Trickle Research

Every raging river, every great lake, every deep blue sea starts … with a trickle

Initiating Research Coverage

SelectisHealth

Selectis Health, Inc.

(OTC: GBCS)

Report Date: 02/23/22

12- 24 month Price Target: $19.00

Allocation: 4

Closing Stock Price at Initiation (Closing Px: 02/22/22): $7.00

Prepared By:
David L. Lavigne
Senior Analyst, Managing Partner
Trickle Research

Disclosure: Portions of this report are excerpted from Selectis Health's filings, website(s), presentations or other public collateral. We have attempted to identify those excerpts by *italicizing* them in the text**.**

Company Overview

Selectis Health. Inc. ("Selectis") owns Independent Living Facilities ("ILF"), Assisted Living Facilities ("ALF"), and Skilled Nursing Facilities ("SNF"). The Company currently operates 9 facilities located in Georgia, and Oklahoma.

Selectis (formerly Global Healthcare REIT, Inc.) was initially organized for the purpose of investing in real estate related to the long-term care industry. Intentionally, in 2019 the Company's focus began to shift from leasing long-term care facilities to third-party, independent operators towards an owner and operator model, where wholly-owned subsidiaries operate these facilities. The Company has a fire wall behind the real estate ownership and the operations ownership through separate subsidiaries. The Company largely completed that transition including the adoption of the tradename "Selectis Health, Inc." in early 2021.

The Company's existing facilities offer varying degrees of amenities/assistance to its residents based on each facility's designation. These variations include Independent Living Facilities**,** Assisted Living Facilities, Skilled Nursing Facilities and Continuing Care Retirement Communities (CCRCs). We will provide some color on the particulars of each.

Selectis presented at our recent (Fall 2021) conference, where we were reintroduced to the story. To edify, we have known the name for quite some time through some of its iterations (the healthcare REIT for instance). Further, we have also covered names in the space in the past so we are familiar with some of the nuances of the industry, and we submit, that familiarity embodies some of our enthusiasm here. More specifically, as noted above, over the past two years or so, management has been transitioning the focus of the Company from being an owner and lessor of skilled nursing related properties in a REIT format, to being an owner *and operator* of the same and/or same type of facilities. To be clear, those are two entirely different pursuits. That said, that transition is largely complete and the Company's business and related performance going forward will reflect that owner and operator status. Succinctly, the Company's improving performance through the transition is clearly identifiable but in our view, has largely gone unnoticed. For reasons we will cover in this report, we think Selectis is poised to continue delivering improving results that we think will point to higher valuations for the Company and the underlying shares. Further, as we will also try to delineate, we also think the Company's underlying (real estate) assets may represent a "hidden value" in the story, that we believe they will be able to leverage.

More broadly, we think the Company's opportunities may sit at the intersection of a couple of issues. First, the elephant in the room, Covid and its impact on the space in general and second, the growing gap between an aging population and the availability of associated care facilities. In short, we are not sure there is a good answer to where all that aging population is going to be cared for. We submit the first of those issues certainly creates challenges for operators like Selectis, however we also think the latter should create considerable opportunity as well. The following should shed some light on both.

Industry Overview

-Demand for Senior Care Facilities and Services

The "Senior Care" industry includes various types of facilities that differ in terms of the levels and types of services they provide their occupants. As we alluded to in the Company Overview these facilities include Independent Living Facilities ("ILF"), Assisted Living Facilities ("ALF"), and Skilled Nursing Facilities ("SNF"). Currently, Selectis operates (or is preparing to operate) facilities in each of these categories.

- ***Independent Living Facilities*** *accommodate Seniors who can provide for their own needs as related to the activities for daily living but are looking for senior communities that offer a variety of services such as on-site activities, off-site excursions, amenities such as a salon, fitness center, social venue, concierge service, and others.*

- ***Assisted Living Facilities*** *provide assistance with daily life tasks such as managing medications, dressing and bathing as well as services like housekeeping and dining so residents can spend more time pursuing their hobbies, enjoying fun social events and making new friends. Assisted living communities provide a safe environment where occupants can be assisted with the care they need when they need it to help maintain an independent lifestyle.*

