homeless patients are defined as records with the code V600 or Z590.

Table 12: Number of Psychiatric Emergency Department Visits by Estimated Time in ED for Patients Who Are Homeless by Year, CY 2010- CY 2018

Estimated Time in ED	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	1,223	1,242	1,445	1,500	1,609	2,011	2,281	2,691	2,838
Between 24 hours and 48 hours	67	58	45	53	77	102	114	103	159
More than 48 Hours	16	11	15	15	18	35	51	40	105
Total	1,306	1,311	1,505	1,568	1,704	2,148	2,446	2,834	3,102

Source: MHCC staff analysis of Health Services Cost Review Commission outpatient hospital data, CY 2010- CY 2018.
Note: Estimated time is based on subtracting the date of admission and the end date for each visit. Psychiatric patients are defined by records with an ICD-9 code in the following ranges: 293-302 and 306-319 or a corresponding ICD-10 code. Homeless patients are defined as records with the code V600 or Z590.

Table 13: Number of Hospital Psychiatric Discharges by Homeless Status and Year, CY 2010- CY 2018

Homeless Status	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
No	40,954	42,120	42,300	41,128	40,321	39,604	39,860	37,234	36,530
Yes	3,796	4,185	4,147	4,552	4,707	5,020	5,532	5,535	5,171
Total	44,750	46,305	46,447	45,680	45,028	44,624	45,392	42,769	41,701

Source: MHCC staff analysis of Health Services Cost Review Commission dicharge hospital data for acute care general hospitals and private psychiatric hospitals, CY 2010- CY 2018.

Note: Psychiatric patients are defined as records with major diagnostic category (MDC) equal to 19. Homeless patients are defined as records with the code V600 or Z590.

Table 14: Number of Psychiatric Emergency Department Visits by Medication Adherence, CY 2010- CY 2018

Medication Adherence	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
No	50,387	53,853	58,128	57,585	59,417	61,667	60,992	62,866	62,336
Yes	1,177	1,254	1,364	1,688	1,926	2,090	2,051	2,270	2,482
Total	51,564	55,107	59,492	59,273	61,343	63,757	63,043	65,136	64,818

Source: MHCC staff analysis of Health Services Cost Review Commission discharge data, CY 2010- CY 2018.
Note: Records with the following codes indicate a lack of adherence to medication: "V1581" "Z9119" "Z9114" "Z91120" "Z91138." Psychiatric discharges are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code.

Table 15: Number of Psychiatric Emergency Department Visits by Estimated Boarding Time Without Indication for Lack of Medication Adherence, CY 2010- CY 2018

Estimated Time in ED	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
ED_Days						58,687	57,447	59,005	58,077
Less than 24 hours	49,186	52,448	56,587	55,847	57,180	2,007	2,260	2,327	2,432
Between 24 hours and 48 hours	848	1,032	1,139	1,179	1,623	973	1,285	1,534	1,827
More than 48 Hours	353	373	402	559	614	61,667	60,992	62,866	62,336
Total	50,387	53,853	58,128	57,585	59,417	59,530	51,817	53,192	52,751

Source: MHCC staff analysis of Health Services Cost Review Commission outpatient data, CY 2010- CY 2018.
Note: Records with the following codes indicate a lack of adherence to medication: "V1581" "Z9119" "Z9114" "Z91120" "Z91138." Psychiatric discharges are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code.

Table 16: Number of Psychiatric Emergency Department Visits by Estimated Boarding Time With Indication for Lack of Medication Adherence, CY 2010- CY 2018

Estimated Time in ED	Year								
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	1,110	1,188	1,288	1,570	1,786	1,915	1,833	2,039	2,157
Between 24 hours and 48 hours	42	55	56	87	104	113	116	148	177
More than 48 Hours	25	11	20	31	36	62	102	83	148
Total	1,177	1,254	1,364	1,688	1,926	2,090	2,051	2,270	2,482

Source: MHCC staff analysis of Health Services Cost Review Commission outpatient data, CY 2010- CY 2018.
Note: Records with the following codes indicate a lack of adherence to medication: "V1581" "Z9119" "Z9114" "Z91120" "Z91138." Psychiatric discharges are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code.

Table 17: Number of Psychiatric ED Visits With Social Determinants Coded, CY 2016- CY 2018

Social Determinant Codes	Year		
	2016	2017	2018
No	59,106	60,791	59,189
Yes	3,937	4,345	5,629
Total	63,043	65,136	64,818

Source: MHCC staff analysis of HSCRC outpatient data, CY 2016- CY 2018.
Notes: Psychiatric discharges are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis. Social determinant codes for this analysis are listed in a separate table.

Table 18: Number of Psychiatric ED Visits With Zero Social Determinants Coded, CY 2016- CY 2018

Estimated Time in ED	Year		
	2016	2017	2018
Less than 24 hours	55,656	56,979	55,188
Between 24 hours and 48 hours	2,160	2,284	2,260
More than 48 Hours	1,290	1,528	1,741
Total	59,106	60,791	59,189

Source: MHCC staff analysis of HSCRC outpatient data, CY 2016- CY 2018.
Notes: Psychiatric discharges are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis. Social determinant codes for this analysis are listed in a separate table.

Table 19: Number of Psychiatric ED Visits With Social Determinants Coded, CY 2016- CY 2018

Estimated Time in ED	Year		
	2016	2017	2018
Less than 24 hours	3,624	4,065	5,046
Between 24 hours and 48 hours	216	191	349
More than 48 Hours	97	89	234
Total	3,937	4,345	5,629

Source: MHCC staff analysis of HSCRC outpatient data, CY 2016- CY 2018.

Notes: Psychiatric discharges are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis. Social determinant codes for this analysis are listed in a separate table.

Social Determinants of Health Codes

ICD10	Description
Z550	Illiteracy and low-level literacy
Z551	Schooling unavailable and unattainable
Z552	Failed school examinations
Z553	Underachievement in school
Z554	Educational maladjustment and discord with
Z558	Other problems related to education and li
Z559	Problems related to education and literacy
Z560	Unemployment, unspecified
Z561	Change of job
Z562	Threat of job loss
Z563	Stressful work schedule
Z564	Discord with boss and workmates
Z565	Uncongenial work environment
Z566	Other physical and mental strain related t
Z5681	Sexual harassment on the job
Z5682	Military deployment status
Z5689	Other problems related to employment
Z569	Unspecified problems related to employment
Z570	Occupational exposure to noise
Z571	Occupational exposure to radiation
Z572	Occupational exposure to dust
Z5731	Occupational exposure to environmental tob
Z5739	Occupational exposure to other air contami
Z574	Occupational exposure to toxic agents in a
Z575	Occupational exposure to toxic agents in o
Z576	Occupational exposure to extreme temperatu
Z577	Occupational exposure to vibration
Z578	Occupational exposure to other risk factor
Z579	Occupational exposure to unspecified risk
Z590	Homelessness
Z591	Inadequate housing
Z592	Discord with neighbors, lodgers and landlo
Z593	Problems related to living in residential
Z594	Lack of adequate food and safe drinking wa
Z595	Extreme poverty
Z596	Low income
Z597	Insufficient social insurance and welfare
Z598	Other problems related to housing and econ
Z599	Problem related to housing and economic ci
Z600	Problems of adjustment to life-cycle trans
Z602	Problems related to living alone
Z603	Acculturation difficulty
Z604	Social exclusion and rejection
Z605	Target of (perceived) adverse discriminati
Z608	Other problems related to social environme

Social Determinants of Health Codes (continued)

Z609	Problem related to social environment, uns
Z620	Inadequate parental supervision and contro
Z621	Parental overprotection
Z6221	Child in welfare custody
Z6222	Institutional upbringing
Z6229	Other upbringing away from parents
Z623	Hostility towards and scapegoating of chil
Z626	Inappropriate (excessive) parental pressur
Z62810	Personal history of physical and sexual ab
Z62811	Personal history of psychological abuse in
Z62812	Personal history of neglect in childhood
Z62819	Personal history of unspecified abuse in c
Z62820	Parent-biological child conflict
Z62821	Parent-adopted child conflict
Z62822	Parent-foster child conflict
Z62890	Parent-child estrangement NEC
Z62891	Sibling rivalry
Z62898	Other specified problems related to upbrin
Z629	Problem related to upbringing, unspecified
Z630	Problems in relationship with spouse or pa
Z631	Problems in relationship with in-laws
Z6331	Absence of family member due to military d
Z6332	Other absence of family member
Z634	Disappearance and death of family member
Z635	Disruption of family by separation and div
Z636	Dependent relative needing care at home
Z6371	Stress on family due to return of family m
Z6372	Alcoholism and drug addiction in family
Z6379	Other stressful life events affecting fami
Z638	Other specified problems related to primar
Z639	Problem related to primary support group,
Z640	Problems related to unwanted pregnancy
Z641	Problems related to multiparity
Z644	Discord with counselors
Z650	Conviction in civil and criminal proceedin
Z651	Imprisonment and other incarceration
Z652	Problems related to release from prison
Z653	Problems related to other legal circumstan
Z654	Victim of crime and terrorism
Z655	Exposure to disaster, war and other hostil
Z658	Other specified problems related to psycho
Z659	Problem related to unspecified psychosocia

EXHIBIT 20

NON-BINDING DISCUSSION SHEET

Fulton Bank

This Non-Binding Discussion Sheet (this "*Discussion Sheet*") has been prepared by Fulton Bank (the "*Bank*") for discussion purposes only. ***Please note that this Discussion Sheet is not binding on the Bank, and is not an offer of financing or a commitment to lend.*** This Discussion Sheet is provided only as a basis for the discussion of financing needs that might lead to an offer of financing by the Bank. Without limiting the foregoing, this Discussion Sheet does not include a comprehensive list of all terms and conditions of any offer of financing that might be made by the Bank.

Date: May 17, 2023

Borrower: Hope Health Systems, Inc. & Hope Health Properties

Proposed Loan #1:	$6,040,000
Purpose:	Commercial Mortgage
Term:	5 year term, amortized over 20 years
Payment:	Monthly Principal and Interest
Rate:	The indicative interest rate as of May 9, 2023 is 6.97%. The rate would be set five (5) days prior to the loan closing based on the then-current Bank cost of funds.
Collateral:	1726 Whitehead Road, Woodlawn, MD 21208, 2605 Banister Road Greenspring, MD
Guarantees:	Hope Health Systems, Inc. and Hope Health Properties
Prepayment Charge:	2%

Proposed Loan #2:	$1,500,000
Purpose:	Working Capital Line of Credit
Term:	Demand Facility
Payment:	Interest Only
Rate:	Bank Fixed Rate Option: The interest rate would be based on the term choice for U.S. Dollars published by Bloomberg (or any successor or replacement publication) in place as of the close of business five (5) days prior to the loan closing plus 2.5%, in each case as determined by the Lender.
Collateral:	Secured by a first lien on equipment purchased Secured by a first lien on all business assets
Guarantees:	Hope Health Systems, Inc.
Prepayment Charge:	Standard 2% on Bank Fixed Rate if paid off from outside proceeds. No prepayment charge if paid off from loss of use or from operating profits.
Advances:	100% of invoice less taxes and freight.

Financial Covenants:

1. Minimum annual debt coverage ratio

   Borrower shall maintain as of each measurement date a debt service coverage ratio of not less than 1.2 to 1.0, defined as the ratio of the following items of Borrower: Cash Flow (as hereinafter defined) to the sum of the regularly scheduled payments of principal and interest on all obligations including capitalized lease obligations and any subordinated debt (in each case as such items are shown on the applicable Financial Deliverables). As used herein, the term "*Cash Flow*" shall mean (a) net income [change in unrestricted net assets], (b) minus income or plus loss from discontinued operations, extraordinary items, and non-recurring items (as determined by Lender), (c) plus depreciation, depletion, amortization and other non-cash charges, (d) plus interest expense on all obligations, and (e) minus dividends and withdrawals (in each case as such items are shown on the applicable Financial Deliverables). Compliance with this covenant shall be determined by Lender (in its sole discretion), measured (tested) on an annual basis commencing on December 31, 2023, using the results of the twelve-month reporting period(s) shown on the particular Financial Deliverable(s).

2. Maximum annual debt to tangible net worth

   Borrower shall maintain as of each measurement date a debt to Tangible Net Worth (as hereinafter defined) ratio of less than 2.Sto 1.0, defined as the ratio of the following items of Borrower: total liabilities as shown on the applicable Financial Deliverables less Fully Subordinated Debt (as hereinafter defined) to Tangible Net Worth. As used herein, the term "*Tangible Net Worth*" shall mean (a) total assets, (b) minus intangible assets, (c) minus due from related parties, (d) minus total liabilities, and (e) plus Fully Subordinated Debt (in each case as such items are shown on the applicable Financial Deliverables). For these purposes, the term "*Fully Subordinated Debt*" shall mean that no payments of any kind on the subordinated debt may be made without Lender's express prior written consent, regardless of whether an event of default has been declared under the indebtedness to Lender. Compliance with this covenant shall be determined by Lender (in its sole discretion), measured (tested) on an annual basis commencing on December 31, 2023, using the results of the twelve-month reporting period(s) shown on the particular Financial Deliverable(s).

Subject to credit approval

Financial Reporting Requirements:

1. Annual reviewed financial statements and debt schedule.

Loan Documentation Fees:

1. All Documentation to be prepared by outside legal counsel appointed by Fulton Bank, N.A.
2. In addition, borrower to pay for fees incurred or imposed by the Bank for preparing or modifying loan documents drafted by counsel for the Bank.

Additional Items:

1. Borrower to establish and maintain full deposit, treasury and merchant relationship with the Bank.
2. Fire/hazard/liability insurance naming the Bank as mortgagee/lender loss payee/additional insured as required by the Bank

3. Loan payment to be automatically debited from an account with Fulton Bank
4. All third-party fees to be paid by borrower

EXHIBIT 21

INDEPENDENT CONTRACTOR AGREEMENT

THIS INDEPENDENT CONTRACTOR AGREEMENT (the "Agreement") is entered into as of March 20, 2023, by and between *Hope Health Systems, Inc.*, (the "Company") and Scott Migdole, located at 131 Grove Beach Road South, Westbrook, CT ("Contractor").

WITNESSETH

WHEREAS, the Company wishes to engage Contractor on a non-exclusive basis to provide the services described herein; and

WHEREAS, Contractor has agreed to provide such services to the Company on the terms and conditions set forth below.

NOW, THEREFORE, the parties hereto, intending to be legally bound hereby, and in consideration of the mutual covenants and promises contained herein agree as follows:

1. Consulting Engagement and Services. The Company hereby engages Contractor as an independent contractor to provide consulting services (the "Services").

2. Term. The term of this Agreement (the "Term") will commence on March 20, 2023, and automatically renew on January 1 of each proceeding year unless earlier terminated in accordance with Section 6.

3. Fees and Expenses. During the Term, as a consulting fee for all Services to be performed by Contractor hereunder, the Company will pay Contractor $275/hour for clinician services (e.g., LCSW/RN/Ph.D., other non-physicians) or $350/hour for psychiatrist (e.g., DO/MD) services or fixed project price as agreed upon by both parties. Invoices for Services rendered are payable within thirty (30) days from the date of receipt of the relevant and properly prepared invoice.

4. Relationship of the Parties.

a. It is understood and agreed that in performing Services pursuant to this Agreement, Contractor will be an independent contractor, and this Agreement is not, under any circumstances, to be construed as creating any joint venture, partnership, employment or agency relationship between Contractor and the Company or of the Company's affiliates. Contractor will not be an employee of the Company or its affiliates or be entitled to any rights or benefits to which employees of the Company or its affiliates are entitled. Employees and/or agents of Contractor similarly are not entitled to any Company employment rights or benefits.

b. Contractor will be solely responsible for the performance of Contractor's Services and, subject to Section 1, will have sole discretion and control of Contractor's work and the manner in which it is performed. Contractor agrees to perform

at the highest professional level of independent contractors or consultants performing like services in the same or similar areas.

c. Due to the need to ensure that deliverables comport to applicable requirements, Contractor agrees that there shall be no subcontracting to or by any third party regarding any Services without the express prior written approval of the Company. *Proposed subcontractors are attached herein as Exhibit A to this contract.*

d. Contractor has no authority to make and will not make any agreements on behalf of the Company, nor will Contractor make any agreements rendering or purporting to make the Company liable for the payment and/or repayment of expenses or any other sums, except as specifically set forth in this Agreement. Contractor has no authority to commit the Company to provide services to any client or prospective client without first obtaining the Company's written authorization.

5. Confidential Information:

a. Upon the Company's written request at any time, and at the end of the Term, Contractor promptly will return to the Company: (i) any originals and all copies of all files, notes, documents, slides (including transparencies), computer disks, printouts, reports, lists of the Company's clients or leads or referrals to prospective clients, and other media or property in the Contractor's possession or control which contain or pertain to Confidential Information or trade secrets; and (ii) all property of the Company, including, without limitation, supplies, keys, access devices, books, identification cards, computers, telephones and other equipment. Contractor agrees that upon completion of the obligations set forth in this subparagraph, and if requested by the Company, Contractor will execute a statement declaring that he or she has retained no property of the Company or materials containing Confidential Information or trade secrets, nor has he or she supplied the same to any person, except as required to carry out his or her duties. A receipt signed by an Officer of the Company itemizing the returned property is necessary to demonstrate that Contractor has returned such property to the Company. These confidentiality provisions will survive the end of the Term.

b. Contractor acknowledges and agrees that Contractor is not authorized to access and use the Company's computer systems and protected computers, including laptop computers and Company PDAs, and the data contained therein, for personal gain or to benefit third parties (other than in the course of Contractor's performance of Services for the Company or as expressly and specifically authorized by the Company) and that any such access or use is unauthorized and may be punishable by law as well as constituting a breach of this Agreement.

