Application for Certificate of Need

Establishment of Freestanding Inpatient Psychiatric Hospital
Children & Adolescents

Hope Health Systems, Inc.

October 21, 2020

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For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Hope Health Systems**

Address:

1726 Whitehead Rd.	**Woodlawn**	**21207**	**Baltimore**
Street	City	Zip	County

Name of Owner (if differs from applicant):
Hope Health Systems, Inc.

2. OWNER

Name of owner: **Hope Health Systems, Inc.**

3. APPLICANT. ***If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.***

Legal Name of Project Applicant
Hope Health Systems, Inc.

Address:

1726 Whitehead Rd.	**Woodlawn**	**21207**	**MD**	**Baltimore**
Street	City	Zip	State	County

Telephone: **410-265-8737**

Name of Owner/Chief Executive: **Mr. Oladipo Fadiora**

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:
Hope Health Systems, Inc.

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☒	
	(3) Close	☐	State & date of incorporation
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☐	

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

A. Lead or primary contact:

Name and Title: Mr. Yinka Fadiora

Mailing Address:

1726 Whitehead Rd.	**Woodlawn**	**21207**	**MD**
Street	City	Zip	State

Telephone: **410-265-8737**
E-mail Address (required): **yfadiora@hopehealthsystems.com**
Fax: **410-265-1258**

B. Additional or alternate contact:

Name and Title: Bryan Niehaus

Mailing Address:

7840 Graphics Dr Suite 100	**Tinley Park**	**60477**	**IL**
Street	City	Zip	State

Telephone: **248-990-3402**
E-mail Address (required): **bniehaus@advis.com**
Fax: **7084787094**

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1) A new health care facility built, developed, or established ☒
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf ☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

Applicant Response

(1) Brief Description of the Project

The applicant, Hope Health Systems Inc. ("HHS") is proposing to establish a 16- bed psychiatric hospital specifically for children and adolescents. The facility will provide for four (4) single patient rooms to treat the child patient population and twelve (12) single patient rooms to treat the adolescent patient population. The inpatient facility would be established in a renovated portion of a building that HHS owns in Woodlawn, Baltimore county. The facility already includes an outpatient facility with a psychiatric partial hospitalization program (for children and adolescents below 18 years of age).

The hallmark of HHS' mental health hospital will be to provide an integrated, comprehensive, personalized mental health treatment facility to children and adolescents in Baltimore county and city area. Specifically, the project will: provide improved access to care for patients, increase access for those who are publicly insured, provide high-quality care through its step-down approach before discharging the patient to the community, diversify the provider market for inpatient mental health care, deliver culturally competent care, integrate the care continuum for patients, improve care coordination, and ultimately help reduce readmission rates.

HHS currently provides a number of services to the community, including partial hospitalization, outpatient mental health, expanded school mental health, DOJ service, rehabilitation programs, substance abuse, and mobile treatment. As a result, HHS is uniquely positioned to provide its

discharged inpatients with continued follow up to help reintegrate them into the community and reduce readmissions.

(2) Rationale for the Project

At present, there are only seven (7) hospitals in the State that provide child psychiatric services, and just five (5) of these hospitals handle over 95% of admissions. Only eleven (11) hospitals provide adolescent psychiatric services within the State, and just seven (7) of these hospitals handle 95% of admissions. The current level and concentration of access is not sufficient to meet patient needs, as is further outlined in the response under 10.24.01.08G(3)(b).

In addition to the need for more access, health care providers and community stakeholders have identified lack of care after a patient is discharged from a psychiatric unit to be a major concern[1]. The transition from acute mental health inpatient to community care is a vulnerable period, where patients can experience a risk to their mental health.

The term "revolving door" is widely used to describe how mental health service users (children, adolescents, as well as forensic patients) can repeatedly transition between hospital and community care and then back to hospital within a very short period of time[2]. This issue of "revolving door" has been a big concern for service users due to increased readmission rates over years, resulting in increased cost of care for patients. For Maryland residents, the rate of readmissions across all three age groups increased between 2014 and 2017. For children it went from 7.2 to 10.0 per 100 discharges, and adolescents went from 4.6 to 8.1 per discharge[3].

The 'circuit of care' as well as increased readmission rate stems not only from patient's health condition but also from the lack of continuous care after inpatient discharge. HHS has developed several components of its vision to provide an integrated personalized care to its patients. HHS' care transition program will help reduce the readmission rates by providing comprehensive care through its various programs, which we describe in more detail in our response to 10.24.01.08G(3)(b).

Finally, as an existing provider in the community, HHS understands that many face additional burdens in the form of structural racism, cultural biases, and health disparities that are not sufficiently recognized and addressed through existing care options. HHS is a Minority Business Enterprise (MBE) that has made diversity and culturally competent care a guiding principle of our organization. We both employ a diverse clinical and support staff workforce and train all staff on the important principles of culturally competent care. With strong ties to the under-served Medicaid patient population this project will service, HHS is the best choice to expand inpatient capacity for the patient population.

(3) Cost

As seen in Exhibit 1, table E, the total cost of the project is $4,500,000.00.

[1] Tyler, N., Wright, N. & Waring, J. Interventions to improve discharge from acute adult mental health inpatient care to the community: systematic review and narrative synthesis. BMC Health Serv Res 19, 883 (2019).
[2] Id.
3 Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019.

(4) Master Facility Plans

The project will be completed in a single phase with two parts, with the first portion of the project to demolish the existing rooms and fixtures within the space that has been designated as the new hospital space. Following the demolition, the construction team will proceed with the renovation efforts to update the space within the existing facility to meet hospital FGI standards for an inpatient psychiatric hospital.

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

Applicant Response

1. *Construction, renovation, and demolition plans;*

The project shall consist of a gut renovation within a portion of the existing building currently leased by HHS. The space is currently vacant but was historically used as offices, classrooms, and conference rooms to support HHS's existing outpatient service lines. The renovated space totals 10,134 square feet.

The newly renovated space will be separate and distinct from the existing outpatient services offered within the building, and will have a separate entrance for patients and visitors. The space will feature private sleeping rooms and the variety of rooms and environments required by the Facility Guidelines and recommended by evidence based best practices.

As seen in the attached floor plans in Exhibit 2, the space shall be distinct between the adolescent and children age groups which shall each have available nursing stations and protocols to allow for a specialized treatment based upon the age group being treated. The facility will include features that are friendly to families, children, and adolescents, enabling the family, as appropriate, to participate in care. Utility services to the unit are supplied from the existing infrastructure in the building.

2. *Changes in square footage of departments and units;*

The space being renovated was not previously a licensed space and this is a newly proposed special hospital.

3. *Physical plant or location changes;*

The present mechanical, electrical, and plumbing (MEP) infrastructure within the building is adequate to serve the area identified for renovation. The project includes all new MEP services within the project area and modifications to the controls systems as necessitated by the design.

4. *Changes to affected services following completion of the project; and*

This is a new hospital that will only share a building with outpatient clinical services, none of which will be affected. The inpatient care will be constructed in an area that is currently vacant and constitutes 23% of the existing building. The building was recently constructed, hence, heavy construction that could disrupt daily work activity will not occur.

5. *If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.*

The project is planned as a single phase of construction.

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

Applicant Response

See HHS Form Tables, Exhibit 1, Table A

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size:

Applicant Response

The project will affect a total of 10,134 gross departmental square feet. See HHS Form Tables, Exhibit1, Table B for additional information. See Exhibit 2 for a floor plan of the proposed hospital.

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO __X___ (If NO, describe below the current status and timetable for receiving necessary approvals.)

Applicant Response

Please see Exhibit 8 for a statement from our engineer engaged on zoning.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: . _____
Please provide a copy of the deed.

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: . _____

Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: Hope Health Systems, Inc.
Please provide a copy of the option to lease as an attachment. Included as Exhibit 3.

(5) Other: _____
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	4	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	1	months
Completion of project from capital obligation or purchase order, as applicable	6	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent		months

	phase of construction within 12 months after completion of immediately preceding phase		
	Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
	Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Applicant Response

The project drawings are attached as Exhibit 2.

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

Applicant Response

See Exhibit 1, HHS Form Tables, Table C, Table D.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

Applicant Response

The present water, sewer, electrical power, emergency power, heating ventilation and air conditioning, fire suppression, detection and alarm, and electronic security systems (the utilities) that service the facility are adequate to serve the new hospital use of the space. Updates will be made to serve all the new rooms in keeping with state and federal guidelines.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Applicant Response

See Exhibit 1, HHS Form Tables, Table E.

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

1. List names and addresses of all owners and individuals responsible for the proposed project.

Applicant Response

Mr. Yinka Fadiora
Address: 26 Bellchase court, Pikesville, MD- 21208

Mr. Oladipo Fadiora
Address: 8616 Glen Hannah, Windsor Mill, MD- 21244

Mr. Lanre Fadiora
Address: 4252 Pinefield, Baltimore, MD 21133

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

Applicant Response

The following are not defined under the CON regulations as "health care facilities", but are existing outpatient treatment sites operated by HHS.

1. Woodlawn, MD
6707 Whitestone Rd
Suite 106
Baltimore, MD 21207
Phone 1: 410.944.HOPE
Phone 2: 410.265.8737
Fax: 410.265.1258
Email: info@hopehealthsystems.com
All the programs including: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Intensive outpatient program, Partial hospitalization Programs, Substance abuse Treatment and consulting services.

2. Greenspring, MD
2605 Banister Rd
Baltimore, MD 21215
Phone: 410.878.0236
Fax: 410.567.0399
All the programs including: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Intensive

outpatient program, Partial hospitalization Programs, Substance abuse Treatment and consulting services.

3. Carroll County No PHP AND IOP
6210 Georgetown Blvd
Suites A, B & C
Eldersburg, MD 21784
Phone: 410.216.5500
Fax: 410.567.0401
All the programs including: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Substance abuse Treatment and consulting services.

4. Middletown, DE
417 E Main St
Middletown, DE 19709
Phone: 302.376.9619
Fax: 302.378.1028
All the programs including: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Substance abuse Treatment and consulting services.

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3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions)? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No.

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4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

No.

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5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

Date

Signature of Owner or Board-designated Official

CFO

Position/Title

Lanre Fadiora

Printed Name

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

Date

Signature of Owner or Board-designated Official

Executive Director
Position/Title

Yinka Fadiora
Printed Name

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

Date

Signature of Owner or Board-designated Official

CEO

Position/Title

Oladipo Fadiora

Printed Name

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

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. <u>In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.</u>

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

<u>Applicant Response</u>

Applicable State Health Plan Chapter include COMAR 10.24.07, the Psychiatric Services Section, and COMAR 10.24.10, Acute Hospital Services.

Availability

AP la. The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories~ net acute psychiatric bed need, and/or state hospital conversion bed need.

Applicant Response

HHS is applying for a 16-bed inpatient psychiatric hospital, twelve (12) of the beds will be used to treat adolescents and four (4) of the beds will be used to treat children.

The Commission has determined that Standards AP 1a – 1d are no longer applicable because they are based on an obsolete bed need projection. In re Anne Arundel Medical Center Mental Health Hospital, Docket No. 16-02-2375, Decision at p. 9 (April 19, 2018). Accordingly, HHS prepared a bed need assessment for its proposed project based on hospital utilization patterns and other indicators that identify community need. Based upon the HHS analysis, there is a demonstrative need for inpatient psychiatric beds for children and adolescents. The addition of beds proposed in this project will help meet that need by helping to increase the number of available beds. Please refer to the response to COMAR 10.24.01.08G(3)(b) for HHS's more detailed need analysis.

AP lb. A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

Applicant Response

Inapplicable, as there are no delicensing requirements applicable to this project and the Commission has determined that the standard is based on an obsolete bed need projection. In re Anne Arundel Medical Center Mental Health Hospital, Docket No. 16-02-2375, Decision at p. 9 (April 19, 2018).

AP 1c. The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

- **i. the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;**
- **ii. that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;**

iii. that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and

iv. **that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant**.

Applicant Response

Inapplicable, this project does not involve state hospital conversion beds and the Commission has determined that the standard is based on an obsolete bed need projection. In re Anne Arundel Medical Center Mental Health Hospital, Docket No. 16-02-2375, Decision at p. 9 (April 19, 2018).

AP ld. Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need", as defined, who sign a written agreement with the Mental Hygiene Administration as described in part (i) and (iii) of Standard AP lc.

Applicant Response

Inapplicable, this is a not a comparative review and the Commission has determined that the standard is based on an obsolete bed need projection. In re Anne Arundel Medical Center Mental Health Hospital, Docket No. 16-02-2375, Decision at p. 9 (April 19, 2018).

AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late-night shifts.

Applicant Response

Inapplicable, as HHS is not a general acute care hospital and is seeking approval to become a Special Hospital offering inpatient psychiatric services to children and adolescents.

AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

Applicant Response

Inapplicable, as HHS is not a general acute care hospital and is seeking approval to become a Special Hospital offering inpatient psychiatric services to children and adolescents.

AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

Applicant Response

Inapplicable, as HHS is not a general acute care hospital and is seeking approval to become a Special Hospital offering inpatient psychiatric services to children and adolescents.

AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response

The facility will perform all of the above referenced services, as ordered by physicians and as deemed medically necessary. The facility shall use a multidisciplinary team consisting of aides, nursing staff, social workers, occupational therapists, psychiatrists, and psychologists to provide the required services.

AP 3b. In addition to the services mandated in Standard 3a, inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Applicant Response

The facility will perform all of the above referenced services, as ordered by physicians and as deemed medically necessary. As referenced in the above response, the facility shall use a multidisciplinary team of aides, nursing staff, social workers, occupational therapists, psychiatrists, and psychologists. The team will coordinate services through a multidisciplinary approach that will focus not only on therapies identified in AP 3a, above, but also to address daily living skill, psychoeducational development, vocational development, opportunities to develop interpersonal skills, restoration of family functioning, and other specialized needs of the patient and family.

HHS is uniquely positioned to provide these services as we are already providing these services on an outpatient basis for these patient populations. HHS can bridge the outpatient to inpatient care gap by extending its services to treat the acute inpatient patient needs of the population to ensure patients receive specific and continuous care through discharge and beyond. Our various outpatient programs today include:

- Outpatient Mental Health Clinic (OHMC)
- Behavioral Health Care Coordination
- Expanded School-Based Mental Health (ESMH)
- Mobile Treatment Services Unit (MTS)
- Substance Abuse Treatment Services
- Health Homes
- Psychiatric Rehabilitation Programs (PRP)
- Correctional and Aftercare Mental Health Services
- Family League and Family Recovery Program (FRP)

HHS will not only provide inpatient treatment that addresses the acute needs of patient for daily living skills, interpersonal skills in groups, family functioning, and other specialized needs – we will provide care based on our extensive experience with the child and adolescent patient populations and connect the care to supportive outpatient services.

In addition to Individualized Treatment Plans (ITPs) for each patient that consider the unique needs of their age, the proposed facility will provide services to child and adolescent patients in separate wings with their own nursing units. This will allow for the facility to meet the individual needs of each patient in an appropriate care setting. HHS will obtain The Joint Commission ("TJC") accreditation and further abide by all their standards.

AP 3c. All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicant Response

Inapplicable, as HHS is not a general acute care hospital, and is seeking approval to become a Special Hospital offering inpatient psychiatric services to children and adolescents. All psychiatric consultation services will be provided by directly by Hope Health Systems, Inc. psychiatrists.

AP 4a. A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Applicant Response

HHS is proposing to establish a 16-bed psychiatric hospital specifically for children and adolescents. The facility will provide for four (4) single patient rooms to treat the child patient population and twelve (12) single patient rooms to treat the adolescent patient population.

AP 4b. Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

Applicant Response

As demonstrated in the floor plan attached as Exhibit 2, HHS has designed the hospital to serve both the children and adolescent patient population in separate units. In keeping therewith, HHS shall ensure that each unit is separately staffed by a RN at all times, with each unit having an individualized nursing station The team psychiatrists shall float between both units, as necessary and provider the overall care to both patient populations. Programmatic distinctions will be made through individualized treatment plans and therapies that consider the patient age. HHS will obtain TJC accreditation and further abide by all their standards.

Accessibility

AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available: intake screening and admission; arrangements for transfer to a more appropriate facility for care if medically indicated; or necessary evaluation to define the patient's psychiatric problem and/or emergency treatment.

Applicant Response

For all patients requesting admission to this facility, the following services will be offered:

- Intake screening and admission –the facility will provide intake screening and admissions as required.
- Arrangements to transfer to a more appropriate facility for care if medically indicated will be provided through in-house medical/surgical consultation - The facility will have written transfer agreements in place with locale hospitals to ensure access to medical, surgical, and psychiatric needs not provided in-house.
- Evaluation to define the patient's psychiatric problem and/or emergency treatment –All patients admitted to the psychiatric inpatient units at this facility are provided a full evaluation by licensed psychiatric providers.
- Emergency treatment will be made available to all patients in need and in accordance with federal and state law and all accreditation standards.

HHS will obtain TJC accreditation and further abide by all their standards.

AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations including: children, adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.

Applicant Response

The child and adolescent treatment plans and quality assurance programs differ to ensure that each patient population is provided with age appropriate protocols in keeping with the multidisciplinary team approach. Furthermore, additional guidelines will be established to treat those with a secondary diagnosis of substance abuse. The treatment teams are trained and provided with all of the tools necessary to ensure each specific patient is treated in keeping with best practices for their age group.

AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

Applicant Response

The proposed facility will not deny admission to any patient based on their legal status. HHS shall also accept involuntary admissions, as needed to treat the eligible patient population based upon emergency petitions.

AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12 month period.

Applicant Response

Hope Health Systems, Inc. intends to provide a level of uncompensated care that equals or exceeds the average of uncompensated for acute inpatient services in the service area. HHS's service area for inpatient psychiatric services will include Baltimore County and Baltimore City, however in keeping with state plan guidance's, HHS assessed the UCC rate for the entire central planning region below. As seen in the below table, Hope Health Systems, Inc. will meet or exceed the 3.96% uncompensated care average for all acute general hospitals in the service area. The UCC rate used was based upon the blended rate identified by HSCRC for 2020.[1] This estimate is built into our financials, as seen in Exhibit 1 Table J & K.

Figure 1 – Uncompensated Care Percentage

Hospital	UCC Percentage 2020	County
Anne Arundel Medical Center	3.14%	Anne Arundel
Carroll Hospital	2.56%	Carroll
Grace Medical Center	3.12%	Baltimore City
Greater Baltimore Medical Center	2.85%	Baltimore
Howard County General Hospital	3.91%	Howard
Johns Hopkins Bayview Medical Center	4.84%	Baltimore City
MedStar Franklin Square Medical Center	3.88%	Baltimore
MedStar Good Samaritan Hospital	4.27%	Baltimore City
MedStar Harbor Hospital	4.29%	Baltimore City
MedStar Union Memorial Hospital	3.69%	Baltimore City
Mercy Medical Center	4.19%	Baltimore City
Northwest Hospital	4.65%	Baltimore
Saint Agnes Hospital	5.21%	Baltimore City
Sinai Hospital of Baltimore	3.67%	Baltimore City
The Johns Hopkins Hospital	2.80%	Baltimore City
UM Baltimore Washington Medical Center	5.09%	Anne Arundel
UM Harford Memorial Hospital	5.72%	Harford
UM St Joseph Medical Center	3.90%	Baltimore
UM Upper Chesapeake Medical Center	3.22%	Harford
UMMC Midtown Campus (FKA Maryland General Hospital)	4.62%	Baltimore City
University of Maryland Medical Center	3.53%	Baltimore City
AVERAGE	**3.96%**	

AP 9. If there are no child acute psychiatric beds available within a 45-minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

Applicant Response

Inapplicable, as the facility will offer child acute psychiatric beds, other facilities offer child acute psychiatric beds within a 45-minute drive time, and there will not be any general pediatric beds at the proposed facility.

[1] Appendix 1 - https://hscrc.maryland.gov/Documents/Hospitals/gbr-tpr-update/FY-2020/UCCCareReport.pdf

Cost

AP 10. Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application. psychiatric Bed Range (PBR):

PBR<20 – 80%
20<PBR<40- 85%
PBR> 40 – 90%

Applicant Response

Inapplicable, as HHS does not seek to expand any existing adult psychiatric beds.

AP 11. Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (< 30 days) Psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Applicant Response

HHS analysis the data provided by the HSCSC which included all the general acute care hospitals within the central planning area that had established psychiatric inpatient cases and requested the total average cost of each case. HHS excluded those hospitals with under ten admissions in compliance with our HSCRC data use agreements. As demonstrated in the table below, the average cost per case was $15,791.61 for patients under the age of 18.

HHS projects an average total cost in year one of $10,439.37.

Figure 2 - Average Total Cost of Acute Psychiatric Admission – Central Planning Area

Hospital Name	Total IP Discharges (2019)	Age-Adjusted Average Total Cost Per Discharge	Total Costs
Children (0-12)			
University of Maryland	440	$16,524.25	$7,270,670.00
Johns Hopkins	160	$12,999.40	$2,079,904.00
MedStar Franklin Square	43	$11,643.04	$500,650.72
Mt. Washington Pediatric Hospital	34	$31,387.22	$1,067,165.48
Adolescents (13-17)			
University of Maryland	11	$18,171.52	$199,886.72
Johns Hopkins	457	$17,063.87	$7,798,188.59
MedStar Franklin Square	297	$11,926.32	$3,542,117.04
Carroll Hospital Center	75	$20,174.42	$1,513,081.50
Total Costs Per Age-Adjusted Patient Admission			**$15,802.02**

Quality

AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicant Response

HHS shall provide the requisite services and the clinical supervision of a qualified psychiatrist. HHS current has four (4) Board Certified Child and Adolescent Psychiatrists (see response to AP 12 below as well) on staff and have an established plan to expand its staff to meet needs.

AP 12b. Staffing of acute psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven day per week treatment program.

Applicant Response

HHS shall provide for aftercare coordinators to facilitate the transition of the patients from the inpatient setting to an outpatient care program, as necessary. As referenced in the above response, the facility shall use a multidisciplinary team of aides, nursing staff, social workers, occupational therapists, psychiatrists, and psychologists.

HHS is uniquely positioned to ensure successful transition to an outpatient venue since it is currently successfully operating a suite of outpatient services, including:

- Outpatient Mental Health Clinic (OHMC)
- Behavioral Health Care Coordination
- Expanded School-Based Mental Health (ESMH)
- Mobile Treatment Services Unit (MTS)
- Substance Abuse Treatment Services
- Health Homes
- Psychiatric Rehabilitation Programs (PRP)
- Correctional and Aftercare Mental Health Services
- Family League and Family Recovery Program (FRP)

AP 12c. Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

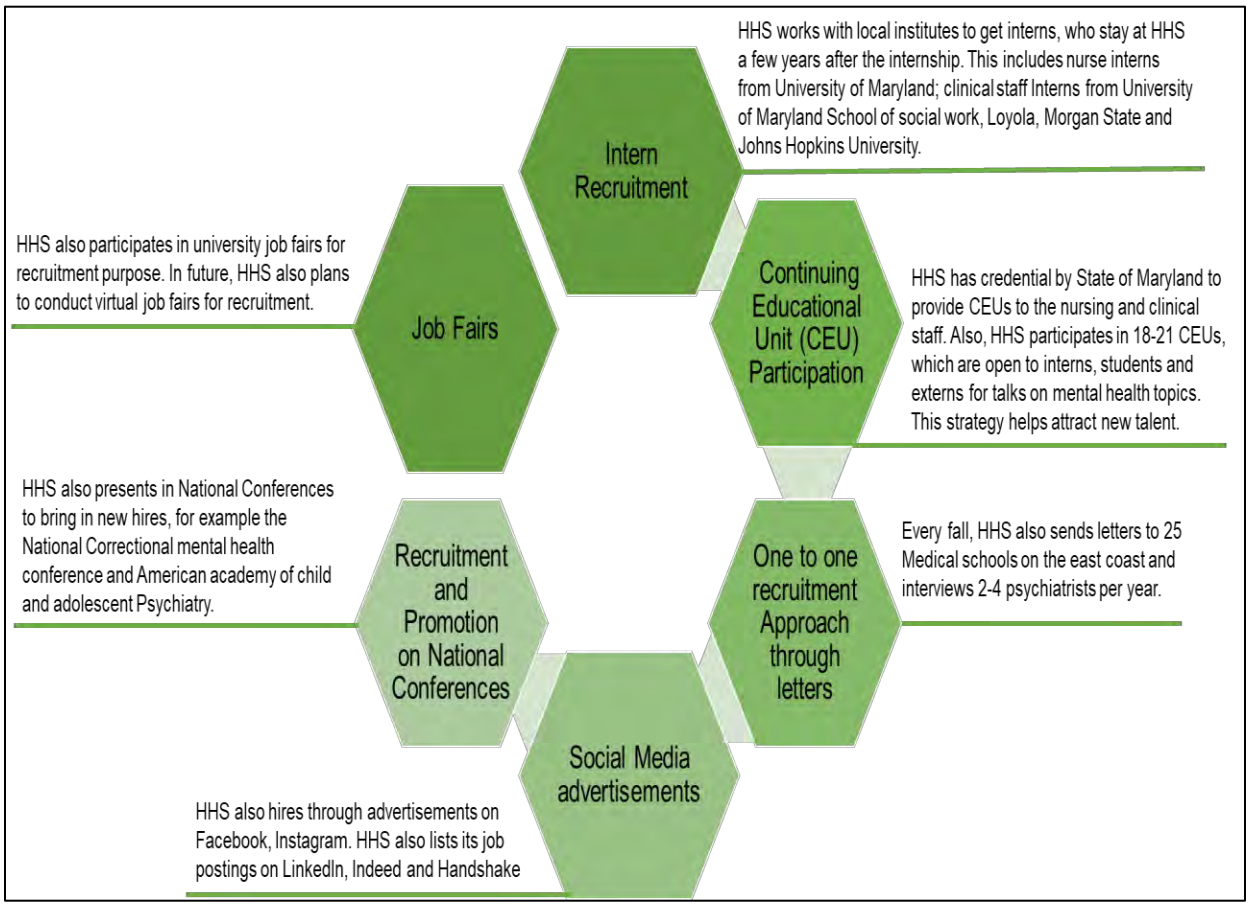
Applicant Response

HHS will employ and staff the facility with staff that are experienced and trained in child/adolescent psychiatric care.

As noted above, HHS' current staff members already have specialization in children and adolescent mental health treatment. In addition, prior to the opening and admission of the intended patient population, all staff will go through additional training and HHS shall ensure each staff has the appropriate competencies to treat each age group appropriately. The current staff includes:

Figure 3 - Current HHS Clinical Staff	
Credentials	**Number of Current Staff**
Board Certified Child and Adolescent Psychiatrist	4
Board Certified Psychiatrist	2
Psychologist	1
Psychiatric Nurse Practitioner	1
Licensed Clinical Professional Counselor	4
Licensed Clinical Social Worker	2
Licensed Master Social Worker	3
Licensed Clinical Alcohol and Drug Counselor	1

Furthermore, additional staff needed to treat the patient population will be recruited as needed, utilizing HHS's established recruitment and hiring process as outlined in part below:



Continuity

AP 13. Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicant Response

HHS will maintain policies that would be utilized for the proposed project to address admission, planning, and discharge guidelines. For a draft example please see Exhibit 4.

Acceptability

AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following: the local and state mental health advisory council{s);

i. the local community mental health center(s);
ii. the Department of Health and Mental Hygiene; and
iii. the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Applicant Response

The applicant has letters of support as demonstrated in Exhibit 5, including from the following:

- Mary Beth Haller, Esq. Deputy Commissioner of Health – Baltimore City Health Department
- Antionette McLeod, Executive Director for Operations, MD Department of Juvenile Services
- Dr. Gregory Branch, Health Officer, Department of Health, Baltimore County
- Charles E. Sydnor III, Esq, Senate of Maryland, Legislative District 44
- Andrea Brown, Executive Director, Black Mental Health Alliance,
- Dr. Ronald Means, Chief Medical Officer, Catholic Charities of Baltimore
- Dr. Jonathan Shepherd, President, Board of Directors, Black Mental Health Alliance
- James Omotosho, Program Director, Optimum Health Systems, Inc.
- Subramonianpillai Teal, Clinical Director/Co-Founder, Leading by Example Behavioral Health
- Deborah Okonofua, DNP, Agape Health Systems
- Tiffany Carroll, Executive Director, Empowering Minds Resource Center, LLP
- Stacey Bass, Executive Director, Healthy Minds Resource Center
- Nick Mosby, Legislative District 40, Baltimore City
- Dr. Annelle Primm, Former deputy Director, American Psychiatric Association
- Dr. Akin Akintola, Board Certified Child, Adolescent, and Adult Psychiatrist
- Dr. Ernest L. Carter, Health Officer, Prince George's County Health Department
- Dr. Kimberly Gordon-Achebe, MD, FAPA, Medical Director of Intensive Services, Hope Health Systems

(1) Information Regarding Charges.
Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

- **a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;**
- **b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and**
- **c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.**

Applicant Response

HHS Shall comply with this standard as seen in the policy attached as Exhibit 6.

(2) Charity Care Policy.
Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay

- **a) The policy shall provide:**
  - **i) Determination of Probable 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.**
  - **ii) Minimum Required Notice of Charity Care Policy.**
    1. **Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and, in a format, understandable by the target population on an annual basis;**
    2. **Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and**
    3. **Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.**
- **b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.**

Applicant Response

HHS shall comply with this standard as seen in the policy attached as Exhibit 6. HHS shall also have appropriate notices posted within the hospital to provide appropriate notice to patients and their family.

(3) Quality of Care.
An acute care hospital shall provide high quality care.

- **a) Each hospital shall document that it is:**

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;
(ii) Accredited by the Joint Commission; and
(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Applicant Response

Inapplicable, as HHS is seeking approval to establish a new hospital. HHS will be seeking TJC accreditation for the hospital, and HHS is already licensed for its outpatient services with TJC and CARF for its outpatient services.

COMAR 10.24.10 Acute Care – Project Review Standards

(1) **Geographic Accessibility.**
A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

Applicant Response

Inapplicable, as HHS is not seeking to establish or replace an acute general hospital.

(2) Identification of Bed Need and Addition of Beds.
Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

- **a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.**
- **b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.**
- **c) Additional MSGA or pediatric beds may be developed or put into operation only if:**
  - **i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or**
  - **ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or**
  - **iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or**
  - **iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.**

Applicant Response

Inapplicable, as HHS is seeking approval for a special - psychiatric hospital.

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit.
An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

- **a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or**

b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

Applicant Response

Inapplicable, as HHS does not seek to establish an acute care pediatric unit.

(4) Adverse Impact.
A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

Applicant Response

a) HHS is seeking approval for a new hospital and does not seek to increase rates; however, it reserves the right to do so in the future.
b) The project does not reduce any existing facility or service.

(5) Cost-Effectiveness.
A proposed hospital capital project should represent the most cost-effective approach to meeting the needs that the project seeks to address.

a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:
  i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;
  ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and
  iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis

outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

i) That it has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

iv) That the proposed project site is superior, in terms of cost effectiveness, to the alternative project site or sites located within a Priority Funding Area.

Applicant Response

The primary objective of this project is to address the identified shortage of inpatient access for children and adolescents in need of inpatient mental health services in the State and amongst the Baltimore metropolitan area surrounding the facility.

a) HHS has considered

1) **Establish a psychiatric inpatient unit for only children or only adolescents** – As discussed in the need section at 10.24.01.08G(3)(b), the applicant has identified there is a quantifiable need for additional inpatient psychiatric services for both children and adolescents. The applicant considered an approach for development of care for a single patient population, but identified that both age groups require additional beds within the patient population. HHS has identified below, there is a current need for adolescent beds in the state and the Central Planning Area, with the area providers currently reaching high utilization rates that cause patient delays in care and restrict access. Without establishing both bed types HHS determined that there would remain a gap of care for its intended patient population and would further cause burdens to the health care system, and would only partially achieve the objectives of the project.

   The proposed project would also have required substantially similar costs due to the fact that the current project is expected to be completed in space currently owned by the applicant. If the beds for one service type was not pursued at this time, HHS identified that there would remain a need in the future that would force the expansion of services which may have burdened the existing services, in order that it may continue to be co-located. By completing both age groups simultaneously, HHS shall also be able to experience additional efficiencies to allow for a single recruitment and training of staff, and additional administrative requirements to provide care for each patient population.

   This alternative was rejected due to the limited effectiveness at meeting the overall goals.

2) **Do not Establish a Psychiatric hospital** – HHS also considered not establishing any inpatient beds to treat the psychiatric population. This project would not have any associated costs and would not achieve the primary objective of the proposed project. The applicant has identified a need for additional inpatient psychiatric beds, as identified above. In addition, without establishing any of the proposed beds, the ability of HHS to meaningfully address the unmet needs and negative outcomes experienced by current access issues and integration with outpatient services is limited to cooperation from other area providers. As just one example, and noted in more detail in the need section below, the Maryland Hospital Association published a report in September of 2019 specifically focused on behavioral health discharge delays in Maryland hospitals[4]. The study identified that patients under the age of 18 had a discharge delay two times the adult population, with an average of 18 hours per patient. The study noted that the most common reason for the delay was due to lack of available bed space.

   The proposed project will be located close to existing HHS outpatient programs and the population center of metropolitan Baltimore to increase access for patients. HHS current outpatient suite of services is not capable of meeting patient demand for inpatient services.

   Accordingly, the alternative of not providing any inpatients bed was rejected due to the ineffectiveness at meeting the overall goals.

b) See section a., above.

c) The proposed hospital is located within the Priority Funding Area pursuant to § 5-7B-02(6)

(6) Burden of Proof Regarding Need.
A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

Applicant Response

See Section 10.24.01.08G(3)(b), below.

(7) Construction Cost of Hospital Space.
The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of 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, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. 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

4 Maryland Hospital Association: "Behavioral Health Patient Delays in Emergency Departments". September 2019.

those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response

HHS has provided the Marshall Valuation Services benchmark analysis as Exhibit 10. As noted therein, the project both falls below the MVS benchmark for Grade A hospital construction, and is reasonable and consistent with current industry cost experience in Maryland.

As noted within the MVS report in Exhibit 10, the project costs are $167.14 per sq. ft., which is below the required regulatory threshold for Grade A construction.

HHS recognizes any rate will not include any amounts in excess of the Marshall Valuation Service benchmark.

(8) Construction Cost of Non-Hospital Space.
The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. 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 non-hospital space 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. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

Applicant Response

The project does not include any non-hospital space.

(9) Inpatient Nursing Unit Space.
Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, 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 for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicant Response

Excluding the administrative, group therapy, dining, and social area space, the clinical nursing units are below 500 sq. ft. per bed. The facility is not an existing hospital accordingly there will not be any rate increases associated with the size of the project.

(10) Rate Reduction Agreement.
A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Applicant Response

Not applicable.

(11) Efficiency.
A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, the manner in which the planning and design of the project took efficiency improvements into account; and
b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or
c) Demonstrate why improvements in operational efficiency cannot be achieved.

Applicant Response

The proposed project is not eliminating any diagnostic or treatment facilities.

(12) Patient Safety.
The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

Applicant Response

The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. Notably, the facility includes separate nursing stations for each patient age category that allow for staff to quickly and efficiently respond to any and all patient emergencies. With direct line of site maximized, the facility will allow staff to follow best practices in patient safety and suicide prevention measures. Appropriate security measures promoting appropriate perimeter security.

The facility design also includes the availability of safe spaces for the patient. The facility includes both “noisy” and “quiet” social interaction rooms that will be multi-functional, a setting for group/family therapy, dining areas, and offices for staff. All equipment shall be selected with care to ensure appropriate safety measure are met.

(13) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.

b) Each applicant must document that:

i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and

iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital’s primary service area population.

Applicant Response

The proposed project will be financially feasible. The financial feasibility of the proposed HHS project is based on the following assumptions:

(b)(i) Utilization projections are consistent with observed historic trends of like hospitals and conservative assumptions on growth, as demonstrated in the section 10.24.01.08G(3)(b) and Table I of the Exhibits.

(b)(ii) Revenue estimates are consistent with utilization projections and are based on historic rates of reimbursement as presented by the Maryland Health Care Commission, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by alike providers. (Tables J & K).

(b)(iii) Staffing and overall expense projections that are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by similar projects (Table L).

(b)(iv) Depreciation, interest, and other operating costs associated with the renovated space are in keeping with industry standards (Part III COMAR 10.24.01.08G(3)(d) – Tables J and K)

As Table J shows, HHS will generate excess revenues over total expenses.

(14) Emergency Department Treatment Capacity and Space.

a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;

ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;

iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;

iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and

v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

Applicant Response

Not applicable, this facility will not have an emergency department.

(15) Emergency Department Expansion.

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;

b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

Applicant Response

Not applicable, this facility will not have an emergency department.

(16) Shell Space.

a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

i) Considers the most likely use identified by the hospital for the unfinished space;

ii) Considers the time frame projected for finishing the space; and

iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Service Cost Review Commission

Applicant Response

Not applicable, this facility will not have shell space.

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

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

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response

Hope Health Systems, Inc. ("HHS") is seeking approval for the proposed facility to be a vital lifeline to expand access for those in need of inpatient care, while connecting them and discharging them to intensive and supportive outpatient programs. The inpatient facility will integrate community health providers and ensure smooth transitions, appropriate placements, and less recidivism. The goal is to heal those suffering from mental health disorders and provide the support necessary so they can continue to lead productive lives.

The project will address the mental health needs of the children and adolescent patient population by providing more psychiatric inpatient services. Specifically, the project is to establish a 16-bed inpatient psychiatric facility to increase the availability of beds for Children (ages 0-12) and Adolescents (ages 13-17). Higher level or acute psychiatric care for youth is intended to be active but short-term with treatment focusing on crisis stabilization, assessment, safety monitoring, and longer-term treatment planning.

The below analysis of the need for child and adolescent inpatient psychiatric beds considers the population, historical use rates, future trends, and incorporates unmet needs to quantify the need for the facility. We look at both the primary service area and State-wide needs given the limited options available to these patient populations in need of acute psychiatric services.