- ***Skilled Nursing Facilities*** *offer short-term and long-term rehabilitation services, including physical, occupational and speech therapy. These disciplines deliver therapy services with the goal of achieving and maintaining the highest functional level of independence possible. Their therapists have extensive and diverse clinical expertise that covers a wide range of chronic and acute conditions with an emphasis on community re-entry.*

- ***Continuing Care Retirement Communities*** *(CCRCs). CCRCs are multi-level care facilities that combine residential accommodations with health services for older adults. The goal of a CCRC is to allow residents to receive the appropriate level of care across a continuum, from independent living to assisted living to skilled nursing care, as their health status changes and without having to move out of the retirement community. As these communities provide multiple levels of care in one location, they're considered the "one-stop shopping" of the retirement world and ensure occupants are cared for through the end of their life. This makes CCRCs a good choice for single adults and for couples who wish to remain near each other, or loved ones, should one become ill and require more care than the other.*

(To edify, while we have categorized these facility types, recognize that many facilities may provide varying levels of services to their occupants/patients. That is, many facilities may look more like combinations of these rather than one or the other).

Obviously, each of the facility types above apply to particular demographic portions of the elderly care industry again driven largely by the level of assistance each demographic requires. However, as category 4 above delineates, in combination, these facilities provide a progressive solution for seniors as their care requirements advance. As Grandview Research noted in a 2021 industry report, *"The concept of continual care retirement communities is gaining traction among seniors with high disposable income. These retirement communities are known to cater to people aged 50 years and above. The idea behind these communities is to prevent seniors from relocating when additional care is needed"*. We would add that holistic approach is something that Selectis has embraced, and in our view embodies *part of* their opportunity in the context of other industry trends. That said, here are some of the industry characteristics and trends that we think are particularly important to industry participants like Selectis.

-Payments and Reimbursements

Just as the industry includes a handful of facility/service types, the payment and/or reimbursement environment for those facilities and service vary as well and understanding the nuances of those is paramount to understanding the challenges and opportunities within that framework.

To put that into perspective, according to the Administration on Aging, *"you might need long-term care if you have a disability, chronic health condition or a cognitive impairment such as dementia. Women (because they on average live longer than men) are more likely than men to need nursing care, and they're more likely to need care for a longer period — 3.7 years versus 2.2 years".*

The median annual cost for long-term care can range from $17,900 for adult day-care services to $45,800 for assisted living to $91,300 for skilled nursing care, according to a report by the Bipartisan Policy Center. Because health insurance and Medicare don't cover long-term care, more than half of people who need this sort of care pay for it out of pocket or are on Medicaid. https://havenlife.com/blog/plan-for-long-term-care/.

Table 1. below provides an overview of some of those payment/reimbursement nuances.

Table 1.

Who Pays for Elderly Care Services/Facilities?

Facility Type	Individual Payers	Private LTC Insurance	Medicare	Medicaid
Independent Living Facilities ("ILF")	Yes	Depends on the policy but not generally	No	No
Assisted Living Facilities ("ALF")	Yes	Depends on the policy, but generally for some services	No	No
Skilled Nursing Facilities ("SNF")	Yes	Yes	Sometimes See **(1)** Below	Sometimes See **(2)** Below

(1). Medicare is a federal health insurance program that generally covers qualified people 65 years and older (as well as some younger people with disabilities). Medicare is paid for through payroll deductions, so in effect, it is a government administered pre-paid medical insurance program. As such, it was designed and is operated to provide medical care to its insured once they have moved into retirement age. In that regard, the types of care provided by Medicare are divided into categories, which in part determine the type/breadth of the coverage as well as associated deductibles and other variables. The major categories and function of the different parts of Medicare are as follows: (From Medicare.gov; What's Medicare? | Medicare)

- *Medicare Part A (Hospital Insurance). Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.*
- *Medicare Part B (Medical Insurance). Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.*
- *Medicare Part C is different from traditional Medicare in that private companies manage recipients' benefits and provider claims reimbursement. Part C is also referred to as "Medicare Advantage".*

- *Medicare Part D (prescription drug coverage). Helps cover the cost of prescription drugs (including many recommended shots or vaccines).*

As noted above, Medicare is designed to provide its insured with healthcare, and that includes "skilled nursing facilities" however, Medicare's coverage for SNF facilities is limited, and does not cover long term residency in these facilities. Rather, SNFs' roll in treating Medicare patients is generally limited to short term rehabilitation scenarios. More specifically: (from: https://www.kindredhealthcare.com/resources/blog-kindred-spirit/2018/09/13/your-guide-to-medicare-and-rehabilitation-services):