6. Termination. This Agreement will terminate in the event of the death or total disability of Contractor. It is further understood that the Company shall have the right to terminate this Agreement for convenience upon fifteen (15) days' prior written notice to Contractor, and Contractor shall have the right to terminate this Agreement upon fifteen (15) days' prior written notice to the Company. The Company may

terminate this Agreement without notice if Contractor is deemed to have engaged in misconduct, unethical behavior, or actions that disrupt or are inappropriate in the workplace, or if Contractor fails to perform the Services. In the event of any such termination, Contractor will be entitled to payment for services rendered prior to the effective date of termination, it being agreed that such payment will constitute full settlement of any and all claims of Contractor of every description.

7. Notices.

All notices required or permitted under this Agreement will be validly given only if in writing and will be deemed to have been given only if personally delivered or mailed by first class registered or certified mail, return receipt requested, addressed to the parties at their respective addresses set forth below, as follows:

If to Contractor:

Scott Migdole
131 Grove Beach Road South
Westbrook, CT 06498

If to the Company:

Aastha Vashist, MS. HCM, MPH
Data analyst/Contract Specialist
Hope Health Systems, Inc.
1726 Whitehead Rd.
Woodlawn, MD 21207

8. Entire Agreement. Contractor acknowledges that he or she has not relied on any representations or statements, whether oral or written, regarding the provision of the Services to the Company, other than as contained in this Agreement. Contractor warrants that no promise or inducement has been offered or made except as herein set forth and that the consideration stated herein is the sole consideration for this Agreement. Except as otherwise specifically set forth herein, this Agreement sets forth the entire agreement between Contractor and the Company, and supersedes any and all prior agreements and undertakings, both written and oral, with respect to the subject matter hereof. This Agreement may not be changed orally, and no modification, amendment or waiver of any of the provisions contained in this Agreement, nor any future representation, promise or condition in connection with the subject matter hereof, shall be binding upon any party unless made in writing and signed by such party. If any provision of this Agreement is rendered invalid or unenforceable by judicial, legislative or administrative action, the remaining provisions hereof shall remain in full force and effect and shall in no way be affected, impaired or invalidated. The parties expressly agree and authorize that if any provision of this Agreement is rendered invalid or unenforceable, such provision shall be construed as rewritten to the extent necessary to

comply with existing law and to enforce this Agreement as modified to the maximum extent permitted by law.

9. Severability. In the event any provision of this Agreement is held to be void, voidable, unlawful or for any reason unenforceable in whole or in part, such provision will be deemed to be severed or limited, but only to the extent required to render the remaining provisions and portions of this Agreement enforceable and such remaining provisions and portions will remain in full force and effect. If any provision is held invalid or unenforceable with respect to particular circumstances, it nevertheless will remain in full force and effect in all other circumstances. The unenforceability or invalidity of a provision of this Agreement in one jurisdiction will not invalidate or render that provision unenforceable in any other jurisdiction. The parties expressly authorize a court or arbitrator to modify any term or provision of this Agreement to the extent necessary to comply with existing law and to enforce this Agreement as modified to the maximum extent permitted by law.

10. Assignability. This Agreement is binding upon and shall inure to the benefit of the parties hereto. The Company may assign or delegate its powers, duties, and responsibilities hereunder to its successors or to any company controlled by, controlling, or under common control with the Company. Performance by such company shall then be deemed performance by the Company. Neither this Agreement, nor any of the obligations or benefits provided hereunder, may be assigned by Contractor.

11. Counterparts. This Agreement may be executed in several counterparts, each of which shall be deemed an original, and all of said counterparts together shall constitute but one and the same instrument. Facsimile or .pdf versions of the original shall be accepted and enforceable as if they were original.

[Signature Page to Follow]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

By : _____

Printed Name: Yinka Ladapo

Title: Program Director

CONTRACTOR:

_____

Printed Name: Scott Migdole

Exhibit A-Subcontractors (resumes attached)

A. *Scott Migdole, MSW, LICSW, ACSW*

Mr. Migdole would serve as the Project Lead/Manager for this contract. As such he is responsible for all aspects of project management and ensuring contractual standards are met. He is the Chief Operating Officer of Yale Behavioral Health and the Yale Program on Supervision and holds an appointment as Assistant Clinical Professor in the Department of Psychiatry of the Yale School of Medicine. As a turnaround specialist, Mr. Migdole has extensive experience in consulting/managing agencies under Consent Order and was the interim CEO of Crossroads, a 155-bed addiction treatment center, and interim CEO for Dixwell-Newhaville, a community-based mental health clinic serving an African American population. He also worked with St. Elizabeth's Hospital in Washington, DC which was under an Olmstead Consent Order administered by the United States Department of Justice. He provides organizational consultation, including to the Albert J. Solnit Children's Center, a state-administered psychiatric facility for Connecticut's children who are under the age of eighteen. He is a highly sought-after expert in adult and adolescent behavioral health, serving as an expert witness in hospital and juvenile justice malpractice cases. He serves on the editorial board of the journal *Clinical Supervisor*, has authored numerous peer-reviewed publications, and has provided extensive training and organizational consultation across the nation.

B. *Mary Thornton, RN, MBA*

Ms. Thornton is a nationally recognized consultant in the areas of corporate compliance, medical necessity, HIPAA, billing/revenue management and hospital administrative practices. She is the author of the best-selling book "Ahead of the Game: Compliance Strategies for the Behavioral Healthcare Industry" and edited a newsletter called "Compliance Watch." She has extensive experience in working with hospitals under Consent Order, including St. Elizabeth's Hospital in Washington, DC which was under an Olmstead Consent Order administered by the United States Department of Justice. She also acted as Project Manager for a hospital in a large west coast city that had failed 3 consecutive state audits and developed and implemented a plan for remediation that resulted in a 100% error free audit last year. Ms. Thornton has worked on a number of smaller projects designed to help providers devise relevant and robust compliance programs to ensure patient safety, high quality, and safe revenue.

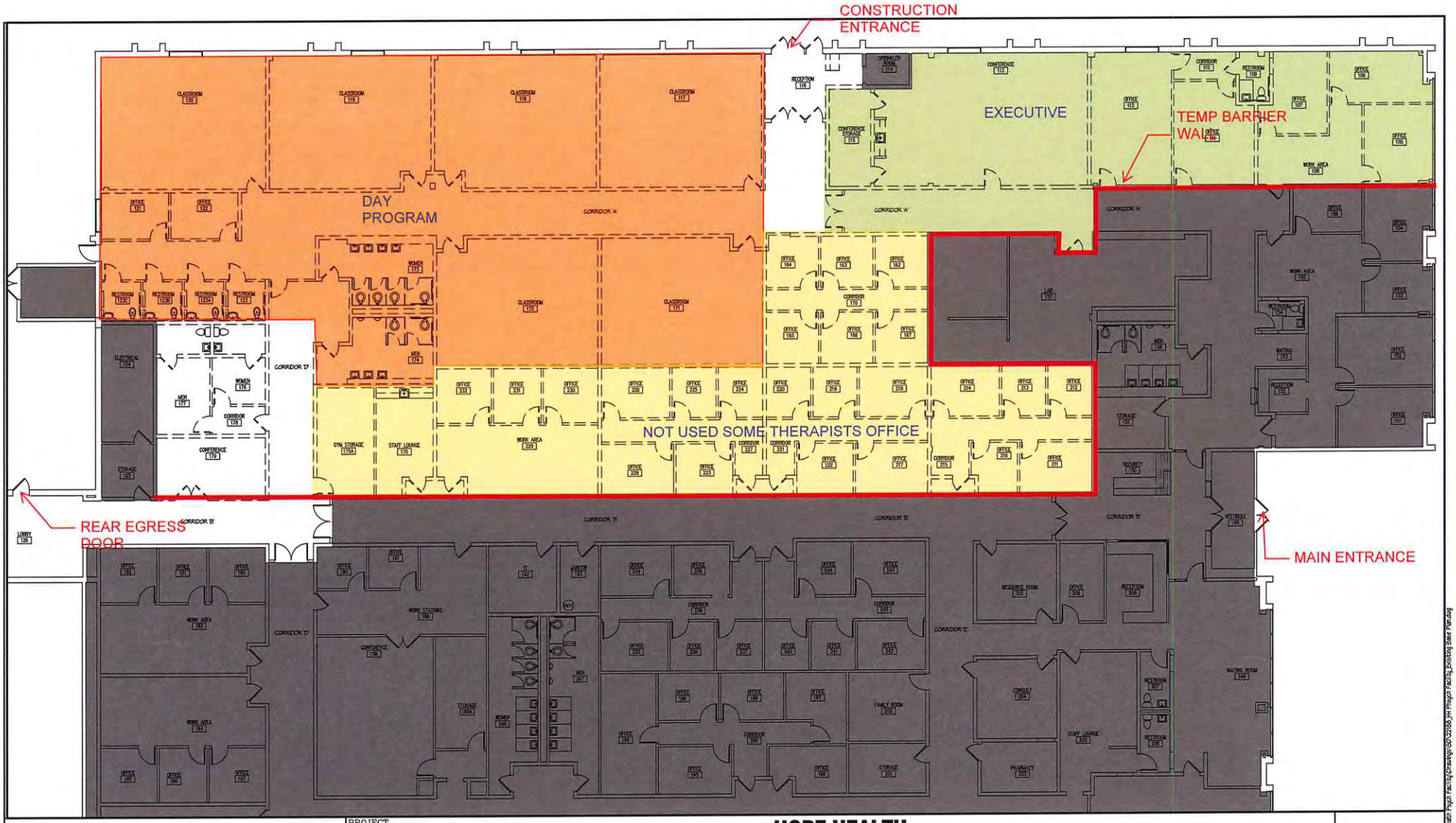
C. *Lesa Yawn, Ph.D., JD*

Dr. Yawn is dually degreed in psychology and as an attorney. She has served on the Joint Commission Technical Professional Advisory Committee (PTAC) on Behavioral Healthcare, CARF Board of Trustees and the COA Standards Advisory Committee. Dr. Yawn also has extensive clinical expertise having been the Director of Professional Services, Director of Women's Clinical Services, and the Director of Children and Adolescents Clinical Services for HCA Peninsula Hospital in Hampton, Virginia. Additionally, Dr. Yawn has significant experience in managed care, including serving in the role of Vice President for Medicaid Implementation, Executive Director for Clinical Operations, and Vice President for Quality Performance and Outcomes Research for a national managed behavioral healthcare company. Finally, Dr. Yawn has worked with hospitals under Consent Order, including in Washington, DC with St. Elizabeth's Hospital who was under a Consent Order through the Department of Justice.

D. *Colette Poole-Boykin, MD*

Dr. Poole-Boykin is a child/adolescent psychiatrist with expertise extending to autism spectrum disorders. She completed a military residency in adult psychiatry in San Antonio, TX and served as a physician in the United States Air Force. Dr. Poole-Boykin then completed a fellowship in Child and Adolescent Psychiatry at Yale Child Study Center. In 2019, she published a paper entitled "The case of the red herring: toddler with rare genetic disorder and delirium." Dr. Poole is an ABC news contributor and a Yale clinical faculty member.

EXHIBIT 22



HD2 ARCHITECTURE + DESIGN
516 N Charles Street
Suite 500
Baltimore, MD 21201
410.752.2700
hd2design.com

PROJECT TITLE:

HOPE HEALTH
PSYCHIATRIC FACILTITY
1726 WHITEHEAD RD
WOODLAWN, MD 21208

SHT. TITLE: **DEMOLITION FLOOR PLAN**

DATE: 03/13/2023 | SCALE: 1/16" = 1'-0" | PROJ. #: 22188

SK-0

EXHIBIT 23

FIRST AMENDMENT TO LEASE

THIS AMENDMENT TO LEASE AGREEMENT (this "Amendment") is made as of the ____day of May, 2023 (the "Effective Date"), by and between HOPE HEALTH PROPERTIES, LLC, a Maryland limited liability company ("Landlord"), and HOPE HEALTH SYSTEMS, INC, ("Tenant"). Landlord and Tenant are referred to from time to time herein as the "Parties".

RECITALS

WHEREAS, Landlord and Tenant are parties to that certain Lease made as of the 1st day of October, 2023 (as so amended by this First Amendment, the "Lease") pursuant to which Landlord leased the Premises to Tenant;

WHEREAS, the Parties desire to amend the Lease to address certain post-termination issues and amend other terms of the Lease.

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are acknowledged, the Parties agree as follows:

AGREEMENT

1. Recitals; Defined Terms. The Parties acknowledge the accuracy of the foregoing recitals. Any capitalized terms not defined herein shall have the meanings given in the Lease.

2. Paragraph 6. LANDLORD ACCESS Paragraph 6 shall be amended as follows:

a) *Access*. Landlord and its agents, employees, invitees, and contractors may enter the Property and Premises at all normal business hours to inspect the same and confirm that Tenant is complying with all its obligations hereunder, to make repairs to the same, or for any other reason, in Landlord's commercially reasonable judgment. Landlord shall (except in the event of any emergency or if Landlord's presence is requested by Tenant) provide Tenant with a minimum of twenty-four (24) hours' prior written notice of such access and, during access, to minimize any interference with Tenant's business operations.

b) *HIPPA and Privacy*. Landlord acknowledges that Tenant is subject to: (i) the provisions of the Health Insurance Portability and Accountability Act of 1997 and related regulations ("HIPAA"); (ii) similar state laws regarding the confidentiality of patient information; and (iii) may be or become subject to other state or federal privacy or confidentiality laws or regulations imposed upon providers of health care services (collectively, with HIPAA, "Confidentiality Requirements"), and that the Confidentiality Requirements require Tenant to ensure the safety and confidentiality of patient medical records. Landlord further acknowledges that, in order for Tenant to comply with the Confidentiality Requirements, Tenant must restrict access or require access accompanied by an authorized representative of Tenant to the portions of the Premises where patient medical records are kept or stored. Landlord hereby agrees, that notwithstanding the rights granted to Landlord pursuant to this Lease,

except for an emergency entry into the Premises taken pursuant to this Lease or when accompanied by an authorized representative of Tenant, neither Landlord, nor its employees, agents, representatives or contractors shall be permitted to enter those areas of the Premises designated by Tenant as locations where patient medical records are kept or stored or such other areas required to be secured by Confidentiality Requirements or other applicable law and identified as such to Landlord. Tenant agrees to reasonably safeguard any protected health information from any intentional or unintentional disclosure in violation of the Confidentiality Requirements by implementing appropriate administrative, technical, and physical safeguards to protect the privacy of such protected health information. The parties agree that neither the Landlord nor its contractors, subcontractors or agents shall need access to, nor shall they use or disclose, any protected health information of Tenant. The parties agree that the foregoing does not create and is not intended to create a "business associate" relationship between the parties. Landlord further agrees that notwithstanding any other provision of this Lease to the contrary, in exercising any remedies under this Lease or in entering the Premises at any time, whether due to an event of default or inspection, maintenance and repair, Landlord may not enter an examination room or other area of the Premises occupied by Tenant's patients at the time of the inspection or Tenant's file room(s) containing patient medical records unless Landlord is accompanied and supervised by an authorized representative of Tenant, except in the event of an emergency, in which event Landlord shall use diligent efforts to comply with the terms herein given the circumstances that exist at the time. Tenant hereby assumes full responsibility and liability to remove all patient medical records upon the surrender of the Premises and in no event shall Landlord have any liability in connection therewith.

3. Paragraph 21. LANDLORD'S REMEDIES UPON DEFAULT Following the last paragraph of Paragraph 21 of the Lease, the Lease shall be amended to add the following:

Notwithstanding anything herein to the contrary, Landlord's rights and remedies with respect to a Default under the lease or otherwise are subject to: (i) the rights of any patients of Tenant and any Sublessees who are not Affiliates of Tenant; and (ii) compliance with any and all laws, rules, regulations, and orders of the Federal, State, or local authorities relating to the wind-down and closure of a psychiatric hospital.

4. Exhibit B: Within the text following the Exhibit B heading, the Lease shall be amended to add the following:

Landlord shall perform all work as directed by the Tenant to render the Premises in the condition so that upon installation of Tenant's personal property the Premises shall be suitable for the opening and operation of Tenant's Psychiatric Hospital; provided that (i) the Tenant shall furnish the landlord with detailed, permit ready drawings and specifications for all work to be performed by Landlord; and (ii) the Landlord shall not be required to expend more than Five-Million Dollars ($5,000,000) to complete the work requested by the Tenant and the Landlord shall have no responsibility for any deficiencies, errors or omissions in the drawings and specifications furnished by the Tenant.

5. Counterparts. This Amendment may be executed in separate and multiple counterparts, each of which shall be deemed an original but all of which taken together shall be deemed to constitute one and the same instrument. This Amendment may be executed and delivered by facsimile or other electronic transmission (including .pdf or any electronic signature complying with the U.S. federal ESIGN Act of 2000, e.g., www.docusign.com) and such delivery will have the same force and effect as any other delivery of a manually signed copy of this Agreement.

[Signature page follows]

The Parties have caused this Amendment to be duly executed as of the date first above written.

LANDLORD:

HOPE HEALTH PROPERTIES, LLC,
a Maryland limited liability company

By: _____

Title: Owner

TENANT:

HOPE HEALTH SYSTEMS, INC.
a Maryland corporation

By: _____

Title: Executive Program Director

EXHIBIT 24

Patient Financial Services – Hospital Statement of Charges, Financial Assistance, Charity Care, Billing & Collection Policies

SCOPE: Hope Health Systems, Inc.

PURPOSE: To secure fair treatment and access to all medically necessary services for individuals regardless of their ability to pay. To provide a method of documenting uncompensated care for applicants. To ensure the patient responsibilities are clearly communicated through effective and consistent means. To foster an efficient channel to resolve questions regarding charges, insurance benefit, and collections. To make certain the hospital meets the requirements of Maryland standards for hospital billing and collection practices.