To quantify the need for this project, HHS examined the current State guidelines, MHCC's psychiatric services work group's recent review of standards, and research on determining beds need for child and adolescent inpatient psychiatric services. As the State has not defined one formula for determining need, HHS reviewed influential data metrics and observable outcomes indicative of the unmet need this project will help address.

As it is not an existing hospital provider, HHS also provides background on the organization as it is relevant to understanding how HHS already addresses needs on an outpatient basis and how the project responds to the identified needs for inpatient care that can be responsive to the coordination and integration of inpatient and outpatient services.

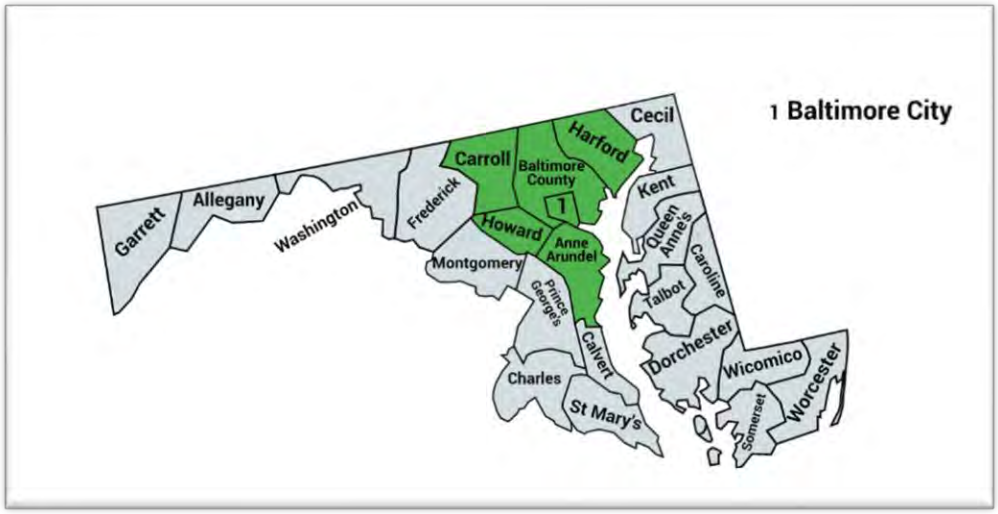
HHS has organized its response as follows:

Based on these factors, and as described in more detail below, the service area defined by HHS has an identifiable need for additional inpatient psychiatric bed capacity for children and adolescents. Further, the project is responsive to the overall coordinated and comprehensive care plan for Maryland's response to the mental health crisis.

I. Service Area Definition

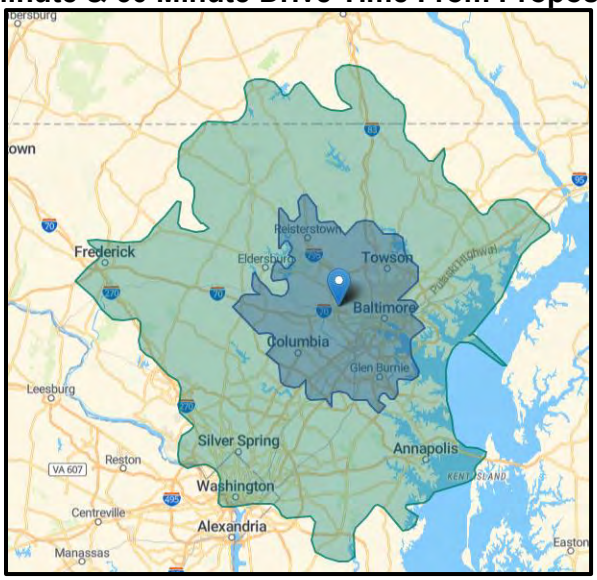
Hope Health Systems, Inc.'s primary service area for the proposed inpatient psychiatric hospital is the Central Planning region encompassing Anne Arundel, Carroll, Hartford, Howard, Baltimore County, and Baltimore City. As outlined below, HHS identifies a need for beds across the State of Maryland, but also a concentration of population and need in the Central Planning Region focused around the Baltimore metropolitan area. HHS expects to draw patients from across the State given the limited access option for children and adolescents. For example, the applicant is aware of children and adolescents with delays waiting for inpatient services in surrounding areas such as Prince George's county that may seek services at the proposed facility.

Figure 4
Map of Proposed Service Area



As seen below, the 30-minute and 60-minute drive time surrounding the selected location encompasses the central planning region and even extends into some surrounding areas.

Figure 5
Map of 30-Minute & 60 Minute Drive Time From Proposed Hospital



II. Population Estimates

The estimated patient population of Baltimore County and city are expected to some growth through 2027, based upon the state of Maryland population estimates published by the Maryland Department of Planning[5] and US Census Bureau[6] growth trends.

To estimate the patient population, HHS reviewed the Maryland Department of Planning estimated trends for population between 2020 -2030, and amended the data to reflect 2021 – 2027, which mirror the tables and analysis provided in Exhibit 1. HHS identified that the change in estimated population was in keeping with the Census Bureau trends in population, and therefore utilized the state-based data projections.

However, since the state-based data project age categories did not specifically line up with the Child and Adolescent patient population age ranges, HHS assumed the ages were equally distributed throughout each age range. The state age ranges were 0-4, 5-9, 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% of the 10-14 age range to the children analysis to reflect the state child age range of 0-127. The total for each column reflects this analysis.

The patient population was then equally distributed on a year over year basis to equal the estimated population changes indicated in the state data. The following tables summarize the anticipated patient population for the service area over the next five years.

Figure 6

State of Maryland Population 2021-2027				
Year	Total (Ages 0-12)	Percent Change	Total (Ages 13-17)	Percent Change
Total 2021	962,003		390,660	
Total 2022	967,073		390,812	
Total 2023	972,142		390,963	
Total 2024	977,212		391,115	
Total 2025	982,281		391,267	
Total 2026	987,351		391,419	
Total 2027	992,420	3.16%	391,571	0.23%

Figure 7

Maryland Central Planning Region Children (Ages 0-12) Population 2021-2027			
County	Year	Total (Ages 0-12)	Percent Change
Anne Arundel Co.	2021	91,506	
Anne Arundel Co.	2027	92,766	1.4%
Baltimore Co.	2021	130,709	
Baltimore Co.	2027	129,067	-1.3%
Carroll Co.	2021	23,351	

[5] https://planning.maryland.gov/MSDC/Pages/s3_projection.aspx
[6] https://data.census.gov/cedsci/
7 HHS notes that the 40%/60% assumptions led to results in line with the State-wide population figures reported by age from the US Census for 2019.

Carroll Co.	2027	24,374	4.4%
Harford	2021	39,336	
Harford	2027	41,501	5.5%
Howard	2021	56,407	
Howard	2027	59,164	4.9%
Baltimore City	2021	92,613	
Baltimore City	2027	92,257	-0.4%
Total All 2021		433,922	
Total All 2027		439,129	1.2%

Figure 8

Maryland Central Planning Region Adolescents (Ages 13-17) Population 2021-2027			
County	Year	Total (Ages 13-17)	Percent Change
Anne Arundel Co.	2021	35,225	
Anne Arundel Co.	2027	35,508	1%
Baltimore Co.	2021	54,103	
Baltimore Co.	2027	54,591	1%
Carroll Co.	2021	10,584	
Carroll Co.	2027	9,537	-10%
Harford	2021	16,320	
Harford	2027	15,579	-5%
Howard	2021	22,657	
Howard	2027	23,343	3%
Baltimore City	2021	36,339	
Baltimore City	2027	36,104	-1%
Total All 2021		175,228	
Total All 2027		174,662	-0.3%

III. Bed Shortages Based on Expert's Bed per Population Standards

One metric for determining bed need is the consensus from experts within the field on how many beds are required to service a given population. The Treatment Advocacy Center (TAC) has been the most-cited source of a per-population bed need assessment in recent decades. Although not focused on child and adolescent age groups, their research in 2008 and 2016 has reported an estimate of 40-60 inpatient beds per 100,000 in population, with a consensus of about 50 beds per 100,000 for inpatient psychiatric care. For comparison, the ratio in England in 2008 was 63.2 beds per 100,000.

While the population grew and awareness of mental health increased in America over the last decades, there was a concurrent long-term trend of inpatient psychiatric bed reductions. In fact, ninety-five percent of public psychiatry beds available in 1955 were no longer available as of 2005. Maryland's state beds decreased from 4,390 in 1982 to 950 in 2016. In Maryland today there is only one (1) state run inpatient mental health unit that serves adolescents, and there are zero (0) inpatient beds for children. As reported by the Maryland Hospital Association[8], the closing of state-operated psychiatric beds has not been offset by greater access to community-based services.

[8] https://www.mhaonline.org/docs/default-source/publications/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf?sfvrsn=f7c0da0d_4

As reported by the Maryland Health Care Commission (MHCC) in 2019, Maryland ranks near the average of States in inpatient psychiatric bed counts, with a reported 34.3 beds per 100,000 in population. This places Maryland at 26th of 52 reporting States. Although not a definitive report, MHCC's Psychiatric Services Work Group published a preliminary analysis of psychiatric bed counts by age group as part of the March 17, 2020 meeting materials. This is the most specific breakdown of beds by age group currently available publicly.

Per "Agenda Item 3 (Part 1) – Current Health Planning regions for Acute Psychiatric Services in Hospital", the following were estimates on the current bed counts[9]. HHS added in population estimates from the US Census to calculate beds per 100,000 in population.

Figure 9
Bed Estimates Per 100,000 in Population

	Population*	Staffed Bed Count	Bed Per 100,000 in Population	Staffed Bed Count at "Single Occupancy"**	Beds Per 100,000
Maryland (Age 13-17)	390,660	150	38.39	95	24.32
Maryland (Age 0-12)	962,003	71	7.38	63	6.55

*Per US Census for 2021
*Staffed beds identified by MHCC as "Semi-Private" were reduced to single occupancy to provide additional context on available beds. "Semi-Private" rooms often only bed (1) psychiatric patient.

As seen in the above chart, the availability of beds for children is far below the 40-60 bed estimates reported by TAC. Likewise, the bed availability for Adolescents is near or below the TAC figures. This is especially true when treating semi-private rooms with 2 or more beds as a single bed, which is a consideration HHS incorporated because semi-private rooms often function as private rooms due to a variety of patient safety and staffing challenges that prevent patients from sharing a semi-private room.

IV. Historical Discharge Analysis

HHS references the reported per-population discharge rates for the applicable age groups from MHHC's recent publications. The following table from MHCC showcases the use rates per 100,000 in population from 2008-2017.

Figure 10 Psychiatric Discharge Rates per 100,000 Population, CY 2008-CY 2017[10]

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Use Rate Change
Child (0-12)	179	189	204	209	217	201	192	170	175	183	2.30%
Adolescent (13-17)	1,008	1,199	1,190	1,291	1,294	1,328	1,329	1,318	1,273	1,273	26.40%
Adult (>18)	853	896	896	905	887	869	850	804	802	772	-9.60%
All Ages	752	799	801	816	804	790	775	734	731	709	-5.60%

[9] https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Agenda%20Item%203_part1.docx.pdf
10 Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019

In addition, HHS obtained data from HSCRC for CY 2017-2019, showing the following discharges rates for APR-DRGs 740-776.

Figure 11 Psychiatric Discharge Rates per 100,000 Population, CY 2017-CY 2019

	2017	2018	2019
Child (0-12)	200	198	188
Adolescent (13-17)	1,319	1,280	1,133

Experts generally agree there is no definitive formulaic methodology for assessing the need for inpatient psychiatric beds at this time. However, HHS has used historical data to produce a basic analysis using the most common factors considered by many states/agencies for contextualizing their bed needs.

Based on the HSCRC data, HHS has outlined the following bed need/demand analysis. HHS focused on state-wide figures as the concentration of beds in the central planning region distorts a regional analysis.

Figure 12
State of Maryland Bed Demand / Need Calculation

Children	Ages (0-12)	Adolescent	(Ages 13-17)
Population in 2022[1]	967,072	Population	390,811
Projected Discharges (188 per 100,000)[2]	1,818.10	Projected Discharges (1,133 per 100,000)	4,427.89
Projected Patient Days (10.5 ALOS)[3]	19,090.00	Projected Patient Days (11.4 ALOS)	50,477.93
Bed Demand at 100% Occupancy	52.30	Bed Demand at 100% Occupancy	138.30
Bed Demand at 85% Occupancy	61.53	Bed Demand at 85% Occupancy	162.70
Bed Demand at 70% Occupancy	74.72	Bed Demand at 70% Occupancy	197.57
Staff Beds per MHCC[4]	71	Staff Beds per MHCC	150
Bed Need	**3.72**	Bed Need	**47.57**
Staff Beds per MHCC[4] (Single Occupancy)	63	Staff Beds per MHCC (Single Occupancy)	95
Bed Need	**11.72**	Bed Need	**102.57**

1: Population based on Maryland Department of Planning and estimates from Section (II) in this 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 HSCRC data
4. Staffed bed totals based on MHCC Psychiatric Services work group survey & "single occupancy" equates to all private rooms.

The State-wide assessment paints a telling picture of the need for additional inpatient psychiatric beds. The above table displays bed need at an occupancy level of 70%, as this has been discussed by the MHCC Staff and Psychiatric Services Work Group as a level at which the state should consider evaluation of additional beds for facilities under 20 beds to further increase access points. The 70% occupancy rate for target bed counts is supported by research discussed under "Bed Occupancy Rates" section below. As further outlined below, HHS in fact expects a higher need and occupancy rate for the proposed facility, as unmet need is evident in the planning region and likely not identifiable solely by looking at historical use rates.

While HHS does not believe this formulaic approach is a definitive analysis of bed need, the results of the analysis do lend further credence to the position that the state requires additional bed capacity, particularly for adolescents, that this project would provide.

V. Need Based on Historical Bed Occupancy Rates

HHS has prepared the below analysis of the occupancy rate at the two largest providers of inpatient psychiatric services in the State of Maryland for Children and Adolescents, which also have a publicly reported figure for their bed dedicated to under age 18 patients. HHS also notes occupancy rates at the age group level are notoriously difficult to track, as some facilities flex their staffed beds and beds dedicated to certain age groups as demand dictates. However, the data does indicate an acute need for additional private psychiatric bed capacity to service the patient population.

For the most age-specific analysis from public data, HHS reviewed the HSCRC financial data reports for psychiatric specialty hospitals in Maryland. Included in these reports are volume figures and bed count for the "PCD PSYCHIATRIC - CHILD/ADOLESCENT" cost accounting center. Included in this cost center are all patient days for care provided to patients under the age of 18. The same reports for general acute care providers do not provide the same age-specific breakdowns for psychiatric care by cost center. HHS then applied the HSCRC data obtained for 2017-2019 against those bed counts to assess occupancy levels.

Figure 13
Bed Occupancy Rates FY2017-FY2019

Provider	Time Period	Total Patient Days	Total Patient Admissions	ALOS	Bed Count	Occupancy Rate
Sheppard Pratt	FY 2019	36,491	2,442	14.94	96	104.14%
	FY 2018	35,582	2,739	12.99	96	101.55%
	FY 2017	35,168	2,933	11.99	96	100.37%
Brook Lane	FY 2019	9,871	954	10.35	28	96.59%
	FY 2018	13,112	1,043	12.57	28	128.30%
	FY 2017	8,921	1,016	8.78	28	87.29%

As seen above, both Brook Lane and Sheppard Pratt show occupancy rates between ~87% and 128% over the last three fiscal years. Of further concern is that recent research indicates the State Health plan threshold occupancy rates (related to existing facilities seeking additional beds) are too high. As cited by MHCC meeting minutes from the Psychiatric Service Work Group:

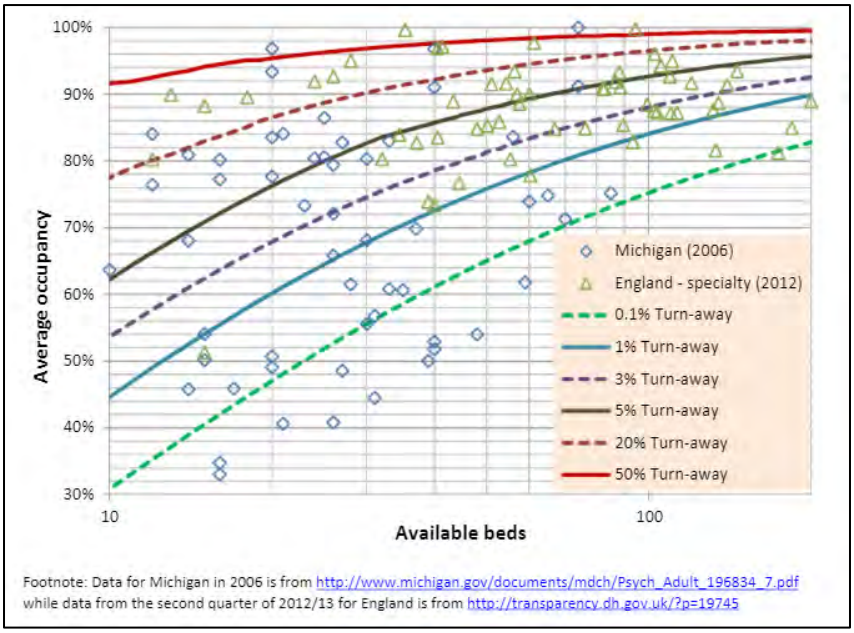
> The threshold standard for a facility with 40 beds is an occupancy rate of at least 90%. For a facility with between 20 and 39 beds, the threshold occupancy rate is 85%. For a facility with less than 20 psychiatric beds, the threshold occupancy rate is 80%. MHCC staff considers these occupancy thresholds too high.[11]

Research focusing on occupancy rates agrees with MHCC staff concern. For example, a 2013 statistical study identified increasing rates of patient turn-away when bed occupancy increases[12].

[11] https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Final%20MHCC%20psych%20workgroup%20June%202019%20meeting%20summary_20190617.pdf
[12] Jones, Rodney. (2013). Optimum bed occupancy in psychiatric hospitals.

Turn-away is the percentage of time that a bed will be unavailable for the next arriving patient who must either wait for admission or go elsewhere (if immediate admission is a priority). Occupancy rates above 90% can cause around a 50% rate of patient turn-away, as seen in the following figure:

Figure 14
Average Occupancy Rates & Patient Turn-Away



Footnote: Data for Michigan in 2006 is from http://www.michigan.gov/documents/mdch/Psych_Adult_196834_7.pdf while data from the second quarter of 2012/13 for England is from http://transparency.dh.gov.uk/?p=19745

Sheppard Pratt and Brook Lane have both been at a very high average occupancy rate for the last 3 years. Using the projections from the above study, we can see that the two freestanding psychiatric facilities with the majority of the children and adolescent inpatient psychiatric access in Maryland may have to deny or delay an admission anywhere from 20% to 50% or more of the time as staffed bed availability and patient demand fluctuates.

As further stated in the same study:

> If immediate access is considered to be a desirable feature such as in […] psychiatric care; then optimum occupancy could be said to lie somewhere near to the 0.1% turn-away line, which as [Figure 12 above] demonstrates, relies upon an average occupancy well below 85% in all but the very largest bed pools.
>
> […] A recent review of average occupancy in English and US acute hospitals has concluded that the 'optimum' whole hospital occupancy, i.e. across multiple constituent specialty bed pools, is around 72% for a 200 bed hospital, 78% for 500 and 83% at 1,000 beds.

Finally, HHS notes that Sheppard Pratt represents approximately 96 of the 151 staffed beds for children and adolescents in the Central Region. With the majority of central planning region beds above a 90% occupancy rate, the private psychiatric hospital bed availability is under enormous strain and there is insufficient capacity for additional patient demand. As further discussed below, this strain on access is showing up in observable patient outcomes in the region.

VI. Need Based on Discharge Delays & ED Boarding

Recent research has begun to focus on observable outcomes in patient populations as a key indicator of bed need shortages for inpatient psychiatric care[13]. The idea is that necessary levels of psychiatric beds can be connected to observable outcomes in the population. A key focus of this approach has been upon research showing that extended wait times in Emergency Departments by psychiatric patients (i.e. "ED Boarding") is a sign of inadequate inpatient psychiatric bed supply.

In the most common definition of the term, psychiatric boarding can be characterized as the period of time a psychiatric patient waits in an emergency department following a disposition decision after evaluation by a clinician (i.e., admission, transfer or discharge). The Joint Commission recommends that boarding not exceed 4 hours. There are various problems associated with boarding including delayed care, negative outcomes for patients, families and the hospital system, along with financial losses. It is not difficult to understand how the ED environment can overwhelm a child already experiencing mental health challenges, or how the same child would be a difficult patient for ED staff to care for appropriately when designated mental health professionals are scarce in most EDs.

This is also not an unknown issue, as research has been reported through the news, research studies and clinical papers, including, but not limited to:

- Hlavinka, E. (2020, January 7). Teenager in Psych Crisis Waits 25 Days in ED for Admission. *MedPage Today*. https://www.medpagetoday.com/special-reports/exclusives/84236
- Jones, R. (2016, October 2). Kids with mental illness forced to wait for care. Exclusive: In Crisis, Out of Room. *ABC WXYZ Detroit*. https://www.wxyz.com/longform/in-crisis-out-of-room
- Appleby, J. (2008, June 17). Mentally Ill Face Extra-Long ER Waits. *ABC News.* https://abcnews.go.com/Health/MindMoodNews/story?id=5183940&page=1
- Kutcher, B. (2013, November 16). Bedding, not Boarding – Psychiatric patients boarded in hospital Eds create crisis for patient care and hospital finances. *Modern Healthcare.*: https://www.modernhealthcare.com/article/20131116/MAGAZINE/311169992/bedding-not-boarding
- Greene, J. (Emergency rooms fill up with psych patients – and then they wait. Modern Healthcare. https://www.modernhealthcare.com/article/20190128/NEWS/190129944/emergency-rooms-fill-up-with-psych-patients-and-then-they-wait
- Claudius I, Donofrio JJ, Lam CN, Santillanes G. Impact of boarding pediatric psychiatric patients on a medical ward. Hosp Pediatr. 2014;4:125-132.
- Hazen EP, Prager LM. A quiet crisis: pediatric patients waiting for inpatient psychiatric care. J Am Child Adolesc Psychiatry. 2017;56(8):631-3

In addition, following resources represent some of the most targeted, recent, and relevant reports on the issue of ED Boarding for children and adolescents in Maryland.

- Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019.

13 O'Reilly, R., Allison, S. & Bastiampiallai, T. Observed Outcomes: An Approach to Calculate the Optimum Number of Psychiatric Beds. *Adm Policy Ment Health* **46,** 507–517 (2019). https://doi.org/10.1007/s10488-018-00917-8

- Maryland Hospital Association: “Behavioral Health Patient Delays in Emergency Departments”. September 2019.
- Maryland Hospital Association: “Delays in Hospital Discharges of Behavioral Health Patients”. January 2019.
- Maryland Report / Capital News Service: “MD. Youths Needing Psychiatric Care Find Long Waits, Drives”. December 2019
- Maryland Hospital Association: “A Roadmap to an Essential, Comprehensive System of Behavioral Health Care for Maryland”. 2018

MHCC recognized ED Boarding in April 2019 in its publication “White Paper: Maryland Acute Psychiatric Hospital Services”, covering the topic under “Evidence of Access Barriers”. As noted therein: “Wait times in Maryland hospital emergency departments (EDs) have been identified, in recent years, as among the longest in the nation”. While we understand MHCC also noted they do not have access to data that allows a broad and detailed analysis of this problem, the available data and widely reported issues in Maryland (akin to much of the United States) demonstrates that the number of providers and available beds for children and adolescents is deficient today.

To begin, a key citation in MHCC’s publication about the ED Boarding issue are the reports compiled by the Maryland Hospital Association. The Maryland Hospital Association published a report in January of 2019 specifically focused on behavioral health discharge delays in Maryland hospital. Based on their survey work, they estimated behavioral health patients experiencing a discharge delay wait an average of 13 days per patient. Per the MHA report:

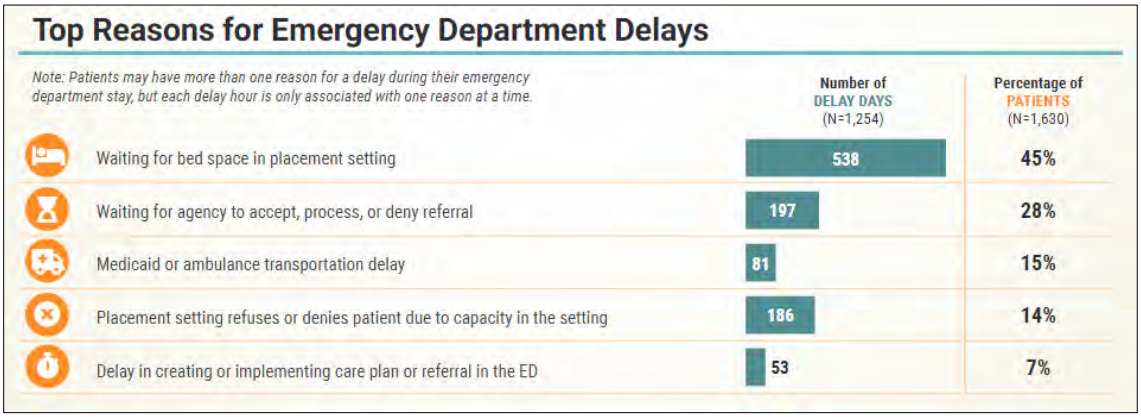
- What was the most common discharge destination for those experiencing a delay?
    - **An inpatient acute psychiatric unit.**

- What was the most common reason for a delay?
    - **A lack of bed space.**

A subsequent report by the Maryland Hospital Association in September of 2019 focus even more acutely on the issue. The results were both informative and alarming. Key findings included:

- 42% of behavioral health ED patients experienced a delay being discharged or transferred
- These patients were delayed for 1,676 days — an average of 20 hours per patient
- Delays account for 48% of the time those patients spend in EDs
- **Patients under age 18 tended to have delays 2x as long** (median=18 hours) as those age 18 and over (median=9 hours). This difference is statistically significant.
- Over the 45-day study, 22% or 442 of the patients with a discharge delay were under the age of 18.
    - NOTE: To annualize this figure, this would equal ~3,585 patients under 18 with behavioral health diagnoses and discharge delays in EDs.
- Three of the top four most common reasons for discharge delays were associated with placement setting barriers, including denying admission (14%), taking too long to process referrals (28%), or **lacking bed space (45%)**. These reasons alone accounted for well over half of the delay days in the study.

Figure 15
MHA Report Chart on Reasons for Emergency Department Delays



As reported in the MHCC white paper, ED visits with a psychiatric diagnosis not resulting in inpatient admission increased by ~19% from 2008 to 2017 across all age groups. As noted by MHCC, "The growth in ED visits with a primary psychiatric diagnosis that did not result in an admission could be related, to some extent, to the boarding of patients in general hospital EDs". Additional research further indicates this issue is growing and acute for children in Maryland.

A December 2019 report by Capitol News Services posted by the Maryland Reporter further detailed the issue with an emphasis on children and adolescents in an article titled "MD. Youths Needing Psychiatric Care Find Long Waits, Drives". As they reported, at the heart of the issue is that there were only five (5) inpatient psychiatric units for children and seven (7) for adolescents in the entire State.

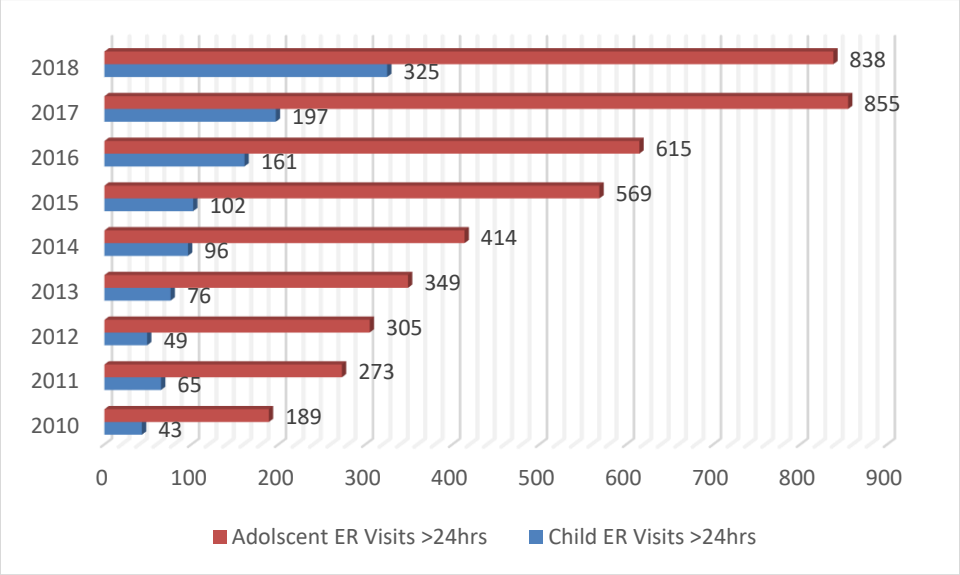
Per the Capital News Service report and based on MHCC data, in 2018 there were 4,106 child visits and 8,198 adolescent visits to emergency departments across the state for psychiatric issues, according to a report from the Maryland Health Care Commission and data from the Maryland Health Services Cost Review Commission. Of those 12,304 juvenile visits, 1,163 of them lasted anywhere from over 24 hours to 20 or more days in the emergency department, waiting for a bed elsewhere. However, the Maryland Hospital Association studies (as referenced above) indicate nearly 9,000 of these 12,304 visits may extend beyond 4 hours, which is a common benchmark for ED Boarding.

Figure 16
ED Visits for Children + Adolescents by Estimated Time – CY 2010 - 2018

Estimated Time in ED	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	9,728	10,331	11,179	11,385	11,786	11,920	10,773	10,931	11,141
Between 24 and 48 hours	173	241	248	275	345	427	433	526	568
2-3 days	33	51	51	65	91	110	145	208	263
4-8 days	20	43	46	69	69	127	178	269	282
9-20 days	5	3	6	14	3	5	20	41	45
20+ days	1	0	3	2	2	2	0	8	5
Total	9,960	10,669	11,533	11,810	12,296	12,591	11,549	11,983	12,304

The following chart visualizes how many children and adolescents were reported to experience ED visits lasting a day or more waiting for a psychiatric bed.

Figure 17
ED Visits for Children / Adolescents - >24 Hours



In its document "A Roadmap to an Essential, Comprehensive System of Behavioral Health Care for Maryland", the Maryland Hospital Association had this to say about the crisis:

> Heightening the hospital crisis is a lack of placement options for children. One hospital leader recently attributed "an alarming increase" in the lengths of stay for young behavioral health patients to an inability to transfer them to more appropriate settings of care, in turn causing longer wait times in the emergency department. Some hospitals report children being hospitalized more than 100 days beyond what is medically necessary; others have experienced their entire pediatric unit being filled with behavioral health patients. Many hospitals report that when transfers of pediatric and adolescent patients do take place, they are increasingly being sent to an out-of-state facility.[14]

The ED boarding and discharge delays of youths with mental illness are also costly, particularly for the State through the Medicaid population. In its 2020 report on 2019 utilization, the Baltimore City LBHA stated the following in regards to discharge delays:

> Such delays, even in a small percent of the population, can drive up costs. The largest proportion of discharge delay cases in the state occurred in Baltimore City (29%), and 83% of the cases across the state occurred among the publicly insured or uninsured. Often the reason for delayed discharges across the state involved consumers being unable to transfer to another facility, indicating that though the capacity and utilization in Baltimore City and the state are increasing, the needs of the consumers may not always be met in a timely manner.[15]

In addition, the recent application by UMMS for additional adolescent bed capacity highlighted the issue of ED Boarding within their facility. As they stated for their facility alone:

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[14] https://www.mhaonline.org/docs/default-source/publications/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf?sfvrsn=2

[15] https://www.bhsbaltimore.org/wp-content/uploads/2019/06/BHSB-Behavioral-Health-Crisis-System-Plan-Final.pdf

The 70 patients transferred to an inpatient facility waited from one to nine days with an average wait time of 33 hours to be transferred. Of the patients who were not discharged to an inpatient psychiatric facility, 45 patients had a length of stay between two and 11 days in the PED and would have benefited from an inpatient psychiatric bed if one could have been secured. Instead, these patients were stabilized in the PED until it was medically safe to discharge them with outpatient psychiatric support services. Thus, a total of at least 115 patients (70 + 45) were eligible for inpatient care in FY18.

The above statistics and findings are evidence of how the high average occupancy rates reported by existing providers of inpatient children and adolescent psychiatric services have a negative impact on patients in need of services. Finally, to roughly estimate the scope of the issue and need through patient admissions, HHS provides the following analysis of how its patient admissions could be based on reducing ED delays for patients seeking inpatient mental health care.

Figure 18
Patient Admissions Based on Alleviating ED Boarding – Children (0-12)

2018 MHCC ED Visits[1]	Number of Patients w/ ED Boarding[2]	Estimated # of Patients Expanded Bed Capacity can Address[3]	Total Served by HHS (85% Occupancy)
4,106	1,130	508	234

Figure 19
Patient Admissions Based on Alleviating ED Boarding – Adolescents (13-17)

2018 MHCC ED Visits[1]	Number of Patients w/ ED Boarding[2]	Estimated # of Patients Expanded Bed Capacity can Address[3]	Total Served by HHS (85% Occupancy)
8,198	2,255	1,015	300

1. The 2019 MHA Report on Discharge Delays found 442 patients under the age of 18 experienced a delay of 4 or more hours in the Emergency Department based on a 45-day survey. This equals 3,585 patients annualized.
2. The MHCC reported 12,304 ED visits by those aged under 18 in 2018. Dividing 3,585 estimated patients experiencing ED Boarding (Assumption #1) by the MHCC figure gives us an ED Boarding ratio of 27.51%.
3. Per the MHA Report, 45% of the ED Boarding hours was due to patients waiting on bed capacity.

As shown above, the current demands on the system that are apparent solely based on ED Boarding are arguably sufficient to justify this project at 85% occupancy.

VII. Re-admissions

As with the discharge delay and patient boarding outcomes showing a need for additional psychiatric beds, re-admissions are another trend evidencing a need for additional provider resources for both inpatient capacity and a provider that can provide outpatient support to prevent re-admissions.

As a measure of quality of inpatient care, readmission rates have become a national focus. Recurrent hospitalizations are disruptive for families and a driver of cost to the health care system[16]. Thus, targeting readmissions is both an opportunity for improve quality and clinical outcomes and helping address the shortage in bed access. Per the figures reported in the

[16] Jeremy Y. Feng, Sara L. Toomey, Alan M. Zaslavsky, Mari M. Nakamura and Mark A. Schuster Pediatrics December 2017, 140 (6) e20171571; DOI: https://doi.org/10.1542/peds.2017-1571

MHCC's "White Paper: Maryland Acute Psychiatric Hospital Services", the rate of readmission rose for both children and adolescents from 2014 to 2017.

Figure 20: Readmission Rates for Maryland Residents per 100 Psychiatric Discharges

Age Group	CY 2014	CY 2015	CY 2016	CY 2017
Children (0-12)	7.2	9.5	10.1	10.0
Adolescents (13-17)	4.6	7.7	7.7	8.1
Adult (18+)	11.0	12.0	12.3	11.9
All Ages	10.1	11.4	11.7	11.4

As evidenced in the section below addressing our history and current services, Hope Health Systems has a multitude of outpatient services and experience in managing ongoing relationships with these patients. This ability to connect inpatient and outpatient treatment and manage care is a key component in addressing and reducing re-admissions.

For example, poor discharge planning has been linked with frequent readmissions. One study found that patients without outpatient appointments in place before discharge from a psychiatric hospitalization were twice as likely to be readmitted within the same year[17]. Likewise, primary care physicians of publicly insured and uninsured patients reported more difficulties accessing outpatient mental health services because of lack of provider options and longer wait times.

Thus, beyond the need for additional beds, HHS will also be able to more directly connect its inpatients with outpatient services and be in position to readily address and track outpatient needs with our comprehensive set of services. Already working with a predominant Medicaid patient population, we understand the needs of those most at risk for re-admission. The needs in the community are not only inpatient beds, but also high-quality discharge and outpatient care for these patients. Both will be addressed by this project.

VIII. Mental Health Professional & CAP Shortages

In 2012, the AACAP estimated that only 15% to 25% of children with psychiatric disorders received specialty care, and approximately three-quarters of children with mental health disorders were seen by their pediatric primary care physician. The American Academy of Child and Adolescent Psychiatry estimates that the country needs 47 child psychiatrists per 100,000 in population. For Maryland, the American Academy of Child & Adolescent Psychiatry has identified a high shortage at 25 CAPs per 100,000 in children younger than 18. A 2017 report from the National Council for Behavioral Health found that by 2025, nationwide demand for psychiatrists may outstrip supply by anywhere from 6,090 to 15,600 professionals.

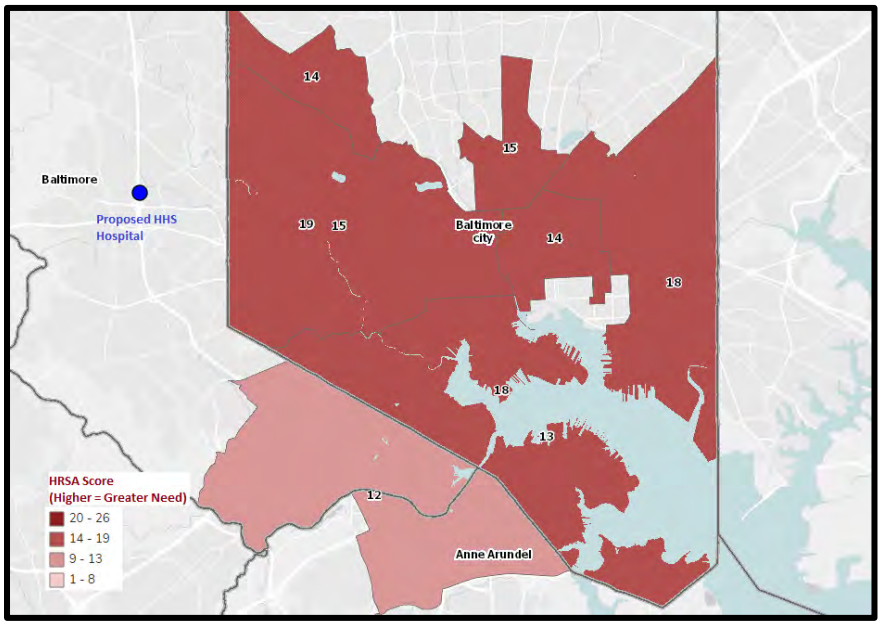
The federal government's Health Resources and Services Administration (HRSA), maintains records on designated Mental Health Professional Shortage areas. An identified shortage area indicates a need for additional health professionals to service the population. HRSA scores HPSAs on a scale of 0-25 for mental health, with higher scores indicating greater need. As seen below, the intended service area for this facility is responsive to the identified need for additional professional resources based on the HPSA designations.