> *Medicare pays for the first 20 days at 100 percent. For the next 80 days, you must pay a daily co-payment. Medicare does not pay for rehabilitation services after 100 days. (Stays longer than 100 days are paid by the patient).*
>
> *For Medicare to cover your stay in a rehabilitation hospital, your doctor must determine that this care is medically necessary, and you meet the following conditions to ensure safe and effective treatment:*
>
> - *You need 24-hour access to a doctor, and see one at least every two to three days*
> - *You need 24-hour access to a Registered Nurse who has specialized training or experience in rehabilitation*
> - *Your condition requires intensive therapy, which generally means at least three hours of therapy per day (but you may still be able to get inpatient rehab if you are not yet healthy enough for this length of daily rehab)*
> - *You need a coordinated team of providers including, at minimum, a doctor, a rehabilitation nurse and one therapist*
> - *have been admitted to a hospital for at least 3 days before entering the nursing facility or have a medical condition that began during the stay*
> - *be admitted to a Medicare-certified facility within 30 days*

While Selectis has facilities across the landscape of the industry, most of their facilities fall into the SNF/ category, and as such, they provide services across the gambit of healthcare payors; Individual Consumers, Private Insurance Companies, Medicare and Medicaid. That said, because the Company's SNF's include a host of payor types, they also receive different rates/reimbursements depending on the status of their care recipient. That distinction is an integral part of the Company's business, and ultimately its success, in part because as we will expand upon further in this report, the Medicare reimbursement for rehabilitation service is significantly higher than a Medicaid reimbursement for a long term resident.

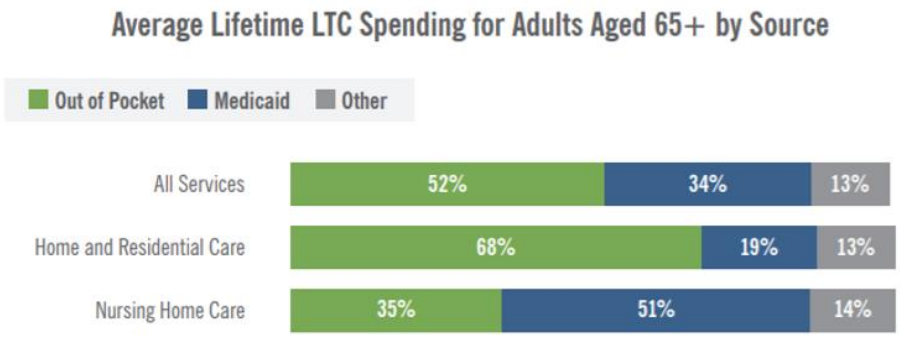
(2). Medicaid is much different than Medicare. Medicaid is in effect a welfare program and it is administered on the basis of financial need rather than age. As such, unlike Medicare, *Medicaid* does, within parameters, provide for the payment of long term care in nursing homes and/or other SNF related facilities.

With respect to nursing homes and/or SNF's, we have excerpted some narrative from another publication that provides a good overview https://www.investopedia.com/articles/personal-finance/072215/quick-guide-medicaid-and-nursing-home-rules.asp :

> *Medicaid was created in 1965 as a social healthcare program to help people with low incomes receive medical attention. Many seniors rely on Medicaid to pay for long-term nursing home care (although nursing homes are not required to accept Medicaid patients). Most people pay out of their own pockets for long-term care until they become eligible for Medicaid. Though Medicare is an entitlement program, Medicaid is a form of welfare—or at least that's how it began. So, to be eligible, you must become 'impoverished' under the program's guidelines.*
>
> *Income standards are usually based on the Federal Poverty Level. Each state has its own guidelines and eligibility requirements. For example, in New York state, there is an income limit of $1,482 monthly (in*

2021) for individuals, but in Mississippi, the limit is $1,047 for individuals and $1,394 for couples. Separate limits apply with regard to the amount of financial resources (such as bank accounts, cash, real property, etc.) someone can have to be Medicaid-eligible.