POLICY STATEMENTS & PROCEDURES:

Patient Statement of Charges

- A summary bill of charges will be mailed to each inpatient within 15 days of discharge from the hospital, which will contain information on the insurance company billed and contact information for the HHS Billing Department for further questions or assistance with the HSCRC required patient billing information included on the bill.
- A patient may request a copy of their itemized bill at any time and any requests or inquiries on specific charges, services, or procedures will be directed to the HHS Billing Department or specific department within HHS. The Billing Department will communicate with the patient to provide a thorough explanation of services using CPT codes, service descriptions, the hospital charge master, and reviews of similar procedures when applicable.
- A representation of services and charges is available to the public upon request and every effort will be made to respond to patient requests in a timely manner depending on the information needed to sufficiently answer an inquiry or further research a charge.
- HHS will inform patients of cost estimates upon request and the patient will also be informed that cost quotes and/or estimates can vary depending on the circumstances of the procedure(s) performed, supplies used, staff required, hospital stay, and other relevant charges.
- A representative list of services and charges is available to the public on the hospital's website and in written form. The website will be updated quarterly with the most recent average charge per case for each of the services.
- Requests and inquires for current charges for specific procedures/services will be directed to the HHS Financial Representative. The Representative will communicate with the patient and the patient's provider of care to provide the best possible estimate. Every effort will be made to respond to the request for charges within 2 business days depending on information needed to fulfill the patient's request.
- The HHS Financial Representative and supporting staff will be trained regarding HHS's procedures for inquiries related to patient charges and the applicable State and Federal regulatory requirements.

Collection Agencies

- If no attempt is made from a patient or a patient representative regarding their inability to pay or attempt to make reasonable payment arrangements, the account will be referred to a third-party collection agency.
- An account will be referred to a collection agency if a patient has not responded to the hospital's attempt to collect on the debt within 90 – 110 days from the first attempt of the hospital without any patient contact.
- The Director of the Billing Department oversees the hospital's business relationship with the collection agency and will be responsible for the Billing Department's review of each case before being referred for legal action.
- HHS does not utilize a credit reporting bureau.
- HHS does not charge interest to patients past due medical bills and the collection agency will establish a payment arrangement with an individual in accordance with HHS's interest free commitment.
- The collection agency will perform an individual financial checkpoint before taking the next step to pursue legal action on past due medical debts.
- The collection agency shall have instructions for referrals for financial counseling when applicable to individuals who have expressed an inability to pay medical debts.
- When applicable, HHS will file suit against an individual, an estate, or a trust fund for collection of past due medical debts. If a court were to make a judgement in favor of the hospital, a formal legal credit mark, a judgement, will be placed on an individual's credit and remain on the credit for a span of ten years. When a full payment is made, the patient may request the judgement to reflect as satisfied on their credit rating.
- HHS does not actively enforce liens against an individual's primary home.

Financial Assistance Communications

- Financial Assistance Signage is conspicuously displayed in English and Spanish throughout the hospital.
- Financial Assistance information is available in English and Spanish at patient entry points and within inpatient rooms.
- Staff receive training on the protocols for patient referrals if financial assistance is needed, including training on how to successfully complete the financial assistance application or provide other resources to patients in need of financial assistance.

Charity Care Program

- HHS is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a state of federal government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.
- HHS will post notices of the availability of charity care within the hospital and notices will be sent to patients with outstanding patient medical bills.
- Patient billing and financial assistance information sheets will be available for patients within the facility and also provided to patients before discharge and/or upon a patient's request for financial assistance.

- Charity care and financial assistance can be extended to patients after a review of the patient's individual financial circumstances. The review of an individual's financial circumstance includes existing medical expenses and obligations but excludes any debts that have subject to ongoing litigation or have received a judgement. Applications for financial assistance may be offered to patients whose accounts have been sent to a collection agency but may only apply to those accounts on which a judgement has not been granted.
- HHS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay.

Determination of Charity Care Eligibility

- Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.
- HHS provides 100% charity to individuals with household income at or below 200% of the US Poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- HHS provides 100% charity to individuals enrolled in the Medicaid program and other means tested State & Local programs. Patients who provide proof of enrollment in one of these programs do not have to complete an application or submit supporting documentation of income to be approved for financial assistance.
- HHS provides a sliding fee scale for individuals with household income at or below 330% of the US poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- HHS provides financial assistance not only to the uninsured but to patients with a demonstrated inability to pay their deductibles, copayments and balance after insurance.
- The hospital excludes assets such as the patient's primary home, method of transportation and cash assets less than $15,000.
- For all income levels, HHS will take into account special circumstances such as the amount of the bill compared to income and cumulative impact of all medical bills.

Exclusions to Coverage of Charity Care

- Services provide by providers who are not affiliated with HHS such as durable medical equipment providers or home health care providers.
- Insurance programs or policy denials for coverage of specific services for which the payment seeks charity care and/or financial assistance.
- Unpaid balances resulting from cosmetic, elective, or other non-medically necessary services.
- Convenience items a patient requested and/or received.
- Patient meals and lodging outside of the facility.
- Physician charges related to the date of services that are otherwise excluded from the charity care policy.

Patient Ineligibility to Charity Care

- Inadequate, incomplete, or refusal to provide requested documentation.

- Insurance coverage through HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that restrict, limit, and/or deny access to the HHS Charity Care program.
- Failure to pay co-payments as required by HHS.
- Failure to keep current on existing payment arrangements with HHS.
- Failure to make appropriate arrangements on past payment obligations owed to HHS, including those patients who were referred to an outside collection agency for a previous debt.
- Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
- Refusal to divulge information pertaining to a pending legal liability claim
- Foreign-nationals traveling to the United States seeking elective, non-emergent medical care
- Patients who have been determined to have the financial capacity to purchase health care insurance or other health care services or patients who otherwise qualify for COBRA health care coverage.

Sliding Fee Scale

	Financial Assistance Level Free / Reduced-Cost Care	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Hospital-Based Physician Practices, and Non-HSCRC Regulated Services**
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 330%	20%	40%
more than 330%	no financial assistance	no financial assistance

Presumptive Eligibility

Patients already enrolled in certain means-tested programs are deemed eligible for Free / Reduced Care on a presumptive basis. Examples of such means-tested programs include but are not limited to:

- Federal Supplemental Nutrition Assistance Program (SNAP);
- Maryland Temporary Cash Assistance (TCA);
- All Dual eligible Medicare / Medicaid Program – SLMB QMB;
- All documented Medicaid Spend Down amounts as documented by Department of Social Services;
- Patients living in a household with children enrolled in the free or reduced-cost meal program;

- State's Energy Assistance Program;
- Federal Special Supplemental Food Program for Women, Infants, and Children (WIC);
- Patients receiving benefits from any other social service program as determined by the Department and the Commission; and
- Out of State Medicaid Programs.

HHS will continually evaluate any publicly-funded programs for eligibility under the Presumptive Eligibility provision of this policy.

Additional presumptively eligible categories will include with minimal documentation:

- Homeless patients as documented during the registration/clinical intake interview processes.
- Deceased patients with no known estate based on medical record documentation, death certificate, and confirmation with Registrar of Wills.

Patients found to be eligible for Presumptive Eligibility are automatically waived from Program Exclusions as defined in the Exclusion section of this policy.

EXHIBIT 25

A Real Estate Cost Report

Marshall Valuation Cost Analysis
Hope Health Psychiatric Facility

Located at
1726 Whitehead Road, Woodlawn, Maryland 21208

Prepared for
Yinka Fadiora, MHS, M Ed., CCHP
Executive Program Director
Hope Health Systems, Inc.
1726 Whitehead Road
Woodlawn, Maryland 21208

Prepared by
Treffer Appraisal Group
1244 Ritchie Highway, Suite 19
Arnold, Maryland 21012
(410) 544-7744

Effective Date
Effective March 1, 2023

File Number:TW201015

Treffer | Appraisal Group
The value of experience.

April 27, 2023

Yinka Fadiora, MHS, M Ed., CCHP
Executive Program Director
Hope Health Systems, Inc.
1726 Whitehead Road
Woodlawn, Maryland 21208

Re: Marshall Valuation Cost Analysis
Hope Health Psychiatric Facility
1726 Whitehead Road, Woodlawn, Maryland 21208

Dear Mr. Fadiora:

In accordance with your assignment request I have prepared this Marshall Valuation Cost Analysis for the property referenced above. The subject of this assignment (subject property) is currently operating as a psychiatric training and treatment center for youth. Currently the center provides day programs and services only. The center has plans for expanding the scope of their services to include overnight and short term stays. The purpose of this Cost Analysis is to compare the proposed conversion and construction costs to the Marshall Valuation benchmark to provide support that the actual proposed cost for converting a portion of the building to convalescent care is reasonable and consistent with the current industry cost experience in Maryland.

The costs rates included in this report relate to the proposed conversion of a portion of the existing building. The cost amounts presented do not represent the replacement costs for constructing an entirely new structure. The following report presents engineering cost estimates for the proposed work of converting approximately 23% of the existing building to a sixteen bed facility. The analysis compares the engineering cost estimate to the replacement cost new for the equivalent building components found in the Marshall Valuation publication.

State of Maryland guidelines stipulate that the proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The scope of this assignment includes comparing the current construction estimate on a projected cost per square foot is to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service guide. The based cost quoted by Marshall Valuation is adjusted by current cost and location multipliers.

The base rate for Good quality Class A General Hospitals in the Marshall Valuation guide is $485.00 per square foot. The total cost for the proposed sixteen bed facility at Hope Health Psychiatric is $271.92 per square foot. The primary reason for the difference in the two cost rates is that the preliminary construction budget for the subject property is not for a ground up

Class A General Hospital building. The $271.92 per square foot cost total is for the conversion of space in an existing building. The core building components (concrete floors, masonry walls, and roof) of the 16 bed conversion already exist and are not components contractors quote. Also, the level of interior building improvements is suited for the impatient care of psychiatric patients. The proposed conversion of the subject property is not designed to provide surgical or ambulatory care or treatment. Therefore, the cost proposed for the subject property is less than the costs for general hospital construction. Based on Marshall Valuation definitions, a closer match to the proposed subject improvements is a Convalescent Hospital. However, in accordance with COMAR guidance "a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service guide." Therefore, the cost analysis developed in this report is based on a comparison of the proposed subject costs to equivalent cost for an good quality Class A General Hospital.

If the projected cost per square foot exceeds the Marshall Valuation Service benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

I certify that to the best of my knowledge the facts and data contained herein are correct, and that I have no present or contemplated future interest in the property beyond this estimate of value. This transmittal letter and executive summary do not constitute an appraisal report. If this letter or summary is disjoined from the attached appraisal report, then the indicated value opinions become invalid and may not be relied on because they cannot be properly understood apart from the analyses, opinions, and conclusions contained in the accompanying cost analysis.

As a result of my valuation procedures, it is opinion that the proposed Preliminary Construction Budget for the subject property approximates the benchmark cost compiled by the Marshal Valuation Service in total and on a square foot basis effective March 1, 2023:

Respectfully submitted,

Thomas A. Weigand, MAI, SRA
Certified General Appraiser
Maryland License #04-27637
Expiration: December 27, 2025

Certification Statement

I certify that, to the best of my knowledge and belief:

- The statements of fact contained in this report are true and correct.
- The reported analyses, opinions and conclusions are limited only by the reported assumptions and limiting conditions, and reflects my personal, impartial, and unbiased professional analyses, opinions and conclusions.
- I have no present or prospective interest in the property that is the subject of this report and have no personal interest with respect to the parties involved.
- I have performed prior benchmark cost analysis, as an appraiser regarding the property that is the subject of this report within the three-year period immediately preceding acceptance of this assignment.
- I have no bias with respect to the property that is the subject of this report, or to the parties involved with this assignment.
- My engagement in this assignment was not contingent upon developing or reporting predetermined results.
- The compensation for completing this assignment is not contingent upon the development or reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value estimate, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of this appraisal.
- My analyses, opinions, and conclusions were developed, and this report has been prepared, in conformity with the Uniform Standards of Professional Appraisal Practice.
- Thomas A. Weigand, MAI, SRA has made an exterior inspection of the subject property of this report.
- No one provided significant real property appraisal or cost analysis assistance to the person signing this certification.
- The reported analyses, opinions, and conclusions were developed, and this report has been prepared, in conformity with the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute.
- The use of this report is subject to the requirements of the Appraisal Institute relating to review by its duly authorized representatives.
- As of the date of this report, Thomas A. Weigand, MAI has completed the Standards and Ethics Education Requirements for Designated Members of the Appraisal Institute.

Thomas A. Weigand, MAI, SRA
Certified General Appraiser
Maryland License #04-27637
Expiration: December 27, 2025

Date: April 27, 2023

Subject Property Photographs

North Elevation Proposed Entrance

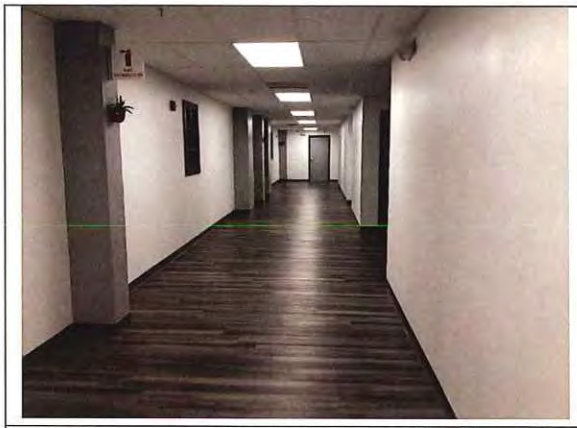
West Elevation

West Elevation

East Elevation and Parking

Current Front Entrance

East Elevation and Parking



Representative Interior Finishes

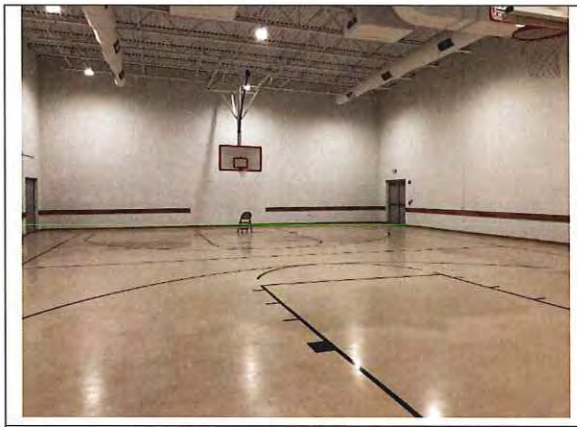
Fully Sprinklered

Common Area Bathroom

Representative Training Room

Representative Interior Finishes

Upgraded Electric



Gymnasium Not Part of Building Conversion

Area to be Converted to Hospital

Area to be Converted to Hospital

Area to be Converted to Hospital

Area to be Converted to Hospital

Administrative Offices

Cost Analysis

The following pages compare the subject's specific project cost estimate with the corresponding costs cited in the Marshall Valuation benchmark. The cost rates included in this report relate to the proposed conversion of a portion of the existing building. The amounts presented do not represent the replacement cost for the entire structure. The following report presents engineering cost estimates for the proposed work of converting approximately 23% of the existing building to a sixteen bed facility. The analysis compares the engineering cost estimate to the replacement cost (new) for the equivalent building components found in the Marshall Valuation publication. Based on my physical examination of the subject property, review of the propose building floor plan, and interview with the property representatives I have classified the proposed project in the following manner within the Marshall Valuation Service cost guide.

Cost Source:	Marshall Valuation		
Section:	#15: Offices, Medical and Public Buildings		
Class:	Class A General Hospital - Good		
Gross Building Area:	15,674.0		
No. of Stories Multiplier:	1.000	**Local Multiplier:**	1.010
Height/Story Multiplier:	1.000	**Current Cost Multiplier:**	1.220
Perimeter Multiplier:	1.000	**Combined Multipliers:**	**1.230**

At this stage of the proposed building conversion a specific construction quote has been prepared by Costcon Construction Services. The quote is dated January 24, 2023 and a copy is included in the report Addendum. The construction cost estimates are presented in the table below under the columns labeled "Costcon Construction Budget". The preliminary budget amounts are compared and contrasted with the adjacent columns labeled "Costs from Marshall Valuation". The cost estimates are presented along with the related "Cost Surplus Deficit" column.

New Construction versus Remodel and Retro Fit: All costs in the Marshall valuation manual are based on new construction. The costs include provisions for hard and soft costs including contractor fees, overhead and profit, sales taxes, permit fees, and insurance during construction. The proposed project for the subject property as a repurposing of existing space. Conversion of existing space is typically less efficient than new construction and can run 10 to 20 percent higher than comparable new construction costs because of burdens caused by limits on workspace, logistics, and items like temporary shoring. The Marshall Valuation costs have not been adjusted for any premium or additional burden caused by the nature of the renovation.

Project Description: The proposed project includes a redesign and installation of 15,674 square feet of building area to support a sixteen bed acute (psychiatric) hospital. In addition to the patient rooms the redesign includes an improved secured entrance, three nurses stations, a dining area, and several meeting and social rooms. The engineering estimate includes line items for mechanical and electrical work that may benefit the entire structure.