[17] Id.

Figure 21
HRSA HPSA Designations in Baltimore Area

HPSA Name	Designation Type	Primary State Name	County Name	HPSA Score
LI - Northwest Baltimore City	Low Income Population HPSA	Maryland	Baltimore City, MD | Baltimore County, MD	20
ME-Upper Anne Arundel & Lower Baltimore Counties	Medicaid Eligible Population HPSA	Maryland	Anne Arundel County, MD | Baltimore County, MD	12
ME-Southeastern Baltimore City	Medicaid Eligible Population HPSA	Maryland	Baltimore City, MD	18
Harford County	Geographic HPSA	Maryland	Harford County, MD	5
ME-East Baltimore City	Medicaid Eligible Population HPSA	Maryland	Baltimore City, MD	16
ME - South Baltimore	Medicaid Eligible Population HPSA	Maryland	Baltimore City, MD	18
ME-West Central Baltimore City	Medicaid Eligible Population HPSA	Maryland	Baltimore City, MD	19

Figure 22
Map of HPSA Designations in Baltimore Area



Although HPSA is not age-specific, it is clear there is an acute need for additional mental health resources in the Baltimore region for the low-income and Medicaid populations, which have high-need HPSA scores today. Hope Health Systems, Inc. has designed this project to be responsive to the need of children and adolescents, with a focus on the low-income and Medicaid eligible patient populations. By connecting our outpatient services with inpatient capabilities, we will be positioned to service patients in need in a more holistic manner.

As an established outpatient provider of mental health services in Maryland, Hope Health Systems, Inc. will bring a stable and growing roster of CAPs to staff and direct care at the proposed facility. With four Child and Adolescent Psychiatrists and four more Psychiatrists, Psychologists and Psychiatric Nurse Practitioners on staff already, Hope Health Systems, Inc. is

well-positioned to provide the specialized care the child and adolescent patient population requires in the in inpatient and outpatient setting.

To ensure our growing patient population's needs are met, Hope Health Systems runs an active provider recruitment process to develop and maintain specialized providers for our patients, as further discussed in response to AP 12c in this filing.

IX. 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:

- The American Psychiatric Association (APA) reported that up to 12 million children in U.S. under the age of 18 suffer from mental illnesses that include depression, anxiety, PTSD, mood disturbances, eating disorders, substance abuse, psychosis and suicidal ideation.

- Inpatient Admissions Increase: Research has reported inpatient admissions for mental health problems amongst youth increased 24% from 2007-2010 alone[18]. Maryland reported a 26% increase in inpatient admissions for adolescents and 2.3% increase for children from 2008-2017 (See Figure 10 above).

- 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).

- 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), and has received recognition as a Top 100 MBE organization. Many of our staff and clinical providers are also minorities that reflect the communities we serve. Our culture, training, and diversity will be a welcoming aspect of our care to patients and their family.

[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3966505/

- In Baltimore City, the Local Behavioral Health Agency's (LBHA) most recent annual report[19] 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 past 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%.

    - Suicide: The Maryland Youth Risk Behavior Surveillance System (YRBSS) offers a unique look into the emotional needs and behavioral health risks of youth in Baltimore City. The percentage of high school students who seriously considered attempting suicide in Baltimore City was higher (19.2%) than both the state and national rates.

    - Medicaid Utilization for Mental Health: The number of under 18 individuals with Medicaid receiving mental health services increased each year from 2018-2019.

- 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 recent 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%)[20].

[19] https://www.bhsbaltimore.org/wp-content/uploads/2020/05/FY-19-Activities-Indicators-Utilization-Revised-Apr-2020-1.pdf
[20] https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm#T2_down

The above are just some reference points for 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 individuals in psychiatric crisis or otherwise in need of intensive services.

X. Cumulative Project Need / Discharge Assumptions

The issues outlined in sections "III" through "IX" above have identified a number of quantitative and qualitative factors indicating need for additional inpatient psychiatric beds for children and adolescents.

Today, it appears the number of psychiatric beds for children and adolescents per person fall below expert's consensus figures. The historical discharge rates, ALOS, population assumptions, and current bed counts show that the market 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, both ED Boarding and re-admissions have 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 this community, 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 and that the proposed facility will operate at least 85% occupancy based on demand outstripping the additional beds entering the market. 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.

Figure 23
Need Addressed by HHS – Children Beds

	2021	2022	2023	2024	2025
ED Boarding / High Occupancy*	117	125	128	131	133
Unmet Need**	10	10	10	10	10
Total Admissions	127	135	138	141	143

*As seen in Section XI on ED Boarding above, an estimate of need for additional beds was shown for 508 children.
**Unmet need includes rises mental illness rates, increasing awareness/diagnoses, and patients lost due to access.

Figure 24
HHS Volume Assumptions – Children Beds

	2022	2023	2024	2025	2026
Number of Beds	4	4	4	4	4
Occupancy Rate	80%	85%	85%	85%	85%
Total Bed Days	1,168	1,241	1,241	1,241	1,241
ALOS	9.2	9.2	9	8.8	8.7
Total Discharges	127	135	138	141	143

Figure 25
Need Addressed by HHS – Adolescent Beds

	2021	2022	2023	2024	2025
ED Boarding / High Occupancy*	341	365	374	383	388
Unmet Need**	40	40	40	40	40
Total Admissions	381	405	414	423	428

*As seen in Section XI on ED Boarding above, an estimate of need for additional beds was shown for 1,015 adolescents.
**Unmet need includes rises mental illness rates, increasing awareness/diagnoses, and patients lost due to access.

Figure 26
HHS Volume Assumptions – Adolescent Beds

	2022	2023	2024	2025	2026
Number of Beds	12	12	12	12	12
Occupancy Rate	80%	85%	85%	85%	85%
Total Bed Days	3,504	3,723	3,723	3,723	3,723
ALOS	9.2	9.2	9	8.8	8.7
Total Discharges	381	405	414	423	428

XII. Hope Health Systems, Inc.'s Background & Rationale for Project

As identified above, the current level of access is not sufficient to meet patient needs. The data and research show that the community requires additional beds, continuity of care between inpatient and outpatient services, and culturally competent care for children and adolescents.

As stated earlier, the term "revolving door" is widely used to describe how mental health service users (children, adolescents, as well as forensic patients) can repeatedly transition between hospital and community care and then back to hospital within a very short period of time[21]. This issue of "revolving door" has been a big concern for service users due to increased readmission rates over years, resulting in increased cost of care for patients.

The 'circuit of care' as well as increased readmission rate stems not only from patient's health condition but also from the lack of continuous care after inpatient discharge. HHS' has developed several components of its vision to provide an integrated personalized care to its patients. HHS' care transition program will help reduce the readmission rates by providing comprehensive care through its various programs, which we describe in more detail below.

1. Psychiatric Partial Hospitalization Program / Mobile Treatment Services:

HHS provides a psychiatric partial hospitalization program (PHP) to serve up to 30 patients at any one time. The PHP currently offers lower-cost community-based alternative to the inpatient setting. HHS' goal is to use PHP as a step-down level of care for patients who are admitted to the inpatient facilities to make the transition to the community smoother. HHS' mobile treatment services (MTS) are community-based, intensive, outpatient mental health services designed for individuals who have exhausted traditional forms of outpatient treatment interventions or who have had repeated psychiatric hospitalizations. Once a patient is discharged from the inpatient setting, HHS will transfer the patients based on severity of the condition to its PHP or MTS and a case manager will be responsible for ensuring that a timely personalized care is provided to the patient.

21 Id.

2. Intensive Outpatient Program

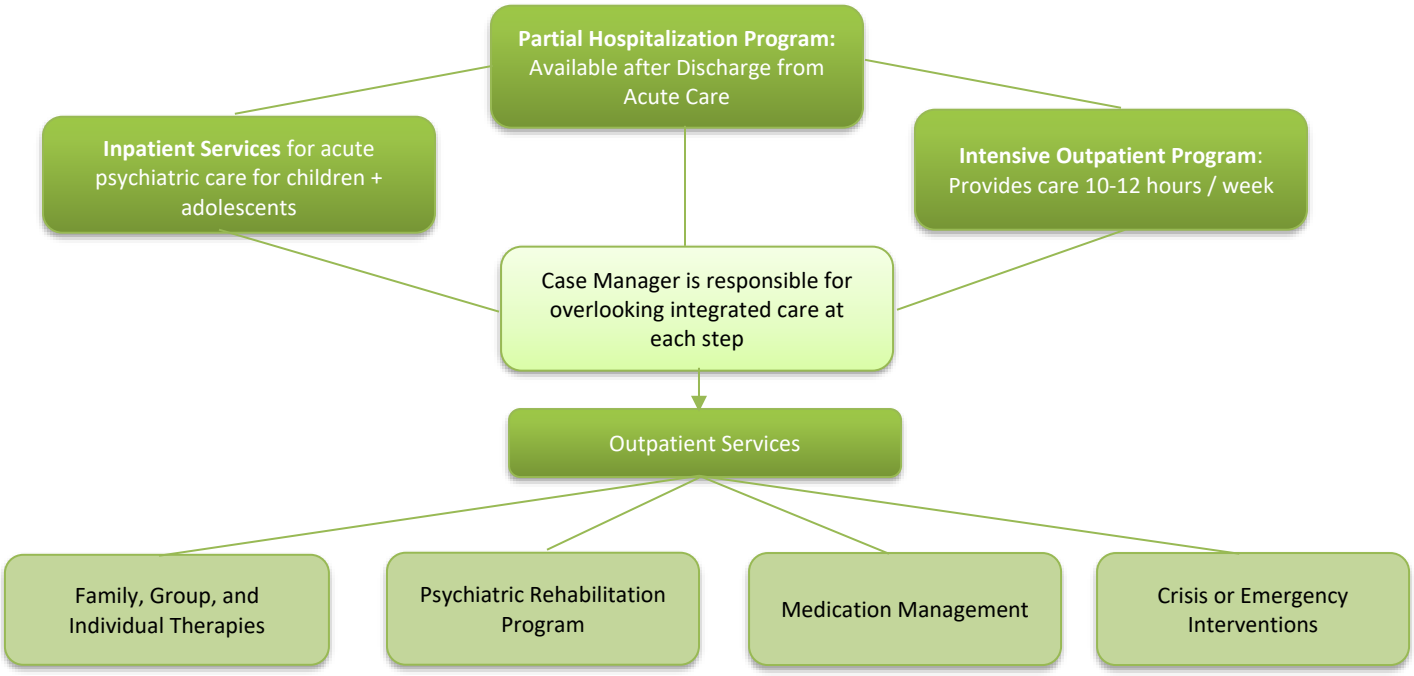
HHS' Intensive outpatient program (IOP) allows patients to continue their therapies on a part-time yet intensive schedule designed to accommodate work and family balance. This program will help in discharging a patient sooner from the PHP to the next step in the step-down protocol. The IOP provides 10-12 hours of group as well as individual therapy each week before the patient is moved to the next stage of outpatient care.

3. Outpatient Program

The final stage in the HHS' care continuum is outpatient care. HHS, when appropriate, works in collaboration with schools, child welfare/foster system, and other child/family caring agencies to provide comprehensive care to the patient. HHS' outpatient program consists of:

- Family, Group and Individual Therapies: This therapy generally occurs weekly until sufficient progress has occurred to decrease the frequency of sessions. The case manager works with a multi-disciplinary team to assess the duration and the frequency of the sessions as well as goals that need to be accomplished before a complete transition into the community takes place.
- Psychiatric Rehabilitation Program (PRP): HHS' child and adolescent PRP is goal directed, outcome focused, and provides time-limited interventions designed to reduce maladaptive behaviours and to restore and strengthen specific age appropriate skills so that the youth can function to their highest potential up to and including independence. PRP treatment is seen as a planned and integrated adjunct to outpatient mental health treatment.
- Medication Management Services: Medication services are provided as needed. These services include providing prescriptions, monitoring and patient education.
- Crisis or Emergency Interventions: This service offers 24/7 mobile crisis intervention as well emergency care to patients who contact the facility.

Figure 27: HHS' integrated care continuum



Accordingly, the applicant is seeking to establish an inpatient psychiatric facility to treat children and adolescents in order to improve the overall continuum of care for its patients, and to alleviate the growing burden to psychiatric services currently imposed upon the state health hospitals. As stated in the Maryland Health Care Commission Center for Health Care Facilities Planning and Development White Paper: Maryland Acute Psychiatric Hospital Services "Patient care will be optimized if the continuum of facilities and services can by systemized for timely and coordinated transfer of patients and delivery of services along the continuum."

Background on Hope Health Systems, Inc.

Founded in Woodlawn, Maryland in 1999, HHS is a private, for-profit organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. Hope Health Systems, Inc. (HHS), is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Minority Business Enterprise (MBE), and has received recognition as a Top 100 MBE organization. Many of our staff and providers are minorities that reflect the communities we serve.

HHS' vast wealth of programs include but are not limited to: onsite/offsite Outpatient Mental Health Programs, Substance Abuse Treatment Program, Psychiatric Rehabilitation Program (PRP), Case Management Services, Mental Health and Substance Abuse Services (Baltimore City and County Department of Juvenile Service (BCJJC, Hickey, Waxter, Cheltenham), Department of Corrections, behavioral assistance in Baltimore City and County schools, one-on-one behavioral assistance in Baltimore City and County schools, Mobile Treatment Services, and Expanded School Mental Health (ESMH) program. HHS is a Maryland Department of Transportation (MDOT) certified Minority Business Enterprise (MBE) that offers comprehensive outpatient mental health services to children, adolescents, young adults, adults, geriatrics, and their families throughout the Baltimore City/County area.

In 2019, HHS delivered nearly 30,000 service encounters to patients through these programs. This included over 4,500 PRP visits for children, over 17,000 outpatient mental health clinic visits, nearly 2,000 mobile treatment services, and over 2,200 case management services.

HHS has five centralized offices in Baltimore City (Greenspring), Baltimore County (Woodlawn and Gwynn Oak), Carroll County (Eldersburg), and Delaware (Middletown). Its award-winning staff of mental health professionals has decades of experience in the mental health field. HHS specializes in early interventions enhancing preventative and treatment services, including psychiatric evaluations, family counseling, individual counseling, group counseling, psychiatric rehabilitations, referral services, trainings, and consultations, in addition to many other mental health/substance abuse related services.

With its qualified and culturally competent staff of mental health professionals, substance abuse treatment professionals, and support staff, HHS has partnered with state, local and community organizations to provide an interdisciplinary and collaborative program of mental health, substance abuse, and support services to children, adolescents, young adults, adults, geriatrics, families, and at-risk populations.

HHS' Mission, Vision and Values Statement

Mission

- HHS' mission has always required it to reach beyond the activities of a normal business day to see and understand the lives of its patients, the importance of targeting the emotional stability of the child, and the importance of extending our focus to the family as the basic unity of the community. This is to ensure the child maintains optimal levels of functioning.

Vision

- HHS' goal is to become a national leader of mental health services and to continue to provide services which will allow children, adolescents/youth, and adults become productive citizens in their communities and society.

Values

- Provide a great work environment and treat everyone with respect and dignity
- Embrace diversity as an essential component
- Apply the highest standards of excellence to providing quality health care services to children, adults, and their families.
- Contribute positively to the community.
- Recognize that profitability is essential to future success.

Partnerships

Through partnerships with physicians, therapists, schools, behavioral health care centers, and community-based organizations, HHS works to foster healthier and promising futures for patients and their families. That is what partnership means at HHS. HHS has partnered and collaborated with local and national child-serving and community-based organizations, public and charter schools, colleges and universities, hospitals, other mental health clinics and facilities, and federal and local government agencies which include but are not limited to the following:

- Behavioral Health Systems Baltimore
- KIPP Charter Schools
- Kennedy Krieger Institute and Universal Counseling
- Baltimore City and County Public Schools
- Family League of Baltimore
- Maryland Department of Labor (DOL)
- Maryland Department of Justice (DOJ)
- My Sister's Place
- Our Daily Bread
- Hannah More Emergency Shelter
- Eastern Family Resource Center

Department of Juvenile System Project

HHS has a long history of providing access to care for underserved populations. HHS' work with Maryland Department of Juvenile system (DJS) has been providing mental health and substance abuse services to detained youth for over a decade. At the Baltimore City Juvenile Justice Centre, HHS was able to have all the existing Civil Rights of Institutionalized Persons ACT (CRIPA)

deficiencies removed. The areas covered included: Protection from Harm, Suicide Prevention, Mental Health, and Quality Assurance.

HHS provides a range of mental health and substance abuse treatment services to youth involved in the juvenile justice system. HHS helped DJS achieve the long-needed reform to ensure that every child has the services and support needed to succeed by:

- Implementation of mental health assessments: HHS administered Youth Admission Questionnaire and the Facility Initial Reception Referral Screening Tool (FIRRST) to help DJS determine if the youth has any medical, mental health or substance abuse conditions that would render admission unsafe.
- Developing Policies and Protocols: HHS helped DJS write policies and procedures to address the mental health issues.
- Helped Create an Intensive Services Unit (ISU): HHS' assistance in the creation of ISU helped monitor youths in danger of harming themselves or others as well as treating individuals who attempt suicide.
- Developing suicide protocols and suicide prevention training: HHS helped establish two-levels of suicide watch for supervision, intervention, and prevention for youth at risk of suicide. This included one to one supervision for observation and monitoring, followed by immediate consultation or intervention services. HHS established a training protocol that included identifying warning signs and symptoms of suicidal behaviour, responding to suicidal and depressed youth, and follow-up monitoring of youth who attempt suicide.
- Protocols for treatment planning: The comprehensive juvenile justice services provided by HHS include: psychiatric evaluation, psychological testing, medication management, counselling (individual, group and family), suicide assessments, crisis interventions and referral services, aggressive reduction therapy and training for direct care staff on de-escalation skills and peer relations. HHS Juvenile Justice services are provided based on an integrated treatment model with care providers who have extensive training in treating youth who have mental health and/or substance abuse disorders.
- Improved record keeping protocols: HHS implemented the documentation of all face to face crisis behavioural health assessments. This included date and time of the clinical interview, risk assessment record, the presence and severity of mental health issues as well as detailed description of the specific counselling or treatment intervention.
- Implemented standards for providing access to adequate mental health treatment within a reasonable time frame: HHS helped reduce the average length of stay for youth by 30% by providing evidence-based programs such as multi-systemic therapy and functional family therapy.

At the request of the Maryland's Department of Juvenile Services, HHS' work regarding suicide prevention practices within the Baltimore City Juvenile Justice Center in Baltimore was evaluated by Lindsay M. Hayes, Project Director of the National Center on Institutions and Alternatives. The evaluation report commended the in-service training of mental health clinicians sponsored by HHS. HHS' mental health clinicians screened and assessed each newly admitted youth within 72 hours of arrival. Lindsay M. Hayes evaluated the screening methods implemented by HHS and concluded, "The screening and assessment forms utilized by Hope Health Systems regarding suicide risk inquiry are excellent."

Cultural Diversity Trainings at Hope Health Systems

Cultural competence is a learning theme option for clinical supervisors to check off on individual supervision notes with their supervisees. In addition, we incorporate this subject into treatment teams that are led by an HHS psychiatrist with clinicians and trainings. HHS also provides 18-21 Continuing education units (CEUs) per year to its therapists and clinicians. Some of the trainings provided by HHS include but are not limited to:

- **Racism in Clinical Care:** Trained the employees in social determinants of health, and integrated behavioral health to help address the physical, social, and mental health needs of vulnerable urban and rural populations.
- **Welcoming Sexual and Gender Diversity into Practice for Clinicians:** Training was provided to help reduce prejudices that include the cognitive, affective, and behavioral components. This training was aimed at educating providers about the sexual and gender diversity.
- **Cultural competence: The Unspoken Skill:** This training was aimed at increasing the ability to understand, communicate with, and effectively interact with people across cultures. The training helped clinicians develop positive attitude towards cultural differences as well as increase knowledge of different cultural practices and world views.
- **Equitable Trauma informed Trainings:** The training was aimed at increasing understanding of how to incorporate a racial justice lens in the development and implementation of a trauma awareness and resilience organization.

HHS also has ethics in Diversity trainings on an ongoing basis for new employees.

HHS' current Programs

Currently, HHS operates several programs that provide activities and support to children, adolescents, adults, and families who are in recovery from mental illness, substance abuse or co-occurring disorders. Its vast wealth of programs include, but are not limited to: onsite/offsite Outpatient mental health programs; substance abuse treatment programs; Psychiatric Rehabilitation Programs (PRP); Partial hospitalization programs (PHP); Geriatric Services; Maryland Department of Public Safety and Correctional Services (Mental Health Services); Baltimore City Juvenile Justice Center; Charles Hickey School; Cheltenham Youth Detention Center for DJS (interdisciplinary program of mental health and substance abuse treatment for youth detained at DJS); the Family League of Baltimore (and its Family Recovery Program (FRP)) with one-on-one behavioral assistance via its Mobile Treatment Program; Care Coordination services for Baltimore City and Baltimore County; and, the Expanded School Mental Health (ESMH) Program. A detailed description of each program is mentioned below:

Outpatient Mental Health Clinic (OMHC)

Services at the OMHC level are designed to promote mental health and improve functioning in children, youth, adults and families. In addition, HHS' services at the OMHC are tools used to effectively decrease the prevalence and incidence of mental illness, emotional disturbance and social dysfunction. The responsibility for diagnostic and treatment services is vested in a multi-disciplinary team comprised of psychiatrists, licensed social workers, licensed professional counsellors, marriage and family licensed therapists, public health educators and other mental health professionals. The services at HHS include but are not limited to:

- Diagnostic Evaluation
- Psychiatric Evaluation

- Family, Group and Individual Therapies
- Psychiatric Rehabilitation Program
- Medication Management Services
- Crisis or Emergency Interventions

Expanded School Mental Health

Hope Health Systems' Expanded School Based Program strives every year to be the best clinical Program serving Public and Charter Schools in Baltimore City, Baltimore County and Charles County. HHS' goal, for each school serviced by them, is to strive for excellence in service, promote academic success, establish and develop students' personal assets and capabilities; and, provide high quality services that will incorporate evidence-based practices and practice-based evidence interventions, continuum of care, authentic parent/family engagement, meaningful youth involvement, culturally and linguistically competent service provisions, training, consultation services, and, data-driven planning, evaluation, and quality improvement. The scope of ESMH programs included:

- Mental health screening
- Psychiatric assessment and Diagnosis
- Individual treatment Plan (ITP)
- Continuing evaluation and Treatment
- Referral Services
- Medicaid services
- In school services
- Discharge Planning/ After Care Services

Mobile treatment Services

Mobile Treatment Services (MTS) are community-based, intensive, outpatient mental health services designed for individuals who have exhausted traditional forms of outpatient treatment interventions or who have had repeated psychiatric hospitalizations. HHS' MTS provides assertive outreach, treatment and support to children, adolescents and adults with mental illness who, according to medical necessity, are unable to utilize traditional outpatient mental health services because of the seriousness of their problems. HHS mobile treatment offers the following services:

- Therapy at home, school, street, shelter and in the community
- Psychiatric Evaluation and Treatment
- Clinical Assessment
- Medication Management/Monitoring
- Case Management
- One-on-one Counselling
- Training/Support with daily living skills
- Psychiatric Rehabilitation
- Crisis stabilization
- Referral Services (Continuity of Care)

Substance Abuse Treatment

HHS offers holistic and highly individualized substance abuse treatment program for adolescents and adults. At HHS, the goal is to treat the whole person, not just the addiction.

The services offered include:

- Alcohol and drugs of abuse evaluation, medication management
- Assessments for Juvenile Justice/JOINS with ongoing progress reports
- Coordination of twelve step self-help programs
- Case management services
- Randomized Urinalysis
- Specialized groups (including gender specific)
- Family, couple, and individual counselling sessions
- Individualized treatment planning & collaborative treatment approach
- DUI/Parole and Probation/Court Ordered Drug and Alcohol Counselling

Psychiatric Rehabilitation Program (PRP)

Hope Health System's child and adolescent PRP program is goal directed, outcome focused, and time-limited interventions designed to reduce maladaptive behaviors and to restore and strengthen specific age appropriate skills so that the youth can function to their highest potential up to and including independence. PRP treatment is seen as a planned and integrated adjunct to outpatient mental health treatment, and the total plan of care or the youth. PRP includes a combination of psychoeducation, emotional and behavioral awareness competency, and social skills training in groups or individually, at the agency site, or in the youth's home or in the community. The focus of the Psychiatric Rehabilitation Program treatment model has been directed towards the reduction of emotional or behavioral problems, and the restoration of age-appropriate skills, including:

- Facilitating the enhancement of an individual's independent living and social skills, including the individual's ability to make decisions about his or her life, while creating opportunities for choice regarding home, school or work, or community.
- Promoting community resources to integrate the individual into the community.

Targeted Case Management

HHS' child and adolescent Case Management Program provides help and hope to minor with psychiatric illnesses while providing their family with support and access to resources within the community. Families are assigned a care coordinator to help assess, prioritize, and advocate for their needs while developing a supportive team of people. Families' needs are addressed through referral to appropriate services, and through coordination of services with multiple providers and unpaid supporters. HHS provides wraparound services to support our client's growth, independence, and success in their future.

Partial Hospitalization Program (PHP)

The Partial Hospital Program (P.H.P.) is structured and patientcare oriented with a multidisciplinary team approach. HHS' PHP program acts as a step-down approach as well as a short-term program to treat patients with acute psychiatric symptoms who need significant support. Patients receive treatment for 6.5 hours a day, up to five days a week. Each patient's treatment needs are reviewed shortly after admission, and an individualized treatment plan is developed. Daily group-oriented programs focus on symptom management, stabilization, psychoeducation, and coping skills. The length of each patient's participation in the program varies based on the individual's response to treatment, with a maximum of 30 treatment days per admission. Discharge plans are made for each patient in conjunction with the referral source. This

program will help move patients from the inpatient setting to partial hospitalization before the patient is discharged back to the community.

Intensive Outpatient Program (IOP)

The Intensive Outpatient Program (I.O.P.) offers more therapy than is available in a typical outpatient setting but involves less contact than the PHP. This program of HHS helps patients stabilize their symptoms and quickly return to work or their community. Patients receive four hours of treatment per day, three to five times per week. Patients with acute psychiatric symptoms will be discharged from HHS' inpatient setting to a partial hospital setting followed by an intensive outpatient setting, depending on their condition. This will help provide comprehensive care to the patient.

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

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

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

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

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

Applicant Response:

Hope Health Systems (HHS) proposes to establish a new 16 bed child and adolescent acute psychiatric inpatient facility in the Baltimore metropolitan area (Baltimore County and Baltimore City) focusing on individuals under the age of 18 years insured by Medicaid. Upon approval, the HHS acute child and adolescent psychiatric inpatient special hospital will provide comprehensive mental and behavioral services through structured psychiatric treatment in a safe and consistent environment. Estimated total cost associated with the project are $4,500,000.

The project has two main objectives for HHS. The first is to provide acute psychiatric care for children and adolescents under 18 years of age. The second goal of HHS' project is to provide a comprehensive care through its step-down approach to help address the "revolving door" issue. Achieving these goals will allow HHS to provide quality, integrated and personalized care to the underserved population in the Baltimore area and help reduce ED Boarding, the 30-days readmission rates, and the length of stay in the hospital.

Given the stated goals of the project, the alternatives to consider were limited by nature (See (5) Cost Effectiveness section above). HHS has been a provider of outpatient mental health services and worked with inpatient facilities for many years in Maryland. Working heavily with the Medicaid patient population and the underserved, HHS has actively encountered the access barriers for inpatient care and disconnected inpatient to outpatient treatment.

HHS does not have a viable option to manage a child or adolescent in need of inpatient treatment through either outpatient or population health measures. Only being a provider of inpatient mental health services allows us to directly address access related challenges for those under the age of 18. We are seeking to use an existing building to provide these needed services in the most cost-effective manner possible.

10.24.01.08G(3)(d). Viability of the Proposal.

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

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

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

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

- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response:

The proposed project is financially feasible. Tables J, K and L are attached as Exhibit 1. The facility reaches an operating margin of 12.5% by 2027 and a net income of $813,192 which is sufficient to cover the annual debt service from the project.

HHS shall fund the project through a Small Business Administration (SBA) 504 loan. We are engaged with an experienced financial consultant with multiple lenders prepared to finance the project. Terms are currently set at 6.5% interest over 30 years. A pre-qualification letter from our financial consultant is attached as Exhibit 9. HHS will provide further evidence of lending commitments as requested and available.

The applicant has letters of support as demonstrated in Exhibit 5, including from the following:

- Mary Beth Haller, Esq. Deputy Commissioner of Health – Baltimore City Health Department
- Antionette McLeod, Executive Director for Operations, MD Department of Juvenile Services
- Dr. Gregory Branch, Health Officer, Department of Health, Baltimore County
- Charles E. Sydnor III, Esq, Senate of Maryland, Legislative District 44
- Andrea Brown, Executive Director, Black Mental Health Alliance,
- Dr. Ronald Means, Chief Medical Officer, Catholic Charities of Baltimore
- Dr. Jonathan Shepherd, President, Board of Directors, Black Mental Health Alliance
- James Omotosho, Program Director, Optimum Health Systems, Inc.
- Subramonianpillai Teal, Clinical Director/Co-Founder, Leading by Example Behavioral Health
- Deborah Okonofua, DNP, Agape Health Systems
- Tiffany Carroll, Executive Director, Empowering Minds Resource Center, LLP
- Stacey Bass, Executive Director, Healthy Minds Resource Center
- Nick Mosby, Legislative District 40, Baltimore City
- Dr. Annelle Primm, Former deputy Director, American Psychiatric Association
- Dr. Akin Akintola, Board Certified Child, Adolescent, and Adult Psychiatrist
- Dr. Ernest L. Carter, Health Officer, Prince George's County Health Department
- Dr. Kimberly Gordon-Achebe, MD, FAPA, Medical Director of Intensive Services, Hope Health Systems

Pursuant to COMAR § 10.24.01.12.C, Performance Requirements, if this application is approved, HHS will have 36 months to obligate not less than 51% of the approved capital expenditure. HHS shall have up to 36 months after the effective date of the binding construction contract to complete the project. The renovation is expected to take 16 weeks.

HHS anticipates meeting the performance requirements if the application is approved. HHS anticipates obligating not less than 51% of the approved capital within 4 months of approval, and thereafter initiating construction within one month and completing construction within 6 months.

Audited financial statements are attached as Exhibit 7.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

Inapplicable, as this is the Applicant's first Certificate of Need filing.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[22];

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

c) On costs to the health care delivery system.

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

[22] **Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.**

Applicant Response:

The following table shows an estimated impact to the existing providers for children services based on the 2019 discharges per HSCRC by provider, the associated increase in population for 2022, and then the projected shift to HHS by provider starting in 2022. As seen below, the largest impact would be on Sheppard Pratt with an approximately 10% reduction in current volume and 64 discharges in year 1. This would bring down their total discharges down from 687 to 623. The impact of this shift would be to expand bed availability to increase overall access for patients, reduce ED boarding, and optimize the current market.

HHS built in modest unmet need assumptions, with 10 new patients entering the market overall. Ultimately, the impact to Sheppard Pratt and others may provide more muted should a more substantial spike in admissions occur in this age group.

Figure 28 – Impact on Existing Providers (Children)

Hospital	Market Share 2019	Population Increase 2022	Total Discharges 2022 (Before Project)	Year 1 Shift	Year 2 Shift	Year 3 Shift	Year 4 Shift	Year 5 Shift	% Impact
OOS				7	7	7	7	7	
University of Maryland	24.32%	4	444	18	19	20	20	21	4%
Johns Hopkins	8.84%	1	161	9	10	10	10	10	6%
Sinai Hospital	0.06%	0	1	0	0	0	0	0	0%
MedStar Franklin Square	2.38%	0	43	4	4	4	5	5	10%
Johns Hopkins Bayview Acute Care	0.06%	0	1	0	0	0	0	0	0%
Carroll Hospital Center	0.06%	0	1	0	0	0	0	0	0%
UM Shore Medical Center at Easton	0.06%	0	1	0	0	0	0	0	0%
Shady Grove Adventist	8.40%	1	153	9	10	10	10	10	6%
MedStar Southern Maryland	0.06%	0	1	0	0	0	0	0	0%
Mt. Washington Pediatric Hospital	1.88%	0	34	0	0	0	0	0	0%
Sheppard Pratt Health System	37.65%	6	687	64	69	70	72	73	10%
Brook Lane Health Services	16.25%	3	297	6	6	7	7	7	2%
Unmet Need				10	10	10	10	10	
State Total	1			117	125	128	131	133	

The following table shows an estimated impact to the existing providers for adolescent services based on the 2019 discharges per HSCRC by provider, the associated increase in population for 2022, and adjustment for the new UMMS unit, and then the projected shift to HHS by provider starting in 2022. As seen below, the largest impact would be on Sheppard Pratt with an approximately 12% reduction in current volume and 190 discharges in year 1. This would bring

down their total discharges down from 1,750 to 1,560. Again, this shift is intended to relieve pressures on the existing provider beds and improve access for patients. The shift in volume should not threaten the viability of any existing programs.

HHS built in modest unmet need assumptions, with 40 new patients entering the market overall. As noted above, the impact to Sheppard Pratt and others may provide more muted should a more substantial spike in admissions occur in this age group.

Figure 29 – Impact on Existing Providers (Adolescents)

Hospital	Market Share (2019)	Pop. 2022	UMMS CON (2018)	Total Discharges 2022 (Before Project)	Year 1 Shift	Year 2 Shift	Year 3 Shift	Year 4 Shift	Year 5 Shift	% Impact
OOS					20	21	22	23	24	
University of Maryland	0.26%	0	260	271	22	24	24	25	25	9%
Johns Hopkins	10.75%	19	-1	475	31	33	34	35	35	7%
Sinai Hospital	0.05%			2		0	0	0	0	0%
MedStar Franklin Square	6.98%	12	-35	274	24	26	26	27	27	9%
MedStar Montgomery General	4.47%	8	-5	193	5	5	6	6	6	3%
Suburban Hospital	1.06%	2	-5	42	1	1	1	1	1	2%
MedStar Saint Mary's Hospital	0.61%	1		27		0	0	0	0	0%
Carroll Hospital Center	1.76%	3	-5	73	3	3	3	3	3	4%
UM Medical Center Midtown Campus	0.02%			1		0	0	0	0	0%
Calvert Health Medical Center, Inc.	3.64%	6	-5	156		0	0	0	0	0%
UM Baltimore Washington Medical Center	0.02%			1		0	0	0	0	0%
Shady Grove Adventist	13.43%	23		594	30	32	33	34	34	5%
UM Saint Joseph Medical Center	0.02%			1		0	0	0	0	0%
Sheppard Pratt Health System	41.41%	72	-83	1750	190	203	208	213	216	12%
Brook Lane Health Services	15.52%	27		687	15	17	17	17	17	2%
Unmet Need					40	40	40	40	40	
State Total				4547	381	405	414	423	428	

In addition to the above tables showcasing the impact on existing providers and unmet need, HHS notes the responses to 10.24.01.08G(3)(b) on need further identify why additional access is necessary and beneficial for the patient population. These beds will assist in decreasing ED Boarding by alleviate bottlenecks at existing providers for these age groups. Doing so will decrease costs for patients, payors (including the State), and improve quality of care.

EXHIBITS

Exhibit number	Description
1	Excel Tables
2	Floor & Site Plans
3	Lease
4	Discharge Planning Policy
5	Letters of Support
6	Charges / Charity Care Policy
7	Audited Financials
8	Zoning Statement
9	Pre-Qualification Letter
10	MVS Report

EXHIBIT 1

Table Number	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Departmental Gross Square Feet**	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	**Construction Characteristics**	All applicants proposing new construction or renovation must complete Table C.
Table D	**Site and Offsite Costs Included and Excluded in Marshall Valuation Costs**	All applicants proposing new construction or renovation must complete Table D.
Table E	**Project Budget**	All applicants, regardless of project type or scope, must complete Table E.
Table F	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	**Revenues & Expenses, Inflated - Entire Facility**	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	**Revenues & Expenses, Inflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	**Work Force Information**	All applicants, regardless of project type or scope, must complete Table L.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/201_	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							ACUTE CARE					
General Medical/ Surgical*					0	0	General Medical/ Surgical*				0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
SUBTOTAL Gen. Med/Surg*							SUBTOTAL Gen. Med/Surg*					
ICU/CCU					0	0	ICU/CCU				0	0
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA							TOTAL MSGA					
Obstetrics					0	0	Obstetrics				0	0
Pediatrics					0	0	Pediatrics				0	0
Psychiatric					0	0	Psychiatric		16		16	16
TOTAL ACUTE		0	0	0	0	0	TOTAL ACUTE		16	0	16	16
NON-ACUTE CARE							NON-ACUTE CARE					
Dedicated Observation**					0	0	Dedicated Observation**				0	0
Rehabilitation					0	0	Rehabilitation				0	0
Comprehensive Care					0	0	Comprehensive Care				0	0
Other *(Specify/add rows as needed)*					0	0	Other *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE							TOTAL NON-ACUTE					
HOSPITAL TOTAL		0	0	0	0	0	HOSPITAL TOTAL		16	0	16	16

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the "Observation Center". Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION : Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Patient Rooms			1,799		1,799
Clinical Service Areas			1,658		1,658
Staff and Support Area			6,677		6,677
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total			10,134		10,134

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☐	☐
Class B	☐	☐
Class C	☐	☑
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☐	☑
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		10,134
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet		**10,134**
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		582
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		**582**
Average Linear Feet		**582**
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		10 ft
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		**10**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		N/A
Freight		N/A
Sprinklers	**Square Feet Covered**	
Wet System		10,134
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	VAV INDEPENDENT SYSTEM	
Type of Exterior Walls for proposed project		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation		$50,000
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs		**$50,000**
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$0**	**$50,000**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$0**	**$50,000**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application.

NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.d as a use of funds and on line B.8 as a source of funds

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure		$50,000	$50,000
(4) Architect/Engineering Fees		$9,400	$9,400
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$59,400**	**$59,400**
b. Renovations			
(1) Building	$2,287,498		$2,287,498
(2) Fixed Equipment (not included in construction)	$131,250		$131,250
(3) Architect/Engineering Fees	$128,500		$128,500
(4) Permits (Building, Utilities, Etc.)	$2,500		$2,500
SUBTOTAL	**$2,549,748**	**$0**	**$2,549,748**
c. Other Capital Costs			
(1) Movable Equipment	$875,000		$875,000
(2) Contingency Allowance	$318,718		$318,718
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$1,193,718***	***$0***	**$1,193,718**
TOTAL CURRENT CAPITAL COSTS	**$3,743,466**	**$59,400**	**$3,802,866**
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	**$3,743,466**	**$59,400**	**$3,802,866**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance	**$60,000**		$60,000
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			$0
d. Non-CON Consulting Fees			$0
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*	**$637,134**		$637,134
SUBTOTAL	**$697,134**	**$0**	**$697,134**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	**$4,440,600**	**$59,400**	**$4,500,000**
B. Sources of Funds			
1. Cash	**$4,440,600**	**$59,400**	$4,500,000
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	**$4,440,600**	**$59,400**	**$4,500,000**
	Hospital Building	**Other Structure**	**Total**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building	**$180,000**		$180,000
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease. Initial intent to lease is for 5 year with options to extend up to 6 six years. The annual cost of the lease shall be 180,000 with out interest

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION : After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**
1. DISCHARGES							
a. General Medical/Surgical*	0						
b. ICU/CCU	0						
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0						
d. Obstetric	0						
e. Acute Psychiatric	508	540	550	562	573	585	597
Total Acute	**508**	**540**	**550**	**562**	**573**	**585**	**597**
f. Rehabilitation	0						
g. Comprehensive Care	0						
h. Other (Specify/add rows of needed)	0						
TOTAL DISCHARGES	**508**	**540**	**550**	**562**	**573**	**585**	**597**
2. PATIENT DAYS							
a. General Medical/Surgical*	0						
b. ICU/CCU	0						
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0						
d. Obstetric	0						
e. Acute Psychiatric	4672	4964	4964	4964	4964	4964	4964
Total Acute	**4672**	**4964**	**4964**	**4964**	**4964**	**4964**	**4964**
f. Rehabilitation	0						
g. Comprehensive Care	0						
h. Other (Specify/add rows of needed)	0						
TOTAL PATIENT DAYS	**4,672**	**4,964**	**4,964**	**4,964**	**4,964**	**4,964**	**4,964**
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	9.2	9.2	9.0	8.8	8.7	8.5	8.3
Total Acute	9.2	9.2	9.0	8.8	8.7	8.5	8.3
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL AVERAGE LENGTH OF STAY	9.2	9.2	9.0	8.8	8.6	8.5	8.3

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION : After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	16	16	16	16	16	16	16
Total Acute	***16***	***16***	***16***	***16***	***16***	***16***	***16***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS							
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	80.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Total Acute	**80.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %							
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

*Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**
1. REVENUE							
a. Inpatient Services	$ 7,747,880	$ 8,232,122	$ 8,232,122	$ 8,232,122	$ 8,232,122	$ 8,232,122	$ 8,232,122
b. Outpatient Services							
Gross Patient Service Revenues	***$ 7,747,880***	***$ 8,232,122***	***$ 8,232,122***	***$ 8,232,122***	***$ 8,232,122***	***$ 8,232,122***	***$ 8,232,122***
c. Allowance For Bad Debt	$ 852,267	$ 905,533	$ 905,533	$ 905,533	$ 905,533	$ 905,533	$ 905,533
d. Contractual Allowance	$ 464,873	$ 493,927	$ 493,927	$ 493,927	$ 493,927	$ 493,927	$ 493,927
e. Charity Care	$ 318,438	$ 338,340	$ 338,340	$ 338,340	$ 338,340	$ 338,340	$ 338,340
Net Patient Services Revenue	***$ 6,112,302***	***$ 6,494,322***	***$ 6,494,322***	***$ 6,494,322***	***$ 6,494,322***	***$ 6,494,322***	***$ 6,494,322***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ 6,112,302***	***$ 6,494,322***	***$ 6,494,322***	***$ 6,494,322***	***$ 6,494,322***	***$ 6,494,322***	***$ 6,494,322***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,558,457	$ 3,832,782	$ 3,832,782	$ 3,832,782	$ 3,832,782	$ 3,832,782	$ 3,832,782
b. Contractual Services	$ 608,769	$ 646,817	$ 646,817	$ 646,817	$ 646,817	$ 646,817	$ 646,817
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization	$ 341,317	$ 341,317	$ 341,317	$ 341,317	$ 341,317	$ 341,317	$ 341,317
i. Supplies	$ 522,555	$ 555,214	$ 555,214	$ 555,214	$ 555,214	$ 555,214	$ 555,214
j. Other Expenses (Specify)	$ 305,000	$ 305,000	$ 305,000	$ 305,000	$ 305,000	$ 305,000	$ 305,000
TOTAL OPERATING EXPENSES	***$ 5,336,098***	***$ 5,681,130***	***$ 5,681,130***	***$ 5,681,130***	***$ 5,681,130***	***$ 5,681,130***	***$ 5,681,130***
3. INCOME							
a. Income From Operation	**$ 776,205**	**$ 813,192**	**$ 813,192**	**$ 813,192**	**$ 813,192**	**$ 813,192**	**$ 813,192**
b. Non-Operating Income							
SUBTOTAL	***$ 776,205***	***$ 813,192***	***$ 813,192***	***$ 813,192***	***$ 813,192***	***$ 813,192***	***$ 813,192***
c. Income Taxes							
NET INCOME (LOSS)	***$ 776,205***	***$ 813,192***	***$ 813,192***	***$ 813,192***	***$ 813,192***	***$ 813,192***	***$ 813,192***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%
3) Blue Cross	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
4) Commercial Insurance	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
5) Self-pay	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
6) Other	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%
3) Blue Cross	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
4) Commercial Insurance	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
5) Self-pay	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
6) Other	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**
1. REVENUE							
a. Inpatient Services	$ 7,747,880	$ 8,460,152	$ 8,688,182	$ 8,916,211	$ 9,144,241	$ 9,372,271	$ 9,600,301
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 7,747,880***	***$ 8,460,152***	***$ 8,688,182***	***$ 8,916,211***	***$ 9,144,241***	***$ 9,372,271***	***$ 9,600,301***
c. Allowance For Bad Debt	$ 852,267	$ 930,616	$ 955,700	$ 980,783	$ 1,005,866	$ 1,030,949	$ 1,056,033
d. Contractual Allowance	$ 464,873	$ 507,609	$ 521,291	$ 534,972	$ 548,654	$ 562,336	$ 576,018
e. Charity Care	$ 318,438	$ 347,712	$ 357,084	$ 366,456	$ 375,828	$ 385,200	$ 394,572
Net Patient Services Revenue	***$ 6,112,302***	***$ 6,674,215***	***$ 6,854,107***	***$ 7,034,000***	***$ 7,213,893***	***$ 7,393,786***	***$ 7,573,678***
f. Other Operating Revenues (Specify/add rows of needed)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NET OPERATING REVENUE	***$ 6,112,302***	***$ 6,674,215***	***$ 6,854,107***	***$ 7,034,000***	***$ 7,213,893***	***$ 7,393,786***	***$ 7,573,678***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,558,457	$ 3,909,438	$ 3,986,093	$ 4,062,749	$ 4,139,405	$ 4,216,060	$ 4,292,716
b. Contractual Services	$ 608,769	$ 659,753	$ 672,690	$ 685,626	$ 698,562	$ 711,499	$ 724,435
c. Interest on Current Debt	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Current Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -
g. Current Amortization	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
h. Project Amortization	$ 341,317	$ 341,317	$ 341,317	$ 341,317	$ 341,317	$ 341,317	$ 341,317
i. Supplies	$ 522,555	$ 566,318	$ 577,423	$ 588,527	$ 599,631	$ 610,735	$ 621,840
j. Other Expenses (Specify/add rows of needed)	$ 305,000	$ 311,100	$ 317,200	$ 323,300	$ 329,400	$ 335,500	$ 341,600
TOTAL OPERATING EXPENSES	***$ 5,336,098***	***$ 5,787,926***	***$ 5,894,723***	***$ 6,001,519***	***$ 6,108,315***	***$ 6,215,111***	***$ 6,321,908***
3. INCOME							
a. Income From Operation	**$ 776,204**	**$ 886,289**	**$ 959,384**	**$ 1,032,481**	**$ 1,105,578**	**$ 1,178,675**	**$ 1,251,770**
b. Non-Operating Income							
SUBTOTAL	***$ 776,204***	***$ 886,289***	***$ 959,384***	***$ 1,032,481***	***$ 1,105,578***	***$ 1,178,675***	***$ 1,251,770***
c. Income Taxes							
NET INCOME (LOSS)	***$ 776,204***	***$ 886,289***	***$ 959,384***	***$ 1,032,481***	***$ 1,105,578***	***$ 1,178,675***	***$ 1,251,770***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%
3) Blue Cross	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
4) Commercial Insurance	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
5) Self-pay	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
6) Other	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%
3) Blue Cross	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
4) Commercial Insurance	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
5) Self-pay	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
6) Other	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE L. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
			$0	1.0	$158,400	$158,400			$0	1.0	$158,400
			$0	1.0	$109,300	$109,300			$0	1.0	$109,300
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0	2.0		$267,700			$0	2.0	$267,700
Direct Care Staff *(List general categories, add rows if needed)*											
Recreation Therapist			$0	1.0	$46,410	$46,410			$0	1.0	$46,410
Psychologist			$0	2.0	$70,600	$141,200			$0	2.0	$141,200
Psychiatrist			$0	4.0	$195,260	$781,040			$0	4.0	$781,040
Social Worker			$0	3.0	$52,710	$158,130			$0	3.0	$158,130
RN			$0	9.5	$77,910	$740,145			$0	9.5	$740,145
Occ. Therapist			$0	1.0	$87,610	$87,610			$0	1.0	$87,610
Psych Tech			$0	16.0	$35,910	$574,560			$0	16.0	$574,560
Nurse Manager			$0	1.0	$100,000	$100,000			$0	1.0	$100,000
Total Direct Care			$0	37.5		$2,629,095			$0	37.5	$2,629,095
Support Staff *(List general categories, add rows if needed)*											
Discharge Coordinator			$0	1.5	$60,700	$91,050			$0	1.5	$91,050
Finance Staff			$0	3.0	$75,900	$227,700			$0	3.0	$227,700
Food and Nutrition			$0	2.5	$41,925	$104,813			$0	2.5	$104,813
Reception/Assistant			$0	3.5	$32,600	$114,100			$0	3.5	$114,100
Security Officer			$0	7.2	$36,920	$265,824			$0	7.2	$265,824

TABLE L. WORKFORCE INFORMATION

UR/Billing			$0	2.5	$53,000	$132,500			$0	2.5	$132,500
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support			$0	20.2		$935,987			$0	20.2	$935,987
REGULAR EMPLOYEES TOTAL			$0	***59.7***		$3,832,782			$0	59.7	$3,832,782
2. Contractual Employees											

TABLE L. WORKFORCE INFORMATION

Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**											
TOTAL COST	***0.0***		***$0***	***59.7***		***$3,832,782***	***0.0***		***$0***		***$3,832,782***

Hope Health Care - Psychiatric Facility - Prelim. Construction Budget

General Conditions		
Supervision		$42,000.00
Dumpsters		$7,500.00
Floor prep/Demo		$53,175.00
Final Cleaning		$3,293.75
	Subtotal	**$105,968.75**
Concrete		
Saw cut Concrete		$40,625.00
New Window openings		$8,125.00
Generator Pad/fencing		$6,250.00
	Subtotal	**$55,000.00**
Thermal Moist. Protect.		
Roofing		$15,562.50
	Subtotal	**$15,562.50**
Finishes		
Framing & Drywall		$101,250.00
Top out exist wall for demising partition		$21,093.75
Ceiling Grid and tile		$44,362.50
Doors and Hardware		$78,375.00
Door installation		$16,500.00
Auto Openers at entrance vestibule		$15,250.00
Windows		$75,000.00
Millwork		$187,500.00
Painting		$35,300.00
Flooring- carpet		$4,000.00
Seamless flooring		$156,250.00
	Subtotal	**$734,881.25**
Specialties		
Fire Extinguishers		$1,000.00
Fire Extinguisher Cabinets		$1,250.00
Corner Guards		$5,250.00
Crash Rail		$8,000.00
Window Treatments		$9,000.00
Restroom Accessories		$12,000.00
Blocking		$3,750.00
	Subtotal	**$40,250.00**
HVAC		
New HVAC and VAV's		$762,500.00
	Subtotal	**$762,500.00**
Plumbing		
Demo		$6,250.00
Supply/install and suppply lines and fixtures		$85,625.00
ADA shower stalls		$80,000.00
	Subtotal	**$171,875.00**
Sprinklers		
Spinklers (includes drawings)		$37,500.00
	Subtotal	**$37,500.00**
Electrical		
Demo exisitng electrical		$2,500.00
Fire Alarm		$43,750.00
200 KW Stand by Generator		$131,250.00
General		$177,500.00
	Subtotal	**$355,000.00**
Overhead/Profit		$177,710.00
	Total Construction Budget	**$2,418,747.50**

TABLE E: Assumptions

1.Capital Costs
(a). New Construction – Other Structure
(3) Site and Infrastructure: Based upon guidance from HHS engaged engineering firm Century Engineering for a concept plan, PTABP, Survey Services.
(4) Architect and Engineering fees: Based upon guidance from HHS engaged engineering firm Century Engineering to complete work to reformate parking lot due to new entrance of the facility.

(b).
(1) Estimates based upon architecture documents which have been attached following the Table in the Exhibit package.
(2) Estimates based upon architecture documents which have been attached following the Table in the Exhibit package.
(3) Fees provided by architect firm
(4) Fee provided by architect firm

c. other capital costs
(1) Estimated movable equipment based upon furnishing hospital with staff functional equipment and to furnish all 16 patient rooms. Costs have been compared to previously complete project in the area.
(2) contingency costs of 12.5% based upon industry standards

2. Financing Cost and Other Cash Requirements
c. Estimated costs for consulting firm Advis through project completion.
f. Additional contingency for miscellaneous items and troubleshooting throughout the start up process.

Revenue & Expenses:

Revenue: Since HHS does not have an approved acute psychiatric room rate, HHS calculated the median charge rate for existing hospitals, based upon the MHCC data, specifically for the appropriate mental health DRGs that may be provided to the patient population. HHS anticipated an average rate based upon the ratio of total claims, (e.g. those APR-DRGs that accounted for the most claims within the state between 1/1/2019 – 6/30/2019 were weighted more heavily to determine the final reimbursement rate). HHS determined the rate based upon the Medicaid patient population and the Commercial patient population. This analysis resulted in an average rate of $ $1,658.36 per day. (For reference the rate utilized by AAMC in 2016 was approximately $1,411.91 in 2016) HHS assumed an equal distribution of the severity rate between level 1 and 2 to calculate the resulting CMI, which is anticipated to be 1.01. The rate is then reduced in the calculation for contractual reductions in the amount of 6% to account for the Medicaid patient population and an addition 11% in bad debt to adjust for denials and uncollectable copayments. It also includes a charity care amount of 4.11%.

Expenses:

Salaries and wages: based upon final amount in Table L

Contractual services: HHS calculated the total amount paid by similarly situated hospitals, (e.g. Shepherd Pratt based upon its most recently filed cost report and identified certain contractual based services such as laundry and linen, housekeeping, and dietary. HHS identified the amount on a per patient day basis and adjusted it upward by 115% to adjust for inefficiencies in size and scale for the smaller proposed location. The per bed day amount was then applied to the anticipated patient days at the proposed hospital

Current Depreciation: The complete hospital was valued at $6 million dollar and a straight-line depreciation over 20 years was applied.

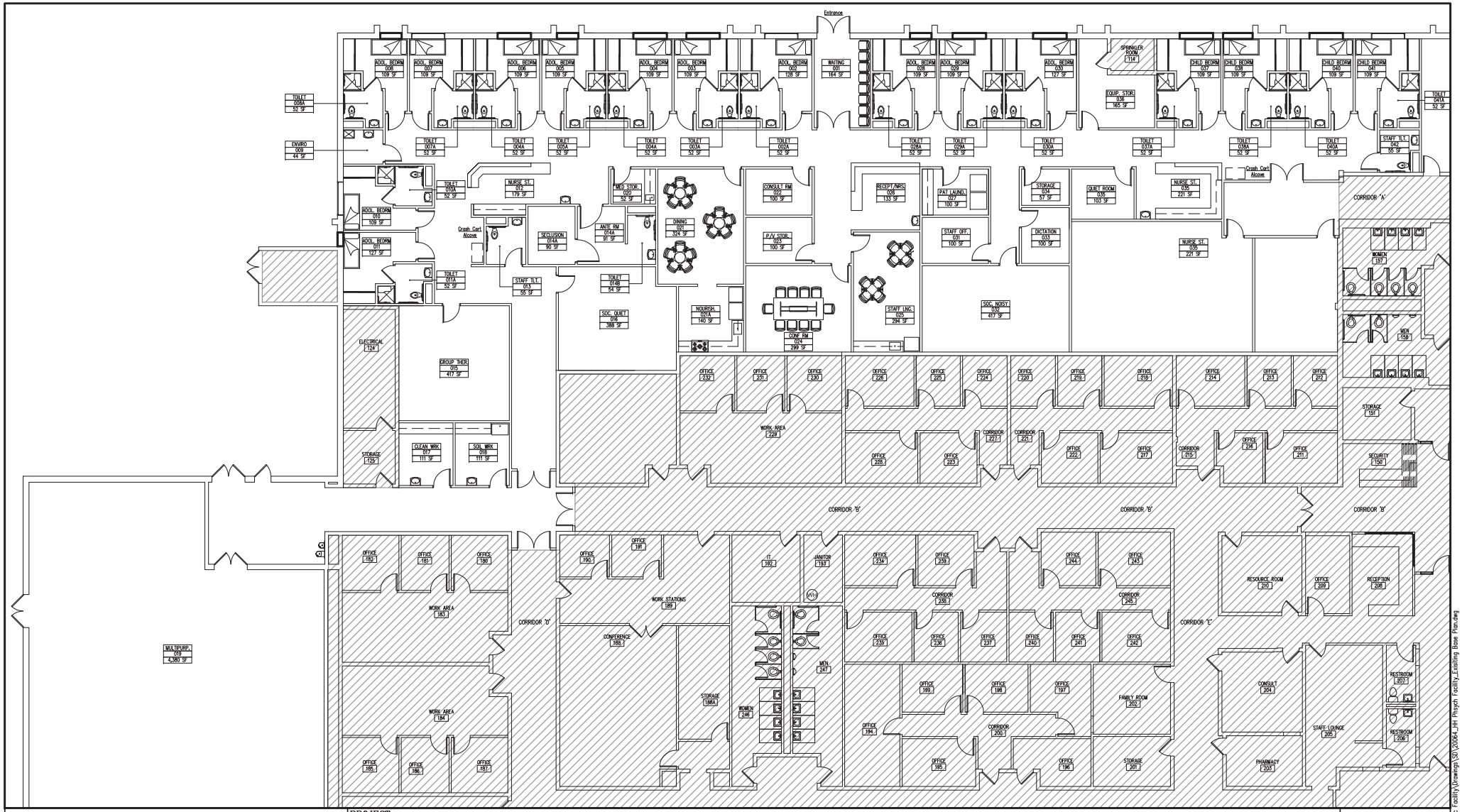
Project amortization: include financing costs associated with the letter included following this exhibit which includes a $4.5 million loan at 6.5% at 20 years.

Other expenses: estimates based upon current operations for the outpatient facility increase to reflect the additional staff and credentialed staff members required. It also includes the annual lease amount as stated in the attached lease.

Patient Mix: based upon current operations and is an anticipated reflective payer mix of the intended patient population.

Inflation: HHS estimates a revenue increase of 2.77% on a year of year basis. HHS also anticipates an increase in certain expenses in the amount of 2% on a year over year basis.

EXHIBIT 2



Heath Design Group
ARCHITECTURE AND INTERIORS
516 N. Charles Street, Suite 500
Baltimore, Maryland 21201
p: 410.752.2700
f: 410.752.2752
www.heathdesigngroup.com

PROJECT TITLE:

HOPE HEALTH
PSYCHIATRIC FACILTITY
1726 WHITEHEAD RD
WOODLAWN, MD 21208

SHT. TITLE: **PROPOSED FLOOR PLAN LAYOUT - REVISED**

DATE: 10/07/2020 | SCALE: 2 1/16" = 1'-0" | PROJ. #: 20064

SN-1

Heath Design Group
ARCHITECTURE AND INTERIORS
516 N. Charles Street, Suite 500
Baltimore, Maryland 21201
p: 410.752.2700
f: 410.752.2752
www.heathdesigngroup.com

PROJECT TITLE:

HOPE HEALTH
PSYCHIATRIC FACILTITY
1726 WHITEHEAD RD
WOODLAWN, MD 21208

SHT. TITLE: **DEMOLITION FLOOR PLAN**

DATE: 09/23/2020 | SCALE: 3 1/16" = 1'-0" | PROJ. #: 20064

SD-1

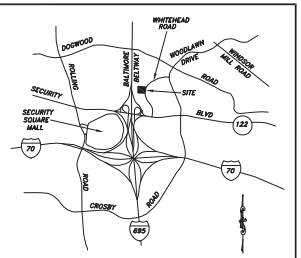
General Notes:

1) This survey is based on The Chicago Title Insurance Company, Title Insurance Commitment Number 18PS16, effective date 4/2/2018.
2) There is no visible evidence of earth moving work, building construction or additions, or the site used as a solid waste dump, sump or a sanitary landfill.
3) The bearings and north arrow shown hereon are in the meridian of the Plat entitled "RESUBDIVISION OF LOT 2–D REVISED PLAT OF MEADOWS INDUSTRIAL PARK" recorded among the land records of Baltimore County, Maryland in Plat Book 78, folio 311.
4) There is no visible evidence of a cemetery on the subject property.
7) The location of utilities shown hereon are by observed evidence only. Some utilities may not be shown due to the utility being obstructed.

LEGAL DESCRIPTION:

ALL THAT certain lot or parcel of land together with all improvements thereon located and being in the County of Baltimore, Maryland and being more particularly described as follows:

BEING KNOWN AND DESIGNATED as Lot 19A, as set forth and shown on the plat entitled "RESUBDIVISION OF LOT 2–D REVISED PLAT OF MEADOWS INDUSTRIAL PARK", dated May 2007 and recorded among the Land Records of Baltimore County, Maryland in Plat Book 78, folio 311. Containing 2.457 acres of land, more or less.



VICINITY MAP

Notes of Possible Encroachments:

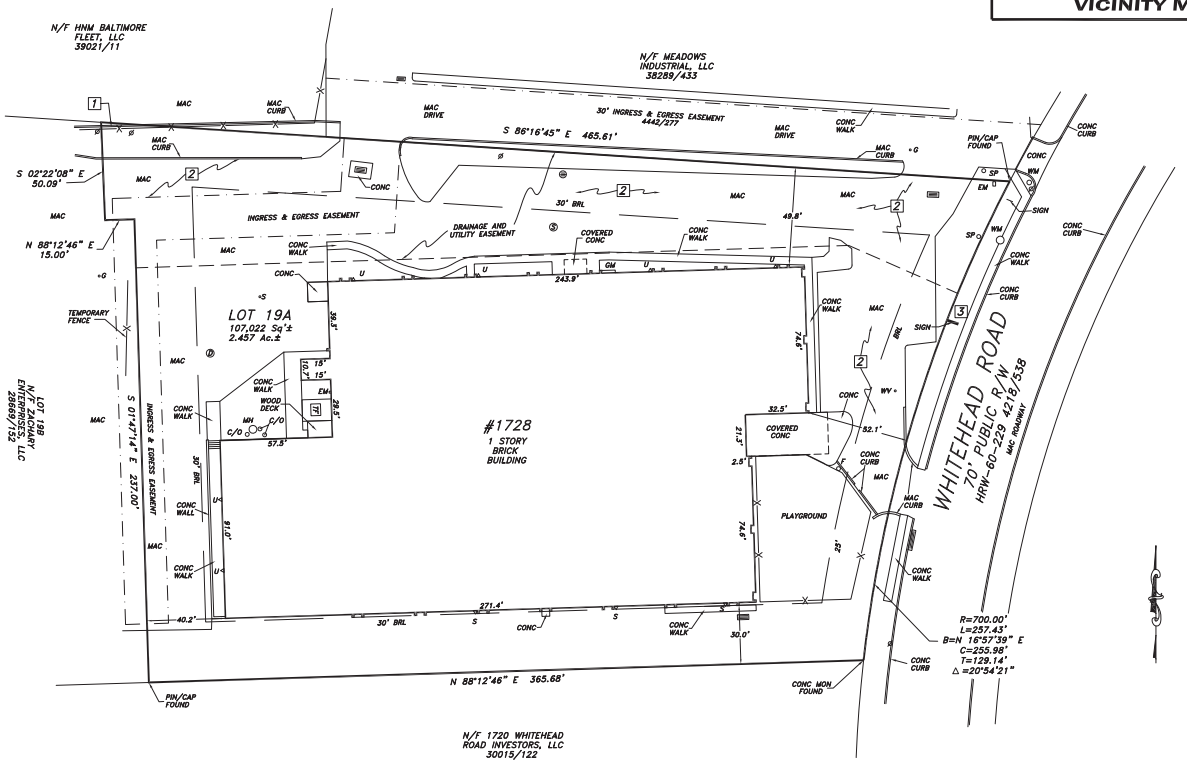
1 The Macadam Curb, Fence and Macadam Drive from 39021/11 encroach into the Subject Property.

2 Vehicular Traffic to Lot 19B was observed outside the Ingress & Egress Easement.

3 The sign encroaches off the subject property into Whitehead Road.

Notes Pertaining to SCHEDULE B - PART II EXCEPTIONS:

Item 1 – Liber 3756, folio 51 creates restrictions for a parcel that the Subject Property is a portion of, it is unclear if these restrictions affect the Subject Property as now layed out, and therefore are not shown hereon.
Item 2 – Liber 3750, Folio 372 grants Utility Easements to Baltimore Gas & Electric Company, however is not shown. (The location cannot be determined from the record document)
Item 3 – Liber 5895, folio 553 creates an ingress and egress easement, however is not shown. (It is not on, or does not touch the Surveyed Property)
Item 4 – Liber 7103, folio 483 creates a sewer easement, however is not shown. (It is not on, or does not touch the Surveyed Property)
Item 5 – Liber 10329, folio 41 creates a drainage & utility easement, however is not shown. (It is not on, or does not touch the Surveyed Property)
Item 6 – Liber 4624, folio 603 creates a storm drain easement or right–of–way, however is not shown. (It is not on, or does not touch the Surveyed Property)
Item 7 – Liber 5153, folio 379 creates a gas line easement, however is not shown. (It is not on, or does not touch the Surveyed Property)
Item 8 – Liber 26737, folio 46 confirms the establishment of the easements shown as proposed on the plat recorded in Plat Book 78, folio 311, shown hereon.
Item 9 – Liber 29236, folio 124 sets forth the terms of a Master Lease, and mentions the 30' Right–of–Way for ingress and egress shown hereon.
Item 10 – Liber 29236, folio 132 sets forth the terms of a Subordination, Non–Disturbance and Attornment Agreement, and mentions the 30' Right–of–Way for ingress and egress shown hereon.
Item 11 – Matters, facts, dedications, easements, reservations, notes and building setback lines as shown on the plat entitled "RESUBDIVISION OF LOT 2–D REVISED PLAT OF MEADOW INDUSTRIAL PARK" recorded in Plat Book 78, folio 311 shown hereon.



SURVEYOR'S CERTIFICATE:

To Chicago Title Insurance Company, Pinderhughes Title, LLC, Hope Health Properties, LLC, Branch Banking and Trust Company and to their successors and/or assigns as their interests may appear, that:

This is to certify that this map or plat and the survey on which it is based were made in accordance with the 2016 Minimum Standard Detail Requirements for ALTA/NSPS Land Title Surveys, jointly established and adopted by ALTA and NSPS, and includes items 2, 3, 4, 8, 13, and 16 of Table A thereof.
The field work was completed on 1/15/2018.

Date of Plat or Map: 1/16/2018

J. Carl Hudgins PLS #96

Subject property is shown in Zone X on the FIRM Map of Baltimore County, Maryland on Community Panel Number 2400100378 F, effective 9/26/2008

NTT Associates, Inc.
16205 Old Frederick Rd.
Mt. Airy, Maryland 21771
Phone: (410) 442–2031
Fax: (410) 442–1315
www.nttsurveyors.com

LEGEND

⌀	UTILITY POLE	○ C/O	CLEAN–OUT
TF	TRANSFORMER	◦ G	GAS VALVE
Ⓢ	SEWER MANHOLE	◦ WV	WATER VALVE
Ⓓ	STORMDRAIN MANHOLE	○ F	FLAG POLE
◯ MH	MANHOLE	▯ EM	ELECTRIC METER
	STORM DRAIN INLET	GM	GAS METER
U	DOWNSPOUT (UNDERGROUND)	○ SP	SPRINKLER HOOKUP
S	DOWNSPOUT (SURFACE)	◯ WM	WATER METER
		—//—	WOOD FENCE
		—/—/—	METAL FENCE

This is to certify that I either personally prepared or was in responsible charge over the preparation of this drawing and the surveying work reflected in it, all set forth in Regulation .12 of Chapter 09.13.06 of the Code of Maryland Annotated Regulations.

JAMES CARL HUDGINS
MD. PROPERTY LINE SURVEYOR # 96
EXPIRES 3/11/2020

DATE	REVISIONS
4/24/18	new commitment

ALTA/NSPS LAND TITLE SURVEY

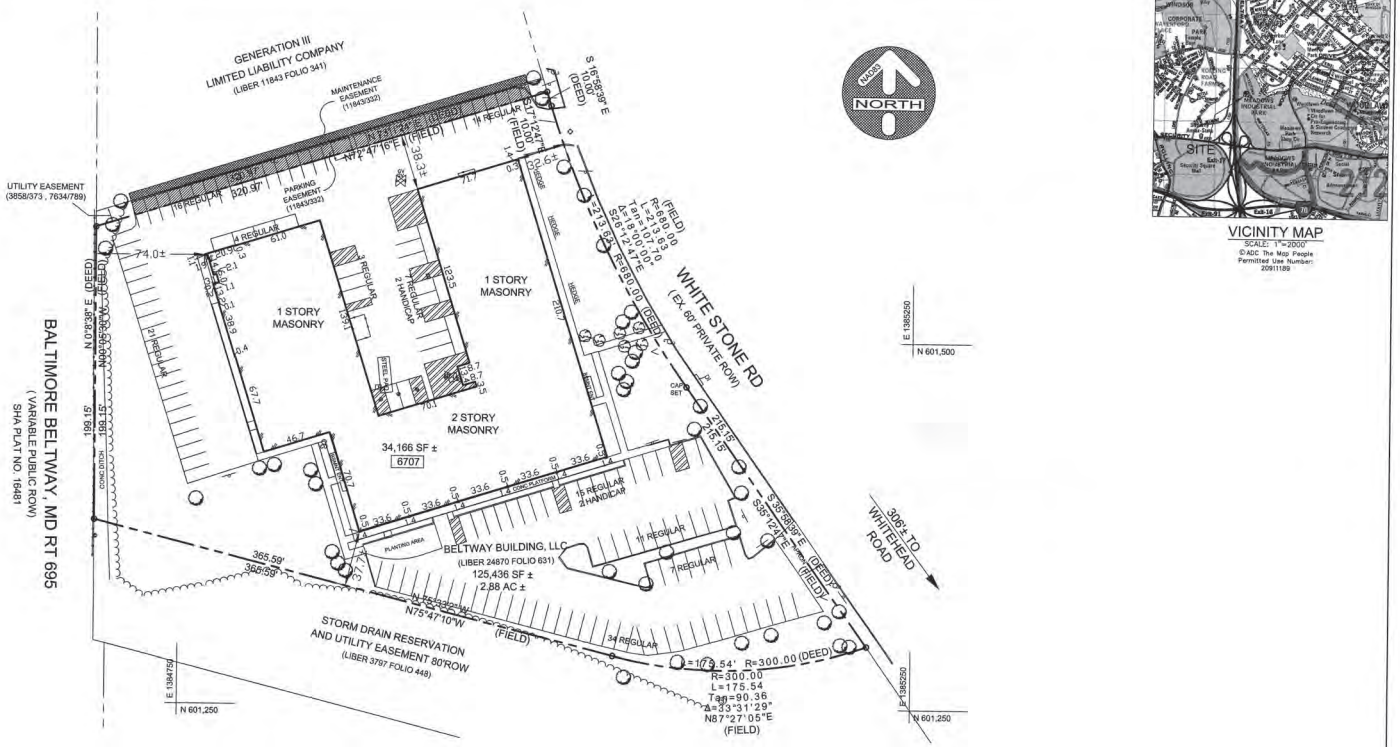
1728 WHITEHEAD ROAD
TAX MAP 88, GRID 19, PARCEL 609
LIBER 35360, FOLIO 108
LOT 19A, PLAT BOOK 78, FOLIO 311
TAX ID # 01–2500003692
1st ELECTION DISTRICT
BALTIMORE COUNTY, MARYLAND
SCALE 1" = 30' SHEET 1 OF 1

0' 30' 60' 90'

DRAWN BY: SCK | FILE # 18PS16 | DATE: 1/15/2018

LEGEND

- CAP FOUND
- POWER POLE
- FENCE LINE
- GUY
- ELECTRICAL JUNCTION BOX
- SEWER MANHOLE
- CLEAN OUT
- WATER METER
- GAS VALVE
- SIGN
- STORM DRAIN MANHOLE
- BUILDING PERIMETER



VICINITY MAP
SCALE: 1"=2000'
©ADC The Map People
Permitted Use Number: 20911189

MONUMENT NOTE

COORDINATES AND BEARINGS SHOWN ON THIS PLAT ARE BASED UPON BALTIMORE CO. DEPARTMENT OF PUBLIC WORKS CONTROL MONUMENTS:

MON. #735; BEING A PIPE WITH CAP FOUND ON THE WEST SIDE OF WHITE STONE ROAD.

MON. #736; BEING A PIPE WITH CAP FOUND ON THE WEST SIDE OF WHITE STONE ROAD.

PARKING SPACES PROVIDED

REGULAR _____ 132
HANDICAP _____ 4

FLOOD HAZARD NOTE

NOTE: THIS LOT LIES IN FLOOD ZONE " X " OF FLOOD INSURANCE RATE MAP COMMUNITY PANEL NO. 240010-0378F EFF. 5-2-83

SURVEYOR'S CERTIFICATE

TO: LENDER: CFG COMMUNITY BANK

BORROWER: WHITESTONE, LLC

TITLE COMPANY: SECURITY TITLE GUARANTEE CORPORATION OF BALTIMORE

TITLE COMMITMENT: A06-027047 DATE: APRIL 11, 2010

I HEREBY CERTIFY TO WHITESTONE,LLC, SECURITY TITLE GUARANTEE CORPORATION OF BALTIMORE, CFG COMMUNITY BANK, AND TO THEIR HEIRS, SUCCESSORS AND ASSIGNS, THAT I HAVE SURVEYED, ON THE GROUND, THE PROPERTY LEGALLY DESCRIBED HEREON; THAT THIS PLAT OF SURVEY IS A TRUE, CORRECT AND ACCURATE DRAWING AND REPRESENTATION OF SAID PROPERTY AND THE BOUNDARIES THEREOF; THAT THIS PLAT OF SURVEY AND THE SURVEY ON WHICH IT IS BASED WERE MADE IN ACCORDANCE WITH THE "MINIMUM STANDARD DETAIL REQUIREMENTS FOR ALTA/ACSM LAND TITLE SURVEYS," AS JOINTLY ESTABLISHED AND ADOPTED BY ALTA AND NSPS IN 2005, AND INCLUDES ITEMS 1, 2, 3, 4, 7(a), 8 ,9 ,10, 11(a), 13, 14, 16 OF "TABLE A". IN LOCATING OR IDENTIFYING RECORDED EASEMENTS OR OTHER RECORDED DOCUMENTS I HAVE RELIED UPON A COMMITMENT FOR TITLE INSURANCE ISSUED BY SECURITY TITLE GUARANTEE CORPORATION OF BALTIMORE, HAVING AN EFFECTIVE DATE OF APRIL 11, 2010 AND BEARING FILE NUMBER A06-027047. NONE OF THE BUILDINGS SHOWN ENCROACH ON ANY STREET, TITLE OR BUILDING LINES, NOR ARE THERE ENCROACHMENTS FROM ADJOINING PROPERTIES, EXCEPT AS SHOWN.