While Medicaid is a federal program, it is administered by each state individually through federal grants that help subsidize some of the states' costs. In terms of Medicaid payments for the care of people in nursing homes and/or SNF's, each state sets its own reimbursement schedule that delineates the daily rate they will pay for that care. As a result, that reimbursement rate varies from one state to the next, as well as one region to the next, but generally, we believe the daily average is somewhere in the ± $200 range. Specifically, in the case of Selectis we believe their Medicaid reimbursements range from $169 to $215. In terms of all payor types, Medicaid typically represent the lowest reimbursement rate of the group. Regardless, Medicaid pays for roughly 60% of all nursing home residents and over 50% of all LTC spending:



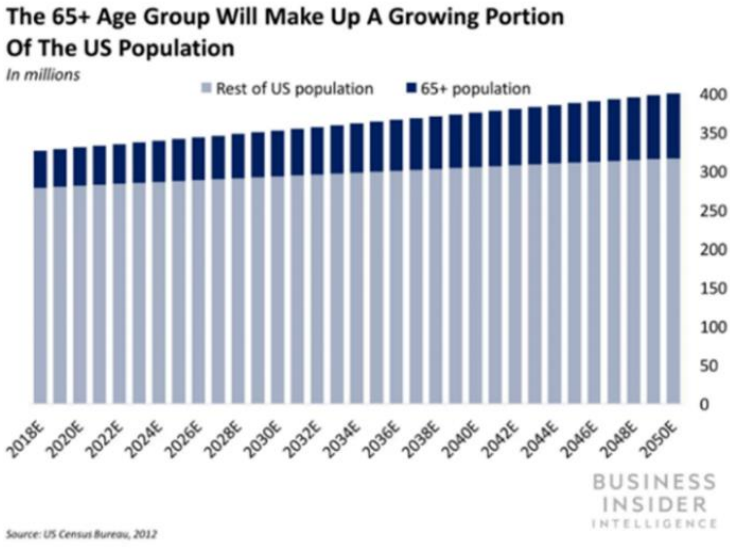
Source: Original data: Favreault, M. M., & Dey, J. 2015. Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief. Available at: https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief.

Graphical concept: Anne Tumlinson Innovations. 2016. The Case for Financing Older America's Long-Term Care Need. Available at: http://www.thescanfoundation.org/sites/default/files/financing_long-term_care_chartpack_092016_final.pptx.

https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/BPC-Health-Financing-Long-Term-Services-and-Supports.pdf

-Evolving Demographics and Demand for Services

Table 2.



While most people are likely already aware of this on some level, the U.S. population in the aggregate is getting older. Specifically, the last of the Baby Boomers will turn 65 by 2030, and that group will represent roughly 20 percent of the entire U.S. population. Further, as Jonathan Vespa, a demographer with the U.S. Census Bureau notes *"The aging of baby boomers means that within just a couple decades, older people are projected to outnumber children for the first time in U.S. history,"* . US Aging Population Problems & Healthcare Issues (businessinsider.com) . That, from some vantage points, is a sobering revelation going especially from the perspective of "who is to take care of all of them?". To put that notion into further perspective, the U.S. Department of Health and Human Services notes the following: https://acl.gov/ltc/basic-needs/how-much-care-will-you-need

- *Someone turning age 65 today has almost a 70% chance of needing some type of long-term care services and support in their remaining years*
- *Women need care longer (3.7 years) than men (2.2 years)*
- *One-third of today's 65 year-olds may never need long-term care support,* ***but 20 percent will need it for longer than 5 years***

The above is the raw and perhaps most often cited portions of the aging population metrics, and these are particularly topical to discussions of issues surrounding elderly care. The inference here is that the aging population is likely to create increasing demand pressure on elderly care service and facilities of all types, which by some measures are already in short supply. That said, while already ominous, there are some additional *numbers within the numbers* that we think are worth noting with respect to the coming growth in demand for elderly care facilities.

Inasmuch as we are arguing that the aging population will in turn likely drive future growth of assisted living facilities, the fact is that historically a significant portion of the elderly who require care receive that care from family members. According to a report from the National Center for Biotechnology Information (NCBI) *"more than 1 in 5 adults, a total of 53 million adult Americans, are now unpaid family caregivers*".

Table 3.