Cost Comparison Chart - Hope Health Facility - Summary Format

	Costcon Construction Budget			Costs From Marshall Valuation			
	Line Item Cost	Cost Per Unit	Quantity	Cost Per Unit	Project Size	Line Item Cost	Marshall Variance Over (Under)
General Conditions							
General Conditions are 10% of the cost of subcontracts	$313,942.06		10.00%				$313,942.06
Demolition	$220,291.59	$14.05	15,674.23	$23.20	15,674.23	$363,642.14	($143,350.55)
Concrete - (Patching and Repairs Only)	$15,674.23	$1.00	15,674.23				$15,674.23
Masonry - (Patching and Repairs Only)	$15,674.23	$1.00	15,674.23				$15,674.23
Metal							
Awning, overhang and signage at ambulance drop off	$22,500.00	$500.00	45.00				
Inserts and anchors	$7,837.12	$0.50	15,674.23				
Metal Total	$30,337.12			$305.00	45.00	$13,725.00	$16,612.12
Carpentry							
Install doors and frames	$28,700.00	$350.00	82.00				
Blocking and installation	$39,185.58	$2.50	15,674.23				
Wardrobes in resident rooms	$72,496.00	$800.00	90.62				
Nurse station	$15,480.00	$600.00	25.80				
Clean room base, solid surface countertop and wall cabnet	$8,302.50	$750.00	11.07				
Soiled work room base, solid surface countertop and wall cabnet	$5,782.50	$750.00	7.71				
Medical storage base, solid surface countertop and wall cabnet	$7,695.00	$750.00	10.26				
Security and recpetion work top and supports	$4,666.00	$200.00	23.33				
Staff and lounge base, solid surface countertop and wall cabnet	$6,802.50	$750.00	9.07				
Remove and replace all window sills	$6,303.05	$65.00	96.97				
Brochure rack in waiting area	$750.00	$750.00	1.00				
Other millwork	$15,674.23	$1.00	15,674.23				
Carpentry Total	$211,837.36			$38.00	15,674.23	$595,620.74	($383,783.39)
Moisture Protection							
Caulking and sealants	$1,567.42	$0.10	15,674.23				$1,567.42
Doors, Windows, and Glass							
Special access doors at residence rooms	$72,000.00	$4,500.00	16.00				
Special ani-ligature doors at residence rooms toilets	$48,000.00	$3,000.00	16.00				
SCW doors	$96,000.00	$2,000.00	48.00				
Storefront unit entry doors (pair)	$5,000.00	$5,000.00	1.00				
New doors at ambulance drop off	$7,500.00	$2,500.00	3.00				
Windows - remove and replace with insulated blind/impact	$66,045.00	$175.00	377.40				
Glazing	$15,674.23	$1.00	15,674.23				
	$310,219.23						$310,219.23
Finishes							
Partitions							
Interior partitions - average	$328,196.40	$14.00	23,442.60	$54.00	15,674.23	$846,408.42	($518,212.02)
Patching and repairs to existing	$23,511.35	$1.50	15,674.23				$23,511.35
Flooring							
Floor prep	$21,172.50	$1.50	14,115.00	$2.68	14,115.00	$37,828.20	($16,655.70)
Rubber sheet flooring	$20,889.70	$10.00	2,088.97	$14.55	2,088.97	$30,394.51	($9,504.81)
Poured epoxy flooring	$11,997.54	$18.00	666.53	$10.05	666.53	$6,698.63	$5,298.91
VCT	$18,691.56	$4.00	4,672.89	$6.01	4,672.89	$28,084.07	($9,392.51)
LVT	$46,529.82	$9.00	5,169.98	$11.90	5,169.98	$61,522.76	($14,992.94)
Carpet Tile	$4,050.00	$45.00	90.00	$13.70	90.00	$1,233.00	$2,817.00
Sheetgoods for comercial kitchen dining room	$6,005.76	$8.00	750.72	$11.90	750.72	$8,933.57	($2,927.81)
Ceramic Tile							
Ceramic tile floor	$3,805.28	$17.00	223.84	$29.50	223.84	$6,603.28	($2,798.00)
Ceramic tile walls	$17,136.00	$17.00	1,008.00	$29.50	1,008.00	$29,736.00	($12,600.00)
H/C transition	$400.00	$100.00	4.00	$0.00	4.00	$0.00	$400.00
Base							
Rubber sheet flooring - intregal bese	$11,172.00	$12.00	931.00	$14.55	931.00	$13,546.05	($2,374.05)
Poured epoxy flooring - intregal base	$5,316.00	$12.00	443.00	$10.05	443.00	$4,452.15	$863.85
VCT resilient cove base	$5,647.50	$3.75	1,506.00	$4.34	1,500.00	$6,536.04	($888.54)
H/C resilient cove base	$1,661.25	$3.75	443.00	$4.34	443.00	$1,922.62	($261.37)
Carpet tile resilient cove base	$813.75	$3.75	217.00	$4.34	217.00	$941.78	($128.03)
Sheetgoods for comercial kitchen dining room	$450.00	$3.75	120.00	$4.34	120.00	$520.80	($70.80)
Ceilings							
ACT and support grid	$102,197.52	$9.00	11,355.28	$21.70	11,355.28	$246,409.58	($144,212.06)
GWB ceiling	$21,314.80	$6.50	3,279.20	$3.84	3,279.20	$12,592.13	$8,722.67
Bulkhead allowance	$15,674.23	$1.00	15,674.23	$0.00	15,674.23	$0.00	$15,674.23
Painting							
Paint walls	$19,592.79	$1.25	15,674.23	$1.72	15,674.23	$26,959.68	($7,366.89)
Paint ceilings and bulkheads	$2,973.75	$1.25	2,379.00	$1.72	2,379.00	$4,091.88	($1,118.13)
Paint doors and frames	$12,300.00	$150.00	82.00	$92.00	82.00	$7,544.00	$4,756.00
Paint miscellaneous and touch up	$3,134.85	$0.20	15,674.23		15,674.23	$0.00	$3,134.85
Total Finishes	$704,634.34						

Specialties							
Interior signage	$11,755.67	$0.75	15,674.23	$0.00	15,674.23	$0.00	$11,755.67
Fire Extinguishers and Cabnets	$1,500.00	$500.00	3.00	$683.00	3.00	$2,049.00	($549.00)
Stainless mirrors above sinks	$3,000.00	$300.00	10.00	$248.00	10.00	$2,480.00	$520.00
Soap dispenser	$765.00	$85.00	9.00	$97.00	9.00	$873.00	($108.00)
H/C bars at toilets (set)	$1,000.00	$200.00	5.00	$191.00	5.00	$955.00	$45.00
Toilet roll dispenser	$425.00	$85.00	5.00	$127.00	5.00	$635.00	($210.00)
Paper towel/waste	$2,500.00	$500.00	5.00	$439.00	5.00	$2,195.00	$305.00
Mop rack and shelf	$350.00	$350.00	1.00	$250.00	1.00	$250.00	$100.00
TV brackets for video locations	$525.00	$175.00	3.00	$80.00	3.00	$240.00	$285.00
Accessories Residents							
Anti-ligature handrail in showers	$9,600.00	$600.00	16.00	$555.00	16.00	$8,880.00	$720.00
Anti-ligature toilet ADA bars-set	$9,600.00	$600.00	16.00	$555.00	16.00	$8,880.00	$720.00
Anti-ligature toilet roll dispenser	$4,000.00	$250.00	16.00	$127.00	16.00	$2,032.00	$1,968.00
Anti-ligature shower curtain rod	$3,200.00	$200.00	16.00	$237.00	16.00	$3,792.00	($592.00)
Stainless steel mirrors above sinks in resident rooms	$4,800.00	$300.00	16.00	$248.00	16.00	$3,968.00	$832.00
Fold down shower seat	$560.00	$35.00	16.00	$69.50	16.00	$1,112.00	($552.00)
Wall Protection							
Corner guards	$6,100.00	$100.00	61.00		61.00	$0.00	$6,100.00
Other wall protection	$2,500.00	$2,500.00	1.00		1.00	$0.00	$2,500.00
Total Specialties	**$62,180.67**						
Equipment - Appliance Allowance Staff Lounge	**$3,500.00**	$3,500.00	1.00		1.00	$0.00	$3,500.00
Special Construction							
Security and CCTV allowance	$47,022.69	$3.00	15,674.23	$1.00	15,674.23	$15,674.23	$31,348.46
Nurse call system	$31,348.46	$2.00	15,674.23	$2.00	15,674.23	$31,348.46	$0.00
Wonder Guard syatem allowance	$47,022.69	$3.00	15,674.23	$3.00	15,674.23	$47,022.69	$0.00
Total Special Construction	**$125,393.84**						
Mechanical							
HVAC	$705,340.35	$45.00	15,674.23	$52.50	15,674.23	$822,897.08	($117,556.73)
Plumbing	$219,439.22	$14.00	15,674.23	$59.50	15,674.23	$932,616.69	($713,177.47)
Total Mechanical	**$924,779.57**						
Electrical	**$501,575.36**	$32.00	15,674.23	$86.50	15,674.23	$1,355,820.90	($854,245.54)
Miscellaneous	**$11,755.67**	$0.75	15,674.23				$11,755.67
Subtotal Before Overhead and Profit	**$3,453,362.69**					$5,599,668.05	($2,146,305.36)
Adjusted for Current Cost Multiplier @ 1.22%	**$0.00**					$6,831,595.02	($1,231,926.97)
Baltimore Local Cost Multiplier @ 1.01%	**$0.00**					$6,899,910.97	($68,315.95)
Overhead & Profit @ 10%	**$345,336.27**	**$17.54**	19,688.50			$0.00	$345,336.27
Bond	**$75,973.98**					$75,973.98	
Design Contingency @10%	**$387,467.29**					$387,467.29	
Total Construction Budget	**$4,262,140.23**	**$271.92**	15,674.23	**$469.77**	15,674.23	$7,363,352.24	($3,101,212.02)

In accordance with the scope of this assignment, I have compared the construction cost estimates with cost data published by Marshall Valuation Service. The Marshall Valuation cost components are not an exact match but correlate closely with the cost categories on the estimate prepared by Costcon Construction Services.

In most cases when a range of rates was resented by Marshall, the midpoint of the range was selected for the cost comparison. In some cases, a precise line item match was not published in the Marshall guide. For example, the specialty items were not costed out, as a result the specialty items make up most of the difference between the preliminary cost estimate and the Marshall benchmark.

As shown in the overall quote, the quoted construction cost, including bonding, contingency, and overhead and profit total $4,262,140.22, or $271.92 per square foot. The compilation of the Marshall benchmark after adjusting for current and local cost multipliers total $7,363,352.84 or

$469.77 per square foot. This amount is $3,101,212.02 higher than the total construction costs submitted by Costcon Construction Services. Most of this difference (54%) is in the HVAC, Mechanical, and Plumbing areas. Much of the remaining difference is attributed to the savings related to conversion of existing space and core building components.

The Marshall Valuation Service (MVS) is a nationally recognized cost service and is also recognized within the region as a viable source for many types of commercial construction cost. MVS cost figures include various elements of project costs, including labor, materials, supervision, contractors' profit and overhead, architects' plans and specifications, engineering, permitting, grading, and legal fees.

For convalescent hospitals similar to the proposed renovation MVS also includes a typical cost range on a per bed basis. As a test of reasonableness, in the table below I have compared the constriction cost estimates with the per bed cost data published in the Marshall Valuation Service cost guide.

Total Construction Budget	$4,262,140.23
Number of Beds	16
Cost per Bed	$266,383.76
Class A and B General Hospital Buildings per MVS	
Section 15 Page 39	
Typical Cost Range per Bed	$418,000 - $1,477,000
Average Cost per Bed	$768,000

The specific project cost need the overall test of reasonableness. While the specific project costs are higher than the average cost per bed quoted for convalescent hospitals the estimate for the Hope Health facility is on the upper end of the range of typical costs per bed. In reviewing the subject property's type, construction class, construction type, and property specific buildouts, I have aligned it with the following MVS Cost section. The following applicable explanations are reproduced from the Marshall Valuation manual.

REPAIR AND REMODEL: All costs in this manual are based on new construction. Typical repair work will run 10% to 20% higher because of restricted area, movement of materials, temporary supports, shoring, etc., and other contingencies not encountered in new construction, excluding demolition and removal. For detailed costs we would recommend using our repair and claims products.

Contractors' overhead and profit, sales taxes, permit fees, and insurance during construction are included in the above costs. Interest on interim construction financing is also included, but not financing costs, real estate taxes, or brokers' commissions.

ASSEMBLY/SYSTEMS INTRODUCTION

The Segregated Cost Method is designed to enable the appraiser to give separate consideration to all of the major construction assemblies or systems (groups of components) of a building with a minimum of time-consuming counting and measuring, and to systematically arrive at a reliable replacement cost in a reasonably short time.

Use of this method does require a greater degree of understanding of both building construction techniques and the overall cost relationships between occupancies, classes and quality levels, as well as the basic differences resulting from quantity, material grade or workmanship affecting each component's rating range.

The costs of many parts of a building, such as floor, ceiling and lighting, change directly as the floor area of the building increases. Other building costs vary with relation to parameters other than floor area; however, most costs can be related to floor area, wall area, roof area or sometimes an individual count of unit installations. To facilitate the application of these individualized costs, they are grouped so that all costs related to floor area can be added together and applied to the total floor area. All wall area costs can be added together and applied to the wall area, and all roof costs applied to the ground floor or roofed area.

A breakdown of the components whose costs correspond to the major areas follows:

FLOOR AREA
Site Preparation Floor Cover Sprinklers

Foundation Ceiling Heating, Cooling and Ventilating

Frame Interior Construction Electrical

Floor Structure Plumbing

OUTSIDE WALL
Wall Wall Ornamentation Storefronts

ROOF
Roof Structure Roof Trusses Roof Cover

The Marshall Valuation cost components are not an exact match but correlate closely with the cost categories on the estimate prepared by Costcon Construction Services.

Cost Analysis Conclusion

As demonstrated in this cost analysis the project's cost in total and on a square foot basis approximates the Marshall Valuation Service benchmark. The quoted construction cost, including bonding, contingency, and overhead and profit total $4,262,140.22, or $271.92 per square foot. The compilation of the Marshall benchmark after adjusting for current and local cost multipliers total $4,431,674.48 or $282.74 per square foot. This amount is $169,534.25 higher than the total construction costs submitted by Costcon Construction Services. The difference is less than 4% of the total quote and viewed an immaterial difference that could be explained in by any number of contract variables.

The cost comparison is presented in summary form in the table below. The effective date of this analysis is March 1, 2023.

Cost Comparison Chart - Hope Health Facility - Summary Format							
Subtotal Before Overhead and Profit	$3,453,362.69					$5,599,668.05	($2,146,305.36)
Adjusted for Current Cost Multiplier @ 1.22%	$0.00					$6,831,595.02	($1,231,926.97)
Baltimore Local Cost Multiplier @ 1.01%	$0.00					$6,899,910.97	($68,315.95)
Overhead & Profit @ 10%	$345,336.27	$17.54	19,688.50			$0.00	$345,336.27
Bond	$75,973.98					$75,973.98	
Design Contingency @10%	$387,467.29					$387,467.29	
Total Construction Budget	$4,262,140.23	$271.92	15,674.23	$469.77	15,674.23	$7,363,352.24	($3,101,212.02)

Respectfully submitted,

Thomas A. Weigand, MAI, SRA
Certified General Appraiser
Maryland License #04-27637
Expiration: December 27, 2025

Addendum

Treffer | Appraisal Group
The value of experience.

March 8, 2023

Yinka Fadiora, MHS, M Ed., CCHP
Executive Program Director
Hope Health Systems, Inc.
1726 Whitehead Road
Woodlawn, MD 21207

Re: Marshall Valuation Cost Analysis Hope Health Psychiatric Facility

Dear Mr. Fadiora,

In response to our recent communication, I am submitting this proposal for a Marshall Valuation cost analysis for proposed construction for your building at 1726 Whitehead Road in Woodlawn. This letter is to confirm our understanding of the terms and objectives of my engagement with you and to clarify the nature and limitations of the service I will provide.

A narrative format Marshall Valuation cost analysis will be prepared for you, Yinka Fadiora, Hope Health Systems, our client, and the State of Maryland. The intended use of this cost report is to assist with the cost reporting requirements of the State of Maryland as they relate to your proposed facility expansion. Use of this report by any other party for any other use is not intended by our firm.

At completion of the assignment, you will receive an electronic (PDF) copy of the Marshall Valuation cost analysis. The fee for this assignment is $1,800. If required, my hourly rate for deposition, court preparation and testimony related to this matter is $425 per hour. If you agree with the terms stated in this letter, please return a signed copy of this letter with payment made payable to Treffer Appraisal Group.

The members of my firm and I will do our best to provide quality service to you. We do not anticipate any difficulties in meeting the expectations recited in this letter. However, in the unlikely event that there are any disagreements regarding our services, any claims against Treffer Appraisal Group as a result of this engagement must be brought within one year of the date our work is completed. We mutually agree that the laws of the State of Maryland will govern any disputes regarding this engagement.

Our relationship with you is limited to the relationship described in this letter. As such, you understand and agree that we are acting solely as appraisers of the subject real estate. We are not acting in any way as a fiduciary or assuming any fiduciary responsibilities for you.

Our maximum liability relating to services rendered under this letter (regardless of form of action, whether in contract, negligence, or otherwise) shall be limited to the charges paid to us for the portion of our services or work product giving rise to the liability. In no event shall we be liable for

consequential, special, incidental or punitive loss, damage or expense (including without limitation, lost profits, opportunity costs, etc.) even if we have been advised of their possible existence.

This letter constitutes the entire agreement regarding the real estate appraisal service we will provide and supersedes all prior agreements, understandings, negotiations and discussions between us, whether written or oral. This agreement may be supplemented only by other written agreements.

If the terms are in accordance with your understanding and are acceptable to you, please sign, date and return the duplicate copy of this letter with payment to us.

We very much appreciate the opportunity to serve you. Please do not hesitate to call me at 410-544-7744 with any questions or concerns that you may have.

Very truly yours,

Thomas A. Weigand, MAI, SRA
Certified General Appraiser
Treffer Appraisal Group

The services described in the foregoing letter are in accordance with our requirements and we understand the terms, conditions and limitations recited above.