DATED THIS 24 DAY OF AUGUST, 2010.

STATE OF MARYLAND — MARK E. POWELL — 21153 — REGISTERED PROFESSIONAL LAND SURVEYOR

BY: MARK E. POWELL DATE: 24 AUGUST 2010 REGISTRATION NO. 21153
FIRM NAME: DEVELOPMENT FACILITATORS, INC.

DEED DESCRIPTION
WHITESTONE, LLC
TM 88 BLK 19 P/O 494
LIBER 24870, FOLIO 631

BEGINNING FOR THE SAME AT THE POINT FORMED BY THE INTERSECTION OF THE WESTERNMOST SIDE OF WHITE STONE ROAD (60' WIDE PRIVATE R/W) AND THE NORTHERNMOST SIDE OF STORM DRAIN RESERVATION AND UTILITY EASEMENT (80' WIDE), AS SHOWN ON THE REVISED PLAT OF MEADOWS INDUSTRIAL PARK, AND RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY, MARYLAND IN PLAT BOOK WJR NO. 45, FOLIO 137; THENCE FROM THE POINT OF BEGINNING, RUNNING WITH AND BINDING ON THE WESTERNMOST SIDE OF SAID WHITE STONE ROAD, THE THREE FOLLOWING COURSES AS NOW SURVEYED WITH BEARINGS REFERRED TO THE MARYLAND GRID NAD 83:

(1) NORTH 35 DEGREES 12 MINUTES 47 SECONDS WEST, 215.15 FEET; THENCE

(2) NORTHERLY BY THE TANGENT ARC OF A CIRCLE CURVING TO THE EAST WITH A RADIUS OF 680.00 FEET FOR A DISTANCE OF 213.63 FEET AND CHORD BEING NORTH 26 DEGREES 16 MINUTES 02 SECONDS WEST, 212.75 FEET; THENCE

(3) NORTH 17 DEGREES 12 MINUTES 47 SECONDS WEST, 10.00 FEET; THENCE LEAVING SAID ROAD AND RUNNING WITH AND BINDING ON THE DIVISION LINE BETWEEN THE HEREIN DESCRIBED LANDS AND THOSE LANDS CONVEYED TO GENERATION III LIMITED LIABILITY COMPANY BY DEED DATED OCTOBER 10, 1996 AND RECORDED AMONG SAID LAND RECORDS IN LIBER 11843, FOLIO 341

(4) SOUTH 72 DEGREES 47 MINUTES 16 SECONDS WEST, 330.97 FEET TO INTERSECT THE EASTERNMOST SIDE OF MD ROUTE 695 (VARIABLE WIDTH R/W) AND THE WESTERNMOST OUTLINE OF SAID PLAT, AT A POINT DISTANT 199.15 FEET, NORTH 00 DEGREES 05 MINUTES 30 SECONDS EAST FROM THE NORTHERNMOST SIDE OF SAID STORM DRAIN RESERVATION AND UTILITY EASEMENT AS SHOWN ON SAID PLAT; THENCE RUNNING WITH AND BINDING ON A PART OF THE EASTERNMOST SIDE OF MD 695 AND THE WESTERNMOST OUTLINE OF SAID PLAT, AS NOW SURVEYED

(5) SOUTH 00 DEGREES 05 MINUTES 30 SECONDS WEST, 199.15 FEET TO THE NORTHERNMOST SIDE OF SAID STORM DRAIN RESERVATION AND UTILITY EASEMENT; THENCE LEAVING THE EASTERNMOST SIDE OF SAID MD 695 AND THE WESTERNMOST OUTLINE OF SAID PLAT; AND RUNNING WITH AND BINDING ON THE NORTHERNMOST SIDE OF SAID STORM DRAIN RESERVATION AND UTILITY EASEMENT (80 FEET WIDE), THE TWO FOLLOWING COURSES AND DISTANCES, AS NOW SURVEYED:

(6) SOUTH 75 DEGREES 47 MINUTES 10 SECONDS EAST, 365.59 FEET AND

(7) EASTERLY BY THE TANGENT ARC OF A CIRCLE CURVING TO THE NORTH WITH A RADIUS OF 300.00 FEET FOR A DISTANCE OF 175.54 FEET AND CHORD BEING NORTH 87 DEGREES 27 MINUTES 05 SECONDS EAST, 173.04 FEET TO THE PLACE OF BEGINNING.

CONTAINING 125,436 SQUARE FEET, OR 2.88 ACRES OF LAND, MORE OR LESS, ACCORDING TO A SURVEY PERFORMED BY DEVELOPMENT FACILITATORS, INC IN AUGUST, 2010.

TOGETHER WITH THE BENEFIT OF THE INGRESS, EGRESS, PARKING AND MAINTENANCE EASEMENTS SET FORTH IN THE DECLARATION OF PARKING AND ACCESS EASEMENT BY A&E PARTNERS L.P. DATED OCTOBER 8, 1996 AND RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY, MARYLAND IN LIBER 11843, FOLIO 332.

BEING ALL OF "PROPERTY B" OF THOSE LANDS DESCRIBED IN A DEED DATED DECEMBER 1, 2006 AND RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY, MARYLAND IN BOOK 24870, PAGE 631 AND GRANTED AND CONVEYED FROM A&E PARTNERS, L.P. TO BELTWAY BUILDING, LLC; AND ALSO BEING THE "BELTWAY BUILDING" LOT AS SHOWN ON THE REVISED PLAT OF MEADOWS INDUSTRIAL PARK, RECORDED IN PLAT BOOK WJR 45, FOLIO 137.

SCHEDULE B EXCEPTIONS FROM TITLE COMMITMENT #A06-027047

C.(c) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN A DEED TO BALTIMORE COUNTY RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK GLB 3176, PAGE 301.
UTILITY EASEMENT NOW CONTAINED WITHIN R/W FOR WHITE STONE ROAD.

C.(d) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN ZONING AGREEMENT RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK GLB 3322, PAGE 55.
ZONING AGREEMENT THAT DOES NOT APPLY TO THIS PROPERTY.

C.(e) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN AN AGREEMENT REGARDING SEWERS, ETC. RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK GLB 3302, PAGE 450.
UTILITY EASEMENT NOW CONTAINED WITHIN THE PRIVATE R/W FOR WHITE STONE ROAD.

C.(f) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN AN AGREEMENT REGARDING POLES, ETC. RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK WJR 3521, PAGE 68.
GENERAL POLE EASEMENT ALONG SECURITY BLVD.

C.(g) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN AN AGREEMENT REGARDING SEWERS, ETC. RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK WJR 3712, PAGE 484.
CONVEYS SECURITY BLVD TO BECOME A PUBLIC ROAD.

C.(h) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN AN AGREEMENT REGARDING POLES, ETC. RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK WJR 3750, PAGE 370 AND AT BOOK WJR 3750, PAGE 372.
POLE EASEMENT ALONG SECURITY BLVD. AND ALONG PRIVATE ROADS BUT NOT DEFINED.

C.(i) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN AN AGREEMENT REGARDING SEWERS, ETC. RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK WJR 3752, PAGE 588.
PIPES AND UTILITIES IN PRIVATE RIGHTS-OF-WAY AND EASEMENT RESERVE AREAS ON PLAT.

C.(j) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN A UTILITY AGREEMENT RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK WJR 3797, PAGE 448.
CONVEYS STORM DRAIN AND UTILITY RESERVATION AREAS ON PLAT TO BALTIMORE CO. IN FEE SIMPLE.

C.(k) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN A DEED/EASEMENT RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK WJR 3817, PAGE 580.
PART OF COMMERCIAL LOT "A" SHOWN ON PLAT OF "BROOKLAWN". DOES NOT APPLY TO THIS PROPERTY.

C.(l) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN AN AGREEMENT REGARDING POLES, ETC. RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK WJR 3860, PAGE 152.
ELECTRIC POLE EASEMENT ALONG PART OF WHITE STONE ROAD THAT DOES NOT AFFECT THIS PROPERTY.

C.(m) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN AN AGREEMENT REGARDING GAS MAINS RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK RRG 4325, PAGE 22.
GAS EASEMENT ALONG SECURITY BLVD.

C.(n) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN A DEED TO BALTIMORE COUNTY RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK OTG 5131, PAGE 433.
DOES NOT APPLY TO THIS PROPERTY. CONVEYS RIGHT-OF-WAY ON WEST SIDE OF 695.

C.(o) SUBJECT TO COVENANTS AND CONDITIONS CONTAINED IN RESTRICTIONS RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK GLB 3322, PAGE41 AND AT BOOK GLB 3322, PAGE 47.
USE RESTRICTIONS THAT DO NOT APPLY TO THIS PROPERTY.

C.(p) SUBJECT TO TERMS AND CONDITIONS CONTAINED IN DECLARATIONS RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOOK WJR 3709, PAGE 428 AND AT BOOK WJR 3756, PAGE 51.
USE AND SETBACK AGREEMENTS THAT DO NOT APPLY TO THIS PROPERTY.

C.(q) SUBJECT TO TERMS AND CONDITIONS, INCLUDING ANY EASEMENTS CREATED, OF A DECLARATION RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY AT BOO 11843, PAGE 332.
PARKING EASEMENT SHOWN HEREON.

C.(r) SUBJECT TO THE SETBACK LINES, EASEMENTS, ROADS, RIGHTS OF WAY AND TERMS AND CONDITIONS AS PER PLAT ENTITLED "MEADOWS INDUSTRIAL PARK," WHICH PLAT IS RECORDED AMONG THE LAND RECORDS OF BALTIMORE COUNTY, MARYLAND AT PLAT BOOK WJR 27, PAGE 21; AND RECORDED AT PLAT BOOK WJR 45, FOLIO 137.
SUBDIVISION PLATS.

DFI
DEVELOPMENT FACILITATORS INC.
ENGINEERS-SURVEYORS-PLANNERS
CONSTRUCTION MANAGERS
I-97 BUSINESS PARK
1127 BENFIELD BLVD, SUITE K
MILLERSVILLE, MD 21108
WWW.DFIENGINEERING.COM
443-308-2100 FAX 443-308-2108

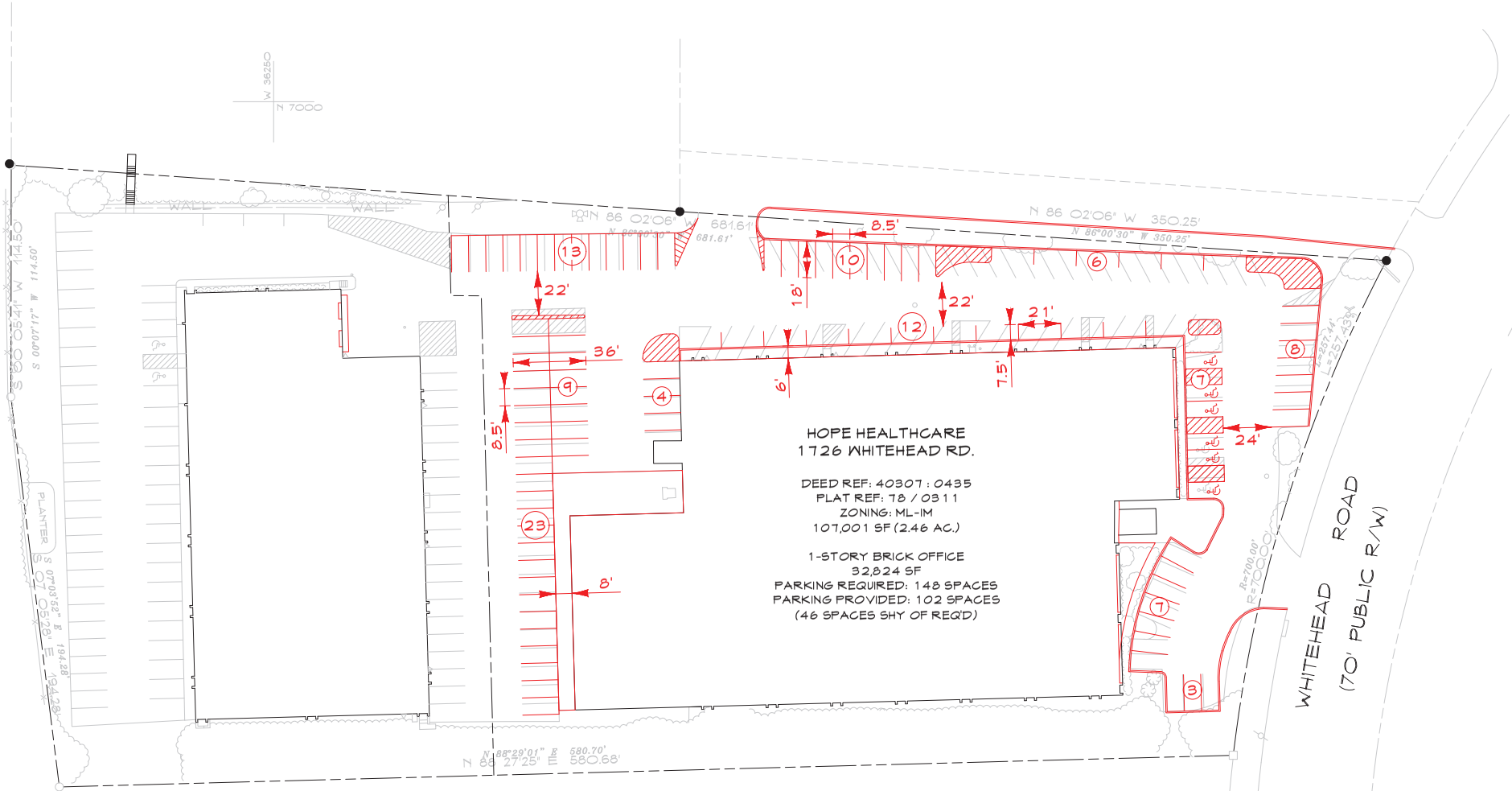
REVISIONS		
NO.	DATE	DESCRIPTION
1	08/24/10	REVISED FOR OWNER AND LENDER NAME CHANGE

PLAN PREPARATION	
DRAWN BY: ANMB	DATE: AUGUST, 2010
DESIGNED BY:	SCALE: 1"= 40'
CHECKED BY: MEP	UPDATED:

ALTA/ACSM SURVEY
FOR
WHITESTONE, LLC
TAX MAP 88 BLOCK 19 PARCEL 494
RECORDED IN LIBER 24870, FOLIO 631
6707 WHITE STONE ROAD
THIRD ASSESSMENT DISTRICT
BALTIMORE COUNTY, MARYLAND

DRAWING NO.

SHEET NO.
1 OF 1



1726 Whitehead Road

Parking Study

CENTURY ENGINEERING
CONSULTING ENGINEERS - PLANNERS
10710 Gilroy Road, Hunt Valley, MD 21031
Phone: 443.589.2400 Fax: 443.589.2401

18 JANUARY 2019

SCALE: 1" = 20'

EXHIBIT 3

LEASE AGREEMENT

THIS LEASE AGREEMENT (this "Lease") is made as of the _1st___ day of October, 2020 (the "Effective Date"), by and between **HOPE HEALTH PROPERTIES, LLC**, a Maryland limited liability company ("Landlord"), and **HOPE HEALTH HOSPITAL,** ("Tenant"). Per our conversation, this correspondence shall serve as a Non-binding agreement to lease the premises - this pending approval of zoning and all pertinent proposals for proposed hospital.

W I T N E S S E T H:

1. PREMISES.

For and in consideration of the rent hereinafter reserved and the mutual covenants hereinafter contained, Landlord hereby leases to Tenant, and Tenant does hereby rent from Landlord, that certain commercial suite located within the freestanding building (the "Building") known as **1726-1728 Whitehead Road, Woodlawn, Maryland 21207**, consisting of approximately **10,134 +/- square feet**, and shown and depicted as the "HOPE HEALTH HOSPITAL" on **Exhibit A** attached hereto and incorporated herein by reference (the "Premises"), all upon the terms and conditions set forth herein. The land upon which the Premises is located and the improvements constituting the Premises is hereinafter sometimes referred to as the "Property" or "Real Property." Tenant acknowledges that Tenant is accepting the Premises and/or Property in it's "as-is" "where-is" condition and that Landlord is not furnishing nor shall be required to furnish any improvement or work of any nature whatsoever except for the Landlord's Work (as defined herein). Upon delivery of possession of the Premises to Tenant hereunder, Tenant shall have satisfied itself as to the physical condition of the Premises, and Landlord shall not be obligated to perform any repairs to the Property except as expressly set forth herein. Tenant shall, at the sole cost and expense of Tenant, observe and comply with all laws, requirements, rules, orders, ordinances, restrictive covenants of record, and regulations applicable to the Premises and/or the Property. Tenant represents that it has independently verified that its use of the Premises complies with applicable zoning ordinances and restrictive covenants of record, and further agrees to assume all liability, responsibility, and costs of its violation or noncompliance with same.

The use and occupation by Tenant of the Premises shall include the use in common with others entitled thereto of the common areas, loading facilities, stairways, and other facilities as may be designated from time to time by Landlord, including, but not limited to the playground area and equipment located in the landscaped area adjacent to Tenant's Premises; subject, however, to the terms and conditions of this Lease and to the reasonable rules and regulations for the use thereof as prescribed from time to time by Landlord. Said common areas shall be under the exclusive control and management of Landlord and provided the same does not materially interfere with Tenant's right to use, access or enjoy the Premises, the Landlord may from time to time, modify, alter, rearrange or relocate any part of the common areas. Tenant's use of such common areas shall be at its sole risk and shall be under a revocable license. If the common areas should be subsequently diminished, there shall be no abatement of rent or liability to Landlord, nor shall there be deemed an actual or constructive eviction.

2. TERM/RENEWAL TERMS.

(a) Initial Term. The term of this Lease (the "Term") shall commence upon the Commencement Date and shall continue for a period of **five (5) years** thereafter, unless the Term is terminated earlier in accordance with the provisions of this Lease (the "Termination Date"); provided, however, that if the Commencement Date is a day other than the first day of a month, then the Term shall commence on the Commencement Date and shall continue for the balance of the month in which the Commencement Date occurs and for a period of the aforesaid number of consecutive years and months thereafter. The "Commencement Date" of the Lease Term is the later to occur of (i) that day Landlord delivers possession (including a key) to the Premises to Tenant in the condition set forth herein or (ii) July 1, 2018. Tenant acknowledges and agrees that upon completion of the Landlord's Work and Landlord's delivery of written notice that a key to the Premises has been delivered to Tenant and/or placed in a lockbox accessible to Tenant shall be deemed delivery of possession. The term "Lease Year," as used herein, shall mean the one (1) year period beginning on the Commencement Date (or the first (1st) day of the next calendar month in the event the Commencement Date does not occur on the first day of a month) and ending on the last day of the twelfth calendar month thereafter. Each successive full twelve (12) month period during the Term shall constitute a Lease Year.

(b) Renewal Terms. Tenant shall have **two (2)** options to extend the Term for period of **three (3) additional years** each (each a "Renewal Term"; the initial Term as extended by any Renewal Term (if exercised), being collectively referred to hereinafter as the "Term"). Provided Tenant is not then in default of this Lease beyond any applicable notice and cure period, each Renewal Term shall commence upon the expiration of the prior term if Tenant notifies Landlord in writing at least ninety (90) days prior to the expiration of such prior term that it has elected to cause the Term to include such Renewal Term. The terms and conditions of this Lease shall remain the same during the Renewal Term, except as otherwise provided herein.

3. RENT.

(a) Rent. Tenant covenants and agrees to pay to Landlord during the Term hereof a fixed base annual rental amount in accordance with the Rent Schedule Rider attached hereto as **Schedule 1** (the "Rent"), in advance, not later than the first (1st) day of each calendar month. Whenever it is provided by the terms of this Lease that Tenant is required to make any payment under this Lease, other than of Rent, such payment shall be deemed to be additional rent ("additional rent") and any failure on the part of Tenant to pay additional rent shall entitle Landlord to the same rights and remedies as the failure on the part of Tenant to pay Rent.

(b) Payment. Rent shall be payable in lawful money of the United States of America to Landlord or to such other person at such place and in such form (including electronic funds transfer) as Landlord may from time to time direct by notice to Tenant, in advance, without previous notice or demand therefor and without deduction or setoff. Tenant acknowledges and agrees that all of its covenants and obligations contained herein are independent of Landlord's covenants and obligations contained herein. Rent shall be due and payable not later than the **first (1st) day** of each and every month during the Term hereof, except as otherwise provided herein. No payment by Tenant or receipt by Landlord of a lesser amount than the amounts herein stipulated shall be deemed to be other than on account of the earliest stipulated rent, nor shall any endorsement or statement on any check or other form of correspondence concerning payment of rent be deemed an accord and satisfaction and Landlord may accept such check or payment, whether by check, wire transfer or other method of payment, without prejudice to Landlord's right to recover the balance of such rent or to pursue any other remedy provided in this Lease. No endorsement or statement on any check or other form of correspondence concerning the application of any payment shall be binding on Landlord, and Landlord may apply any payment received from Tenant to any payment then due. Tenant shall pay Landlord upon demand the sum of Seventy-Five Dollars ($75.00) for each of Tenant's checks or payments returned to Landlord not paid for insufficient funds or other reasons not the fault of Landlord, to cover Landlord's costs in handling such returned items, and Tenant shall thereafter, upon Landlord's request, pay all future sums due hereunder to Landlord in the form of certified or cashier's checks or money orders. The foregoing returned check charge represents the parties' reasonable estimate as of the date hereof of the extra expenses that Landlord will incur in processing returned checks, the exact amount of such charges being difficult to ascertain, and such charge shall not be considered interest.

4. REAL ESTATE TAXES.

(a) Real Estate Taxes and Assessments; Increases.

(i) In addition to Tenant's obligation to pay Monthly Base Rent hereunder, Tenant agrees to pay all real estate taxes and assessments, both general and special, levied or assessed by any lawfu1 authority, for each tax year during the term hereof against the Property and the improvements thereon. The term "real estate taxes" as used herein means Tenant's "pro rata share" (as defined below) of all real property taxes and assessments that are levied or assessed against the entirety of the real property known as 1726-1728 Whitehead Road, Woodlawn, Maryland 21207, Tax Map 88, Lot 19A, Tax No. 01-2500003692, consisting of approximately 2.457 acres, and the improvements thereon (collectively, the "Real Property") by any lawful governmental authority for each calendar year or fiscal year or portion thereof commencing on the Commencement Date. Real estate taxes are to be prorated for any partial Lease year hereunder (including the initial year of this Lease Term). For the purposes of this Lease, Tenant's "pro rata share" shall mean and refer to a fraction, the numerator of which shall equal the square footage of the Premises, and the denominator shall equal the total square footage attributable to the Building. As of the date hereof, Tenant's pro rata share is deemed to be **13.48%**.

(ii) Tenant shall pay to Landlord, as additional rent hereunder, one-twelfth (1/12th) of the total annual real estate taxes due for any applicable taxing year hereunder, on a monthly-basis concurrently with the payment of Monthly Base Rent above. From time to time, Landlord shall notify Tenant in writing of the most current tax assessment against the Premises, together with Landlord's computation of the monthly amount of such tax to be paid by Tenant hereunder. At the end of each full tax year during the term of this Lease and again at the expiration or termination of this Lease, Landlord shall calculate the actual tax paid or owing for the Premises, and Tenant shall be credited or charged, as the case may be, for such adjustments as may be necessary by reason of any difference between the actual amounts determined by Landlord to have been paid or owing for the Premises (or the pro-rata portion of such amount notwithstanding that payment to the taxing authority may not then be due) and the amount of such taxes actually paid by Tenant to Landlord. A copy of a tax bill or assessment bill received by Landlord from the taxing jurisdiction and delivered to Tenant shall at all times be sufficient evidence of the amount of real estate taxes to which such bill relates. As of the Commencement Date hereof, Tenant's estimated monthly payment of real estate taxes is **$831.26** (which amount is subject to adjustment as provided in this Section 4).

(iii) The parties acknowledge that the payments made under this Section 4, are predicated on the present real estate tax payment schedule established in Baltimore County, Maryland, which provides for annual payments of real estate taxes in advance. It is agreed that if any real estate taxes become payable in addition to such annual payment of real estate taxes during any lease year due to partial year assessments of expansion improvements, or the like, or for any other reason, that, upon ten (10) days' notice from Landlord that any such real estate taxes are due and payable, Tenant shall such amount as additional rent in the manner set forth in this Section 4.

(iv) Should any governmental taxing authority acting under any present or future law, ordinance or regulation, levy, assess or impose a tax, excise surcharge or assessment upon or against the rents payable by Tenant to Landlord which tax, excise surcharge or assessment shall be in the nature of a real estate tax, either by way of substitution or addition thereof, then Tenant shall be responsible for and shall pay said tax as additional rent in the manner provided for in this Section 4.

(b) Taxes On Tenant's Property. Tenant shall be liable for and shall before delinquency pay all taxes and assessments of any kind or nature, and penalties and interest thereon, if any, levied against Tenant's property and any other personal property of any kind regardless of ownership located or installed in and upon the Premises, whether or not affixed to the realty.

5. TENANT IMPROVEMENTS.

Tenant shall, at its own cost and expense, be required to install all equipment and trade fixtures and perform all work to complete and place the Premises in a finished condition ready for Tenant to conduct its business therein. Tenant shall provide Landlord with plans and specifications relating to all work to be done by Tenant on the Premises. All of Tenant's work shall conform to applicable statutes, ordinances, regulations and codes and the

requirements of any appropriate insurance company. Prior to the commencement of Tenant's work and until completion thereof, Tenant shall obtain and maintain in effect a builder's risk insurance policy covering Landlord, Tenant, Tenant's contractors and Tenant's subcontractors for all risks that are otherwise required to be insured by Tenant pursuant to this Lease and shall provide a copy of the certificate of insurance simultaneous with the execution of the Lease.. Other than the installation of Tenant's equipment and trade fixtures, Tenant shall make no improvements to the Premises without obtaining Landlord's prior written consent, which consent shall be granted or withheld in accordance with the standards for the making of alterations to the Premises contained in Section 11 below.

6. LANDLORD 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.

7. QUIET ENJOYMENT.

Subject to the terms hereof, Landlord covenants that, if Tenant pays the Rent and all other charges provided for herein, performs all of its obligations provided for hereunder and observes all of the other provisions hereof, Tenant shall at all times during the Term peaceably and quietly have, hold and enjoy the Premises, without any interruption or disturbance from Landlord.

8. UTILITIES AND SERVICES.

(a) Tenant, at its sole cost and expense, shall pay promptly all charges when due for water, gas, electricity, heat, telephone, power, sewer and all other utility services or materials for the Premises, whether supplied by Landlord or by a public or other utility, a public authority, or any other person, or entity, commencing upon the Commencement Date.

(b) Tenant shall provide throughout the Lease Term at its sole cost and expense, its own complete daily janitorial and trash removal services for the Premises.

(c) Promptly after the Commencement Date, Tenant shall arrange with the utility company serving the Premises to provide utility service in Tenant's name and to bill Tenant directly, and Tenant shall pay any deposits required and all amounts due for such utility. Tenant's obligations under this Lease are not affected by any failure or delay in utility supply, installation or repair service.

(d) Landlord shall, under no circumstances, be liable to Tenant in damages or otherwise, for any interruption in service of water, electricity, heating, air conditioning or other utilities and services caused by an unavoidable delay, by the making of any necessary repairs or improvements or by any cause, and the same shall not constitute a termination of this Lease or eviction (constructive or otherwise).

(e) Tenant, after receiving Landlord's prior written consent, which consent shall not be unreasonably, withheld, conditioned, or delayed, shall have the right to alter the utilities, including but not limited to heating, ventilating and air conditioning systems and equipment serving the Premises and Landlord agrees to execute and deliver to Tenant without delay such documentation as may be required to effect such alteration.

9. USE OF PREMISES.

The Premises shall be used and occupied by Tenant as a **In-Patient Clinic**, and for no other purpose ("Permitted Use"). Tenant shall have access to the Premises twenty-four (24) hours a day, seven (7) days a week. Tenant shall not use the Premises or the Property, nor suffer the Premises or the Property to be used, for any unlawful purpose or in any unlawful manner or in violation of any valid regulation of any governmental body, or in

any manner to (i) create any nuisance or trespass; (ii) vitiate any insurance carried by Landlord or on Landlord's behalf; (iii) cause or permit any disruptive, harassing or outrageous conduct; or (iv) be a nuisance, public or private, or menace. In the event of any waste, damage, or manner of use by Tenant, immediately upon written notice to Tenant at the Premises, Tenant shall take such steps as are reasonably necessary to cease such action, and with respect to any necessary repairs, at Landlord's option, Tenant shall make such repairs to Landlord's reasonable satisfaction, or Landlord shall make such repairs and Tenant shall reimburse Landlord, upon demand, for Landlord's cost thereof. Tenant hereby agrees to defend, indemnify and hold Landlord and the Property harmless from and against any and all costs, damages, expenses, and liabilities (including reasonable attorneys' fees) arising out of or related to any breach of this Section 9.

10. SIGNS.

No sign, advertisement, or notice shall be inscribed, painted, affixed or displayed on the windows or exterior walls of the Premises or any public area of the Premises except following Landlord's prior written consent, which consent shall not be withheld, conditioned, or delayed, and in accordance with all applicable laws, regulations, and ordinances.

11. ALTERATIONS; MECHANICS LIENS.

(a) Tenant shall not make or permit to be made any alterations to the Premises without the prior written consent of Landlord, which consent shall not be unreasonably withheld, conditioned, or delayed, both as to whether the alterations may be made and as to how and when they will be made. Any alterations shall be made at Tenant's expense, by its contractors and subcontractors and in accordance with complete plans and specifications approved in advance in writing by Landlord, which approval shall not be shall not be unreasonably withheld, conditioned, or delayed, and only after Tenant: (i) has obtained all necessary permits from governmental authorities having jurisdiction and has furnished copies thereof to Landlord, (ii) has submitted to Landlord an architect's certificate that the alterations will conform to all applicable legal requirements, and (iii) has complied with all other requirements reasonably imposed by Landlord, including without limitation any requirements due to the underwriting guidelines of Landlord's insurance carriers. At Tenant's expense, Landlord shall join in submitting Tenant's plans for any necessary governmental approval, if required by applicable law. Landlord's consent to any alterations and approval of any plans and specifications constitutes approval of no more than the concept of these alterations and is not a representation or warranty with respect to the quality or functioning of such alterations, plans and specifications. Tenant shall pay to Landlord the charge reasonably prescribed by Landlord in consideration for the work of Landlord and its employees and representatives in reviewing and approving such plans and specifications.

(b) In the event Landlord approves Tenant alterations pursuant to the terms of this Section 11, Tenant shall be and is solely responsible for such alterations and for the proper integration thereof with the Property, the Property's systems and existing conditions. Landlord shall have the right, but not the obligation, to supervise the making of any such alterations and to be compensated for such supervision at a rate reasonably prescribed by Landlord. All alterations shall be made at Tenant's expense by contractors which have been approved by Landlord, which approval shall not be unreasonably withheld, conditioned, or delayed. All such construction, alterations, and maintenance work done by or for Tenant shall (i) not alter the exterior appearance of the Property, (ii) not affect the structure or the safety of the Property, (iii) comply with all building, safety, fire, plumbing, electrical, and other codes and governmental and insurance requirements, (iv) not result in any usage in excess of building standard of water, electricity, gas, heating, ventilating, or air conditioning (either during or after such work), unless prior written arrangements reasonably satisfactory to Landlord are made with respect thereto, and (v) be completed promptly and in a good and workmanlike manner, (vi) be performed in compliance with Section 11(e) below.

(c) Following completion of any alterations, at Landlord's request, Tenant (i) shall deliver to Landlord a certificate signed by Tenant stating that such alterations have been completed in accordance with the plans and specifications previously delivered to Landlord and (ii) either shall deliver to Landlord a complete set of "as built" plans showing the alterations or shall reimburse Landlord for any expense incurred by Landlord in causing the Building plans to be modified to reflect the alterations. Tenant hereby agrees to indemnify and hold

Landlord harmless against and from any and all claims, damages, costs, and fines arising out of or connected with such alterations.

(d) If any alterations are made without the prior written consent of Landlord, or which do not conform to plans and specifications approved by Landlord or to other conditions imposed by Landlord pursuant to this Section 11, Landlord may, in its sole discretion, correct or remove such alterations at Tenant's expense.

(e) Tenant shall keep the Premises and the Building free from any liens arising from any work performed, materials furnished, or obligations incurred by or at the request of Tenant. All persons either contracting with Tenant or furnishing or rendering labor and materials to Tenant shall be notified in writing by Tenant that they must look only to Tenant for payment, and a copy of every such writing shall be promptly provided by Tenant to Landlord upon Landlord's request. Nothing contained in this Lease shall be construed as Landlord's consent to any contractor, subcontractor, laborer, or materialman for the performance of any labor or the furnishing of any materials for any specific improvement, alteration, or repair of or to the Premises, nor as giving Tenant any right to contract for, or permit the performance of, any services or the furnishing of any materials that would result in any liens against the Premises or the Building. If any lien is filed against the Premises or Tenant's leasehold interest therein or if any lien is filed against the Property which arises out of any purported act or agreement of Tenant, Tenant shall discharge the same within ten (10) days after its filing by payment, filing of the bond required by law, or otherwise. If Tenant fails to discharge such lien within such period, then, in addition to any other right or remedy of Landlord, Landlord may, at its election, discharge the lien by paying the amount claimed to be due, by obtaining the discharge by deposit with a court or a title company, or by bonding. Tenant shall pay on demand any amount paid by Landlord for the discharge or satisfaction of any such lien and all reasonable attorneys' fees and other costs and expenses of Landlord incurred in defending any such action or in obtaining the discharge of such lien, together with all necessary disbursements in connection therewith.

12. OPERATION; REPAIRS.

(a) Except as set forth in Section 12(d) below, Tenant agrees that it will take good care (including repairs and/or replacements) of the Premises, fixtures, and appurtenances, including exterior doors and windows, window frames, hardware and the like, and meters, plumbing (from the point of connection to the Premises), heating and air conditioning equipment, fire and sprinkler systems, its personal property and equipment, and keep same in good order and repair throughout the Term of this Lease, and suffer or permit no waste or injury, reasonable wear and tear excepted; Landlord shall assign to Tenant, for the benefit of Tenant, to the extent they are assignable, any warranties on such equipment furnished to Landlord; that Tenant will conform to all laws, orders, and regulations of the Federal, State, or local authorities, or any of their departments, and will not, through its own act or neglect, cause any situation to exist in or about the Premises which would constitute a violation of any applicable Federal, State, or local regulation or ordinance governing use, occupancy, health, sanitation, or fire; that it will repair at or before the end of the Term, or sooner if so requested by Landlord, all injury done by the installation or removal of furniture or other property, and will surrender the Premises at the end of the Term broom cleaned in as good condition as they were at the beginning of the Term, ordinary wear and tear and casualties by fire and elements excepted. In the event of any increase in insurance as a result of the failure of Tenant to comply with the provisions of this Section 12, Tenant will pay the amount of such increase as additional rent within thirty (30) days after Landlord's written demand. If required by Landlord in its sole discretion, Tenant, at its sole cost and expense, shall procure and maintain contract(s) with a reputable pest control company for all necessary preventative and extermination services. Landlord shall have the right to require Tenant to increase the level of service or to require Tenant to engage a new pest control company if Landlord deems it necessary.

(b) Any damage sustained by any third party caused by mechanical, electrical, plumbing or any other equipment or installations, whose maintenance and repair is the responsibility of Tenant, shall be paid by Tenant, and Tenant shall indemnify and hold Landlord harmless from and against any and all claims, actions, damages and liability in connection therewith, including, but not limited to attorneys' and other professional fees, and any other cost which Landlord might reasonably incur. All injury to the Premises or the Property and all breakage done by Tenant, or Tenant's agents, contractors, directors, employees, invitees, licensees or officers shall be repaired immediately by Tenant at Tenant's sole expense. Tenant will indemnify and hold Landlord harmless from and against any and all expenses, liens, claims or damages to person or property which may or might arise by reason of the making of any such alterations, installations, changes, replacements, additions or improvements. This provision shall be construed as an additional remedy granted to Landlord and not in limitation of any other rights

and remedies which Landlord has or may have in said circumstances.

(c) Tenant covenants and agrees that it will, at Tenant's cost, procure and maintain service/maintenance contracts/policies (the "Service Contracts"), the issuers and contents of which shall be satisfactory to Landlord (whose judgment in that regard shall be reasonably exercised), in force throughout the Term of this Lease (including any Renewal Term if exercised) for the heating, ventilation, and air conditioning systems serving the Premises, in order that those systems and their components will be kept in good working order. Copies of the Service Contracts will be furnished to Landlord as appropriate, throughout the Term (including any Renewal Term). If Tenant has failed to submit proof to Landlord that the Service Contracts required hereby are in force, at any time, Landlord may (but shall not be required to) procure the appropriate Contracts for Tenant, and the cost thereof shall be additional rent due by Tenant to Landlord and shall be due and payable by Tenant to Landlord within ten (10) days after Landlord sends Tenant documentation thereof. Whether or not such Service Contracts are in force, Tenant shall be responsible for the cost of all needed repairs and/or replacements to each and every component of each and every system.

(d) Landlord, at its sole cost and expense and without contribution from Tenant (except in the case such work is caused by the negligence or willful misconduct of Tenant, its guests, agents, employees, contractors, or licensees), shall keep and maintain in good order, condition and repair, and replace when necessary, the structural components, exterior walls, foundation, roof, gutters and downspouts, parking facilities, landscaped areas, and common areas of the Building.