Percentage of family caregivers by generation

Generation (birth years)	2015	2020	change
Gen Z (1997 or later)	0%	**6%**	N/A
Millennials (1981-1996)	23%	**23%**	—
Gen X (1965-1980)	25%	**29%**	▲
Boomers (1946-1964)	34%	**39%**	▲
Silent/Greatest (1945 or earlier)	13%	**7%**	▼

Source: Caregiving in the U.S. 2020
*In general, members of Gen Z were not old enough to be caregivers in 2015

Study Shows 1 in 5 Americans Provide Unpaid Family Care (aarp.org)

As the table above reflects, family caregivers span the spectrum of major demographic groups, but it also reflects that the older demographic groups make up larger portions of the family caregiver universe…to a point. Obviously, as people age (the "Silent/Greatest" demographic group above), at some point they become less likely to be a family caregiver and ostensibly *more likely* to require a family caregiver. Thinking that through, while the aging of the boomers will most certainly create more people in need of elderly care, it will also likely lead to fewer family care givers, as those same caregiver Boomers become people who *require* elderly care of one form or another. The graphic below provides some additional information regarding the distribution of family caregivers:

Table 4.

Family Relationship	All Caregivers (percentage)	High-Need Caregivers (percentage)
Relationship to recipient		
Spouse	21.5	18.1
Daughter, daughter-in-law, stepdaughter	33.6	38.0
Son, son-in-law, stepson	21.2	21.8
Other	23.7	22.1
Marital status		
Married/partnered	66.6	66.1
Separated/divorced	11.6	12.0
Widowed	5.9	6.0
Never married	14.3	13.7
Lives with the care recipient		
Yes	43.8	42.2
Children younger than 18		
None	82.9	81.0
Any	15.7	17.1

NOTES: Includes family caregivers of Medicare beneficiaries age 65 and older in the continental United States who resided in community or residential care settings (other than nursing homes) and received help with self-care, mobility, or household activities for health or functioning reasons. "High-need" refers to caregivers of older adults who have probable dementia or need assistance with two or more self-care activities (bathing, dressing, eating, toileting, or getting in and out of bed). Percentages may not total 100 due to missing data.

SOURCES: Data from the 2011 NHATS and the companion NSOC.

As if the above dynamics are not sobering enough, we think there is yet another trend that will likely widen the gap between elderly care supply and demand but is perhaps not yet fully rationalized. The U.S. Census Bureau recently published a report that reflects some interesting facts regarding some important minutia of the aging population. Here are some topical excerpts from that report *https://www.census.gov/newsroom/press-releases/2021/childless-older-adult-population.html:*

> *AUG., 31, 2021 — A new, first-ever report of its kind released today by the U.S. Census Bureau shows 15.2 million, nearly 1 in 6 (16.5%), adults age 55 and older are childless, and the levels of childlessness among older adults are expected to increase. The report,* ***Childless Older Americans: 2018*** *uses data from the 2018 Survey of Income and Program Participation (SIPP) to examine the circumstances (socioeconomic status and demographic characteristics), potential caregiving and financial support from family and the community, and health and well-being of child-less older adults. The report also compares these characteristics to those of biological parents of the same age group.*
>
> *Highlights include:*
>
> - *Of all adults ages 55 to 64, 19.6% were childless, compared to 15.9% of those ages 65 to 74, and 10.9% of those 75 years and older.*
> - *Childless adults as a group were more educated than parents. About 38.4% have at least a bachelor's degree, compared to 30.0% of parents. At the lowest education level, 34.5% of childless adults have a high school degree or less, compared to 43.3% of parents. Additionally, a greater share of childless adults 55 years and older were in the labor force, 43.7% compared to 40.1% of parents.*
> - *Among childless adults ages 55 and older, 85.2% were White alone; 79.0% were non-Hispanic White; 9.2% were Black alone; 3.4% were Asian alone; 2.2% were all other races or reported multiple races; and 6.5% were Hispanic (of any race).*
> - *About 22.1 million adults 55 years and older live alone, among whom 6.1 million were childless. This means that 27.7% of older adults who lived alone were childless.*

- *Childlessness was more common among older men living alone than among older women; 34.3% of older men and 23.6% of older women living alone were childless.*
- *Living alone is more common among older adults who were childless than their counterparts who were parents. About 62.5% of parents 55 years and older lived with a spouse, compared to 40.2% of childless older adults.*
- *Poverty rates are higher among childless older adults than they are among older parents. About 12.4% of childless adults had family incomes below the poverty line. Among parents, a greater share of mothers had family incomes below the poverty line (10.5%) than fathers (7.5%).*