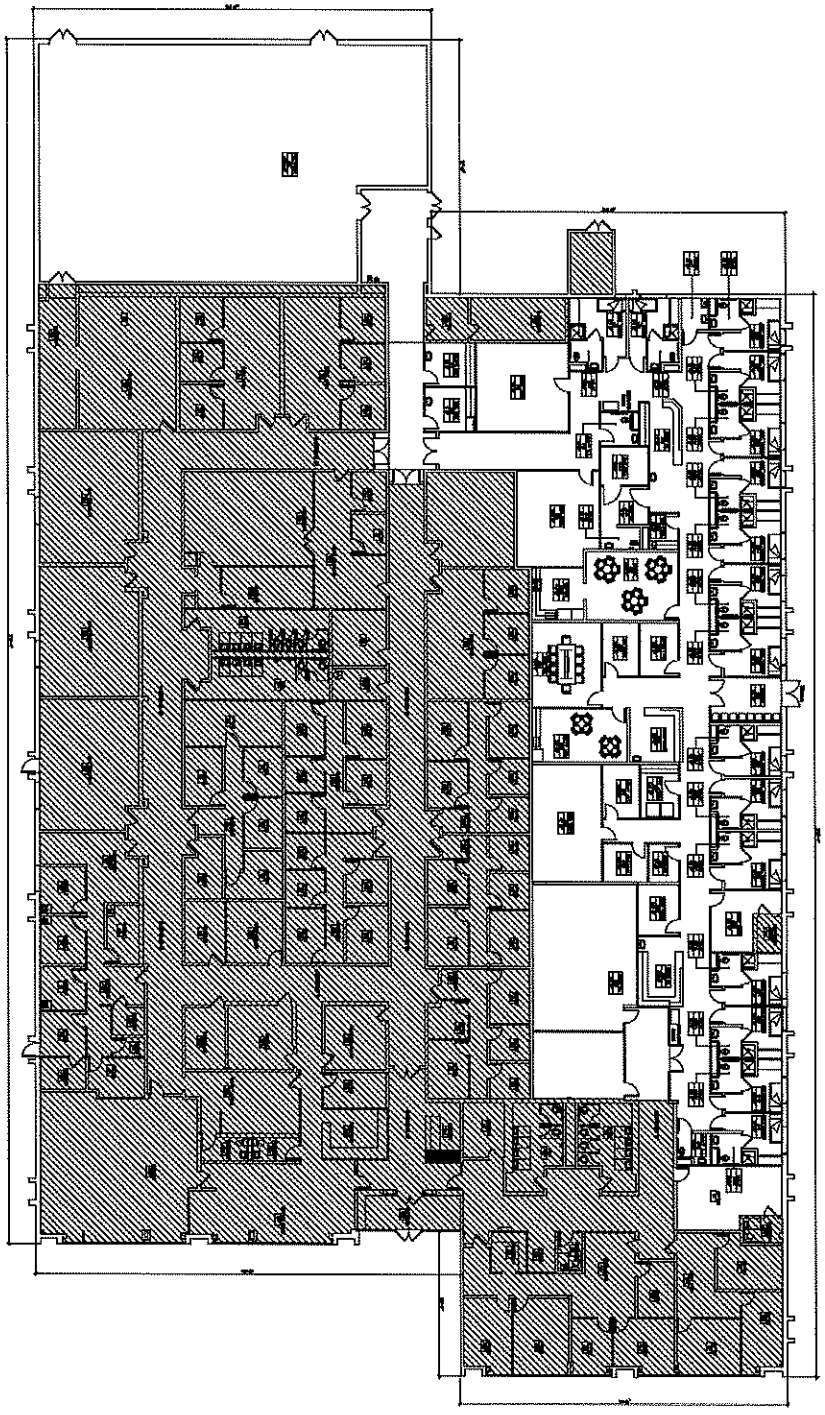
By

Title

Program Director

Date 3/3/2023

Floor Plan of Existing Structure



Gray area to remain unchanged. White section to be converted to acute specialty hospital.

Property Assessment Record

Real Property Data Search ( )
Search Result for BALTIMORE COUNTY

View Map | View GroundRent Redemption | View GroundRent Registration

Special Tax Recapture: None

Account Identifier: District - 01 Account Number - 2500003692

Owner Information

Owner Name:	HOPE HEALTH PROPERTIES LLC	**Use:**	INDUSTRIAL
		Principal Residence:	NO
Mailing Address:	STE 1051 6707 WHITESTONE RD WOODLAWN MD 21207-	**Deed Reference:**	/40307/ 00435

Location & Structure Information

Premises Address:	1728 WHITEHEAD RD BALTIMORE 21235-0000	**Legal Description:**	2.457AC 1728 WHITEHEAD RD NWS MEADOWS INDUSTRIAL PARK

Map:	Grid:	Parcel:	Neighborhood:	Subdivision:	Section:	Block:	Lot:	Assessment Year:	Plat No:	
0088	0019	0629	30000.04	0000			19A	2021	Plat Ref:	0078/ 0311

Town: None

Primary Structure Built	Above Grade Living Area	Finished Basement Area	Property Land Area	County Use
1972	44,149 SF		2.4600 AC	07

Stories	Basement	Type	Exterior	Quality	Full/Half Bath	Garage	Last Notice of Major Improvements
		OFFICE BUILDING	/	C3			

Value Information

	Base Value	Value	Phase-in Assessments	
		As of 01/01/2021	As of 07/01/2022	As of 07/01/2023
Land:	738,000	738,000		
Improvements	5,732,800	5,728,000		
Total:	6,470,800	6,466,000	6,466,000	6,466,000
Preferential Land:	0	0		

Transfer Information

Seller: AEP CHARTER DISCOVERY LLC	**Date:** 06/01/2018	**Price:** $2,700,000
Type: NON-ARMS LENGTH OTHER	**Deed1:** /40307/ 00435	**Deed2:**
Seller: INLAND PPD CHARTER BALTIMORE LLC	**Date:** 09/12/2014	**Price:** $3,500,000
Type: NON-ARMS LENGTH OTHER	**Deed1:** /35360/ 00108	**Deed2:**
Seller: SCHOOLHOUSE FINANCE LLC	**Date:** 03/03/2010	**Price:** $8,562,000
Type: ARMS LENGTH IMPROVED	**Deed1:** /29236/ 00115	**Deed2:**

Exemption Information

Partial Exempt Assessments:	Class	07/01/2022	07/01/2023
County:	000	0.00	
State:	000	0.00	
Municipal:	000	0.00|0.00	0.00|0.00

Special Tax Recapture: None

Homestead Application Information

Homestead Application Status: No Application

Homeowners' Tax Credit Application Information

Homeowners' Tax Credit Application Status: No Application **Date:**

COSTCON
CONSTRUCTION SERVICES

01/24/23

HOPE HEALTH
PSYCHIATRIC UNIT
1726 WHITEHEAD RD, WOODLAWN, MD 21208

CONSTRUCTION AREA	
SF	15674.23

FEASIBLE COST OF CONSTRUCTION ESTIMATE SCHEMATIC DESIGN

ESTIMATE CALCULATED IN 1st 2023 US DOLLARS

CSI Code	Task Description	Unit	Quantity	Cost	Sub-Total	Total
100	GENERAL CONDITIONS					$313,942.06
	General Conditions					
	general conditions as a percentage of the cost of sub contracts	percentage	10.00%	$3,139,420.62	$313,942.06	
200	SITEWORK/DEMOLITION					$220,291.59
	Demolition					
	EXCLUDES REMOVAL OF HAZARDOUS MATERIALS					
	icra- infection control	sf allowance	15674.23	$2.00	$31,348.46	
	demo-doors and frames	ea	72.00	$75.00	$5,400.00	
	demo-floors	sf	15,674.23	$0.95	$14,890.52	
	demo-ceilings	sf	15,674.23	$0.80	$12,539.38	
	demo-partitions	sq ft	20,365.56	$2.50	$50,913.90	
	demo toilet partitions	ea	6.00	$100.00	$600.00	
	demo cabinets and millwork	ft	10.50	$45.00	$472.50	
	demo-electric per sf	sf allowance	15,674.23	$2.00	$31,348.46	
	demo- concrete cutting and removal	sf allowance	15,674.23	$1.00	$15,674.23	
	demo mechanical-sf	sf allowance	15,674.23	$2.00	$31,348.46	
	demo-miscellaneous	sf allowance	15674.23	$0.25	$3,918.56	
	remove debris to dumpsters	sf allowance	15674.23	$0.50	$7,837.12	
	demo dumpsters	ea	20.00	$700.00	$14,000.00	
300	CONCRETE					$15,674.23
	Concrete					
	concrete-patching and repairs	sf allowance	15674.23	$1.00	$15,674.23	
400	MASONRY					$15,674.23
	Masonry					
	masonry -patching and rfepairs to existing	sf allowance	15674.23	$1.00	$15,674.23	
500	METAL					$30,337.12
	Metals					
	awning/overhang and signage above at ambulance drop-off	ft	45.00	$500.00	$22,500.00	
	inserts and anchors	sf allowance	15674.23	$0.50	$7,837.12	
600	Carpentry					$211,837.96
	Carpentry					
	blocking	sf allowance	15674.23	$1.00	$15,674.23	
	install doors and frames	leaf	82.00	$350.00	$28,700.00	

	install- specialties	sf allowance	15674.23	$1.00	$15,674.23	
	install- miscellaneous	sf allowance	15674.23	$0.50	$7,837.12	
	Millwork and Cabinetry					
	resident rooms-built-in wardrobes	ft	90.62	$800.00	$72,496.00	
	nurse station	ft	25.80	$600.00	$15,480.00	
	clean room-base, solid surface countertop and wall cabinet	ft	11.07	$750.00	$8,302.50	
	soiled work room-base, solid surface countertop and wall cabinet	ft	7.71	$750.00	$5,782.50	
	medical storage-base, solid surface countertop and wall cabinet	ft	10.26	$750.00	$7,695.00	
	security/reception- work top and supports	ft	23.33	$200.00	$4,666.00	
	staff/lounge-base, solid surface countertop and wall cabinet	ft	9.07	$750.00	$6,802.50	
	remove and replace all window sills	ft	96.97	$65.00	$6,303.05	
	brochure rack in waiting area	ea	1.00	$750.00	$750.00	
	millwork-other	sf allowance	15,674.23	$1.00	$15,674.23	
700	**MOISTURE PROTECTION**					**$1,567.42**
	Caulking and Sealants					
	caulking and sealants	sf allowance	15674.23	$0.10	$1,567.42	
800	**DOOR, WINDOW, GLASS**					**$310,219.23**
	Doors-Frames and Hardware					
	special access doors at resident rooms	ea	16.00	$4,500.00	$72,000.00	
	special anti-ligature doors at resident room toilets	ea	16.00	$3,000.00	$48,000.00	
	scw doors	ea	48.00	$2,000.00	$96,000.00	
	storefront-new unit entry doors (pair)	ea	1.00	$5,000.00	$5,000.00	
	new doors at ambulance drop off	ea	3.00	$2,500.00	$7,500.00	
	Windows					
	remove and replace resident room windows and replace with insulated/internal blind/impact resistant glazing	sq ft	377.40	$175.00	$66,045.00	
	Glazing					
	interior windows and glazing- special glass	sf allowance	15674.23	$1.00	$15,674.23	
900	**FINISH**					**$704,694.34**
	Partitions					
	interior partitions- average	sq ft	23,442.60	$14.00	$328,196.40	
	patching and repairs to existing	sf allowance	15674.23	$1.50	$23,511.35	
	Flooring					
	floor prep	sf	14115.00	$1.50	$21,172.50	
	rubber sheet flooring	sq ft	2,088.97	$10.00	$20,889.70	
	poured epoxy flooring	sq ft	666.53	$18.00	$11,997.54	
	vct	sq ft	4,672.89	$4.00	$18,691.56	
	lvt	sq ft	5,169.98	$9.00	$46,529.82	
	carpet tile	yrd	90.00	$45.00	$4,050.00	
	sheetgoods-commercial kitchen/dining	sq ft	750.72	$8.00	$6,005.76	
	Ceramic Tile					
	ceramic tile floor	sq ft	223.84	$17.00	$3,805.28	
	ceramic tile walls	sq ft	1008.00	$17.00	$17,136.00	
	h/c transition	ea	4.00	$100.00	$400.00	
	Base					
	rubber sheet flooring-integral base	sq ft	931.00	12.00	$11,172.00	
	poured epoxy flooring-integral base	sq ft	443.00	12.00	$5,316.00	
	vct-resilient cove base	sq ft	1,506.00	3.75	$5,647.50	
	lvt-resilient cove base	sq ft	443.00	3.75	$1,661.25	
	carpet tile-resilient cove base	sq ft	217.00	3.75	$813.75	
	sheetgoods-commercial kitchen/dining	sq ft	120.00	3.75	$450.00	

	Ceilings					
	act and support grid	sq ft	11,355.28	$9.00	$102,197.52	
	gwb ceiling	sq ft	3,279.20	$6.50	$21,314.80	
	bulkhead allowance	sf allowance	15,674.23	$1.00	$15,674.23	
	Painting					
	paint-walls	sf allowance	15674.23	$1.25	$19,592.79	
	paint ceilings and bulkheads	sf	2379.00	$1.25	$2,973.75	
	paint -doors and frames	leaf	82.00	$150.00	$12,300.00	
	paint-miscellaneous and touch-up	sf allowance	15674.23	$0.20	$3,134.85	
1000	**SPECIALTIES**					**$82,180.67**
	Specialties					
	interior signage	sf allowance	15674.23	$0.75	$11,755.67	
	fire extinguishers and cabinets	ea	3.00	$500.00	$1,500.00	
	stainless mirrors above sinks	ea	10.00	$300.00	$3,000.00	
	soap dispenser	ea	9.00	$85.00	$765.00	
	h/c bars at toilets-set	ea	5.00	$200.00	$1,000.00	
	toilet roll dispenser	ea	5.00	$85.00	$425.00	
	paper towel/waste	ea	5.00	$500.00	$2,500.00	
	mop rack and shelf	ea	1.00	$350.00	$350.00	
	tv brackets for video locations	ea	3.00	$175.00	$525.00	
	Accessories-Resident					
	anti-ligature handrail in showers-resident	ea	16.00	$600.00	$9,600.00	
	anti-ligature toilet ada bars-set	set	16.00	$600.00	$9,600.00	
	anti-ligature toilet roll dispenser	ea	16.00	$250.00	$4,000.00	
	anti-ligature shower curtain rod	ea	16.00	$200.00	$3,200.00	
	stainless steel mirrors above sinks in resident rooms	ea	16.00	$300.00	$4,800.00	
	fold down shower seat	ea	16.00	$35.00	$560.00	
	Wall Protection					
	corner guards	ea	61.00	$100.00	$6,100.00	
	other wall protection	ea	1.00	$2,500.00	$2,500.00	
1100	**EQUIPMENT**					**$3,500.00**
	Equipment					
	appliance allowance-staff lounge	allowance	1.00	$3,500.00	$3,500.00	
1200	**FURNISHINGS**					**$0.00**
	Furnishings					
	furnishings	not required	0.00	$0.00	$0.00	
1900	**SPECIAL CONSTRUCTION**					**$125,593.84**
	Special Construction					
	security and cctv-allowance	sf allowance	15674.23	$3.00	$47,022.69	
	nurse call system	sf allowance	15674.23	$2.00	$31,348.46	
	wonder guard system-allowance	sf allowance	15674.23	$3.00	$47,022.69	
1400	**CONVEYING**					**$0.00**
	Conveying					
	conveying	not required	0.00	$0.00	$0.00	
1500	**MECHANICAL**					**$824,779.67**
	HVAC					
	HVAC	sf allowance	15674.23	$45.00	$705,340.35	

	Plumbing					
	plumbing	sf allowance	15674.23	$14.00	**$219,436.22**	
	resident sinks-16ea	see above	0.00	$0.00	**$0.00**	
	resident toilets-16ea	see above	0.00	$0.00	**$0.00**	
	resident showers-16ea	see above	0.00	$0.00	**$0.00**	
	wall hung sinks-9ea	see above	0.00	$0.00	**$0.00**	
	toilets-5ea	see above	0.00	$0.00	**$0.00**	
	stainless steel sink-2ea	see above	0.00	$0.00	**$0.00**	
	mop sink-1ea	see above	0.00	$0.00	**$0.00**	
1600	**ELECTRICAL**					**$501,575.90**
	Electrical					
	electrical	sf allowance	15674.23	$32.00	**$501,575.90**	
1700	**MISCELLANEOUS**					**$11,755.67**
	Miscellaneous					
	final construction clean	sf allowance	15674.23	$0.75	**$11,755.67**	
	miscellaneous	not required	0.00	$0.00	**$0.00**	
				SUBTOTAL	$3,453,362.68	**$3,453,362.68**

01/24/23

COSTCON
CONSTRUCTION SERVICES

HOPE HEALTH
PSYCHIATRIC UNIT
1726 WHITEHEAD RD, WOODLAWN, MD 21208

FEASIBLE COST OF CONSTRUCTION ESTIMATE SCHEMATIC DESIGN

ESTIMATE CALCULATED IN 1st 2023 US DOLLARS

CAT	ESTIMATE / BID SUMMERY		% OF TOT	TOTALS
100	General Conditions		7.37%	$313,942.06
200	Demolition		5.17%	$220,291.59
300	Concrete		0.37%	$15,674.23
400	Masonry		0.37%	$15,674.23
500	Metal		0.71%	$30,337.12
600	Carpentry		4.97%	$211,837.36
700	Moisture Protection		0.04%	$1,567.42
800	Doors Windows & Glass		7.28%	$310,219.23
900	Finish		16.53%	$704,634.34
1000	Specialties		1.46%	$62,180.67
1100	Equipment		0.08%	$3,500.00
1200	Furnishings		0.00%	$0.00
1300	Special Construction		2.94%	$125,393.84
1400	Conveying		0.00%	$0.00
1500	Mechanical		21.70%	$924,779.57
1600	Electrical		11.77%	$501,575.36
1700	Miscellaneous		0.28%	$11,755.67
		SUB TOTAL	81.02%	$3,453,362.69
		Contractor's Overhead and Profit 10.00%	8.10%	$345,336.27
		Bond 2.00%	1.78%	$75,973.98
		Phasing and Logistics 0.00%	0.00%	$0.00
		Escalation to Mid-Point of Construction by owner	0.00%	$0.00
		Design Contingency 10.00%	9.09%	$387,467.29
		TOTAL	100.00%	$4,262,140.22
				$271.92

EXHIBIT 26

Admissions Policy and Procedure

Scope: Inpatient Mental Health Unit

Policy Statement: The Hope Health Psychiatric Hospital ("HHPH") inpatient mental health unit is a short-term, acute psychiatric treatment inpatient service accepting both voluntary and involuntary patients. All patients admitted to the unit must have a primary DSM-V diagnosis.