13. TENANT'S INSURANCE; INDEMNITY; LANDLORD'S INSURANCE

(a) Tenant's Insurance Coverage. Tenant shall carry and keep in full force and effect at all times during the Term (and, in the case of "claims-made" policies, for three years following the Term) for the protection of Landlord and Tenant herein, commercial general liability insurance, with minimum limits of coverage of at least One Million and 00/100 Dollars ($1,000,000.00) for each occurrence with an annual aggregate of at least Two Million and 00/100 Dollars ($2,000,000.00), written on a per location basis. Tenant must also maintain umbrella/excess liability insurance in an amount not less than One Million and 00/100 Dollars ($1,000,000.00), written on a per location basis. Notwithstanding the foregoing, Landlord shall have the right to require Tenant to increase the minimum limits of coverage set forth above from time to time to the standard limits of coverage required in comparable locations in the business area in which the Premises is located. Tenant shall forward to Landlord an endorsement to the foregoing liability policies naming Landlord and Landlord's mortgagee, as their interests may appear, as additional insureds. In addition, Tenant, at Tenant's sole cost and expense, shall obtain and maintain in full force and effect throughout the Term, insurance policies providing for the following coverage: (i) Causes of Loss – Special Form to covered property, insuring all of Tenant's property in the Premises, all in an amount equal to not less than the full replacement value and naming Landlord as loss payees; (ii) business income/extra expense coverage in an amount equal to no less than twelve (12) months' Rent; (iii) workers' compensation insurance with a waiver of subrogation in favor of Landlord and employer liability insurance with minimum limits of Five Hundred Thousand Dollars ($500,000.00); and (iv) such other insurance or such different amounts as may be reasonably required by Landlord (or its lender) from time to time during the Term.

(b) Requirements. All insurance policies carried by Tenant pursuant to this Section 13, and any other insurance policies carried by Tenant with respect to the Premises, shall (i) be issued by an insurance company licensed to do business in the state in which the Premises is located who carries a financial rating of at least A-/IX as designated by A.M. Best or similar rating agency, (ii) be written as primary policy coverage and not contributing with or in excess of any coverage which Landlord may carry; (iii) provide for at least thirty (30) days prior written notice to Landlord of any cancellation of such policy(ies); and (iv) limit deductible amounts to no more than Ten Thousand Dollars ($10,000.00). Prior to Tenant's occupancy of (or earlier entry into) the Premises and thereafter not less than one (1) day prior to the expiration dates of each policy providing all or part of the insurance required pursuant to this Section 13, Tenant shall deliver to Landlord an Acord certificate evidencing Tenant's insurance coverage as required hereunder.

(c) Waiver of Subrogation. To the extent permitted by law and with permission of their insurance carriers, Landlord and Tenant each waive any right to recover against the other on account of any and all property damage claims Landlord or Tenant may have against the other with respect to property insurance actually

carried, or required to be carried hereunder, to the extent of the proceeds realized from such insurance coverage or to the extent proceeds would have been realized had the insurance required hereunder been maintained.

(d) Release of Liability. Tenant hereby releases Landlord and its agents and employees from any and all liability or responsibility to Tenant or any person claiming by, through or under Tenant, by way of subrogation or otherwise, for the death of or injury to Tenant or others, or for the loss of or damage to property of others, or for any indirect or consequential or economic loss, injury or damage of Tenant or others, regardless of the cause, it being understood and agreed that Tenant shall carry adequate insurance to protect itself from any such loss, regardless of the cause. Notwithstanding any other provision of this Lease, in no event shall Landlord be liable to Tenant for consequential damages or lost profits, or speculative, punitive, special or exemplary damages.

(e) Indemnification. Tenant agrees to defend, indemnify and save Landlord harmless from any and all liabilities, damages, causes of action, suits, claims, judgments, costs and expenses of any kind (including reasonable attorneys' fees) (i) relating to or arising from or in connection with the possession, use, occupation, management, repair, maintenance or control of the Premises or any portion thereof, or Tenant's business thereon, (ii) relating to or arising from or in connection with any act or omission of Tenant or Tenant's agents, contractors, employees, invitees, licensees or others for whom Tenant is legally responsible, (iii) relating to or arising from or in connection with any breach of any condition, covenant or obligation of this Lease imposed on Tenant, or (iv) resulting from any injury to person or property or loss of life sustained in or about the Premises. The obligations of Tenant under this section shall survive the termination of the Lease without regard to any statute of limitations.

(f) Insurance by Landlord. At all times during the Term, Landlord shall maintain or cause to be maintained in full force and effect all risk insurance covering the Real Property and Building and commercial general liability insurance. Upon request, Landlord shall provide evidence of said coverage upon the request of Tenant during the Term hereof. In addition, Landlord may, but shall not be obligated to, maintain in full force and effect at any time or times during the Term such other insurance coverage, in such amounts and covering such other liabilities or hazards (including, without limitation, as to earthquakes and floods) as is customary for buildings like the Building. The amounts and scopes of coverage of Landlord's insurance shall be determined by Landlord from time to time in its commercially reasonable discretion. Tenant shall pay to Landlord, as additional rent hereunder, one-twelfth (1/12th) of the Tenant's pro rata share of the total annual premiums for Landlord's insurance, on a monthly-basis concurrently with the payment of Monthly Base Rent above. From time to time, Landlord shall notify Tenant in writing of the most current annual premium amount for such policies of insurance, together with Landlord's computation of the monthly amount of the pro rata share of such insurance premiums to be paid by Tenant hereunder. At the end of each calendar year during the term of this Lease and again at the expiration or termination of this Lease, Landlord shall calculate the actual premiums paid or owing for the Premises, and Tenant shall be credited or charged, as the case may be, for such adjustments as may be necessary by reason of any difference between the actual amounts determined by Landlord to have been paid or owing for the Premises (or the pro-rata portion of such amount notwithstanding that payment to the carrier may not then be due) and the amount of such taxes actually paid by Tenant to Landlord. A copy of a bill or invoice received by Landlord from the insurance carrier and delivered to Tenant shall at all times be sufficient evidence of the amount of Landlord's insurance premiums to which such bill relates. As of the Commencement Date hereof, Tenant's estimated monthly payment of Landlord's insurance premiums is **$ 181.36** (which amount is subject to adjustment as provided above).

14. PROPERTY AT TENANT'S RISK.

All personal property in the Premises, of whatever nature, whether owned by Tenant or any other person, shall be and remain at Tenant's sole risk and Landlord shall not assume any liability or be liable for any damage to or loss of such personal property; it being understood and agreed that Tenant shall carry adequate insurance to protect itself from any such loss.

15. DAMAGE.

If the Premises shall be damaged by fire or other casualty, the damage shall be repaired within a reasonable time by and at the expense of Landlord (subject to available insurance proceeds), and the Rent shall abate pro rata until the repairs shall have been substantially completed, according to the part of the Premises which is thereby rendered unusable by Tenant; provided, however, that (i) Landlord shall have no obligation to repair, replace or

restore Tenant's furniture, furnishings or other personal property and (ii) Tenant shall, with all reasonable diligence and at Tenant's sole expense, repair, replace and restore such furniture, furnishings and other personal property; provided further, however, that if the damage is caused by or results from the negligence or misconduct of Tenant (or anyone acting on behalf of Tenant), the repairs shall be made at the expense of Tenant and the Rent and additional rent shall not abate. Due allowance shall be made in Landlord's repair obligation for reasonable delay which may arise by reason of any adjustment or settlement of insurance claims by Landlord, and for delay on account of events of force majeure.

16. CONDEMNATION.

(a) If all of the Premises is condemned or taken in any manner for public or quasi-public use (including for all purposes of this Section 16, but not limited to, a conveyance or assignment in lieu of a condemnation or taking), this Lease shall automatically terminate as of the date that Tenant is required to surrender possession of the Premises as a result of such condemnation or other taking. If a part of the Premises so condemned or taken renders the remaining portion untenantable and unusable by Tenant for Permitted Use, as determined by Tenant in Tenant's commercially reasonable discretion, this Lease may be terminated by Tenant as of the date Tenant is required to surrender possession of such portion of the Premises, by written notice to Landlord within sixty (60) days following notice to Tenant of the date on which Tenant is required to surrender possession of such portion of the Premises. If a portion of the Premises is condemned or taken so as to require, in the commercially reasonable business judgment of Tenant, a substantial alteration or reconstruction of the remaining portions thereof (i.e., in excess of $1,500,000), this Lease may be terminated by Tenant, as of the date Tenant is required to surrender possession as a result of such condemnation or taking, by written notice to Landlord within sixty (60) days following notice to Tenant as of the date on which possession of the Premises (or such part thereof) must be surrendered.

(b) Landlord shall be entitled to the entire award in any condemnation proceeding or other proceeding for taking for public or quasi-public use, including, without limitation, any award made for the value of the leasehold estate created by this Lease. No award for any partial or entire taking shall be apportioned, and Tenant hereby assigns to Landlord any award that may be made in such condemnation or other taking, together with any and all rights of Tenant now or hereafter arising in or to same or any part thereof; provided, however, that nothing contained herein shall be deemed to give Landlord any interest in, or to require Tenant to assign to Landlord, any separate award made to Tenant specifically for its relocation expenses, the taking of personal property and fixtures belonging to Tenant, or the interruption of or damage to Tenant's business, provided that such award shall not diminish the award to which Landlord is otherwise entitled.

(c) In the event of a partial condemnation or other taking that does not result in a termination of this Lease as to the entire Premises, the Rent shall be reduced in the proportion that the square footage of the portion of the Premises taken by such condemnation or other taking bears to the square footage contained in the Premises immediately prior to such condemnation or other taking. In the event that this Lease shall be terminated pursuant to this Section 16, the Rent shall be adjusted through the date that Tenant is required to surrender possession of the Premises.

(d) If all or any portion of the Premises is condemned or otherwise taken for public or quasi-public use for a limited period of time (not to exceed ninety (90) days), this Lease shall remain in full force and effect and Tenant shall continue to perform all of the terms, conditions and covenants of this Lease; provided, however, that (i) during such limited period, the Rent shall be reduced in the proportion that the square footage of the portion of the Premises taken by such condemnation or other taking bears to the square footage contained in the Premises immediately prior to such condemnation or other taking, and (ii) Landlord shall be entitled to whatever compensation may be payable from the requisitioning authority for the use and occupation of the Premises for the period involved.

17. LAWS AND ORDINANCES.

Tenant shall, at its sole expense, promptly observe and comply with all statutes, laws, ordinances, rules, regulations, orders and requirements of all governmental, quasi-governmental or regulatory authorities including, without limitation, police, fire, health or environmental authorities or agencies, applicable Insurance Rating Bureau, and of any liability or fire insurance company by which Landlord or Tenant may be insured at any time during the

Term, which are applicable to Tenant, the condition, maintenance or operation of the Premises or the leasehold improvements therein or any part thereof, the occupation or use of the Premises or the conduct of any business in, at, upon or from the Premises, or which are applicable to or require the making of repairs, replacements, installations, alterations, additions, changes or improvements to the Premises or the leasehold improvements therein; subject, however, to the other provisions of this Lease requiring Landlord's prior approval of leasehold improvements.

18. LANDLORD'S WORK. Prior to the Commencement Date hereof, Landlord shall perform the construction, installations, improvements, and/or alterations to the Premises (the "Landlord's Work") set forth in **Exhibit B** attached hereto and incorporated herein by reference. Landlord shall diligently prosecute Landlord's Work to completion and shall use commercially reasonable efforts to complete the same on or before **July 1, 2018**. Upon the Commencement Date hereof, Tenant may enter upon the Premises to install its fixtures and perform other work which may be required in order to ready its daycare operation for opening.

19. EXPIRATION, HOLDOVER.

If Tenant holds possession of the Premises after the termination of this Lease or any permitted extension or Renewal Term thereof, or fails to vacate the Premises in accordance with a validly issued termination notice hereunder, then Landlord shall have the option, exercisable in writing at any time within thirty (30) days after the date of termination to treat Tenant as a trespasser, or as a Tenant from month to month; then in any such events, and accounting from the date of termination of the Lease or any permitted extension or renewal term thereof, the tenancy shall be at 200% the base monthly Rent at the time of termination, but otherwise upon all the other terms of this Lease, including the provisions of this Section 19. Said additional term may be terminated by Landlord at any time throughout the duration thereof upon thirty (30) days' notice from Landlord. Nothing contained herein shall be construed within said thirty (30) day period after the date of termination of the Lease to constitute Landlord's permission to occupy the Premises by Tenant after the termination of the Lease or any permitted extension or renewal term thereof. If Landlord elects to treat Tenant as a trespasser, Landlord shall be entitled to the benefit of all public local laws relating to the recovery of the possession of land and tenements held over by tenants, whether now or hereafter in force and effect. Should Landlord fail to exercise its option under this Section 19 within said thirty (30) day period of the date of termination of the Lease or any permitted renewals or extensions, then Tenant shall be considered as a Tenant from month to month, at double the base monthly Rent in effect at the termination of this Lease or any permitted extension or Renewal Term, subject to all provisions of this Lease, including the provisions of this Section 19.

20. EVENTS OF DEFAULT.

The occurrence of any of the following shall be deemed to be an "Event of Default" under this Lease:

(a) if Tenant shall default in the payment, when due, of any amount of Rent or additional rent to be paid by Tenant hereunder and such default shall continue for a period of five (5) days after the date when the same shall become due and payable, although no demand shall have been made for the same;

(b) if Tenant shall default in performing any of the covenants, terms or provisions of this Lease (other than the payment, when due, of any of Tenant's monetary obligations hereunder, or the surrender of the Premises upon the expiration of the Term), or if Tenant shall breach any representation or warranty of Tenant herein, and Tenant fails to cure such default or breach within thirty (30) days after written notice thereof from Landlord, provided that, unless such default endangers the health, safety or welfare of any occupants of the Premises or cannot reasonably be remedied, if said default shall be of such a nature that it cannot reasonably be cured or remedied within said thirty (30) day period, such default by Tenant in the performance of any of the covenants, terms or provisions of this Lease (except as aforesaid) shall not be deemed an Event of Default if Tenant shall have commenced in good faith to cure such default within the aforesaid thirty (30) day period and shall then continuously and diligently pursue such cure to completion within a reasonable time thereafter, not to exceed ninety (90) days total;

(c) if Tenant shall abandon the Premises or vacate the Premises for more than sixty (60) days without Tenant having given prior written notice of such abandonment or vacating to Landlord (so that Landlord

may, among other things, make plans to periodically inspect the vacant or abandoned Premises for leaks or other potential problems);

(d) if any steps are taken or any action or proceedings are instituted by Tenant or by any other party including, without limitation, any court or governmental body of competent jurisdiction for the dissolution, winding up or liquidation of Tenant or the assets thereof;

(e) if Tenant shall become insolvent, make an assignment for the benefit of creditors, or file, be the subject of, or acquiesce in a petition filed in any court in the nature of a bankruptcy, reorganization, composition, extension, arrangement or insolvency proceeding (unless, in the case of a petition filed against Tenant, the same is dismissed within sixty (60) days);

(f) if any seizure, execution, attachment or similar process is issued against Tenant or Tenant's assets or any encumbrancer takes any action or proceeding whereby any of the improvements, fixtures, furniture, equipment or inventory in or relating to the Premises or any portion thereof or the interest of Tenant therein or in this Lease or any business conducted in or from the Premises shall be taken or attempted to be taken;

(g) if a receiver, manager, custodian or any party having similar powers is appointed for all or a portion of the property or business of Tenant, or any assignee, subtenant, concessionaire, licensee or occupant of the Premises;

(h) if any insurance policy on the property of Tenant or any part thereof is canceled or is threatened by the insurer to be canceled, or the coverage thereunder reduced in any way by the insurer and Tenant has failed to remedy the condition giving rise to such cancellation, threatened cancellation or reduction of coverage within five (5) days of the date of such policy cancellation or reduction;

(i) if Tenant purports to make a Transfer other than in compliance with the provisions of this Lease; or

(j) the occurrence of any event which, pursuant to the other terms of this Lease entitles Landlord to re-enter the Premises or terminate this Lease.

21. LANDLORD'S REMEDIES UPON DEFAULT.

Upon the occurrence of any Event of Default, Landlord may, with or without additional notice or demand, Tenant hereby waiving any notice to quit, notice to vacate, or any other notice which may be required by law, and without limiting any other of Landlord's rights or remedies, at its option may pursue any one or more of the following remedies:

(a) Landlord shall have the right, at its sole option, to terminate this Lease. In addition, with or without terminating this Lease, Landlord may reenter the Premises, terminate Tenant's right of possession and take possession of the Premises. If necessary, Landlord may proceed to recover possession under and by virtue of the provisions of the laws of the State of Maryland, or by such other proceedings, including re-entry and possession, as may be applicable. If Landlord elects to terminate this Lease and/or Tenant's right of possession, then everything contained in this Lease to be done and performed by Landlord shall cease, without prejudice, however, to Landlord's right to recover from Tenant all rent and other sums due hereunder through the natural expiration date of the Lease. Whether or not this Lease and/or Tenant's right of possession is terminated, Landlord shall use commercially diligent efforts to relet the Premises for such rent and upon such terms as Landlord is able to obtain at its option, and, if the full Rent shall not be realized by Landlord, Tenant shall be liable for all damages sustained by Landlord, including, without limitation, the deficiency in Rent, reasonable attorneys' fees, other collection costs and all expenses (including leasing fees) of placing the Premises in first class rentable condition; the order of application of Rent to such indebtedness being determined by Landlord in its sole discretion. Any damage or loss sustained by Landlord may be recovered by Landlord, at Landlord's option, (i) at the time of the reletting; (ii) in separate actions, from time to time, as said damage shall have been made more easily ascertainable by successive relettings, or (iii) in an action deferred until the expiration of the Term of this Lease, in which event the cause of action shall not be deemed to have accrued until the date of expiration of said Term.

(b) Tenant hereby appoints the person identified in the Notice section herein as its agent to receive service of all dispossessory or restraint proceedings and notices thereunder and under this Lease.

(c) Any suit brought to collect the amount of any deficiency in Rent for any month shall not prejudice in any way the rights of Landlord to collect the deficiency for any subsequent month by a similar proceeding. Landlord may, in Landlord's sole discretion, choose to defer collection of such amounts until the date upon which the Term expires or would have expired but for such sooner termination, and Tenant hereby agrees that in such event Landlord's cause of action shall be deemed to have accrued as of the date upon which the Term expires or would have expired but for such sooner termination, as the case may be.

Additionally, and not in limitation of any of the foregoing, if Tenant defaults in the making of any payment or in the doing of any act herein required to be made or done by Tenant, then Landlord may, but shall not be required to, make such payment or do such act, and the amount of the expense thereof, if made or done by Landlord, and Tenant shall pay Landlord any such amounts expended by Landlord plus fifteen percent (15%) for Landlord's overhead, and the same shall constitute additional rent hereunder due and payable with the next monthly installment of Rent; but the making of such payment or the doing of such act by Landlord shall not operate to cure such default or to estop Landlord from the pursuit of any remedy to which Landlord would otherwise be entitled.

22. REMEDIES CUMULATIVE; NO WAIVER.

All rights and remedies given herein and/or by law or in equity to Landlord are separate, distinct and cumulative, and no one of them, whether exercised by Landlord or not, shall be deemed to be in exclusion of any others. In the event of any breach or threatened breach by Tenant of any of the covenants or provisions of this Lease, Landlord shall, without limitation, have the right of injunction. No pursuit of any remedy by Landlord shall constitute a forfeiture or waiver of any Rent due to Landlord hereunder or of any damages accruing to Landlord by reason of Tenant's violation of any of the covenants and provisions of this Lease. No failure of Landlord to exercise any power given Landlord hereunder, or to insist upon strict compliance by Tenant with its obligations hereunder, and no custom of practice of the parties at variance with the terms hereof shall constitute a waiver of Landlord's right to demand exact compliance with the terms hereof, unless such waiver shall be given in writing and signed by Landlord.

23. SECURITY DEPOSIT.

Landlord acknowledges receipt of a payment from Tenant at the Lease signing in the sum of **Fifteen Thousand Three Hundred Forty-Four Dollars ($15,344.00)** which payment constitutes a security deposit guarantying Tenant's performance hereunder (the "Security Deposit"). To the extent the Security Deposit has not been applied or exhausted pursuant to the further terms hereof, it shall be returned by Landlord to Tenant at the expiration of the Lease Term. Notwithstanding anything to the contrary contained herein, Landlord shall have the right to apply the Security Deposit to cure any breach by Tenant of any of Tenant's obligations or duties pursuant to this Lease, and Landlord shall be entitled, upon any such application of the Security Deposit, to require Tenant to restore the same (within five (5) days of Landlord's written demand) to the dollar amount set forth in this Paragraph (the un-restored amount shall constitute additional rent hereunder). Landlord shall be entitled to the full use of the Security Deposit, shall not be required to escrow or otherwise segregate the Security Deposit, and no interest shall accrue thereon or be paid or payable by Landlord with respect to the Security Deposit. Tenant's Security Deposit shall be returned, or if the Security Deposit is retained by the Landlord in whole or in part, said retention shall be accounted for by Landlord to Tenant, within thirty (30) days of the termination of Tenant's Lease Term, any renewal period or extension thereof.

24. ASSIGNMENT; SUBLETTING.

Tenant shall not assign, transfer, mortgage or otherwise encumber this Lease or all or any of Tenant's rights hereunder or interest herein, or sublet, license, rent or permit anyone to occupy the Premises or any part thereof, or enter into a management agreement with another person or entity for the management of Tenant's business, without obtaining the prior written consent of Landlord, which consent shall not be unreasonably withheld. A change in the control of Tenant shall constitute an assignment requiring Landlord's consent hereunder. The transfer, on a

cumulative basis, of 20% or more of the voting or management control of Tenant shall constitute a change in control for this purpose. In order to obtain such consent Tenant shall, within ninety (90) days of Tenant's written notice of such proposed assignment/subletting, submit to Landlord written notice containing the following information: financial statements of the proposed assignee/subtenant for its three (3) most recent fiscal years certified by an authorized officer of the assignee/subtenant, the effective date of the proposed assignment, and the identity of the assignee/subtenant, including the assignee's/subtenant's exact legal name, identity of the assignee's/subtenant's owners (unless publicly held), officers and directors and the business of the assignee/subtenant. In no event shall the proposed effective date of assignment/sublease be less than thirty (30) days after the date of Tenant's delivery of the required information set forth above to Landlord. Landlord shall have thirty (30) days from the receipt of both Tenant's initial notice of proposed assignment/sublease and the information required hereunder, to review Tenant's request and to notify Tenant whether it will consent to such proposed assignee. If, as of the effective date of any permitted assignment or subletting the then remaining Term is less than three (3) years, Landlord may, as a condition to its consent: (i) require that the amount and adjustment schedule of the Rent payable under this Lease be adjusted to what is then the market value and/or adjustment schedule for property similar to the Premises as then constituted, as determined by Landlord. Tenant shall pay all of Landlord's costs and expenses (including attorneys' fees) in connection with any proposed subletting or assignment not to exceed $1,500.00 unless litigation is threatened or involved; and in the event of such threatened or actual litigation, Tenant shall pay all of Landlord's costs and expenses (including attorney's fees) pursuant to Section 32 below.

25. SUBORDINATION.

Without the necessity of any additional document being executed by Tenant for the purpose of effecting a subordination, this Lease shall be and is hereby declared to be subject and subordinate at all times to any mortgage or deed of trust which may now exist or be placed upon the Premises, the Premises and/or the Property upon which the Premises or the Premises are situated. Notwithstanding the foregoing, Landlord shall have the right to subordinate or cause to be subordinated any such liens to this Lease. If any mortgage or deed of trust is foreclosed or a conveyance in lieu of foreclosure is made for any reason, Tenant shall, notwithstanding any subordination, at the request of any successor in interest to Landlord, attorney to and become the tenant of the successor in interest to Landlord provided that Tenant shall not be disturbed in its possession under this Lease by such successor in interest so long as Tenant is not in default under this Lease beyond any applicable notice or cure periods. Within ten (10) business days after request by Landlord, Tenant shall execute and deliver any additional commercially reasonable documents evidencing the subordination of this Lease with respect to any such mortgage or deed of trust, in the form requested by Landlord or by any mortgagee or beneficiary under a deed of trust and reasonably acceptable to Tenant.

26. MORTGAGEE PROTECTION.

Tenant agrees to give any mortgagees or trust deed holders, by registered mail, a copy of any notice of default served upon Landlord, provided that prior to such notice Tenant has been notified, in writing of the address of such mortgagees or trust deed holders. Tenant further agrees that if Landlord shall have failed to cure such default within the time provided for in this Lease, then the mortgagees or trust deed holders shall have an additional ninety (90) days within which to cure such default, or if such default cannot be cured within that ninety (90) days, then such additional time as may be necessary if within such time period such mortgagee or trust deed holder shall have commenced and be diligently pursuing the remedies necessary to cure such default (including but not limited to commencement of foreclosure proceedings, if necessary to effect such cure) before Tenant may exercise its remedies under the Lease or in equity or at law.

27. MODIFICATIONS DUE TO FINANCING.

If, in connection with obtaining temporary or permanent financing for the Building or the Property, any lender shall request reasonable modification(s) to this Lease as a condition to such financing, Tenant agrees that Tenant will not unreasonably withhold, delay or defer the execution of an amendment to this Lease to effect such modification(s), provided such modification(s) do not increase the financial obligations of Tenant hereunder or materially and adversely affect (i) the interest hereby created or (ii) Tenant's reasonable use and enjoyment of the Premises.

28. ESTOPPEL CERTIFICATES.

Tenant agrees, at any time and from time to time upon written request from Landlord, to execute, acknowledge and deliver to Landlord or to such person(s) as may be designated by Landlord, within the time period stated by Landlord in such written request (which time period shall not be less than five (5) days from the date thereof), a statement in writing (i) certifying that Tenant is in possession of the Premises, has unconditionally accepted the same and is currently paying the rents reserved hereunder (or, if Tenant has conditionally accepted possession of the Premises, or is not currently paying rent, stating the reasons therefor), (ii) certifying that this Lease is unmodified and in full force and effect (or if there have been modifications, that the Lease is in full force and effect as modified and stating the modifications), (iii) stating the dates to which the Rent and other charges hereunder have been paid by Tenant, (iv) stating whether or not, to the best of Tenant's knowledge, Landlord is in default in the performance of any covenant, agreement or condition contained in this Lease (or of any event which will, upon the passage of time, constitute a default), and, if so, specifying each such default in detail, (v) stating that Tenant has no knowledge of any event having occurred that authorized (or which, but for the passage of time will allow) the termination of this Lease by Tenant (or if Tenant has such knowledge, specifying the same in detail), and (vi) such other information as Landlord or such other person may reasonably request. Any such statement, delivered pursuant hereto may be relied upon by any owner, prospective purchaser, mortgagee or prospective mortgagee of the Premises or the Property or Landlord's interest therein. Landlord agrees to provide similar estoppels from time to time for the benefit of Tenant or its designee. It is further understood and agreed that the failure to provide the estoppel certificate described in this Section within the time period specified shall be an "Event of Default" under this Lease notwithstanding the language in this Lease that otherwise provides additional time to cure a non-monetary default.

29. UNAVOIDABLE DELAY.

In the event Landlord is in any way delayed, interrupted or prevented from performing any of its obligations under this Lease, and such delay, interruption or prevention is due to fire, act of God, governmental act or failure to act, strike, labor dispute, inability to procure materials, or any other cause beyond Landlord's reasonable control (whether similar or dissimilar), then the time for performance of the affected obligation(s) shall be excused for the period of the delay and extended for a period equivalent to the period of such delay, interruption or prevention.

30. NOTICES.

No notice, and no request, consent, approval, waiver or other communication which may be or is required or permitted to be given under this Lease shall be effective unless the same is given in the manner set forth in this Section 30. Each notice given pursuant to this Lease shall be given in writing and shall be (i) delivered in person, (ii) sent by nationally recognized overnight courier service, or (iii) sent by certified mail, return receipt requested, first class postage prepaid, to Landlord or Tenant, as the case may be, at their respective notice addresses as set forth below, or at any such other address that may be given by one party to the other by notice pursuant to this Section 31. Such notices, if given as prescribed in this Section 30, shall be deemed to have been given (a) at the time of delivery if delivery is made in person, (b) on the next business day if deposited with a nationally recognized overnight courier service in time for next day delivery, (c) on the third business day following the date of mailing if mailed, or (d) at the time of delivery if delivery is refused or cannot be effected at the addressee's address (as evidenced in writing). During any interruption or threatened interruption of substantial delay in postal services, all notices shall be delivered personally or by nationally recognized overnight courier service. Electronic communication (i.e. "e-mail") may serve as "written notice" for the purposes described herein.

If to Landlord:

Hope Health Properties, LLC
Attn: Olanrele Fadiora
_____
_____

With a Copy to:

Andrew H. Robinson, Esq.
Offit Kurman, P.A.
8171 Maple Lawn Boulevard
Suite 200
Fulton, Maryland 20759

If to Tenant:
Hope Health Hospital
ATTN: Olayinka Fadiora
c/o the Premises

31. BROKERS.

Landlord and Tenant each represent and warrant one to another that neither of them has employed any broker, agent or finder in carrying on the negotiations relating to this Lease. Landlord shall indemnify and hold Tenant harmless, and Tenant shall indemnify and hold Landlord harmless, from and against any claim or claims for broker or other commissions arising from or out of any breach of the foregoing representation and warranty by the respective indemnitors.

32. ATTORNEYS' FEES.

In the event Tenant defaults in the performance of any of the terms, covenants, agreements or conditions contained in this Lease and Landlord places the enforcement of all or any part of this Lease, the collection of any Rent due or to become due, or recovery of the possession of the Premises, in the hands of an attorney, Tenant agrees to pay Landlord's reasonable attorneys' fees and expenses whether suit is actually filed or not. In addition, if any legal action, arbitration or other proceeding is commenced to enforce and/or interpret any and every provision of this Lease and/or to pursue any remedy for default of this Lease, the "Prevailing Party" shall be entitled to an award of its fees and expenses incurred in connection therewith, including without limitation, reasonable attorneys' fees and disbursements (including fees of paralegals and fees on appeal), expert witness fees, court costs (including the preparation of documents and the filing of any and all papers with the courts and the costs of depositions and investigations) and disbursements. The term "Prevailing Party" shall mean the party who receives substantially the relief desired whether by settlement, dismissal, summary judgment or otherwise. Tenant hereby covenants and agrees to pay to Landlord as additional rent, promptly upon demand, such Landlord's fees and expenses if owed by Tenant to Landlord as provided hereunder. Notwithstanding any judgment related to this contract, the attorneys' fee-shifting provision above shall not be merged into any such judgment but shall survive the same and shall be binding and conclusive on the parties for all time. Post-judgment attorneys' fees and costs incurred related to the enforcement of such judgment related to this contract shall be recoverable hereunder in the same or separate actions.

33. WAIVER OF JURY TRIAL; COUNTERCLAIMS.

LANDLORD AND TENANT EACH HEREBY WAIVE ALL RIGHT TO TRIAL BY JURY IN ANY CLAIM, ACTION, PROCEEDING OR COUNTERCLAIM BY EITHER PARTY AGAINST THE OTHER ON ANY MATTERS ARISING OUT OF OR IN ANY WAY CONNECTED WITH THIS LEASE, THE RELATIONSHIP OF LANDLORD AND TENANT AND/OR TENANT'S USE OR OCCUPANCY OF THE PREMISES. TENANT SHALL NOT IMPOSE ANY COUNTERCLAIM OR COUNTERCLAIMS IN A SUMMARY PROCEEDING OR OTHER ACTION BASED ON TERMINATION OR HOLDOVER UNLESS FAILURE TO DO SO CAUSES TENANT TO LOSE FOREVER ANY SUCH CLAIM BECAUSE IT CAN ONLY BE ASSERTED AS A COUNTERCLAIM IN SUCH A PROCEEDING OR ACTION. THIS WAIVER IS KNOWINGLY, INTENTIONALLY AND VOLUNTARILY MADE BY TENANT AND TENANT ACKNOWLEDGES THAT NEITHER LANDLORD NOR ANY PERSON ACTING ON BEHALF OF LANDLORD HAS MADE ANY REPRESENTATIONS OF FACT TO INDUCE THIS WAIVER OF TRIAL BY JURY OR IN ANY WAY TO MODIFY OR NULLIFY ITS EFFECT. TENANT FURTHER ACKNOWLEDGES THAT IT HAS BEEN REPRESENTED (OR HAS HAD THE OPPORTUNITY TO BE REPRESENTED) IN THE SIGNING OF THIS LEASE AND IN THE MAKING OF THIS WAIVER BY INDEPENDENT LEGAL COUNSEL, SELECTED OF ITS OWN FREE WILL, AND THAT IT HAS HAD THE OPPORTUNITY AND

ACKNOWLEDGES THAT IT HAS READ AND UNDERSTANDS THE MEANING AND RAMIFICATIONS OF THIS WAIVER PROVISION AND AS EVIDENCE OF THE SAME HAS EXECUTED THIS LEASE.

34. ASSIGNS AND SUCCESSORS.

This Lease shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

35. HEADINGS; INTERPRETATION.

(a) The captions and section numbers appearing in this Lease are inserted only as a matter of convenience and reference, and in no way shall be held to explain, modify, amplify, define, limit, construe, or describe the scope or intent of such Sections of this Lease nor in any way add to the interpretation, construction or meaning of any provision or otherwise affect this Lease.

(b) Each obligation of any party hereto expressed in this Lease, even though not expressed as a covenant, is considered to be a covenant for all purposes.

36. SEVERABILITY.

If any term, covenant or condition of this Lease or the application thereof to any person or circumstance shall to any extent be held invalid or unenforceable, the remainder of this Lease or the application of such term, covenant or condition to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby and each term, covenant and condition of this Lease shall be valid and enforced to the fullest extent permitted by law.

37. APPLICABLE LAW; SUBMISSION TO JURISDICTION.

This Lease shall be construed under the laws of the state in which the Premises is located, without regard to the conflict of laws principles thereof. In any action to enforce or interpret this agreement, the parties consent to personal and subject matter jurisdiction in the state or federal courts having jurisdiction in the county and state in which the Premises is located.

38. RECORDING.

Neither this Lease nor any memorandum nor short form hereof shall be recorded in the land or other records of the county in which the Premises is located without the prior written consent of Landlord (which may be withheld in Landlord's sole discretion). Any such memorandum of lease shall provide that Landlord shall have the right to unilaterally release the memorandum upon the expiration or earlier termination of the Lease. Tenant shall bear all taxes and fees in connection with any permitted recordation.

39. TIME IS OF THE ESSENCE.

Time is of the essence in this Lease and of all provisions hereof, except as expressly set forth to the contrary herein.

40. SURVIVAL OF OBLIGATIONS.

All of Tenant's duties and obligations provided for herein, including any and all indemnifications of Landlord and the Property, to the extent that the same shall not be fulfilled during the Term hereof, and Landlord's rights and remedies in respect of such unfulfilled duties and obligations, shall survive and remain in full force and effect notwithstanding the expiration or sooner termination of the Term of this Lease.

41. EXECUTION OF DOCUMENTS.

Tenant irrevocably constitutes Landlord, the agent and attorney of Tenant for the purpose of executing any agreement, certificate, attornment or subordination required by this Lease if Tenant fails to execute any such document within five (5) days after the receipt of a request in respect thereof.

42. ENTIRE AGREEMENT.

This Lease consists of this writing and is intended by the parties as the final expression of their agreement and as a complete and exclusive statement of the terms thereof, all prior negotiations, discussions, representations, warranties, agreements and inducements between the parties having been incorporated herein. No course of prior dealing between the parties or their affiliates shall be relevant or admissible to supplement, explain or vary any of the terms of this Lease. This Lease can only be modified by a writing signed by all of the parties hereto or their duly authorized agents. This Lease may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute a single instrument. Signed facsimile and electronic copies of this Lease shall legally bind the parties to the same extent as original documents.

43. HAZARDOUS MATERIALS.

Tenant shall not use or allow the Premises to be used for the Release, storage, use, treatment, disposal or other handling of any Hazardous Substance, without the prior written consent of Landlord, except for customary office supplies and cleaning supplies, which may be stored or used in the Premises provided the storage, use, handling, treatment and disposal thereof complies with all applicable laws. The term "Release" shall have the same meaning as is ascribed to it in the Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. § 9601 et seq., as amended, ("CERCLA"). The term "Hazardous Substance" means (i) any substance defined as a "hazardous substance" under CERCLA, (ii) petroleum, petroleum products, natural gas, natural gas liquids, liquefied natural gas, and synthetic gas, and (iii) any other substance or material deemed to be hazardous, dangerous, toxic, or a pollutant under any federal, state or local law, code, ordinance or regulation. Tenant shall: (a) comply with all federal, state, and local laws, codes, ordinances, regulations, permits and licensing conditions now existing or hereinafter in effect governing the Release, discharge, emission, or disposal of any Hazardous Substance and prescribing methods for or other limitations on storing, handling, or otherwise managing Hazardous Substances, (b) at its own expense, promptly contain and remediate any Release of Hazardous Substances arising from or related to Tenant's activities in the Premises, the Premises, the Property or the environment and remediate and pay for any resultant damage to property, persons, and/or the environment, (c) give prompt notice to Landlord, and all appropriate regulatory authorities, of any Release of any Hazardous Substance in the Premises, the Premises, the Property or the environment arising from or related to Tenant's activities, which Release is not made pursuant to and in conformance with the terms of any permit or license duly issued by appropriate governmental authorities, (d) at Landlord's request, retain an independent engineer or other qualified consultant or expert acceptable to Landlord, to conduct, at Tenant's expense, an environmental audit of the Premises and immediate surrounding areas, (e) reimburse Landlord, upon demand, the reasonable cost of any testing for the purpose of ascertaining if there has been any Release of Hazardous Substances in the Premises, if such testing is required by any governmental agency or Landlord's Mortgagee, (f) upon expiration or termination of this Lease, surrender the Premises to Landlord free from the presence and contamination of any Hazardous Substance. Tenant shall indemnify, defend, and hold harmless Landlord, the manager of the Premises, and their respective officers, directors, beneficiaries, shareholders, partners, agents, and employees from all fines, suits, procedures, claims, and actions of every kind, and all costs associated therewith (including reasonable attorneys' and consultants' fees) arising out of or in any way connected with any deposit, spill, discharge, or other release of Hazardous Substances that occurs during the Term, at or from the Premises, or which arises at any time from Tenant's use or occupancy of the Premises or the Property, or from Tenant's failure to provide all information, make all submissions, and take all steps required by all governmental authorities under CERCLA and all other applicable environmental laws. Tenant's obligations and liabilities under this Section shall survive the expiration of this Lease.