Again, we will unpack this a bit. Referring back to Table 4. above, which breaks down the relationships of family care givers to family care recipients., we highlighted two rows on the table, which reflect that collectively nearly 55% of family caregivers are the children (or spouses of the children) of the care recipients. Succinctly, as the Census Bureau report suggests, the number of childless aging adults is increasing and additional census bureau data suggest that will continue to do so. As a result, given that a large portion of in-home caregivers are actually family members, and apparently over 50% of those are children or the spouses of children, who is going to take care of the growing number childless elderly? It seems to us this group represents *another growing variable* that will expand the gap between the demand for and the supply of elderly care in the future.

From another perspective, as we noted above the elderly care industry is represented by different types of facilities that cater to people with different requirements and needs. In that regard, while some of these facility types generally address older people, that is not true in all cases. For instances, while SNF's and/or nursing home residents may be predominantly elderly, some are certainly people with disabilities that are congruent with the levels of care provided by particular facilities. In the case of Selectis, that designation is particularly topical. Specifically, while Selectis operates multiple facility types, it is largely focused on SNF and/or rehabilitation centers, that (as the names imply) address short term patients seeking recovery or rehabilitation services after which they will move to any number of otehr situations depending on their post rehabilitation status. That being the case, many of the Company's patients would be better categorized by their need for rehabilitation and associated therapy(s), rather than by age per se. That brings us to an additional emerging demographic that we think is particularly topical to Selectis and its facility mix.

According to the American Academy of Orthopaedic Surgeons:

> *"Total joint replacement (TJR) is one of the most commonly performed, elective surgical procedures in the United States, and the volume of primary and revision TJR procedures has risen continuously in recent decades. Total hip replacement (THR) and total knee replacement (TKR) are clinically and cost-effective procedures for end-stage arthritis, which causes patients ongoing pain, limited function and diminished life quality. According to the National Inpatient Sample, in 2014 there were 370,770 total hip replacements and 680,150 total knee replacements".*

A study presented at the 2018 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS) analyzed models to predict the future volume of TJA procedures in the U.S. https://aaos-annualmeeting-presskit.org/2018/research-news/sloan_tjr/

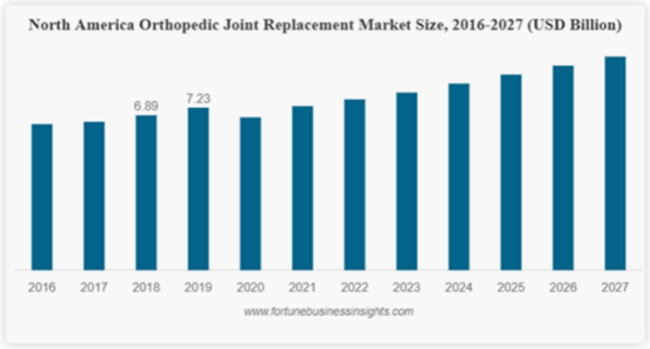
Some of the findings of that study are as follows:

- *By 2030, primary THR is projected to grow 171 percent and primary TKR is projected to grow by up to 189 percent, for a projected 635,000 and 1.28 million procedures, respectively.*
- *Similar gains are expected for revision THR and TKR, growing by 142 percent (72,000 procedures) and 190 percent (120,000 procedures), respectively.*
- *By 2060, primary THR is expected to reach 1.23 million (330 percent increase), primary TKR is expected to reach 2.60 million (382 percent increase), revision THR is expected to reach 110,000 (219 percent increase), and revision TKR is expected to reach 253,000 (400 percent increase).*

- *The mean age for primary total hips has declined significantly from 66.3 years to 64.9 and knees from 68 years to 65.9.*
- *Females continue to make up the majority of patients at 55-62%.*

According to Fortune Business Insights, "*the global orthopedic joint replacement market size was USD 20.00 billion in 2019 and is projected to reach USD 26.89 billion by 2027, exhibiting a CAGR of 7.6% during the forecast period*".

Table 5.