Definitions: None

Procedure:

1) Admissions to the inpatient mental health unit may be voluntary or involuntary, and patients must sign an Application for Voluntary Admission or the referring ED must provide a signed Application for Involuntary Admission and two signed Certificates for Involuntary Admission.

2) Patients admitted to the inpatient mental health unit should be those suited to the unit environment, program structure, skill mix and competency of unit staff and those whose safety and medical needs can be provided for in the program milieu.

3) A patient who is totally dependent on staff for care, such as hygiene, eating, or mobility or whose independent functioning is severely limited may require evaluation with regard to the appropriateness of admission to the inpatient mental health unit. The patient must be manageable within the unit and with available unit staff and areas of expertise.

4) Patients will be considered medically stable by the admitting psychiatrist or covering health professional before admission to the inpatient mental health unit.

    a) The route of admission will determine method of medical clearance:
        i) Transfers from other hospitals –Evidence of medical clearance including CBC, CMP, drug screen, urinalysis and pregnancy test (where appropriate), other tests as appropriate, and supporting documentation are required for initial review and approval by the admitting psychiatrist or covering health professional prior to the patient being accepted for transfer.
        ii) Direct admissions- Patients will be accepted for direct admission upon referral from outpatient providers at the discretion of the admitting psychiatrist or covering health professional, based on available information about the patient and any medical issues present. Patients accepted for direct admission will have CBC, CMP, drug screen, urinalysis and pregnancy test (where appropriate) and other appropriate tests completed at admission.

    b) **Certain patients will not be eligible for admission to the inpatient unit.** These are:
        i) Prisoners
        ii) Patients => 18 years of age
        iii) Patients who require total care (e.g. continuous IV infusion, TPN, central lines, oxygen, suctioning, are physically confined) or whose principal need for intervention is medical or surgical
        iv) Patients who require negative pressure rooms or isolation
        v) Patients who have significant intellectual disabilities or who suffer other cognitive impairments who will not be appropriate, safe, or able to benefit from the therapeutic milieu.
        vi) Unit staff, their significant others or family members

vii) Patients with serum alcohol, potassium, or blood glucose outside safely-managed levels.

c) Questions or problems regarding the appropriateness of a patient for admission to the inpatient mental health unit will be resolved by the program director, nursing director, and medical director. Pre-Certification by the patient's insurance carrier must be obtained prior to admission into the inpatient mental health unit.

5) Notification of Patients' Rights and Status
   a) The Notification to Individual of Admission Status and Rights (must be completed by the nursing staff and placed in the patient's chart within twelve (12) hours of admission.
   b) In the event that the patient is unable to understand the notification, the patient's rights will be explained to their next of kin and documentation of this discussion will be made in the patient's record.

6) Hearings for Patients Involuntarily Admitted
   a) An administrative hearing will be held to determine whether an involuntary patient may be involuntarily committed under Maryland law. An impartial Administrative Law Judge will hear the case and decide whether the patient is to be admitted to or released from the hospital.
   b) Scheduling hearings
      i) Hearings must be held within ten calendar days of the patient's confinement unless a postponement has been arranged. Hearings will be scheduled on a weekly basis. The involuntary patient's hearing will take place on the designated hearing day following confinement. For individuals entering the hospital involuntarily less than 48 hours before a scheduled hearing day, the hearing will be held the following week in order to allow the patient time to obtain legal counsel and to allow an adequate period for observation.
      ii) The date of the hearing may be postponed or continued by the Administrative Law Judge for good cause shown, but in any event, the hearing shall be concluded and a decision made within 17 calendar days from the date of confinement. If a patient and/or his/her legal counsel requests a different hearing date, every effort will be made to schedule the hearing at a time acceptable to all involved. The patient must be present at the hearing unless he/she refuses or waives the right to attend. Any waiver must be knowingly and intelligently made by the patient in the presence of the Administrative Law Judge and the patient's legal representative.

References *(required for clinical)*: **None**

Cross References: None

EXHIBIT 27

HOPE HEALTH SYSTEMS, INC.
AND HOPE HEALTH PROPERTIES LLC

COMBINED FINANCIAL STATEMENTS
AND SUPPLEMENTARY INFORMATION

YEAR ENDED DECEMBER 31, 2021

CPAs | CONSULTANTS | WEALTH ADVISORS

CLAconnect.com

HOPE HEALTH SYSTEMS, INC. AND HOPE HEALTH PROPERTIES LLC
TABLE OF CONTENTS
YEAR ENDED DECEMBER 31, 2021

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
Hope Health Systems, Inc and Hope Health Properties LLC
Baltimore, Maryland

Report on the Audit of the Combined Financial Statements

Opinion

We have audited the accompanying combined financial statements of Hope Health Systems, Inc and Hope Health Properties LLC (collectively, the Companies) which comprise the combined balance sheet as of December 31, 2021, and the related combined statements of operations, member's equity, and cash flows for the year then ended, and the related notes to the combined financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Hope Health Systems, Inc and Hope Health Properties LLC as of December 31, 2021, and the results of their operations and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Combined Financial Statements section of our report. We are required to be independent of the Companies and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Emphasis-of-Matters

Substantial Doubt about the Company's Ability to Continue as a Going Concern

The accompanying combined financial statements have been prepared assuming that the Company will continue as a going concern. As discussed in Note 10 to the combined financial statements, the Company has a line of credit, loan, and a promissory note due to Truist Bank that, as of the date of these audited financial statements, is beyond their respective maturity dates and subject to immediate repayment at the request of Truist Bank, an indication that substantial doubt exists. Management's evaluation of the events and conditions and management's plans regarding those matters are also described in Note 10. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to that matter.

Correction of an Error

As discussed in Note 11 to the combined financial statements, the 2020 financial statements have been restated to correct a misstatement. Our opinion is not modified with respect to this matter.

Change in Reporting Entity
As discussed in Note 1 to the combined financial statements, Hope Health Properties LLC is included in these combined financial statements for the year ended December 31, 2021. The financial statements for the year ended December 31, 2020 did not include Hope Health Properties LLC. Our opinion is not modified with respect to that matter.

Responsibilities of Management for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of the combined financial statements in accordance with accounting principles generally accepted in the United States of America, and for 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.

In preparing the combined financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Companies' ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Combined Financial Statements

Our objectives are to obtain reasonable assurance about whether the combined financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the combined financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the combined financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the combined financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Companies' internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the combined financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Companies' ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the combined financial statements as a whole. The combining balance sheet and combining statement of operations are presented for purposes of additional analysis and are not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Timonium, Maryland
June 7, 2023

HOPE HEALTH SYSTEMS, INC. AND HOPE HEALTH PROPERTIES LLC
COMBINED BALANCE SHEET
DECEMBER 31, 2021

ASSETS	
CURRENT ASSETS	
Cash and Cash Equivalents	$ 168,882
Patient Accounts Receivable	284,097
Other Receivable	36,579
Prepaid Expenses	27,692
Deposits and Other	4,747
Total Current Assets	521,997
DUE FROM RELATED PARTY	35,744
OTHER ASSETS	120,358
PROPERTY AND EQUIPMENT, NET	3,813,543
Total Assets	$ 4,491,642
LIABILITIES AND MEMBER'S DEFICIT	
CURRENT LIABILITIES	
Accounts Payable	$ 437,689
Other Accrued Expenses	304,610
Lines of Credit	409,141
Current Portion of Long-Term Debt	3,222,851
Current Portion of Capital Leases	77,753
Income Taxes Payable	10,000
Total Current Liabilities	4,462,044
LONG-TERM LIABILITIES	
Due to Related Party	192,812
Capital Lease Payable, Long-Term	345,411
Long-Term Debt	1,652,430
Total Long-Term Liabilities	2,190,653
Total Liabilities	6,652,697
MEMBER'S DEFICIT	(2,161,055)
Total Liabilities and Member's Deficit	$ 4,491,642

See accompanying Notes to Combined Financial Statements.

HOPE HEALTH SYSTEMS, INC. AND HOPE HEALTH PROPERTIES LLC
COMBINED STATEMENT OF OPERATIONS
YEAR ENDED DECEMBER 31, 2021

REVENUES	
Net Patient Service Revenue	$ 12,108,287
Other Operating Revenues	213,485
Total Revenues	12,321,772
EXPENSES	
Salaries and Wages	8,876,192
Employee Benefits and Payroll Taxes	1,284,931
Contractual and Purchased Services	2,224,916
Supplies	334,783
Repairs and Maintenance	511,923
Utilities	129,546
Lease Expense	259,146
General and Administrative	571,626
Property Taxes	80,375
Federal and State Income Taxes	142,579
Bad Debt Expense	158,528
Depreciation	239,913
Amortization	9,944
Interest Expense	233,438
Total Expenses	15,057,840
OPERATING LOSS BEFORE OTHER INCOME	(2,736,068)
OTHER INCOME	
Interest Income	1
PPP Loan Forgiveness	1,768,170
Total Other Income	1,768,171
NET LOSS	$ (967,897)

See accompanying Notes to Combined Financial Statements.

HOPE HEALTH SYSTEMS, INC. AND HOPE HEALTH PROPERTIES LLC
COMBINED STATEMENT OF MEMBER'S DEFICIT
YEAR ENDED DECEMBER 31, 2021

BALANCE - JANUARY 1, 2021, AS RESTATED (SEE NOTE 11)	$ (1,193,158)
Net Loss	(967,897)
BALANCE - DECEMBER 31, 2021	$ (2,161,055)

See accompanying Notes to Combined Financial Statements.

HOPE HEALTH SYSTEMS, INC. AND HOPE HEALTH PROPERTIES LLC
COMBINED STATEMENT OF CASH FLOWS
YEAR ENDED DECEMBER 31, 2021

CASH FLOWS FROM OPERATING ACTIVITIES	
Net Loss	$ (967,897)
Adjustments to Reconcile Net Loss to Net Cash Used by Operating Activities:	
Prior Period Adjustment	
Depreciation	239,913
Goodwill Amortization	9,944
PPP Loan Forgiveness	(1,768,170)
(Increase) Decrease in:	
Patient Accounts Receivable	291,476
Other	(18,305)
Prepaid Expenses and Other	297,386
Increase (Decrease) in:	
Accounts Payable	(28,493)
Other Accrued Expenses	200,687
Income Taxes Payable	2,522
Net Cash Used by Operating Activities	(1,740,937)
CASH FLOWS FROM INVESTING ACTIVITIES	
Purchases of Property and Equipment	(273,211)
Investments in Other Businesses	(73,551)
Net Cash Used by Investing Activities	(346,762)
CASH FLOWS FROM FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(60,666)
Payments on Capital Lease Obligations	(72,905)
Lines of Credit Draws, Net	47,155
Proceeds from PPP Loan	1,768,170
Increase in Due to Related Party, Net	64,180
Net Cash Provided by Financing Activities	1,745,934
NET DECREASE IN CASH, CASH EQUIVALENTS	(341,765)
Cash, Cash Equivalents, and Assets Limited as to Use - Beginning of Year	510,647
CASH, CASH EQUIVALENTS, AND ASSETS LIMITED AS TO USE - END OF YEAR	$ 168,882
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION	
Cash Paid for Interest	$ 230,324

See accompanying Notes to Combined Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

Hope Health Systems, Inc. and Hope Health Properties LLC (collectively, the Companies) are owned by the same individual (Owner or Member) that is the sole owner and member of the Companies.

Hope Health Systems, Inc. (HHS)

HHS was formed for the purpose of providing outpatient mental, behavioral, and substance abuse health services to the community. HHS operates in Maryland, Delaware, and Pennsylvania. HHS leases its Woodlawn, Maryland clinical and administrative offices from Hope Health Properties LLC.

Hope Health Properties LLC (HHP)

HHP is the owner of two buildings located in Woodlawn, Maryland, 2605 Bannister Road, and 6707 Whitestone Road. The 2605 Bannister Road building includes third-party business tenants, and the 6706 Whitestone Road building is fully leased to HHS.

Principles of Combination

The accompanying combined financial statements include the accounts of HHS and HHP. All material intercompany transactions and accounts have been eliminated.

Use of Estimates

The preparation of combined financial statements in accordance with accounting principles generally accepted in the Unites States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

The Companies consider all highly liquid investments with an original maturity of three months or less to be cash equivalents.

Patient Accounts Receivable and Allowance for Doubtful Accounts

Patient accounts receivable represents payments due from patients for services provided by HHS. Patient accounts receivable are carried at original invoice amount, less an estimate made for doubtful receivables. HHS provides an allowance for doubtful accounts based on the allowance method using management's judgment. Patients are not required to provide collateral for services rendered. Payment for services is required upon receipt of invoice submitted. An allowance is estimated for accounts receivable based on historical experience. Patient accounts receivable are written off when deemed uncollectible. Recoveries of patient accounts receivable are recorded when received.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Other Receivables

Other receivables included non-patient service receivables outstanding. It includes HHP rent receivables from its Bannister Road building that has third-party business tenants.

Property and Equipment

Property and equipment acquired in business combinations are recorded at fair value at the date of acquisition. Additions are recorded at cost. Depreciation is determined on a straight-line basis over the estimated useful lives of the related assets. The Companies' policy is to capitalize expenditures for major improvements. Maintenance and repairs are charged to operations. Estimated useful lives are 20 to 40 years for buildings, 20 years for leasehold improvements, 5 to 10 years for furniture and fixtures, and 3 to 5 years for computer hardware and software.

Valuation of Long-Lived Assets

The Companies review long-lived assets whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of the long-lived asset is measured by a comparison of the carrying amount of the asset, plus the deferred revenue related to patient contracts to be recognized in the future, to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount of which the carrying amount of the asset exceeds the estimated fair value of the asset. No impairments have occurred to date.

Deposits

Deposits from prospective patients of HHS consisting of reservation fee deposits are deposited in the patient entrance fees escrow funds account. Reservation fee deposits are received from prospective patients pursuant to the execution of the residency agreement and generally represent 10% of the total entrance fee for the unit selected. The escrow funds will be applied to the total entrance fee upon occupancy.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Goodwill

At December 31, 2021, Goodwill is $28,000 with accumulated amortization of $11,200. Goodwill arose from HHP's acquisition of 2605 Bannister Road, Woodlawn, Maryland. HHP elected the Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) 2014-18, *Business Combinations (Topic 805): Accounting for identifiable Intangible Assets in a Business Combination*, which allows private companies an election in which it does not have to separately recognize certain intangible assets from goodwill. Goodwill represents the excess of the purchase price over the fair value of the assets obtained, including the identifiable intangibles, less liabilities assumed. The goodwill is presented at cost, net of accumulated amortization. In accordance with FASB ASU 2014-02, *Intangibles, Goodwill and Other (Topic 350): Accounting for Goodwill*, goodwill is amortized over 10 years and only tested for impairment when there is a triggering event. The assessment of triggering events is made annually and at the entity level.

Amortization expense related to Goodwill was $3,110 for the year ended December 31, 2021.

Patient Services Revenue

Patient services revenue is reported at the amount that reflects the consideration to which HHS expects to be entitled in exchange for providing patient services and care. Patient services include outpatient mental, behavioral and substance abuse health care services on the combined statements of operations. These amounts are due from patients. Generally, HHS bills the patients business-daily for services as the services are performed.

Performance obligations are determined based on the nature of the services provided by HHS. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred. HHS believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving services within the facility or patients receiving services outside of the facility. HHS measures the performance obligation from commencement of services to the point when HHS is no longer required to provide services to that patient, which is generally at the time of discharge or termination of the patient contract.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Patient Services Revenue (Continued)

Revenue for performance obligations satisfied at a point in time is generally recognized when goods are provided to the patients and HHS does not believe it is required to provide additional goods or services related to that sale.

HHS determines the transaction price based on standard charges for goods and services provided, reduced by implicit price concessions provided to patients. HHS determines its estimate of implicit price concessions based on its historical collection experience.

HHS recognizes the majority of its revenue over a period of time from its patients based on fees for services performed.

Revenue recognized due to changes in its estimate of implicit price concessions and discounts were not considered material for the year ended December 31, 2021. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as provision for uncollectible accounts and were not considered material for the years ended December 31, 2021.

A majority of HHS revenue is reimbursed on a contractual basis and HHS reimbursed by ACH and private pay checks.