44. PROHIBITED PERSONS AND TRANSACTIONS.

Tenant represents and covenants to Landlord that: (i) it is currently in compliance with, and shall at all times during the Term (including any extension thereof) remain in compliance with, all anti-terrorism and anti-money laundering laws, including, without limitation, the USA Patriot Act of 2001 (the "Patriot Act") and the International Money Laundering Abatement and Financial Anti-Terrorism Act of 2001 (the "Money Laundering

Act"), together with all rules, regulations and orders issued in connection with such laws, including, without limitation, U.S. Presidential Executive Order 13224 signed on September 23, 2001, and entitled "Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit, or Support Terrorism" (the "Executive Order"); and (ii) neither Tenant, nor any person or entity that directly owns a 10% or greater equity interest in it, nor any of its officers, directors or managing members, is listed on the "Specially Designated Nationals and Blocked Persons List" (published by the Office of Foreign Asset Control of the Department of the Treasury at http://www.ustreas.gov/offices/enforcement/ofac) (the "SDN List"), or is otherwise identified by government or legal authority as a person or entity (each, a "Prohibited Person") with whom U.S. persons or entities are restricted from doing business. In the event of any violation of this section, Landlord shall be entitled to immediately terminate this Lease and take such other actions as are permitted or required to be taken under law or in equity. TENANT SHALL DEFEND, INDEMNIFY AND HOLD HARMLESS LANDLORD FROM AND AGAINST ANY AND ALL CLAIMS, DAMAGES, LOSSES, RISKS, LIABILITIES AND EXPENSES (INCLUDING ATTORNEYS' FEES AND COSTS) INCURRED BY LANDLORD ARISING FROM OR RELATED TO ANY BREACH OF THE FOREGOING CERTIFICATIONS, REPRESENTATIONS OR COVENANTS. These indemnity obligations shall survive the expiration or earlier termination of this Lease.

45. TENANT EXECUTION OF LEASE.

The execution and delivery of this lease by Tenant to Landlord does not constitute a reservation of or option for the Premises, and this Lease shall become effective only if and when Landlord executes and delivers the same to Tenant, provided, however, that the execution and delivery by Tenant of this Lease to Landlord shall constitute an irrevocable offer by Tenant to lease the Premises on the terms and conditions herein contained.

[Signatures appear on following page]

IN WITNESS WHEREOF, Landlord has caused these presents to be signed and sealed by its authorized agent, and Tenant has caused these presents to be signed and sealed in its entity name by its duly authorized officer or partner, all done as of the date first set forth above.

WITNESS/ATTEST:

LANDLORD:

HOPE HEALTH PROPERTIES, LLC

By: _____(SEAL)
Print Name: Olanrele Fadiora
Title: Authorized Agent

WITNESS/ATTEST:

TENANT:

_____(SEAL)
Print Name: Olayinka Fadiora
Title: Authorized Agent
For Hope Health Hospital

SCHEDULE 1

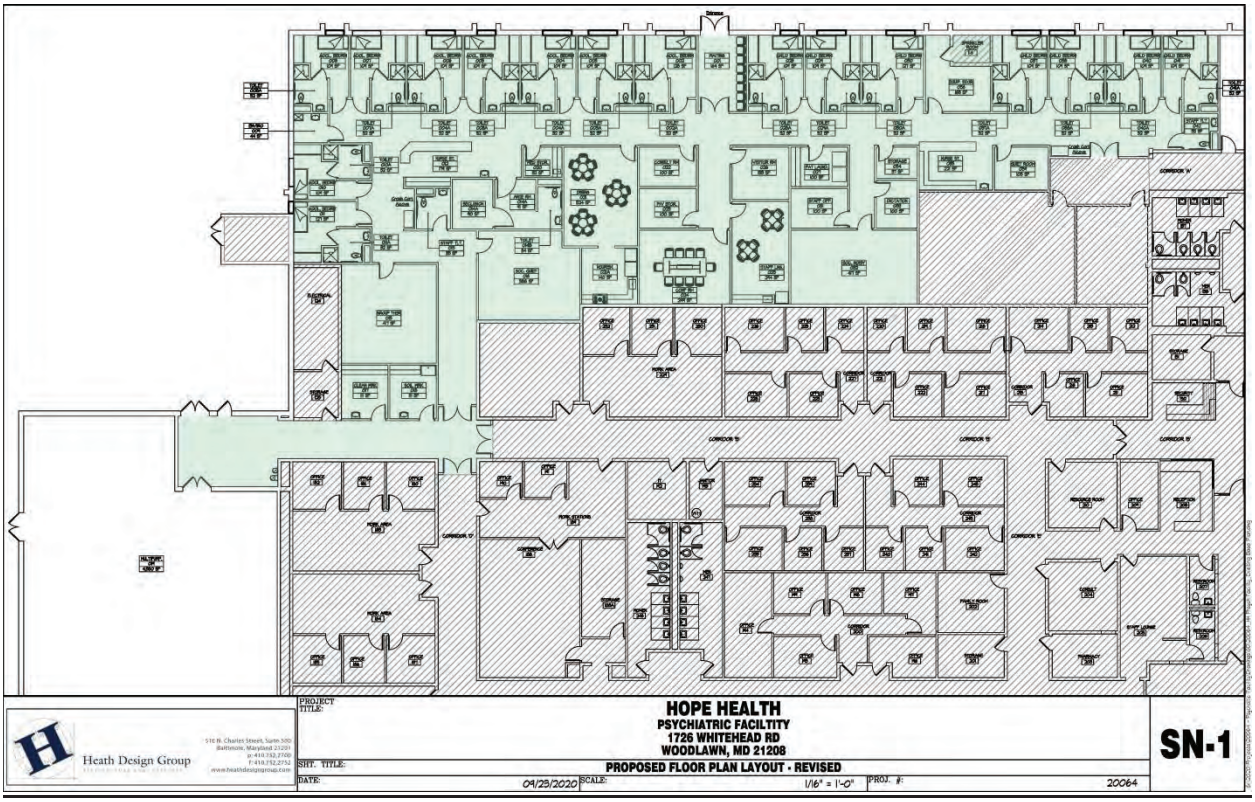
RENT SCHEDULE RIDER – BASE RENT

In addition to all other payment obligations provided hereunder, Tenant shall pay to the Landlord the following base Rent, in monthly installments, subject to and in accordance with the terms and conditions specified in the Lease:

Lease Term	**Base Rent**
6/1/2021 – 7/31/2021	$0.00/month
8/1/2021 – 8/31/2022	$15,000.00/month
9/1/2022 – 9/31/2023	$15,000.00/month
10/1/2023 – 10/31/2024	$15,000.00/month
11/1/2024 – 11/31/2025	$15,000.00/month
12/1/2025 – 12/31/2026	$15,000.00/month
RENEWAL TERM (if exercised)	**Base Rent**
9/1/2026 – 8/31/2027	$15,000.00/month
9/1/2027 – 8/31/2028	$15,000.00/month
9/1/2028 – 8/31/2029	$15,000.00/month
9/1/2029 – 8/31/2030	$15,000.00/month
9/1/2030 – 8/31/2031	$15,000.00/month
RENEWAL TERM (if exercised)	**Base Rent**
9/1/2031 – 8/31/2032	$15,000.00/month
9/1/2032 – 8/31/2033	$15,000.00/month
9/1/2033 – 8/31/2034	$15,000.00/month
9/1/2034 – 8/31/2035	$15,000.00/month
9/1/2035 – 8/31/2036	$15,000.00/month

Tenant warrants and represents to the Landlord that it has physically inspected and independently verified the actual location, area, and dimensions of the Premises prior to the execution of this lease, and that it accepts and is satisfied with the actual location, area, and dimensions of the Premises for its use, at the sums stipulated in this **Schedule 1**.

EXHIBIT A



Hope Health Hospital
Approx. 10,134 sf.

EXHIBIT 4

Discharge Planning

A. OBJECTIVES

At an initial stage of hospitalization, all patients will be evaluated for discharge planning needs. Any inpatient who is identified to be at risk for adverse health consequences or negative outcomes without the benefits of appropriate discharge planning shall have a plan developed and monitored for appropriateness as the patient progresses in their medical treatment. The goal is to map a safe and sustainable plan aimed at minimizing likelihood of re-hospitalization for reasons that could have been prevented. Registered nurse, social worker or other appropriately qualified personnel must develop or supervise the development of the discharge evaluation. The responsible personnel should have experience in discharge planning, knowledge of psychosocial and physical factors that affect functional status at discharge and knowledge of the community resources to meet post-discharge clinical and social needs.

Reducing preventable hospital readmissions is a priority for patient safety. Interdisciplinary discharge planning will be provided to patients in acute care to facilitate the transition of the patient from the hospital and through the continuum and / or to the appropriate post-hospital environment or to another health-care facility. Discharge planning includes, but is not limited to identifying patient, estimating the length of service needed, identifying method of reimbursement, and establishing a feedback mechanism where indicated. Once a patient has been identified as having post-discharge needs, it is necessary to periodically reevaluate physical, emotional, and social status, since these factors may affect his or her readiness for discharge.

HHS staff shall:

A. Screen all patients early in hospitalization to determine which ones are at risk of adverse health consequences / readmission post-discharge. Screening is completed by:
    - Chart review,
    - Patient/family interview, and/or
    - Interdisciplinary rounds
B. The patient or the multidisciplinary health care team can request a discharge evaluation.
C. Evaluate individual medical, psychosocial, and nursing care needs including an evaluation of a patient's capacity for self-care, their goals, the possibility of the patient being cared for in the environment from which he/she entered the organization, and the caregiver's ability to support the patient.
D. Determine whether there is community based or other health care services available for them
E. Develop a discharge plan with the patient/family in collaboration with the physician to identify services to meet the patient's post discharge needs.
F. Disclose to the patient the relationship, if any, between HHS and any post discharge provider/ service before the patient chooses a post discharge provider/service.
G. Inform the patient/family of their freedom to choose among providers and when possible respect their preferences.
H. Determine availability of services available under the payer/insurers or discuss out-of-pocket expenses.
I. If the patient has no preference of a post discharge provider/service or their preference isn't available, then HHS staff will notify the patient who the default service/provider will be and the relationship between the provider/service and HHS, if any.
J. Patient has the right to self-determination and has the right to refuse the discharge recommendations of the health care team.
K. Inform the post discharge provider/service personnel of the patient's choice.

L. Routinely reassess patients for changes that warrant adjustments to the discharge plan.
M. Discuss the finalized discharge plan with the patient/family.
N. Implement the discharge plan prior to discharge

B. DOCUMENTATION

- Document in the patient's electronic medical record the discharge planning evaluation
- Document in the patient's electronic medical record that the results of the evaluation were discussed with the patient or the patient's representative
- Document in the patient's electronic medical record whether the patient accepts the results of the evaluation (not necessary for the hospital to obtain a signature from the patient).
- Document that choices of post discharge providers were given
- Document patient's choice of a post discharge provider/service
- Document the arrangements made for initial implementation of the discharge plan, including any training or materials provided to the patient or patient's informal caregiver or representative.
- Necessary documentation will be provided to the patient's follow up care provider.

EXHIBIT 5

Maryland
DEPARTMENT OF
JUVENILE SERVICES

217 East Redwood Street
Baltimore, MD 21202

Boyd K. Rutherford
Lt. Governor

Larry Hogan
Governor

Sam Abed
Secretary

September 17, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

To Whom It May Concern,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

The State of Maryland does not have enough sufficient inpatient programs to accommodate youth who suffer from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity.

Hope Health Systems is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to children and adolescent clients in institutional and outpatient settings though out Maryland. HHS already offers a full suite of outpatient programs for children and adolescents, so expanding it multitude of services can only better serve our youth population, especially those at risk.

I recommend that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

I have personal witness the quality, professional and caring treatment and services that Hope Health Systems have provide to youth and their families for over 10 years.

Please contact me if you or your staff if needed at 410-736-2722 or antoinette.mcleod@maryland.gov.

Sincerely,

Antoinette McLeod

Executive Director for Operations
MD Department of Juvenile Services

Phone: 410-230-3100 Toll Free: 1-888-639-7499 TDD: 1-800-735-2258

JOHN A. OLSZEWSKI, JR.
County Executive

GREGORY WM. BRANCH, M.D., MBA, CPE, FACP
Health Officer, Department of Health

September 28, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen:

Please accept this correspondence as an official letter of support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private 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 mental 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.

HHS is an organization with 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. HHS 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 ask that the Maryland Health Care Commission recognize the need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application and help Baltimore County be a place where healthy people live, work and play.

Sincerely,

Gregory Wm. Branch, M.D., MBA, CPE, FACP
Health Officer

HEALTH DEPARTMENT
Prince George's County
Office of the Health Officer

September 28, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen:

As the Health Officer of the Prince George's County Health Department and a pediatrician, I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS), to establish a sixteen (16) bed freestanding private psychiatric hospital for children and adolescents.
Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. We have no inpatient psychiatric treatment for adolescents in our County of nearly 1 million people. In FY2019, 8,597 adolescents were served in the public behavioral health system, and there were approximately 500 crisis-related calls for children under the age of 18 to the Prince George's County Crisis Response System. In FY 2019, 373 youth sought inpatient care, which was a 6.6% increase from the prior year. Since we have no inpatient psychiatry services for our youth, this equates to 100% of these youth having to seek care in other jurisdictions, including within the Baltimore metropolitan region. Furthermore, this data does not include the youth served by commercial insurance, which is a significant and often overlooked need because our County is very diverse in its socioeconomic demographics. Because the District of Columbia does not honor our legal processes for involuntary evaluations and admissions, and the fact that the District of Columbia hospitals are some of the closest to our jurisdiction, it is even more difficult to place some our most vulnerable youth such as those in the care of the Department of Social Services when they need inpatient psychiatric care.

Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. In one of our local hospitals, the average length of stay in the emergency department for an adolescent is 1.7 days, and sometimes they can stay for up to a week while awaiting placement. This not only delays care, but also potentially traumatizes them, as they wait in a setting where they are witnessing incoming traumas and other life-threatening medical emergencies. Because of the significant burden that COVID-19 has put on our acute care hospital systems, it is an emergent need that we find timely placement for those with behavioral health conditions so that the emergency departments can use their resources to serve those with the potentially life-threatening virus. Reducing prolonged lengths of stay ensures good psychiatric care as well as prevents unnecessary exposure to COVID-19 for our adolescents while they wait in the emergency department. We are currently seeing an ongoing surge of behavioral health patients in our County emergency departments, and such a facility is of an urgent need for our residents, as we anticipate the need to grow in this COVID era.

Angela D. Alsobrooks
County Executive

Headquarters Building
1701 McCormick Drive, Suite 200, Largo, MD 20774
Office 301-883-7834, *Fax* 301-883-7896, *TTY/STS* Dial 711
www.princegeorgescountymd.gov/health

A disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs. One of these programs is the HHS planned Partial Hospitalization Program (PHP) for adolescents on the campus of the University of Maryland Laurel Regional Hospital in our County. This would be the first PHP for youth in our County. Having an HHS run program like this will help bridge the gap in our intermediate levels of care for our youth with behavioral health concerns. This program will also ensure continuity of care for adolescents served in the proposed HHS facility.

HHS is an organization with more than 20 years of experience providing direct mental health, substance use disorder, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. These include juvenile justice facilities such as the Cheltenham Youth Detention Center within our County. As a minority-owned business with minority medical leaders, such as their medical director, we are confident that HHS will continue to provide culturally sensitive care to meet the needs of our predominantly minority County. With the reinstitutionalization of those with behavioral health conditions in correctional settings and the nation's renewed focus on racial justice, we hope that having an additional facility to serve the behavioral health needs of high acuity youth will help to prevent unnecessary involvement in the criminal justice system for our at-risk residents as well.

I request that the Maryland Health Care Commission urgently recognize the need for additional acute inpatient psychiatric beds for children and adolescents, by supporting Hope Health Systems, Inc.'s CON application.

Please feel free to contact me if you or your staff have any questions at (301) 883-7874.

Sincerely,

Ernest L. Carter, MD, PhD,
Health Officer

Angela D. Alsobrooks
County Executive

Headquarters Building
1701 McCormick Drive, Suite 200, Largo, MD 20774
Office 301-883-7834, *Fax* 301-883-7896, *TTY/STS* Dial 711
www.princegeorgescountymd.gov/health

BALTIMORE CITY HEALTH DEPARTMENT

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Bernard C. "Jack" Young, Mayor
Letitia Dzirasa, M.D., .IGGCMMCIH?LĀI@Ā2?;FNBĀ

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CHARLES E. SYDNOR III, ESQ.
Legislative District 44
Baltimore City and Baltimore County

Judicial Proceedings Committee

Joint Committees

Children, Youth, and Families

Cybersecurity, Information Technology, and Biotechnology

Ending Homelessness

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

James Senate Office Building
11 Bladen Street, Room 216
Annapolis, Maryland 21401
410-841-3612 · 301-858-3612
800-492-7122 *Ext.* 3612
Charles.Sydnor@senate.state.md.us

October 20, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for Hope Health Systems, Inc. ("HHS"), a Woodlawn-based provider and its Certificate of Need ("CON") application. HHS proposes to establish a 16 bed-mental health hospital for children and adolescents in Woodlawn in response to the increased use rates of acute psychiatric inpatient services in the Baltimore metropolitan area.

The hallmark of HHS' mental health hospital will be to provide an integrated, comprehensive, personalized mental health treatment facility to children and adolescents from the Baltimore metropolitan area. Specifically the project will: provide improved access to care for patients who are publicly insured, provide a high-quality care through its step-down approach before discharging the patient to the community, integrate information with the help of case managers to improve care coordination and help reduce readmission rates through its comprehensive treatment designed by specialists.

Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and other providers in the community -to facilitate a full continuum of care for patients. With existing accreditations for its high-quality outpatient services and recognition for their institutional

services, HHS is the right choice to expand options for Maryland's youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting HHS's CON application.

Very truly yours,

Charles E. Sydnor III, Esq.

cc:
Hope Health Systems – avashist@hopehealthsystems.com

NICK J. MOSBY
Legislative District 40
Baltimore City

Ways and Means Committee
Subcommittees
Election Law
Finance Resources
Revenues

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

The Maryland House of Delegates
6 Bladen Street, Room 205
Annapolis, Maryland 21401
410-841-3520 · 301-858-3520
800-492-7122 *Ext.* 3520
Fax 410-841-3199 · 301-858-3199
Nick.Mosby@house.state.md.us

September 16, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. Further, a disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and other providers in the community -to facilitate a full continuum of care for patients. With existing accreditations for its high-quality outpatient services and recognition for their institutional services, HHS is the right choice to expand options for Maryland's at-risk youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

Sincerely,

Nick J. Mosby, District 40

IMPACT THERAPEUTIC & EDUCATIONAL SERVICES LLC

October 2, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. I know this from personal experience while working the last 15 years within the behavioral health units at multiple Department of Juvenile Services detention centers throughout the state. We have often sent youth from our centers that have been in crisis, experiencing severe psychotic symptoms and have had actual suicide attempts while in our facilities. Local ER's have struggled with finding beds for these youth, who then sit in the ER at times for up to four days while ER social workers looks for an open bed at any of the few inpatient facilities that are capable of taking youth throughout the state. This not only takes up the needed beds at the ER, but has had negative effects on the youth and their families. At times, youth who were still considered a risk, would be sent back to our detention center without an inpatient admission. Upon return, we found that the same psychiatric concerns still remained and the process would have to be initiated again days later with the youth sent back to the ER. This causes unnecessary stress on an already inundated system.

Further, a disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and

other providers in the community -to facilitate a full continuum of care for patients. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Maryland Department of Transportation (MDOT) certified Minority Business Enterprise (MBE) that offers high-quality outpatient services and is recognized for their institutional services. I believe HHS is the right choice to expand options for Maryland's at-risk youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

I urge you to contact me if you or your staff have any questions at 443-745-1474 or impacttherapeutic@gmail.com

Sincerely,

Kassandra Jarvi, LCPC-S, LCADS, NCC, MAC

Kassandra Jarvi, LCPC-S, LCADS, NCC, MAC
Chief Executive Officer
Impact Therapeutic & Educational Services LLC
Minority Business Enterprise

Agape Health Systems, Inc.
2300 Garrison Blvd #160
Baltimore, MD 21216
P: 410.362.1600
F: 410.362.6160
info@agapehealthsystems.com

October 15, 2020

Ben Steffen
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Executive Director

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

The State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. Further, a disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

As a Primary care provider in Maryland, Agape Health Systems, has witnessed and referred a number of children and adolescents with mental health issues to HHS. Agape Health Systems has been collaborating with HHS to help children and adolescents in Baltimore area. Most of Agape's Medicaid clients have been able to seek care at HHS and have been satisfied with the care they received. HHS has been providing culturally sensitive care to the children and adolescents with mental health issues with the help of its diverse team of therapists and psychiatrists.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in

institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and other providers in the community -to facilitate a full continuum of care for patients. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Maryland Department of Transportation (MDOT) certified Minority Business Enterprise (MBE) that offers high-quality outpatient services and is recognized for their institutional services. I believe HHS is the right choice to expand options for Maryland's at-risk youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

I urge you to contact me if you or your staff have any questions at 410-362-1600 or info@agapehealthsystem.com.

Sincerely,

Deborah Okonofua
DNP
Agape Health Systems

HOPE HEALTH SYSTEMS, INC.
6707 Whitestone Road, STE 106
Woodlawn, MD 21207-6090

PHONE : 410-265-8737
FAX: 410-265-1258

Providing Help and Hope to Families since 1999

October 2, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. Further, a disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and other providers in the community -to facilitate a full continuum of care for patients. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Maryland Department of Transportation (MDOT) certified Minority Business Enterprise (MBE) that offers high-quality outpatient services and is recognized for their institutional services. I believe HHS is the right choice to expand options for Maryland's at-risk youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

I urge you to contact me if you or your staff have any questions at kgordon@hopehealthsystems.com or (410)265- 8737.

Sincerely,

Kimberly Gordon Achebe

Kimberly Gordon-Achebe, MD, FAPA
Medical Director of Intensive Services

Black Mental Health Alliance

September 29, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. Further, a disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and other providers in the community -to facilitate a full continuum of care for patients. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Maryland Department of Transportation (MDOT) certified Minority Business Enterprise (MBE) that offers high-quality outpatient services and is recognized for their institutional services. I believe HHS is the right choice to expand options for Maryland's at-risk youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

Black Mental Health Alliance for Education and Consultation, Inc.
900 East Fayette Street #22111
Baltimore, MD 21203
Phone: 410-338-2642

Black Mental Health Alliance

I urge you to contact me if you or your staff have any questions at 443-739-7353 or abrown@blackmentalhealth.com.

Sincerely,

Andrea Brown
Executive Director

Black Mental Health Alliance for Education and Consultation, Inc.
900 East Fayette Street #22111
Baltimore, MD 21203
Phone: 410-338-2642

CATHOLIC CHARITIES | CHERISHING THE DIVINE WITHIN ALL

September 25, 2020

Ben Steffen
Executive Director,
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

As the Chief Medical Officer of a large outpatient mental health center that treats many children and adolescents, the dearth of inpatient psychiatric beds poses an obvious problem. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. HHS' proposed facility will be a much-needed resource for Maryland families.

HHS is an organization with more than twenty years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility and other providers in the community to facilitate a full continuum of care for patients. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Maryland Department of Transportation (MDOT) certified Minority Business Enterprise (MBE).

Having worked in collaboration with HHS, I can attest to the high quality of care that is provided. I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application. Please feel free to contact me if you or your staff have any questions at rmeans@cc-md.org.

Sincerely,

Ronald F. Means, M.D.
Chief Medical Officer,
Catholic Charities of Baltimore

HOPE HEALTH SYSTEMS, INC.
6707 Whitestone Road, Suite 106
Woodlawn, MD 21207-6090

PHONE: 410-265-8737
FAX: 410-265-1258

Providing Help and Hope to Families since 1999

October 1, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. Further, a disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

As a resident and practicing physician within the state of Maryland and Baltimore County for more than 11 years, I uniquely understand the dearth of child and adolescent inpatient mental health services available to the members of this community and its surrounding counties, including Baltimore City. Too commonly, families must wait several hours and even days in an emergency room setting with a child or adolescent in mental health crisis hoping that an inpatient bed will become available. With each passing hour, necessary mental health treatment is delayed and the child or adolescent in crisis is further traumatized by being left in an environment that is not well-trained to handle the mental health complexities of his or her situation.

I also acknowledge the significant need for increased child and adolescent inpatient psychiatric care that is culturally competent and sensitive to the needs of the underserved populations in the state of Maryland. I have witnessed Black children admitted to inpatient psychiatric units being given diagnoses and psychotropics medications that are not in line with the presenting complaints or the family's wishes due to the practitioners' failure to view the child as an individual and not a stereotype. HHS is ready and equipped to address these two systemic and institutional ills in our communities.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and other providers in the community -to facilitate a full continuum of care for patients. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Maryland Department of

HOPE HEALTH SYSTEMS, INC.
6707 Whitestone Road, Suite 106
Woodlawn, MD 21207-6090

PHONE: 410-265-8737
FAX: 410-265-1258

Providing Help and Hope to Families since 1999

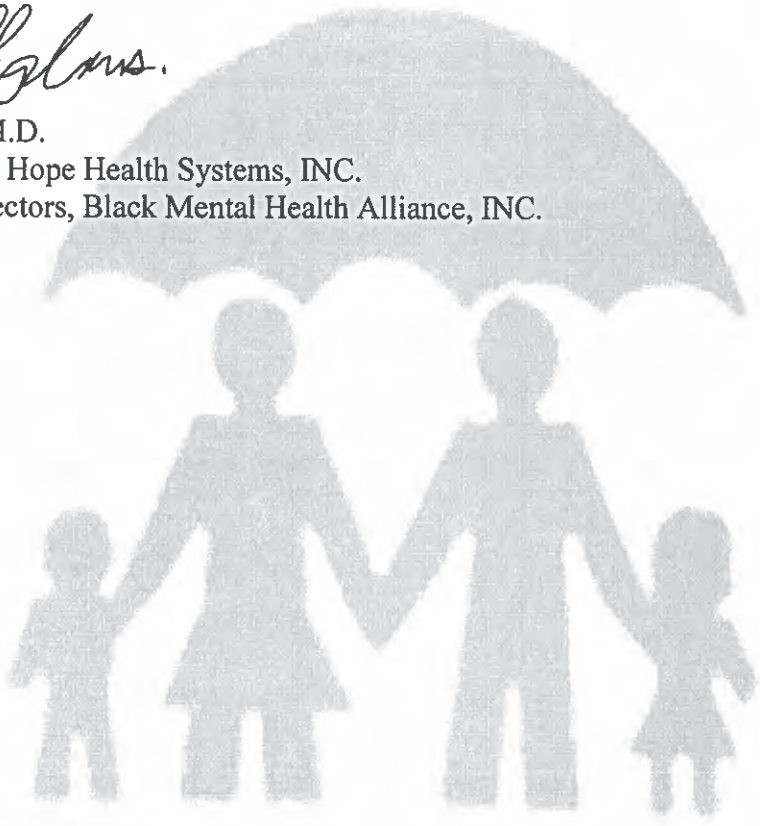
Transportation (MDOT) certified Minority Business Enterprise (MBE) that offers high-quality outpatient services and is recognized for their institutional services. I believe HHS is the right choice to expand options for Maryland's at-risk youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

I urge you to contact me if you or your staff have any questions at 410-265-8737 or jshep2471@gmail.com.

Sincerely,

Jonathan J. Shepherd, M.D.
Chief Medical Director, Hope Health Systems, INC.
President, Board of Directors, Black Mental Health Alliance, INC.



OPTIMUM
HEALTH SYSTEMS INC

Letter of Support

September 23, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. Further, a disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and other providers in the community -to facilitate a full continuum of care for patients. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Maryland Department of Transportation (MDOT) certified Minority Business Enterprise (MBE) that offers high-quality outpatient services and is recognized for their institutional services. I believe HHS is the right choice to expand options for Maryland's at-risk youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

I urge you to contact me if you or your staff have any questions at 443.992.5088 or james@optimummd.com.

Sincerely,

James Omotosho
Program Director
Optimum Health Systems, Inc.

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empowering minds
RESOURCE CENTER

500 REDLAND COURT STE 213 - OWINGS MILLS, MARYLAND 21117
(O) 410-363-3713 (F) 410-363-3715
www.emrcgroup.org

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(O) 410-363-3713 (F) 410-363-3715
www.emrcgroup.org

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Healthy Minds Resource Services

ANNELLE B. PRIMM, MD, MPH
2317 SULGRAVE AVENUE
BALTIMORE, MARYLAND 21209
410-664-1139

September 22, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

This letter is written to articulate my enthusiastic support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescents under 18 years old.

Currently, the State of Maryland has a severe lack of inpatient capacity to ensure provision of timely, convenient, and high-quality access to children and youth suffering from mental health and behavioral disorders. As a result of the insufficient inpatient bed capacity, children and youth commonly experience delays in care which can result in negative consequences for young people and their families. Compounding this unfortunate situation, the lack of connection between inpatient and outpatient care often leads to patients being readmitted to inpatient care in a revolving door fashion. Recognizing the adverse impact of this constellation of challenges, HHS intends to take solution-oriented action by undertaking this freestanding private psychiatric hospital for children and youth. The proposed facility will be a critical lifeline to increase access for children and youth for whom inpatient care is medically necessary and ensure that upon discharge, patients are connected with intensive and supportive outpatient programs.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance use disorder, and community support services to adults, children, and adolescent patients in institutional and outpatient settings in Maryland. HHS already offers a full array of outpatient programs for children and adolescents that will work with the inpatient facility and other providers in the community to effectuate a comprehensive continuum of care for patients. Given its longstanding recognition and accreditation for providing extensive, high-quality outpatient services and school-based services, HHS is the optimal choice to augment options for youth who require inpatient psychiatric services in Maryland.

As a community psychiatrist for nearly forty years, I hereby issue my strongest recommendation to the Maryland Health Care Commission to respond to the significant need for child and adolescent inpatient psychiatry beds by giving serious consideration to the CON application of Hope Health Systems, Inc.

Feel free to contact me if you have any questions at 410 262-4552 or annelleprimm@gmail.com

Sincerely,

Annelle B. Primm, MD, MPH
Former Deputy Director, American Psychiatric Association

September 26, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

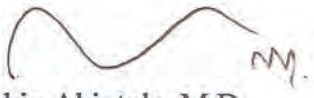
Today, the State of Maryland does not have sufficient inpatient capacity to ensure timely, convenient, and high-quality access to our youth suffering from mental health and behavioral disorders. Children and adolescents routinely experience delays in care due to the shortage of inpatient bed capacity. Further, a disconnect between inpatient and outpatient care often drives patients back to the inpatient setting. Through this project, HHS intends to be one piece of the solution. The proposed facility will be a vital lifeline to expand access for youth in need of inpatient care, while connecting patients and discharging them to intensive and supportive outpatient programs.

HHS is an organization with more than 20 years of experience in providing direct mental health, substance abuse, and community support services to adults, children, and adolescent clients in institutional and outpatient settings in Maryland. HHS already offers a full suite of outpatient programs for children and adolescents that will work in concert with the inpatient facility – and other providers in the community -to facilitate a full continuum of care for patients. HHS is accredited through The Joint Commission (TJC), as well as Commission on Accreditation of Rehabilitation Facilities (CARF) and a deemed status certified provider of Outpatient Mental Health Clinic by The Maryland Department of Health (MDH). HHS is a Maryland Department of Transportation (MDOT) certified Minority Business Enterprise (MBE) that offers high-quality outpatient services and is recognized for their institutional services. I believe HHS is the right choice to expand options for Maryland's at-risk youth in need of inpatient psychiatric care.

I ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

I urge you to contact me if you or your staff have any questions at 443-527-4758 or akin_wand@yahoo.com

Sincerely,



Akin Akintola, M.D.
Board Certified Child, Adolescent and Adult Psychiatrist
Medical City Green Oaks Hospital
Dallas, TX

Patient Support Letter

October 14, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

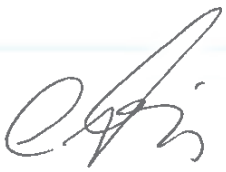
I am writing to express my support for the Certificate of Need (CON) application submitted by Hope Health Systems, Inc. (HHS) to establish a sixteen (16) bed freestanding private psychiatric hospital in the Baltimore metropolitan area for children and adolescent individuals under the age of 18.

My child is a patient of HHS and is being offered high quality and comprehensive care. HHS offered patient-centered, culturally centered care to my child. Their care is unique in that it is based on the views of culturally diverse patients rather than just the views of healthcare professionals (their nurses, psychiatrists, therapists). Having several minority medical leaders, HHS has been able to provide culturally sensitive care to my child and understand the underlying issues that he/she is going through.

During these testing times of pandemic, HHS has extended its care outside their scope of work by providing transportation to pick up and drop off clients to bring them to office for their sessions. HHS extends its support to its client beyond the normal care that a healthcare professional provides. I have been getting services from HHS for the past few months and I have been extremely satisfied with the care that my child has received.

I am confident that the high quality and comprehensive care provided to my family would continue to be offered by HHS with the expansion of its continuum of care to include inpatient services. I therefore ask that the Maryland Health Care Commission recognize the acute need for additional inpatient psychiatric beds for children and adolescents by supporting Hope Health Systems, Inc.'s CON application.

Sincerely,



Patient Support Letter

October 14, 2020

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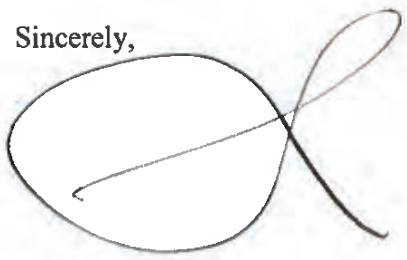

Patient Support Letter

October 14, 2020

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

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Sincerely,

EXHIBIT 6

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.

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.
- 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.

EXHIBIT 7

PATUXENT
ACCOUNTING & TAX

February 25,2019

To the Board of Directors
Hope Health Systems Inc.

Management is responsible for the accompanying financial statements of Hope Health Systems, Inc. which comprise the balance sheet and stockholders' equity as of December 31, 2018 and the related statement of income for the year then ended in accordance with accounting principles generally accepted in the United States of America. We have performed compilation engagements in accordance with the Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. We do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

Management has elected to omit substantially all the disclosures and the statements of cash flows required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the company's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Patuxent Accounting & Tax Services Inc.
Baltimore, Maryland

HOPE HEALTH SYSTEMS, INC
BALANCE SHEET AND STOCKHOLDERS' EQUITY
DECEMBER 31, 2018

ASSETS		
Current Assets:		
Checking and Savings	$	72,991
Accounts Receivable	$	295,235
Other Current Assets	$	392,744
Total Current Assets	$	760,970
Fixed Assets:		
Fixed Assets	$	1,686,947
Accumulated Depreciation	$	(538,189)
Total Fixed Assets	$	1,148,758
TOTAL ASSETS	$	1,909,728
LIABILITIES & STOCKHOLERS'EQUITY		
Current Liabilities:		
Accounts Payable	$	319,165
Credit Cards	$	90,117
Other Current Liabilities	$	360,993
Total Current Liablities	$	770,275
Long Term Liablities:		
Long Term Liablities	$	832,430
Total Long Term Liablities	$	832,430
TOTAL LIABLITIES	$	1,602,706
Stockholders" Equity:		
Equity	$	307,022
TOTAL STOCKHOLDERS' EQUITY	$	307,022
TOTAL LIABLITIES & STOCKHOLDERS' EQUITY	$	1,909,728

See Independent Accountant's Compilation Report

HOPE HEALTH SYSTEMS, INC
STATEMENT OF INCOME
DECEMBER 31, 2018

ORDINARY INCOME		
Service Income	$	13,751,396
Interest Income	$	31
Total Income	$	13,751,427
EXPENSES		
Automobile Expenses	$	81,083
Banking Fees	$	21,069
Business Gifts	$	17,886
Contributions	$	27,371
General Expenses	$	5,119
Insurance	$	607,066
Interest Expense	$	99,589
Legal & Professional Fees	$	768,988
Licenses & Permits	$	30,944
Miscellaneous	$	4,384
Office Expenses	$	91,674
Printing & Reproduction	$	5,817
Rent	$	239,819
Repairs & Maintenance	$	101,095
Salaries	$	8,835,251
Subcontractors	$	1,334,047
Taxes	$	724,934
Telephone	$	98,717
Travel & Entertainment	$	148,663
Utilities	$	63,184
TOTALL EXPENSES	$	13,306,700
NET INCOME	$	444,727

See Independent Accountant's Compilation Report.

PATUXENT
ACCOUNTING & TAX

April 1, 2020

To the Board of Directors
Hope Health Systems Inc.

Management is responsible for the accompanying financial statements of Hope Health Systems Combined Companies which comprise the Balance Sheet and Stockholders' Equity as of December 31, 2019 and the related Statement of Income for the year then ended in accordance with accounting principles generally accepted in the United States of America. We have performed compilation engagements in accordance with the Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. We do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

Management has elected to omit substantially all the disclosures and the statements of cash flows required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the company's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Reginald Palmore, CPA

Patuxent Accounting & Tax Services Inc.
Baltimore, Maryland

HOPE HEALTH SYSTEMS COMBINED COMPANIES
BALANCE SHEET AND STOCKHOLDERS' EQUITY
DECEMBER 31, 2019

ASSETS

Current Assets:		
Cash	$	146,224.59
Accounts Receivable	$	433,427.36
Total Current Assets	$	579,651.95
Fixed Assets:		
Fixed Assets (Less: Accumulated Depreciation)	$	1,011,497.46
Building	$	2,614,850.36
Leasehold Improvements	$	74,273.24
Total Fixed Assets	$	3,700,621.06
Other Assets:		
Security Deposit	$	8,259.34
Other Assets	$	485,524.66
Goodwill (Less Amortization)	$	19,910.00
Due From	$	11,352.08
Total Other Assets	$	525,046.08
TOTAL ASSETS	$	4,805,319.09

See Independent Accountant's Compilation Report.