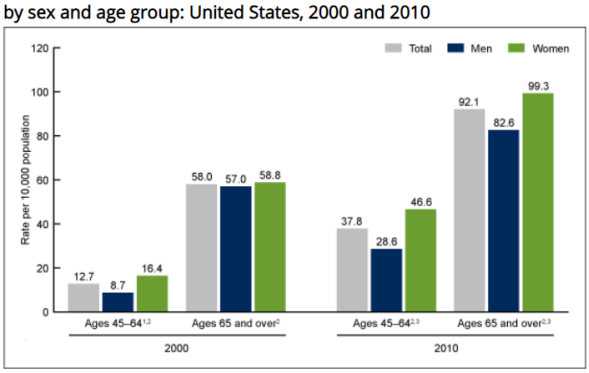


Orthopedic Joint Replacement Market Size & Growth Rate, 2027 (fortunebusinessinsights.com)

Our point here is that the aging population is not likely to be the only driver for the Company's services going forward. In fact, as we alluded to above, given that Selectis is currently more entrenched in the SNF rehabilitation market, the demand for rehabilitation services may be more important to their success than long term care demographics. To further support the notion, not only are procedures like hip and knee replacements expected to increase (both of which typically require rehabilitation services), but according to the CDC, the recipients of those procedure are getting increasingly younger, which we think will essentially increase the Company's "addressable market":

Table 6.

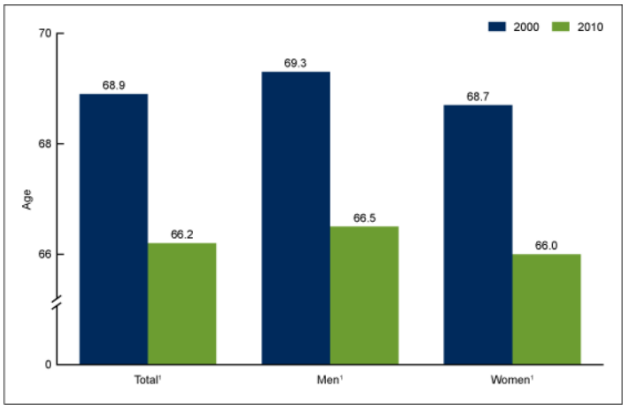
Figure 2. Total knee replacement among inpatients aged 45 and over, by sex and age group: United States, 2000 and 2010



[1]Significant difference in 2000 between men and women within age group ($p < 0.05$).
[2]Significant difference between 2000 and 2010 within sex and age group ($p < 0.05$).
[3]Significant difference in 2010 between men and women within age group ($p < 0.05$).
NOTES: Total knee replacement is defined as code 81.54 of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) for any of four collected procedures. Rates were calculated using U.S. Census Bureau 2000-based postcensal civilian population estimates.
SOURCE: CDC/NCHS, National Hospital Discharge Survey, 2000 and 2010.

Table 7.

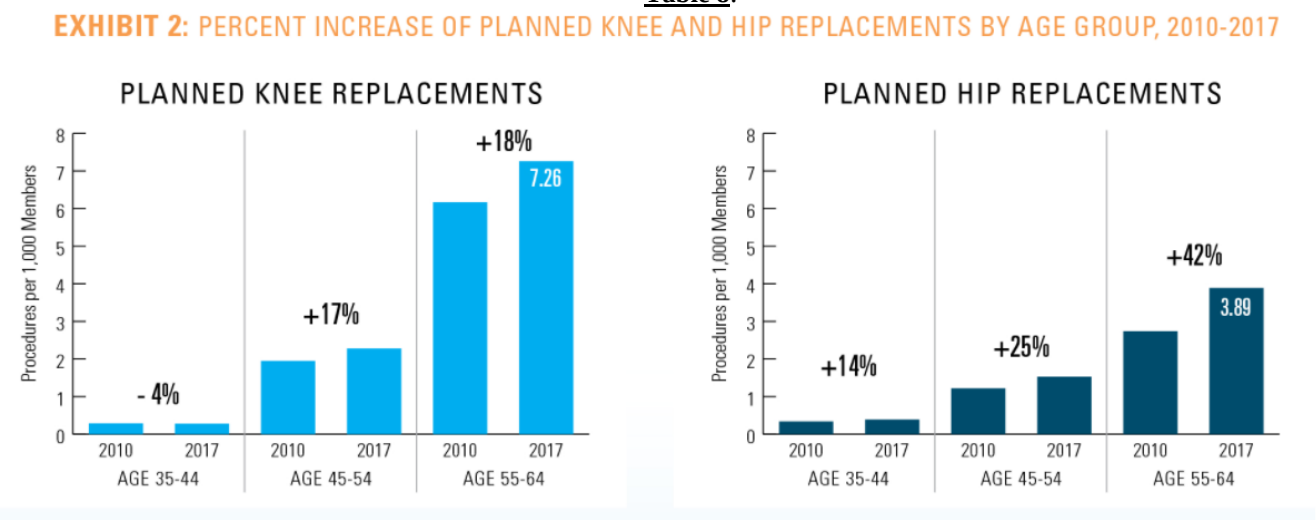
Figure 3. Mean age at total knee replacement among inpatients aged 45 and over, by sex: United States, 2000 and 2010