The composition of patient care service revenue based on its service lines are as follows for the year ended December 31, 2021:

By Service Line:	
Expanded School-Based Mental Health	$ 5,635,753
Department of Juvenile Services	3,287,343
MHM, Inc. Contract	1,685,018
Behaviorial Health Systems, Inc. Contract	214,427
Outpatient Services	1,285,746
Total Net Patient Service Revenue	$ 12,108,287

The opening and closing balances in Patient Accounts Receivable were as follows:

Balance as of January 1, 2021	$ 575,573
Balance as of December 31, 2021	284,097

Financing Component

HHS has elected the practical expedient allowed under FASB Accounting Standards Codification (ASC) 606-10-32-18 and does not adjust the promised amount of consideration from patients for the effects of a significant financing component due to HHS's expectation that the period between the time the service is provided to a patient and the time that the patient pays for that service will be one year or less.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Contract Costs

HHS has applied the practical expedient provided by FASB ASC 340-40-25-4 and all incremental customer contract acquisition costs are expensed as they are incurred as the amortization period of the asset that HHS otherwise would have recognized is one year or less in duration.

Other Operating Revenue

HHS derives other income primarily from non-patient services. HHP rent revenue from HHS eliminates in the combined financial statements.

Income Taxes

HHS is a for-profit corporation that estimates its tax liability. HHP is a single-member limited liability company and, as such, is considered disregarded for federal and state income tax purposes and is not subject to income tax. Both HHS and HHP are 100% owned by a single individual/member.

Management has evaluated the Companies' tax positions and concluded that the Companies have taken no uncertain tax positions that require adjustment to the combined financial statements. The Companies are subject to income tax examinations by the U.S. federal, state, or local tax authorities for years 2019, 2020 and 2021.

Recently Issued Accounting Guidance

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*. This new standard increases transparency and comparability among organizations by requiring the recognition of right-of-use (ROU) assets and lease liabilities on the balance sheet. Most prominent about the changes in the standard is the recognition of ROU assets and lease liabilities by lessees for those leases classified as operating leases. Under the standard, disclosures are required to meet the objective of enabling users of financial statements to assess the amount, timing, and uncertainty of cash flows arising from leases. Management is evaluating the potential impact of these changes on the Companies' combined financial statements.

NOTE 2 PROPERTY AND EQUIPMENT

Property and equipment at December 31, 2021, consist of the following:

Buildings	$	3,300,740
Leasehold Improvements		939,878
Equipment and Furnishings		644,706
Software		243,086
Total Property and Equipment		5,128,410
Less: Accumulated Depreciation		(1,314,867)
Property and Equipment, Net	$	3,813,543

NOTE 3 OTHER ASSETS

Other assets at December 31, 2021, consist of the following:

Goodwill	$	16,800
Peju's Kitchen		39,768
Agape Health Systems		63,790
Total Other Assets	$	120,358

The 100% owner of HHS and HHP and is an 80% owner of Peju's Kitchen, a restaurant, and 100% owner of Agape Health Systems, a primary care clinic.

NOTE 4 CONCENTRATION OF CREDIT RISK

Financial instruments that potentially subject the Companies to concentrations of credit risk consist principally of cash and cash equivalents. The Companies regularly maintain amounts on deposit with various financial institutions in excess of that insured by the FDIC. The Companies believe that they limit their credit exposure by placing their temporary cash investments with what they believe to be high credit quality financial institutions.

NOTE 5 LINES OF CREDIT

Truist Loan 2

On May 10, 2018, HHS entered into a $250,000 loan with Truist Bank (Truist Loan 2) that operates as a revolving line of credit where advances under the loan may be requested orally or in writing. It is interest-only paid monthly at 4.100% interest rate. All principal was to be paid in full by May 29, 2023, the agreement maturity (See Note 10). The Truist Loan 2 is secured by lien on all cash, investments and equipment.

NOTE 5 LINES OF CREDIT (CONTINUED)

Aquina Accounts Receivable Credit Line

On August 25, 2021, HHS entered into a note based on the patient receivables outstanding that allowed access to up to $307,455 in funding (Aquina Credit Line). Repayment, including principal and interest, is made weekly. The effective annual interest rate is 6.000%. All principal must be paid in full by May 2023. The Aquina Credit Line is secured by lien on patient receivables.

Lines of Credit as of December 31, 2021 consisted of the following:

Truist Loan 2	$	218,476
Aquina Patient Receivables Credit Line		190,665
Total Lines of Credit	$	409,141

NOTE 6 LONG-TERM DEBT

State of Maryland Department of Health Advance Loan

During 2020 due to technical issues affecting the Maryland reimbursement of mental health services, HHS received $1,502,431 from the Maryland Department of Health for an Advance Pay loan (MDH Loan). All principal must be repaid in full by December 31, 2023 with interest at 0.000% paid monthly. Beginning February 2023, HHS must pay principal of at least $10,000 per month until the final principal payment of $1,392,431 on December 31, 2023. The MDH Loan is unsecured.

Truist Loan 1

On May 10, 2018, HHP entered into a $750,000 note payable with Truist Bank (Truist Loan 1). Payments including principal and interest are, from June 10, 2018 to April 10, 2023, monthly payments of $4,583, and, on May 29, 2023, a last payment of $673,568 was owed (See Note 10). The effective interest rate is 5.370%. The Truist Loan 1 is secured by lien on HHP building at 6707 Whitestone Road, Woodlawn, Maryland.

SBA Disaster COVID-19 Economic Injury Loan

On June 30, 2020, HHS entered into a $150,000 Disaster COVID-19 Economic Injury loan with the U.S. Small Business Administration. (SBA Loan). It is interest-only paid monthly at 3.750% interest rate. All principal must be paid in full by June 27, 2050. The SBA Loan is secondary in collateral to Truist Loan 1, Truist Loan 2, and Truist Promissory Note.

Truist Promissory Note

On May 10, 2018, HHP entered into a $2,720,000 promissory note payable with Truist Bank (Truist Promissory Note). Monthly payments are interest-only the first six-months and including principal and interest $16,778 from December 10, 2018 to April 10, 2023 and a last payment of $2,465,799 was owed on May 29, 2023 (See Note 10). The effective annual interest rate is 5.370%. The Truist Promissory Note is secured by lien on HHP building at 2605 Bannister Road, Woodlawn, Maryland.

NOTE 6 LONG-TERM DEBT (CONTINUED)

PPP Loan

HHS received loan proceeds under the Paycheck Protection Program (the PPP). The PPP, established as part of the Coronavirus Aid, Relief and Economic Security Act (CARES Act), provides for loans to qualifying businesses for amounts up to 2.5 times of the average monthly payroll expenses of the qualifying business. The principal and accrued interest are forgivable as long as the borrower uses the loan proceeds for eligible purposes, including payroll, benefits, rent and utilities, and maintains its payroll levels. The amount of loan forgiveness will be reduced if the borrower terminates employees or reduces salaries during the forgivable period.

On January 27, 2021, HHS received $1,768,170 on a PPP loan maturing five years from the date of the first disbursement, bearing interest at a rate of 1.00% per annum, and any unpaid principal and accrued interest will be due on maturity ("PPP Loan"). On December 14, 2021, the entire balance PPP Loan was forgiven under the terms of the PPP.

The U.S. Small Business Administration (SBA) may review funding eligibility and usage of funds for compliance with program requirements based on dollar thresholds and other factors. The amount of liability, if any, from potential noncompliance cannot be determined with certainty; however, management is of the opinion that any review will not have a material adverse impact on the HHP's financial position.

Long-term debt as of December 31, 2021 consisted of the following:

MDH Loan	$ 1,502,431
Truist Loan 1	694,357
SBA Loan	150,000
Truist Promissory Note	2,528,493
Total Long-Term Debt	4,875,281
Less: Current Portion of Long-Term Debt	(3,222,851)
Total Long-Term Debt, Less Current Portion	$ 1,652,430

Future maturities of all long-term debt for the next five years and thereafter are as follows:

Year Ending December 31,	Amount
2022	$ 3,222,851
2023	1,502,430
2024	-
2025	-
2026	-
Thereafter	150,000
Total	$ 4,875,281

The Truist Loan 1 and Truist Promissory Note include restrictive covenants. The Company was not in compliance. See Note 10 for Management's Plan.

NOTE 7 LEASES

Capital Leases

HHS has entered into capital lease agreements for a vehicle, furniture and HVAC. As of December 31, 2021, the gross amount of capital lease asset and related accumulated depreciation recorded under the leases is as follows:

Vehicle, Furniture, HVAC	$	515,833
Less: Accumulated Depreciation		(70,632)
Total	$	445,201

Scheduled payments on capital lease obligations at December 31, 2021 are as follows:

Year Ending December 31,		
2022	$	98,181
2023		95,598
2024		87,183
2025		84,860
2026		73,242
Thereafter		42,725
Total Minimum Future Lease Payments	$	481,789
Less: Amount Representing Interest		(58,625)
Present Value of Net Minimum Lease		423,164
Less: Current Portion		(77,753)
Long-Term Portion	$	345,411

Operating Leases

HHS leases property and equipment under non-cancellable agreements. HHS's operating leases are primarily for real estate, including off-campus outpatient facilities, medical office buildings and corporate and other administrative offices, as well as medical and office equipment. HHS's finance leases consist of a real estate lease and several medical equipment leases. Real estate lease agreements typically have initial terms of five to ten years and equipment lease agreements typically have initial terms of three-years.

Future maturities of operating leases at December 31, 2021 are presented in the following table:

Year Ending December 31,		Amount
2022	$	163,751
2023		75,648
2024		38,303
2025		24,363
Total	$	302,065

HHS Rent Agreement with HHP

HHS rents medical office and outpatient facilities from HHP. In year 2021, HHS expensed and paid to HHP $185,051, which eliminates in the combined financial statements. The rental agreement automatically renews annually and, at December 31, 2021, the monthly rent was $17,000.

NOTE 8 RELATED-PARTY RECEIVABLES AND PAYABLES

Related-party receivables and payables as of December 31, 2021 consisted of the following:

	Relationship	Amount
Receivable:		
HHP:		
Oladipo Fadiora	Owner	35,744
Total Receivable		$ 35,744
Payable:		
HHS:		
Oladipo Fadiora	Owner	$ 192,812
Total Payable		$ 192,812

Mr. Oladipo Fadiora, 100% owner of HHP and HHS, does not have maturity or interest rate terms on the collection and repayment of any related-party payables or receivables.

NOTE 9 COMMITMENTS AND CONTINGENCIES

Other

The Companies operate in the health care industry and may be subject to legal proceedings and claims from time to time that arise in the course of providing its services. The Companies maintain malpractice insurance coverage on the claims made basis, which provides coverage for claims occurring and reported during the policy year. Management has determined that no provision is required for amounts expected to be paid under the policy's deductible limits for unasserted claims not covered by the policy and any other uninsured liability. Management has recorded no legal reserve liability for any legal proceedings as of the date of this report.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, and reimbursement for patient services.

COVID-19

During the fiscal year, the World Health Organization declared the spread of Coronavirus Disease (COVID-19) a worldwide pandemic. The COVID-19 pandemic is having significant effects on global markets, supply chains, businesses, and communities. Specific to the Companies, COVID-19 has impacted various parts of their operations for the year ended December 31, 2021, and financial results including but not limited to, additional costs for emergency preparedness, disease control and containment, additional testing, potential shortages of health care and other personnel, and loss of revenue due to reductions in certain revenue streams. Management believes the Companies continue to take appropriate actions to mitigate the negative impact of this pandemic.

NOTE 10 SUBSTANTIAL DOUBT ABOUT THE COMPANY'S ABILITY TO CONTINUE AS A GOING CONCERN

HHS and HHP have debt due to Truist Bank that, as of the date of these audited financial statements, is beyond their respective maturity dates and subject to immediate repayment at the request of Truist Bank. The debt with Truist Bank as of December 31, 2021 is as follows:

Truist Loan 2	$ 218,476
Truist Loan 1	694,357
Truist Promissory Note	2,528,493
Total Truist Bank Debt	$ 3,441,326

Managements' Plan

If Truist Bank demands payment of the above debt prior to a restructuring, it would result in the foreclosure of the Whitehead road and Bannister road buildings that are collateral on the above debt.

1) Management has the ability to shift its operations currently operated in the Whitehead road and Bannister road buildings to other currently leased offices. The Whitehead road and Bannister road buildings are not currently operated at full in-person capacity.
2) All HHS and HHP debt due in year 2023 is below third-party appraisals of the Whitehead road and Bannister road buildings, and, thus, Management does not anticipate contributing more funds to service the debt in year 2023.

NOTE 11 CORRECTION OF AN ERROR

During 2021, there were adjustments required to correct HHS revenue, expense, investments in other assets that related to the prior period. Therefore, the beginning member's equity has been restated to correct these errors.

HHS Member's Equity - As Originally Reported	$ 683,458
HHS Adjustments	(1,753,950)
HHS Member's Equity as of December 31, 2020 - Adjusted	$ (1,070,492)
HHP Member's Equity as of December 31, 2020	(122,666)
HHS and HHP Combined Member's Equity as of December 31, 2020	$ (1,193,158)

NOTE 12 SUBSEQUENT EVENTS

The Companies have evaluated its subsequent events (events occurring after December 31, 2021) through June 7, 2023, which represents the date the combined financial statements were available to be issued.

SUPPLEMENTARY INFORMATION

HOPE HEALTH SYSTEMS, INC. AND HOPE HEALTH PROPERTIES LLC
COMBINING BALANCE SHEET
DECEMBER 31, 2021
(SEE INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION)

	Combined	Eliminations	Hope Health Systems, Inc.	Hope Health Properties LLC
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 168,882	$ -	$ 160,545	$ 8,337
Patient Accounts Receivable	284,097	-	284,097	-
Other Receivable	36,579	-	18,305	18,274
Prepaid Expenses	27,692	-	27,692	-
Deposits and Other	4,747	-	4,747	-
Total Current Assets	521,997	-	495,386	26,611
DUE FROM RELATED PARTY	35,744	-	-	35,744
DUE FROM AFFILIATE	-	(811,021)	809,461	1,560
OTHER ASSETS	120,358	-	120,358	-
PROPERTY AND EQUIPMENT, NET	3,813,543	-	656,178	3,157,365
Total Assets	$ 4,491,642	$ (811,021)	$ 2,081,383	$ 3,221,280
LIABILITIES AND MEMBER'S EQUITY (DEFICIT)				
CURRENT LIABILITIES				
Accounts Payable	$ 437,689	$ -	$ 371,939	$ 65,750
Other Accrued Expenses	304,610	-	304,610	-
Lines of Credit	409,141	-	409,141	-
Current Portion of Long-Term Debt	3,222,851	-	694,358	2,528,493
Current Portion of Capital Leases	77,753	-	77,753	-
Income Taxes Payable	10,000	-	10,000	-
Total Current Liabilities	4,462,044	-	1,867,801	2,594,243
DUE TO RELATED PARTY	192,812	-	192,812	-
DUE TO AFFILIATE	-	(811,021)	61,021	750,000
CAPITAL LEASES PAYABLE, LONG-TERM	345,411	-	345,411	-
LONG-TERM DEBT	1,652,430	-	1,652,430	-
Total Liabilities	6,652,697	(811,021)	4,119,475	3,344,243
MEMBER'S EQUITY (DEFICIT)	(2,161,055)	-	(2,038,092)	(122,963)
Total Liabilities and Member's Equity (Deficit)	$ 4,491,642	$ (811,021)	$ 2,081,383	$ 3,221,280

HOPE HEALTH SYSTEMS, INC. AND HOPE HEALTH PROPERTIES LLC
COMBINING STATEMENT OF OPERATIONS
YEAR ENDED DECEMBER 31, 2021
(SEE INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION)

	Combined	Eliminations	Hope Health Systems, Inc.	Hope Health Properties LLC
REVENUES				
Net Patient Service Revenue	$ 12,108,287	$ -	$ 12,108,287	$ -
Other Operating Revenues	213,485	(185,501)	11,401	387,585
Total Revenues	12,321,772	(185,501)	12,119,688	387,585
OPERATING EXPENSES				
Salaries and Wages	8,876,192	-	8,876,192	-
Employee Benefits and Payroll Taxes	1,284,931	-	1,284,931	-
Contractual and Purchased Services	2,224,916	-	2,183,548	41,368
Supplies	334,783	-	334,783	-
Repairs and Maintenance	511,923	-	497,047	14,876
Utilities	129,546	-	50,432	79,114
Lease Expense	259,146	(185,501)	473,647	(29,000)
General and Administrative	571,626		564,855	6,771
Property Taxes	80,375	-	49,118	31,257
Federal and State Income Taxes	142,579	-	142,579	-
Bad Debt Expense	158,528	-	158,528	-
Depreciation	239,913	-	135,913	104,000
Amortization	9,944	-	9,944	-
Interest Expense	233,438	-	93,942	139,496
Total Operating Expenses	15,057,840	(185,501)	14,855,459	387,882
OPERATING LOSS BEFORE OTHER INCOME	(2,736,068)	-	(2,735,771)	(297)
OTHER INCOME				
Interest Income	1	-	1	-
Forgiveness of PPP Loan	1,768,170	-	1,768,170	-
Total Other Income (Expense)	1,768,171	-	1,768,171	-
NET LOSS	$ (967,897)	$ -	$ (967,600)	$ (297)

EXHIBIT 28

VIII. Additional Factors Indicative of Growing / Unmet Need

In Maryland, and the wider United States, research and provider experiences indicate there is insufficient inpatient mental health capacity to enable adequate access for children (0-12) and adolescents (13-17) suffering from mental health and behavioral disorders. For example:

- Depression/Suicide: Per the CDC, the suicide rate for persons aged 10–14 nearly tripled from 2007 (0.9 per 100,000) to 2017 (2.5 per 100,000). The suicide rate for persons aged 15–19 increased 76% from 2007 (6.7 per 100,000) to 2017 (11.8 per 100,000).

  More recently, the CDC identified downward trends in mental health for high school students.