LIABILITIES & STOCKHOLDERS' EQUITY

Short Term Liabilities:		
Accounts Payable	$	453,483.29
Credit Cards	$	90,618.93
Accrued Liabilities	$	183,201.10
Total Short Term Liablities	$	727,303.32
Long Term Liabilities:		
Notes Payable	$	829,905.08
Building Loan	$	2,648,509.52
Total Long Term Liabilities	$	3,478,414.60
Stockholders' Equity		
Retained Earnings	$	32,509.95
Net Income	$	567,091.22
Total Stockholders' Equity	$	599,601.17
TOTAL LIABILITIES & STOCKHOLDERS' EQUITY	$	4,805,319.09

See Independent Accountant's Compilation Report

HOPE HEALTH SYSTEMS COMBINED COMPANIES
STATEMENT OF INCOME
DECEMBER 31, 2019

Service Income	$	14,466,937.42
Total Service Income	$	14,466,937.42
EXPENSES:		
Payroll Expenses	$	6,156,969.40
Fringe Expenses	$	1,176,210.97
General & Administrative	$	4,928,028.54
Subcontractor Expense	$	1,036,414.59
Advertising & Promotions	$	1,050.00
Automobile Expense	$	79,997.35
Bank & Service Charges	$	4,136.58
Interest Expense	$	137,278.80
Miscellaneous Expense	$	218,544.75
Property Management Expenses	$	9,613.42
Property Taxes	$	140,777.31
Repairs & Maintenance	$	10,824.49
Total Expenses	$	13,899,846.20
Net Income	$	567,091.22

See Independent Accountant's Compilation Report.

EXHIBIT 8

CENTURY ENGINEERING

10710 Gilroy Road
Hunt Valley, MD 21031
t 443.589.2400 f 443.589.2401 centuryeng.com

MEMORANDUM

DATE: October 2, 2020

TO: Mr. Bryan Niehaus, JD, CHG, VP
7840 Graphics Drive, Ste 100
Tinley Park, IL 60477

FROM: Michael Pieranunzi, VP
Century Engineering, Inc.

RE: Hope Health Care
1726 Whitehead Road
Woodlawn, MD 21208

The site is located at 1726 Whitehead Road in Baltimore County. It consists of 2.46 acres and is zoned ML (Manufacturing-Light).

Century Engineering, Inc. has been retained by Hope Health Care to provide civil engineering and survey services.

Approval for revisions to the site will be subject to Baltimore Planning and Zoning and Baltimore County Soil Conservation District. Century is currently surveying the site to prepare an accurate base plan for preparation and submission to Baltimore County.

At this time no plans have been submitted for review.

cc: Kay Ogunnaike

EXHIBIT 9

TAYLOR CAPITAL
CONSULTANTS

877.646.4733
www.taylorcapitalconsultants.com

1629 K St Suite 300, N.W.
Washington, D.C. 20006

October 5, 2020

PRE-QUALIFICATION LETTER

Yinka Fadiora
Program Director
Hope Health Systems, Inc.
1726 Whitestone Rd.
Baltimore, MD 21207

Re: Loan Pre-Qualification for Hope Health Systems, Inc.

Dear Mr. Fadiora:

Based on a review of stated financial information, including a commercial mortgage credit report, Taylor Capital Consultants, LLC are pleased to pre-qualify Mr. Fadiora for commercial construction and working capital loan based on the following criteria:

First Lien Loan Amount:	$4,500,000
Interest Rate:	Prime Rate of 3.75% + 2.75%
Terms:	10 Year Fixed / 30 Year Amortization

Final loan approval is contingent upon an underwriter's review of supporting financial documents, a satisfactory appraisal, survey, title commitment, insurance, approver permits and certifications. A final commitment letter will be issued to you upon the completion of due diligence and final loan approval.

If you have any questions regarding the information provided, please don't hesitate to contact me at 202-570-9748 or jullion@taylorcapitalconsultants.com

Sincerely,

Jullion Taylor, Jr.

Jullion Taylor, Jr.
Managing Partner
Taylor Capital Consultants, LLC

EXHIBIT 10

A Real Estate Cost Report

Marshall Valuation Cost Analysis
Hope Health Psychiatric Facility

Located at
1726 Whitehead Road, Woodlawn, Maryland 21208

Prepared for
Bryan Niehaus
Advis
7840 Graphics Drive, Suite 100
Tinley Park, Illinois 60477

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

Effective Date
Effective October 15, 2020

File Number:TW201015

Treffer | Appraisal Group
The value of experience.

October 21, 2020

Bryan Niehaus
Advis Healthcare Consultants
7840 Graphics Drive, Suite 100
Tinley Park, Illinois, 60477

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

Dear Mr. Niehaus:

In accordance with your assignment request I have prepared a 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 amounts presented are not the replacement cost new 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.

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 projected cost per square foot of 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, updated using Marshall Valuation Service update multipliers, and adjusted as shown in the Marshall Valuation Service guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

The base rate for Good quality Class A General Hospitals in the Marshall Valuation guide is $374.00 per square foot. The total cost for the proposed sixteen bed facility at Hope Health Psychiatric is $167.14 per square foot. The primary reason for the difference in two cost rates is that the preliminary construction budget for the subject property is not for a Class A General Hospital building. 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 falls far short when comparing costs for a general hospital. Based on Marshall Valuation definitions, a closer match to the proposed subject improvements is a Convalescent Hospital. In order to provide more accurate benchmarking, the cost analysis developed in this report is based on a comparison of the proposed subject costs to equivalent cost for an average Class C convalescent 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 October 15, 2020:

Respectfully submitted,

Thomas A. Weigand, MAI
Certified General Appraiser
Maryland License #04-27637
Expiration: December 27, 2022

Certification Statement

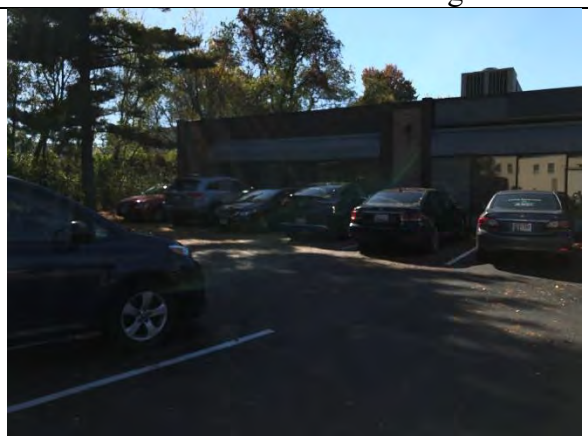
I certify that, to the best of my knowledge and belief:

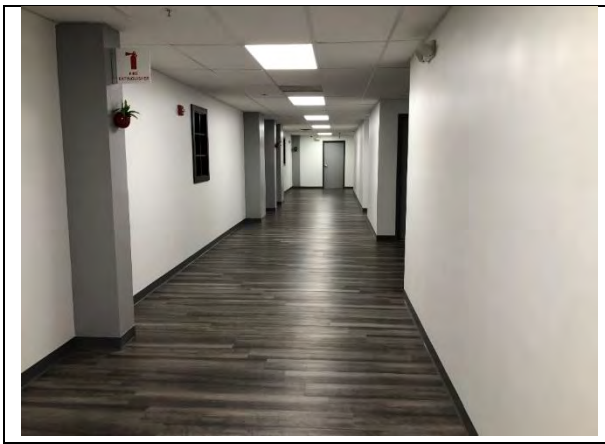
- The statements of fact contained in this report are true and correct.
- The reported analyses, opinions and conclusions are limited only by the reported assumptions and limiting conditions, and reflects my personal, impartial, and unbiased professional analyses, opinions and conclusions.
- I have no 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 not performed prior appraisal or any other valuation services, 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 has made an interior and 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.

Date: October 21, 2020

Thomas A. Weigand, MAI
Certified General Appraiser
Maryland License #04-27637
Expiration: December 27, 2022

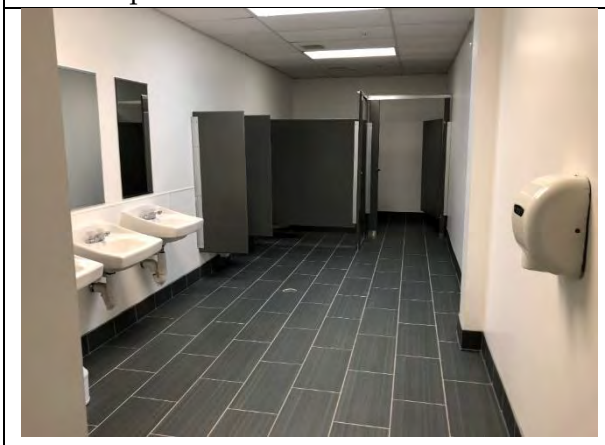
Subject Property Photographs

	
North Elevation Proposed Entrance	West Elevation
	
West Elevation	East Elevation and Parking
	
Current Front Entrance	East Elevation and Parking

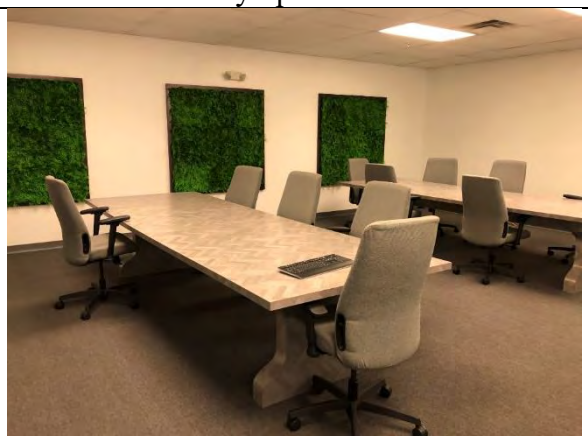


Representative Interior Finishes

Fully Sprinklered

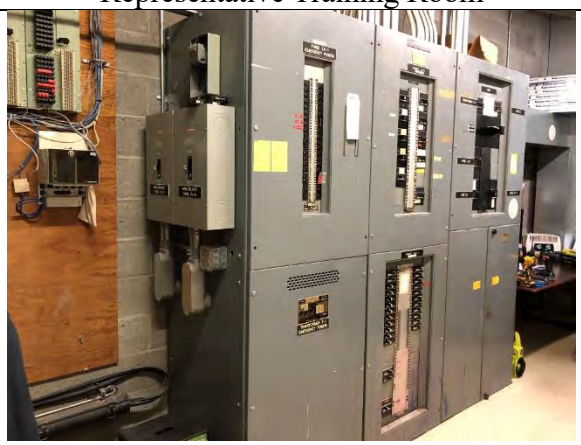


Common Area Bathroom

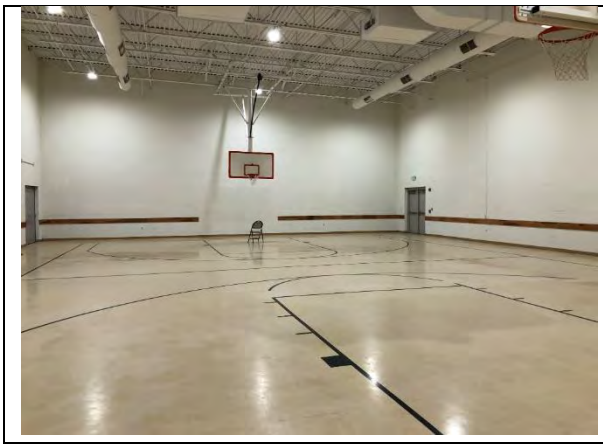
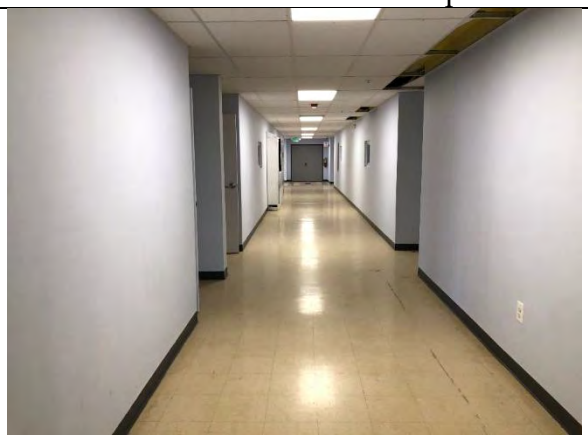
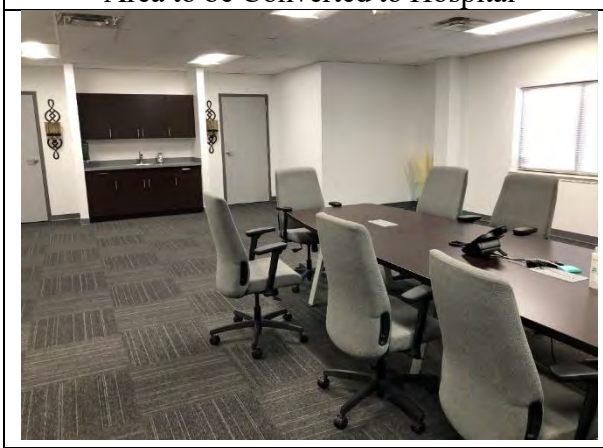
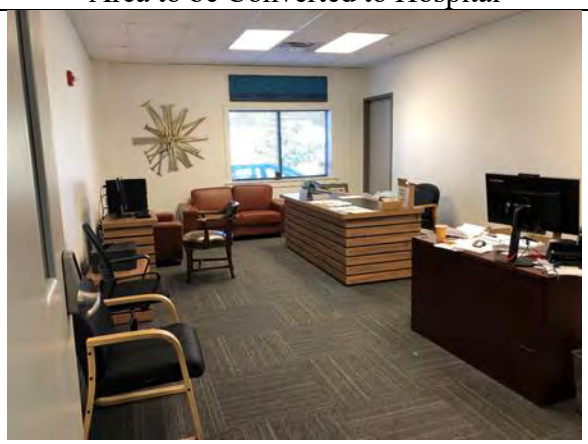


Representative Training Room

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 project costs with the corresponding costs sited in the Marshall Valuation benchmark. The costs rates included in this report relate to the proposed conversion of a portion of the existing building. The amounts presented are not the replacement cost new 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.

Marshall Valuation Service			
Cost Source:	Marshall Valuation		
Section:	#15: Offices, Medical and Public Buildings		
Class:	Class C Nursing Homes (Convalescent Hospitals) (313) Average		
Gross Building Area:	10,134.0		
No. of Stories Multiplier:	1.000	**Local Multiplier:**	1.010
Height/Story Multiplier:	1.000	**Current Cost Multiplier:**	1.050
Perimeter Multiplier:	1.000	**Combined Multipliers:**	**1.060**

At this stage of the proposed building conversion the cost data presented for the subject property has been compiled by the project engineer. Specific construction quotes and cost estimates from the general contractor and subcontractors have not been developed at this stage of the project. The engineering cost estimates are presented in the table below under the columns labeled "Preliminary Construction Budget". The preliminary budget amounts are compared and contrasted with the adjacent columns labeled "Costs from Marshall Valuation". The cost estimate 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 Architects' fees and contractors' 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 work space, 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 10,134 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 does not include any estimate for HVAC work as the system is being replaced separate from the proposed hospital renovations.

Cost Comparison Chart - Hope Health Facility								
	Preliminary Construction Budget			Costs From Marshall Valuation				
	Line Item Cost	Cost Per Unit	Implied Units	Cost Per Unit	Project Size	Line Item Cost		Cost Surplus (Deficit)
General Conditions								
Supervision	$42,000.00	$4.14	10,145					$42,000.00
Dumpsters	$7,500.00	$0.74	10,135					$7,500.00
Floor Prep/ Demo	$53,175.00	$5.25	10,129	$5.00	10,134	$50,670.00		$2,505.00
Final Cleaning	$3,293.75	$0.33	9,981					$3,293.75
	$105,968.75	**$10.46**	**10,131**					
Concrete								
Saw Cut Concrete	$40,625.00	$4.01	10,131	Inc w/ Windows				$40,625.00
New Window Openings	$8,125.00	$0.80	10,156	Inc w/ Windows				$8,125.00
Generator Pad & Fencing	$6,250.00	$0.62	10,081	$2,240.00	Each	$2,240.00		$4,010.00
	$55,000.00	**$5.43**	**10,129**					
Thermal Moisture Protection								
Roofing	**$15,562.50**	**$1.54**	**10,106**	$1.57	10,134	$15,910.38		($347.88)
Finishes								
Framing and Drywall	$101,250.00	$9.99	10,135	$7.79	10,134	$78,943.86		$22,306.14
Top Out Existing Wall for Partition	$21,093.75	$2.08	10,141	Inc Below	10,134			$21,093.75
Ceiling Grid and Tile	$44,362.50	$4.38	10,128	$11.83	10,134	$119,885.22		($75,522.72)
Doors and Hardware	$78,375.00	$7.73	10,139	Inc Below	10,134			$78,375.00
Door Installation	$16,500.00	$1.63	10,123	Inc Below	10,134			$16,500.00
Auto Openers at Entrance Vestibule	$15,250.00	$1.50	10,167	$11.40	10,134	$115,527.60		($100,277.60)
Windows	$75,000.00	$7.40	10,135	$20.00	10,134	$202,680.00		($127,680.00)
Millwork	$187,500.00	$18.50	10,135	$22.65	10,134	$229,535.10		($42,035.10)
Painting	$35,300.00	$3.48	10,144	$0.53	10,134	$5,371.02		$29,928.98
Flooring & Carpet	$4,000.00	$0.39	10,256	$4.38	10,134	$44,386.92		($40,386.92)
Seamless Flooring	$156,250.00	$15.42	10,133	$10.40	10,134	$105,393.60		$50,856.40
	$734,881.25	**$72.50**	**10,136**					
Specialties								
Fire Extinguishers	$1,000.00	$0.10	10,000	$200.00	Each			$1,000.00
Fire Extinguisher Cabnets	$1,250.00	$0.12	10,417	$230.00	Each			$1,250.00
Corner Guards	$5,250.00	$0.52	10,096		Each			$5,250.00
Crash Rail	$8,000.00	$0.79	10,127		Each			$8,000.00
Window Treatments	$9,000.00	$0.89	10,112		Each			$9,000.00
Restroom Accessories	$12,000.00	$1.18	10,169		Each			$12,000.00
Blocking	$3,750.00	$0.37	10,135		Each			$3,750.00
	$40,250.00	**$3.97**	**10,139**					
Plumbing								
Demo	$6,250.00	$0.62	10,081					
Supply and Install Supply Lines and Fixtures	$85,625.00	$8.45	10,133					
ADA Shower Stalls	$80,000.00	$7.89	10,139					
	$171,875.00	**$16.96**	**10,134**	$16.63	10,134	$168,528.42		$3,346.58
Sprinklers								
Sprinklers	**$37,500.00**	**$3.70**	**10,135**	$3.82	10,134	$38,711.88		($1,211.88)
Electrical								
Demo Existing Electrical	$2,500.00	$0.25	10,000		10,134			$2,500.00
Fire Alarm	$43,750.00	$4.32	10,127		10,134	$6,200.00		$37,550.00
200 KW Stand By Generator	$131,250.00	$12.95	10,135	$150,000.00	Each	$150,000.00		($18,750.00)
General	$177,500.00	$17.52	10,131	$21.38	10,134	$216,664.92		($39,164.92)
	$355,000.00	**$35.04**	**10,131**					
Subtotal Before Overhead and Profit	**$1,516,037.50**	**$149.60**	**10,134**			$1,550,648.92		($34,611.42)
Adjusted for Current Cost Multiplier @ 1.05%	**$0.00**					$1,628,181.37		($77,532.45)
Baltimore Local Cost Multiplier @ 1.01%	**$0.00**					$1,644,463.18		($16,281.81)
Overhead & Profit	**$177,710.00**	**$17.54**	**10,132**			$0.00		$177,710.00
Total Construction Budget	**$1,693,747.50**	**$167.14**	**10,134**	**$162.27**		**$1,644,463.18**		**$49,284.32**

In accordance with the scope of this assignment, I have compared the engineering estimates with cost data published by Marshall Valuation Service. In most cases when a range of rates was resented by Marshall, the midpoint of the range was selected for the cost comparison. the 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 to the difference between the preliminary cost estimate and the Marshall benchmark.

As shown in the overall quote, the preliminary construction cost, including engineering, permitting, grading, architectural, and overhead and profit total $1,693,747.50, or $167.14 per square foot. After adjusting for current and local cost multipliers this amount is $49,284.32 higher than the cost benchmark presented by Marshall Valuation. This difference can be explained accounting for $40,250 in specialty items. After subtracting for the specialty items the difference between the preliminary cost estimate and the Marshall benchmark is $9,034.32 or approximately one half of one percent. The remaining $9,034.12 is an immaterial difference that could be absorbed by accounting for inefficiencies typically incurred by a rehab project that are not experienced in new construction.

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 engineering estimates with the per bed cost data published in the Marshall Valuation Service cost guide.

Total Construction Budget		$1,693,747.50
Number of Beds		16
Cost per Bed		$105,859.22
Class C, D, and S Buildings per MVS		
Section 15 Page 39		
Typical Cost Range per Bed		$50,500 - $181,000
Average Cost per Bed		$84,750

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 well within the range of typical costs per bed. In reviewing the subject property's type, construction class, construction type, and property specific build-outs, I have aligned it with the following MVS Cost section.

MARSHALL COST ESTIMATE

Cost Approach Conclusion

As demonstrated in this cost analysis the project's cost in total and on a square foot basis approximate the Marshall Valuation Service benchmark. The preliminary construction cost, including engineering, permitting, grading, architectural, and overhead and profit total $1,693,747.50, or $167.14 per square foot. After adjusting for current and local cost multipliers this amount is $49,284.32 higher than the cost benchmark presented by Marshall Valuation. This difference can be explained accounting for $40,250 in specialty items. All costs are presented in summary form in the table below. The effective date of this analysis is October 15, 2020.

Cost Comparison Chart - Hope Health Facility - Summary Format									
	Preliminary Construction Budget				Costs From Marshall Valuation				
	Line Item Cost	Cost Per Unit	Implied Units		Cost Per Unit	Project Size	Line Item Cost	Cost Surplus (Deficit)	Description
Subtotal Before Overhead and Profit	**$1,516,037.50**	**$149.60**	**10,134**				$1,550,648.92	($34,611.42)	
Adjusted for Current Cost Multiplier @ 1.05%	**$0.00**						$1,628,181.37	($77,532.45)	
Baltimore Local Cost Multiplier @ 1.01%	**$0.00**						$1,644,463.18	($16,281.81)	
Overhead & Profit	**$177,710.00**	**$17.54**	**10,132**				$0.00	$177,710.00	Included in the Marshall Rates
Total Construction Budget	**$1,693,747.50**	**$167.14**	**10,134**		**$162.27**	**10,134**	**$1,644,463.18**	**$49,284.32**	

Respectfully submitted,

Thomas A. Weigand, MAI
Certified General Appraiser
Maryland License #04-27637
Expiration: December 27, 2022

Addendum

Treffer | Appraisal Group
The value of experience

October 6, 2020

Yusufu Ogunnaike
Hope Health Systems, Inc.
1726 Whitehead Road
Woodlawn, Maryland 21235

Re: Marshall Valuation report for the building and planned renovations located at 1726 Whitehead Road, Woodlawn, Maryland 21235.

Dear Ogunnaike,

In response to our recent email communication, my firm is submitting a proposal for the Marshall Valuation cost report for the building referenced above. This letter is to confirm our understanding of the terms and objectives of our engagement with you and to clarify the nature and limitations of the service we will provide.

A narrative format Marshal Valuation cost analysis will be prepared for Hope Health Systems, Inc., (our client), the members of Advis Health Care Consulting, and the State of Maryland. The intended of the report is to assist with the cost reporting requirements of the State of Maryland as that relate to your proposed hospital. Use of this report by any other party for any other purpose is not intended by our firm.

I intend to make a site visit to the property during the week of October 12, 2020. The estimated completion date for this report is October 23, 2020. The delivery date can only be met if I receive from you, in a timely manner, any additional relevant information needed for the completion of this report. Examples of information needed include a description the existing building, engineering reports, and the contractors plans and quotes for all proposed work for the facility.

At completion of the assignment, you will receive an electronic (PDF) copy of the Marshal Valuation cost analysis. My fee for this assignment is $1,800. If needed, my hourly rate for deposition, court preparation and testimony related to this matter is $375 per hour. If you are in agreement with the terms of this letter, please return a copy of this signed letter to our firm with payment of $1,800 payable to Treffer Appraisal Group. After you return a copy of the signature page, I will contact you to make arrangements for inspecting the property.

We will do our best to provide quality service to you. We do not anticipate any difficulties in meeting the expectations recited on 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

1244 Ritchie Highway, Suite 10, Arnold, Maryland 21012 • Phone: 410 544 7744 • appraisals@trefferagroup.com

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

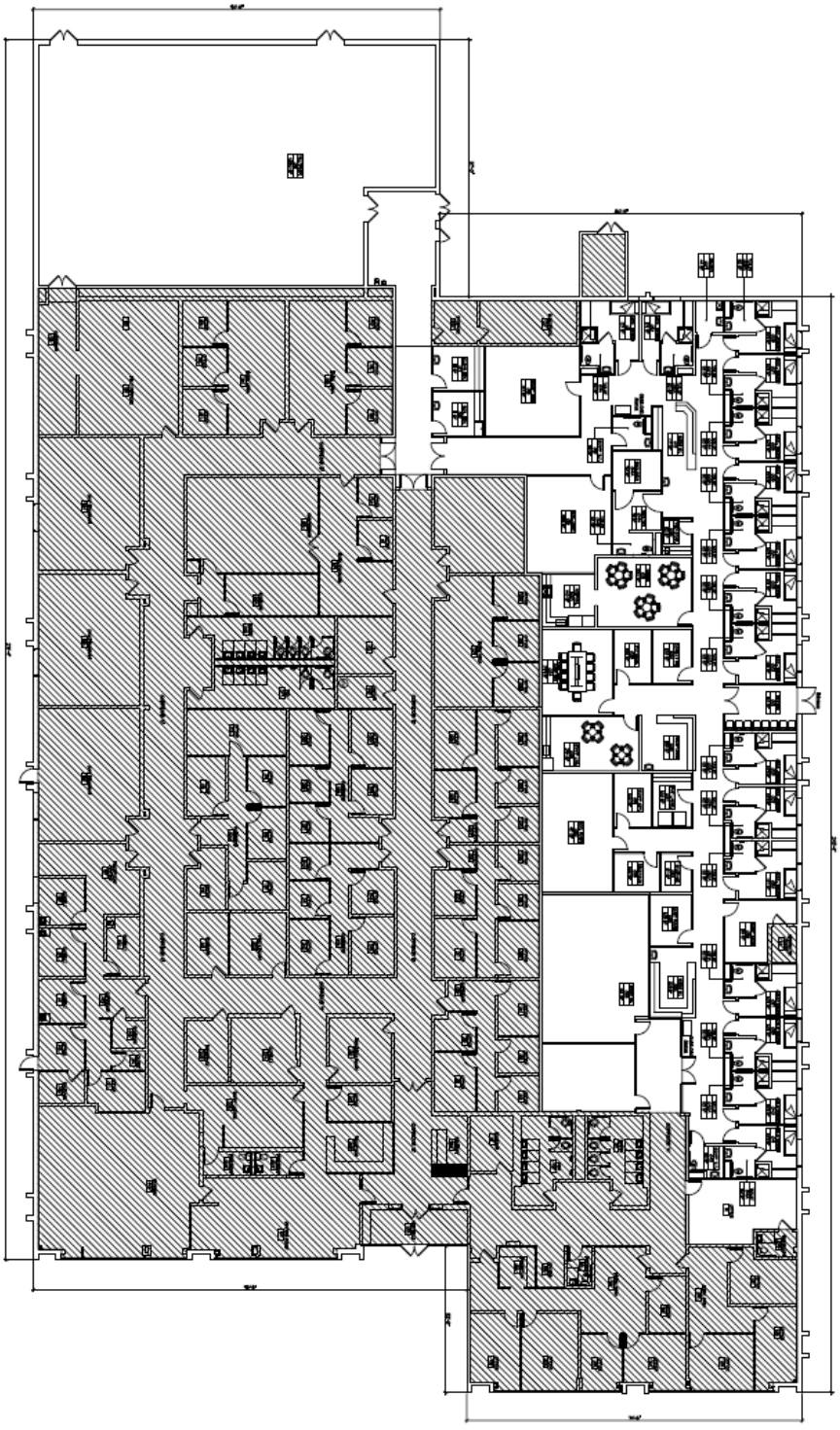
By Yinka Fadiora

Title CEO

10/7/20

Date

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 1061 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	0609	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 As of 01/01/2018	Phase-in Assessments As of 07/01/2020	As of 07/01/2021
Land:	738,000	738,000		
Improvements	5,732,800	5,732,800		
Total:	6,470,800	6,470,800	6,470,800	
Preferential Land:	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	07/01/2020	07/01/2021
County:	000	0.00	
State:	000	0.00	

Engineering Estimate

Hope Health Care - Psychiatric Facility - Prelim. Construction Budget

	Project Sq. ft. **10,134**		Cost PSF
General Conditions			
Supervision		$42,000.00	$4.14
Dumpsters		$7,500.00	$0.74
Floor prep/Demo		$53,175.00	$5.25
Final Cleaning		$3,293.75	$0.33
	Subtotal	**$105,968.75**	**$10.46**
Concrete			
Saw cut Concrete		$40,625.00	$4.01
New Window openings		$8,125.00	$0.80
Generator Pad/fencing		$6,250.00	$0.62
	Subtotal	**$55,000.00**	**$5.43**
Thermal Moist. Protect.			
Roofing		$15,562.50	$1.54
	Subtotal	**$15,562.50**	**$1.54**
Finishes			
Framing & Drywall		$101,250.00	$9.99
Top out exist wall for demising partition		$21,093.75	$2.08
Ceiling Grid and tile		$44,362.50	$4.38
Doors and Hardware		$78,375.00	$7.73
Door installation		$16,500.00	$1.63
Auto Openers at entrance vestibule		$15,250.00	$1.50
Windows		$75,000.00	$7.40
Millwork		$187,500.00	$18.50
Painting		$35,300.00	$3.48
Flooring- carpet		$4,000.00	$0.39
Seamless flooring		$156,250.00	$15.42
	Subtotal	**$734,881.25**	**$72.52**
Specialties			
Fire Extinguishers		$1,000.00	$0.10
Fire Extinguisher Cabinets		$1,250.00	$0.12
Corner Guards		$5,250.00	$0.52
Crash Rail		$8,000.00	$0.79
Window Treatments		$9,000.00	$0.89
Restroom Accessories		$12,000.00	$1.18
Blocking		$3,750.00	$0.37
	Subtotal	**$40,250.00**	**$3.97**

HVAC			
New HVAC and VAV's		$762,500.00	
	Subtotal	**$762,500.00**	**$75.24**
Plumbing			
Demo		$6,250.00	$0.62
Supply/install and suppply lines and fixtures		$85,625.00	$8.45
ADA shower stalls		$80,000.00	$7.89
	Subtotal	**$171,875.00**	**$16.96**
Sprinklers			
Spinklers (includes drawings)		$37,500.00	$3.70
	Subtotal	**$37,500.00**	**$3.70**
Electrical			
Demo exisitng electrical		$2,500.00	$0.25
Fire Alarm		$43,750.00	$4.32
200 KW Stand by Generator		$131,250.00	$12.95
General		$177,500.00	$17.52
	Subtotal	**$355,000.00**	**$35.03**
Overhead/Profit		$177,710.00	$17.54
	Total Construction Budget	**$2,418,747.50**	**$238.68**

This image is an exact copy of the Preliminary Cost Budget that was provided by the property representative. The Total Construction Budget of $2,418,747.50 does not agree with the detail table in used for analysis in this report. The differences relate to the HVAC line item which was removed from the project and the Sprinklers line item which is not included in the total of $2,418,747.50

Detail Cost Analysis

Cost Comparison Chart - Hope Health Facility

	Preliminary Construction Budget			Costs From Marshall Valuation				
	Line Item Cost	Cost Per Unit	Implied Units	Cost Per Unit	Project Size	Line Item Cost	Cost Surplus (Deficit)	Descriptions
General Conditions								
Supervision	$42,000.00	$4.14	10,145				$42,000.00	
Dumpsters	$7,500.00	$0.74	10,135				$7,500.00	General conditions are not separately disclosed in the
Floor Prep/ Demo	$53,175.00	$5.25	10,129	$5.00	10,134	$50,670.00	$2,505.00	Marshall Valuation guide. The allowance for items like
Final Cleaning	$3,293.75	$0.33	9,981				$3,293.75	Supervison, Dumpsters, Floor Prep, and Cleaning are
	$105,968.75	**$10.46**	**10,131**					included in the respective component rates.
Concrete								
Saw Cut Concrete	$40,625.00	$4.01	10,131	Inc w/ Windows			$40,625.00	The labor for cutting concrete and windo openings is not
New Window Openings	$8,125.00	$0.80	10,156	Inc w/ Windows			$8,125.00	separately disclosed in the Marshall guilde.
Generator Pad & Fencing	$6,250.00	$0.62	10,081	$2,240.00	Each	$2,240.00	$4,010.00	Rate per Marshall Guide
	$55,000.00	**$5.43**	**10,129**					
Thermal Moisture Protection								
Roofing	**$15,562.50**	**$1.54**	**10,106**	$1.57	10,134	$15,910.38	($347.88)	Rate per Marshall Guide
Finishes								
Framing and Drywall	$101,250.00	$9.99	10,135	$7.79	10,134	$78,943.86	$22,306.14	Rate per Marshall Guide
Top Out Existing Wall for Partition	$21,093.75	$2.08	10,141	Inc Below	10,134		$21,093.75	
Ceiling Grid and Tile	$44,362.50	$4.38	10,128	$11.83	10,134	$119,885.22	($75,522.72)	Rate per Marshall Guide
Doors and Hardware	$78,375.00	$7.73	10,139	Inc Below	10,134		$78,375.00	
Door Installation	$16,500.00	$1.63	10,123	Inc Below	10,134		$16,500.00	
Auto Openers at Entrance Vestibule	$15,250.00	$1.50	10,167	$11.40	10,134	$115,527.60	($100,277.60)	Rate per Marshall Guide
Windows	$75,000.00	$7.40	10,135	$20.00	10,134	$202,680.00	($127,680.00)	Rate per Marshall Guide
Millwork	$187,500.00	$18.50	10,135	$22.65	10,134	$229,535.10	($42,035.10)	Rate per Marshall Guide
Painting	$35,300.00	$3.48	10,144	$0.53	10,134	$5,371.02	$29,928.98	Rate per Marshall Guide
Flooring & Carpet	$4,000.00	$0.39	10,256	$4.38	10,134	$44,386.92	($40,386.92)	Rate per Marshall Guide
Seamless Flooring	$156,250.00	$15.42	10,133	$10.40	10,134	$105,393.60	$50,856.40	Rate per Marshall Guide
	$734,881.25	**$72.50**	**10,136**					
Specialties								
Fire Extinguishers	$1,000.00	$0.10	10,000	$200.00	Each		$1,000.00	The number of fire extinguishers is unknown
Fire Extinguisher Cabnets	$1,250.00	$0.12	10,417	$230.00	Each		$1,250.00	The number of fire extinguisher cabnets is unknown
Corner Guards	$5,250.00	$0.52	10,096		Each		$5,250.00	The number of corner guards is unknown
Crash Rail	$8,000.00	$0.79	10,127		Each		$8,000.00	The number of crash rails is unknown
Window Treatments	$9,000.00	$0.89	10,112		Each		$9,000.00	The extent of window treatments is unknown
Restroom Accessories	$12,000.00	$1.18	10,169		Each		$12,000.00	The extent of restrom accessories is unknown
Blocking	$3,750.00	$0.37	10,135		Each		$3,750.00	Unknown
	$40,250.00	**$3.97**	**10,139**					
Plumbing								
Demo	$6,250.00	$0.62	10,081					
Supply and Install Supply Lines and Fixtures	$85,625.00	$8.45	10,133					
ADA Shower Stalls	$80,000.00	$7.89	10,139					
	$171,875.00	**$16.96**	**10,134**	$16.63	10,134	$168,528.42	$3,346.58	Rate per Marshall Guide
Sprinklers								
Sprinklers	**$37,500.00**	**$3.70**	**10,135**	$3.82	10,134	$38,711.88	($1,211.88)	Rate per Marshall Guide
Electrical								
Demo Existing Electrical	$2,500.00	$0.25	10,000		10,134		$2,500.00	The extent of demolition is unknown
Fire Alarm	$43,750.00	$4.32	10,127		10,134	$6,200.00	$37,550.00	The number of fire alarms is unknown. Marshall lists $6,200 for the base system
200 KW Stand By Generator	$131,250.00	$12.95	10,135	$150,000.00	Each	$150,000.00	($18,750.00)	
General	$177,500.00	$17.52	10,131	$21.38	10,134	$216,664.92	($39,164.92)	Rate per Marshall Guide
	$355,000.00	**$35.04**	**10,131**					
Subtotal Before Overhead and Profit	**$1,516,037.50**	**$149.60**	**10,134**			$1,550,648.92	($34,611.42)	
Adjusted for Current Cost Multiplier @ 1.05%	**$0.00**					$1,628,181.37	($77,532.45)	
Baltimore Local Cost Multiplier @ 1.01%	**$0.00**					$1,644,463.18	($16,281.81)	
Overhead & Profit	**$177,710.00**	**$17.54**	**10,132**			$0.00	$177,710.00	Included in the Marshall Rates
Total Construction Budget	**$1,693,747.50**	**$167.14**	**10,134**			**$1,644,463.18**	**$49,284.32**	