Figure XX[1]

The Percentage of High School Students Who:*	2011 Total	2013 Total	2015 Total	2017 Total	2019 Total	2021 Total	Trend
Experienced persistent feelings of sadness or hopelessness	28	30	30	31	37	42	
Experienced poor mental health†	–	–	–	–	–	29	–
Seriously considered attempting suicide	16	17	18	17	19	22	
Made a suicide plan	13	14	15	14	16	18	
Attempted suicide	8	8	9	7	9	10	
Were injured in a suicide attempt that had to be treated by a doctor or nurse	2	3	3	2	3	3	

*For the complete wording of YRBS questions, refer to the appendix.
†Variable introduced in 2021.

In wrong direction
No change
In right direction

The Maryland Youth Risk Behavior Surveillance System (YRBSS) offers a more focused look into the emotional needs and behavioral health risks of youth in Maryland. The percentage of middle school and high school students who seriously considered attempting suicide in Maryland increased from 2018-2019 to the 2021-2022 survey period:

1 https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

Figure XX[2]

Middle School Health			
	2018-19	2021-22	Trend
Felt sad/hopeless	25.5%	36.8%	↑
Ever Seriously Considered Suicide	22.9%	26.8%	↑
Ever Made a Suicide Plan	14.3%	19.5%	↑
Attempted Suicide	8.8%	11.0%	↑
High School Health			
	2018-19	2021-22	Trend
Felt sad/hopeless	32.0%	39.2%	↑
Seriously Considered Suicide	18.0%	20.6%	↑
Had Obesity	12.8%	15.9%	↑

- Provider Bias and Inequality of Care: Per the National Alliance on Mental Illness, African Americans have been, and continue to be, negatively affected by prejudice and discrimination in the health care system. Conscious or unconscious bias from providers and lack of cultural competence can result in misdiagnosis, inadequate treatment and mistrust of mental health professionals.

  These disparities can create a distrust in mental health professionals, which can prevent many from seeking or continuing treatment. Per the Black Mental Health Alliance, only 6.2% of psychologists, 5.6% of advanced practice nurses, and 21.3% of psychiatrists are members of minority groups. When a person is experiencing challenges with their mental health, it is essential for them to receive quality and culturally competent care. The Maryland Department of Planning reported that Maryland's minority share in its population is 50%, 72.3% in Baltimore City, and 44.2% in Baltimore County. Overall, Maryland is the 7th most diverse State in the country.

  This issue has been recognized in part by the Maryland Department of Health and Behavioral Health Administration, including in their FY 2019-2020 Cultural and Linguistic Competency Strategic Plan. As they note, culturally competent care is quality care. By increasing cultural competence and providing representative provider options, patients will be more likely to seek and receive treatment in the coming years.

  HHS is a Minority Business Enterprise (MBE) with diverse staff and clinical providers that reflect the communities HHS serves. Its diversity will be a welcoming aspect of care to patients and their families.

2 https://health.maryland.gov/phpa/ccdpc/Reports/Pages/State-Level-Data%2c-2021-2022.aspx

- In Baltimore City, the Local Behavioral Health Authority's (LBHA) most recent annual report[3] related a number of issues indicating additional unmet need in the community:

    - Violence: Baltimore City also continues to experience endemic violence. The homicide rate remains extremely elevated compared to the years leading up to 2015. There was a spike of 342 homicides in 2015, which was exceeded during 2019 with 348 homicides. In addition to the tragic loss of life, each homicide has a traumatic impact on the individuals, families and communities that survive the loss of a family member, friend, or acquaintance. Such losses, particularly when compounded by [other factors], can have long-term negative consequences on health and well-being, including mental health conditions, substance use, asthma, autoimmune, cardiac and other chronic diseases.

    - Rate of Mental Illness: [T]he prevalence of mental illness in the reported year in Baltimore City was 17.8%, which was higher than the state rate of 16.7%. [Youth Risk Behavior Surveillance Survey] YRBSS data shows higher prevalence of mental health symptoms and risk factors among youth compared to state and national averages. Based on this data, it appears that the overall need for mental health services in Baltimore City is higher than the need statewide and that this disparity exists among the city's youth.

    - Systemic Racism: Baltimore City has a disproportionate burden of structures and conditions, which increases the likelihood of chronic behavioral health conditions.

    - ACEs: As the number of Adverse Childhood Experiences (ACEs) increases, there is an increased likelihood of risky behaviors and chronic physical and mental health conditions. Maryland began collecting ACEs data through the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) in 2015. Statewide, the prevalence of three or more ACEs was 24%, whereas for Baltimore it was 42%.

- Improved Diagnosis: Increasing awareness and identification of mental health risk, along with decreasing stigmas, will drive increasing demands for mental health care amongst youth.

- COVID-19: A prior Centers for Disease Control and Prevention (CDC) report found the prevalence of symptoms of anxiety disorder in the second quarter of 2020 was approximately three times those that reported in the second quarter of 2019 (25.5% versus 8.1%); and the prevalence of depressive disorder was approximately four times that reported in the second quarter of 2019 (24.3% versus 6.5%)[4].

  In a 2020 survey of 1,000 parents around the country facilitated by the Ann & Robert H. Lurie Children's Hospital of Chicago, 71% of parents said the pandemic had taken a toll on their child's mental health, and 69% said the pandemic was the worst thing to happen to their child[5].

  Additional studies have found that consistent with previous pandemics (e.g., H1N1 influenza, Ebola), a growing body of literature shows that the COVID-19 pandemic has had a deleterious

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[3] https://www.bhsbaltimore.org/wp-content/uploads/2020/05/FY-19-Activities-Indicators-Utilization-Revised-Apr-2020-1.pdf - FY 2020 is still the last annual report published.
[4] https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm#T2_down
5 https://www.luriechildrens.org/en/blog/childrens-mental-health-pandemic-statistics/

impact on youth mental health[6]. Studies conducted at the onset and throughout the course of the pandemic have noted increased mental health problems among youth, with greater impact noted among vulnerable subgroups, such as those with pre-existing mental health problems, those with physical disabilities, racial and ethnic minorities, and sexual minorities[7].

Research also found that adolescents requiring psychiatric hospitalization during the pandemic reported increased symptom severity compared to adolescents hospitalized on the same inpatient unit in the three years prior to the pandemic[8]. While the long-term impacts of the pandemic on children and adolescent mental health are not predictable, the research suggests additional needs may develop for youth as a result of the pandemic.

The above are just further evidence of unmet need. The issue has many root causes, and while psychiatric hospitals represent only one point on a care continuum, they are a critical one for children and adolescents in psychiatric crisis.

IX. Cumulative Project Need / Discharge Assumptions

The issues outlined above have identified a number of quantitative and qualitative factors indicating need for additional inpatient psychiatric beds for children and adolescents. Today, the number of psychiatric beds for children and adolescents per person fall well below expert's consensus figures. The historical discharge rates, ALOS, population assumptions, and current bed counts show that the market needs and can support more children beds and has a dire need for additional adolescent beds. The current occupancy rates at the two freestanding psychiatric hospitals are very high for the children and adolescent patient populations, leading to upstream access issues for incoming patients seeking admission. Of note, ED boarding has grown quickly in recent years, and the research shows that additional bed capacity and connections with established outpatient programs that HHS can provide are critical to address both issues.

Finally, the unmet need not showing in historical use rates or current providers includes many patients HHS intends to serve through the expanded access. Overall growth in mental health issues and demand for care is linked to issues affecting underserved and minority communities, including violence, racism, suicide, adverse childhood incidents, poverty, and COVID-19. As mental health stigmas are removed, care coverage improves, and awareness/diagnoses increases the need for the proposed services will grow.

The totality of the evidence shows a need for additional inpatient psychiatric beds. To estimate the source of admissions for the proposed facility, HHS has broken down the expected volume and source of admission as seen below. HHS notes the need in the market exceeds these estimates based on the factors analyzed in the proceeding sections. As a conservative position, HHS projected the following discharges and market share assumptions for year 1 of operations.

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6 Meherali S., Punjani N., Louie-Poon S., Abdul Rahim K., Das J.K., Salam R.A., Lassi Z.S. Mental health of children and adolescents amidst CoViD-19 and past pandemics: A rapid systematic review. *International Journal of Environmental Research and Public Health.* 2021;18(7):3432.

7 Hawke L.D., Hayes E., Darnay K., Henderson J. Mental health among transgender and gender diverse youth: An exploration of effects during the COVID-19 pandemic.

8 Millner AJ, Zuromski KL, Joyce VW, Kelly F, Richards C, Buonopane RJ, Nash CC. Increased severity of mental health symptoms among adolescent inpatients during COVID-19. Gen Hosp Psychiatry. 2022 Jul-Aug;77:77-79.

Table 32

Service Area Cases Shifted to HHS from Existing CY2022 Volume			
Source of Admission	**Volume**	**% of CY2022 Admissions**	**% of CY2022 Service Type**
Direct admissions	73	1.95%	1.95%
Admissions from ED	203	5.44%	1.16%
Admissions from observation	41	1.11%	5.69%
Admissions from observation >24 hours	70	1.87%	9.59%
Population growth	2	-	-
Total	**389**	**10.38%**	**-**

From this baseline, HHS forecasts the following year over year growth assumptions:

Table 33

Year over Year Growth Rate			
Yr2 over Yr1	*Yr3 vs Yr2*	*Yr4 vs Yr3*	*Yr5 vs Yr4*
4.88%	*4.88%*	*3.00%*	*3.00%*

Finally, HHS project the following per year discharges, ALOS, and occupancy rates in total:

Table 34

TOTAL PROJECTED DISCHARGES (<18 years-old)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Total # of Discharges	389	408	428	441	454
Average length of stay (ALOS)	10.74	10.74	10.74	10.74	10.74
Total Patient Days	4,177	4,380	4,596	4,735	4,875
Occupancy Rate (16 beds)	72%	75%	79%	81%	83%
CHILD (<13-year-old) PROJECTED DISCHARGES					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Total # of Discharges	102	107	112	115	118
Average length of stay (ALOS)	10.00	10.00	10.00	10.00	10.00
Total Patient Days	1,020	1,070	1,120	1,150	1,180
Occupancy Rate (4-bed unit)	70%	73%	77%	79%	81%
ADOLESCENT (13–17-year-old) PROJECTED DISCHARGES					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Total # of Discharges	287	301	316	326	336
Average length of stay (ALOS)	11.00	11.00	11.00	11.00	11.00
Total Patient Days	3,157	3,311	3,476	3,586	3,696
Occupancy Rate (12-bed unit)	72%	76%	79%	82%	84%

Source: HSCRC Case mix data, patients <18, Dx in F category, for HHS service area zip codes

Assumptions:

-Length of stay is based upon the CY State Averages of 10.28 for Children and 11.42 for Adolescents from pre-pandemic CY 2019 data obtained by HHS from HSCRC. The averages were minimally reduced to a round figure of 10 for children and 11 for Adolescents. These averages are also generally in keeping with Brook Lane for a like-provider comparison.

-4.88% Growth rate in years 1 through 3 based on pent-up demand and program ramp up.
-Growth expected to slow to 3% in years four and five, as facility enters a steady state.

-Year 1 volumes represent a 10.43% market share of HHS service area CY2022 volume, however, portion of cases would likely be conversion of current observation stays greater than 24 hours to inpatient stays, and some existing ED volume conversion to IP stay due to current lack of capacity contributing to walk-away cases, which may have otherwise resulted in an admission.

EXHIBIT 29

HHS Acute Care Children and Adolescent Programs Description

HHS is committed to providing patients admitted to our acute care services with person centered, evidence-based care designed to meet the individualized needs of each patient in order to produce optimum outcomes for the children, adolescents and families served. HHS believes the best approach to achieving desired outcomes and minimizing time spent in this most restrictive level of care is the development and implementation of a four- fold approach to include:

- Active therapeutic milieu
- Robust clinical programming
- Family and care giver orientation and participation
- Multi-disciplinary team

Therapeutic Milieu

HHS proposes an active, trauma informed, participatory, well managed therapeutic milieu in which all elements are organized to achieve the following five goals:

1. Provide treatment for children and adolescents with complex mental health conditions at risk of self-harm, harm to others, destruction of property and/or those individuals who cannot be effectively treated in other settings.
2. Provide individualized, strength based, evidence based and best practice care and services.
3. Provide co-occurring substance use services to those youth who have co-occurring mental health and substance use disorder needs
4. Support a recovery orientation resulting in symptom reduction; behavioral self-management; improved functioning; and skill building/mastery which leads to the return to community and/or familial living as soon as possible.
5. Active collaboration with patients, parents/caretakers, continuum of care service providers, community liaisons and others in order to develop effective discharge and disposition plans that mitigate risk and reduce the likelihood of re-hospitalization or placement outside the community.

Milieu management is core to the health and safety of patients and staff alike. The milieu will be structured and operationalized in such a way as to facilitate patients' and family/caregivers' abilities and skills to better manage symptoms and behaviors and to improve functionality through consistently applied positive behavioral supports. The milieu is managed in such a way as to recognize and attend to each patient's needs as well as his/her strengths and preferences regardless of race, ethnicity, sexual identity, gender orientation, religion, and disability, and to create a climate where each patient is treated with dignity and respect. Milieu management and treatment are to be implemented so as to be trauma-informed, recovery-oriented, person-centered and rehabilitation-focused. The focus of the latter is to assist patients in developing the symptom and behavioral management skills that will allow them to stay in the community and to make progress towards their individualized recovery goals.

Clinical Programming

HHS believes to maximize the short length of stay for our patients, it is imperative that clinical programming is robust and focused to include an intensive therapeutic schedule to include individual, group and family therapies as well as educational instruction and/or tutoring in small groups or individual sessions; active structured recreational time; and opportunities for appropriate socialization.

HHS psychiatrists, primary clinicians, alternative clinical therapists, nurses and mental health counselors collaborate to ensure a schedule of active treatment through the patient's stay regardless of how short or long. Active treatment includes scheduled process, psychoeducational and didactic skill building groups as well as individual therapies and family work utilizing several clinical strategies and selected related interventions. These groups are scheduled for a minimum of four hours daily, seven days per week. The strategies used in all interventions are tied directly to HHS person centered, individualized, recover oriented philosophy and are reflective of the most recent evidence based and best practices.

The evidence based and best practices selected are aligned with the individual patient's needs according to the initial and ongoing assessments and includes age, demographics, diagnoses, symptoms, functionality, behaviors, skills, personal characteristics and preferences. HHS focuses on symptom management, skill building and emotional regulation for both children and adolescent patients.

Using Dr Orr's, "The Spotlight Approach" and Zones of Regulation, children learn to identify and label their feelings and begin to develop specific effective coping skills to self soothe and manage their behaviors. Staff

utilize both DBT and CBT strategies, interventions and activities with adolescent patients to build self-management skills, increase coping and improve communication and interactions. Specialized tracks for patients dealing with symptoms and behaviors related to major mood disorders, psychoses, stress intolerance, aggression and assaultive behaviors are scheduled based on patient needs. When appropriate, formal and informal behavioral plans are developed by psychologist and/or trained BCBA and implemented by the HHS staff.

Family and Caregiver Orientation and Participation

HHS realizes the critical nature of family therapy and work and understands that children and adolescents- although the identified patient- are part of a larger system- whether in home with their family or origin, adoptative families or other caretakers. As such, well trained clinical staff with expertise provide family and caretaker therapy using evidence base practice such as system, structural and strategic theory interventions. In addition to family therapy, HHS offers parenting classes and multi-family group sessions.

Multidisciplinary Treatment Team

The management of the therapeutic milieu, maintenance of intense clinical programming and the provision of evidence-based and best practices is reliant on a team of professional behavioral health staff with expertise and experience working together in a multidisciplinary treatment team. Each patient is assigned a multidisciplinary team at the time of admission that meets on a regular basis during the patient's stay. The patient and designated family member/caretaker are considered to be an active member of the treatment team and are responsible for participating in the developing and signing the treatment plan to the degree possible.

The Multidisciplinary Treatment Team are comprised of all representative disciplines to include psychiatry, clinical therapies (including alternative therapists such as occupational, music, art, movement and recreational therapists) and nursing. The purpose of the Multidisciplinary Treatment Team is to meet on a regular basis and formulate an initial treatment and then to continuously monitor and evergreen the multi-disciplinary treatment plan for the patient. Timeframes for the development, review, revision/updating are aligned with state, accreditation and best practice protocols and addressed in HHS Policy and Procedure.

HHS has used its knowledge and skills-based competencies and vast experience to design the ideal acute care program for Maryland's children, adolescents and their families to include a well- managed therapeutic milieu with robust active treatment provided by a multi-disciplinary team.

EXHIBIT 30

BALTIMORE COUNTY BEHAVIORAL HEALTH ADVISORY COUNCIL

BHAC

TIM SANTONI
Chair

TONY WRIGHT
Co-Chair

March 20, 2023

Hope Health Systems, Inc.
Mr. Oladipo Fadiora, CEO
1726 Whitehead Road
Woodlawn, MD 21207

Dear Mr. Fadiora:

Please accept this correspondence as an official letter of support for your Certificate of Need (CON) application to the Maryland Health Care Commission to establish a sixteen (16) bed freestanding psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

At present, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access for youth suffering from health and behavioral disorders. The proposed project would expand access for youth in need of inpatient care, while connecting them to intensive and supportive outpatient programs upon discharge.

Your organization has more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children and adolescents in institutional and outpatient settings in Maryland and specifically Baltimore County. Hope Health Systems, Inc. currently offers an array of outpatient programs for children and adolescents that will coordinate with the inpatient facility and other providers in the community to provide a full continuum of care.

I support your plan for Hope Health Systems, Inc. to add inpatient psychiatric beds for children and adolescents, helping Baltimore County be a place where healthy people live, work and play.

Sincerely,

Tim Santoni

Tim Santoni, Chair

https://www.baltimorecountymd.gov/Agencies/health/boards/bhac.html