[1]Significant difference in mean age between 2000 and 2010 ($p < 0.05$).
NOTES: Total knee replacement is defined as code 81.54 of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM) for any of four collected procedures. Percentages are calculated only for inpatients aged 45 and over.
SOURCE: CDC/NCHS, National Hospital Discharge Survey, 2000 and 2010.

The tables below are provided as a chronological extension to Tables 6 and 7 above:

Table 8.



Planned knee and hip replacement surgeries are on the rise in the U.S. | Blue Cross Blue Shield (bcbs.com)

To be clear, while we have provided some data reflecting the potential growth of joint replacement surgeries to illustrate its impact on the Company's rehabilitation services, ostensibly we could have made similar assessments about the expected growth of other procedures that generally include the need for post procedure rehabilitation. We chose to highlight the orthopedic/joint replacement space because as we have illustrated, it appears to *include* an increasingly younger patient base, but the fact is many surgery categories are likely to grow (again) as a result of the aging population, which generally requires more surgery than younger demographic groups. The above noted, and as we will expand on later in this report, we think the Company's focus on the rehabilitation segment may prove optimal from an industry perspective.

-Supply of Senior Care Facilities and Services

To summarize the above, we think there is ample evidence to suggest that demand for senior care facilities and services is likely to continue to rise, and that dynamic is the result of a handful of converging demographic trends. That said, and perhaps to the contrary, there are elements of the *supply side* of the senior care industry that may make it difficult for the industry to keep pace with that growing demand.

First, some medical facilities are governed by rules that may seem a bit counterintuitive. Specifically, some hospitals (and SNFs for that matter), are governed by Certificate-of-Need laws (CONs). Certificate-of-Need laws regulate the addition of healthcare services and/or facilities, which includes additions to existing facilities. For instance, if a hospital wanted to add an oncology wing, or a city wanted to build a new hospital, they would have to apply to the state regulatory board and essentially plead their case as to why the community will benefit from the addition(s). That board then has the power to accept or deny the application. Ostensibly, CON laws give regulators the power to control the number of (new) medical facilities (including SNFs) that are allowed to operate in their respective jurisdictions.

As we noted, restricting the supply of medical facilities seems a bit counterintuitive to us, but they were developed around some rationale that at least at the time legislators apparently viewed as sound. The State Policy Network provides the following narrative regarding the history of CONs: Certificate-of-need laws: Why they exist and who they hurt | State Policy Network (spn.org)

> *In 1974, the federal government passed the National Health Planning and Resources Development Act. The legislation withheld funds from states who did not enact certificate-of-need programs. By the early*

1980s, every state except Louisiana had enacted a version of CON laws. These laws were originally put in place to control healthcare costs, increase healthcare quality, and improve access to care for low-income families.

But research shows CON laws have failed to achieve their stated goals and have actually done the opposite of what they were intended to do. The federal government noticed these laws weren't meeting their intended goals and repealed the CON mandate in 1986. Several states followed suit.

Picking up where the above leaves off, the National Conference of State Legislatures ("NCSL") notes:

In the past several years, many states have introduced or enacted legislation to modify their CON programs. Changes range from fully repealing an existing CON program to creating a new CON program. However, most state legislation makes targeted changes to CON oversight, such as excluding specific facilities from CON review.

Currently, 35 states and D.C. maintain some form of CON program. States with CON laws most often regulate hospitals, outpatient facilities and long-term care facilities.

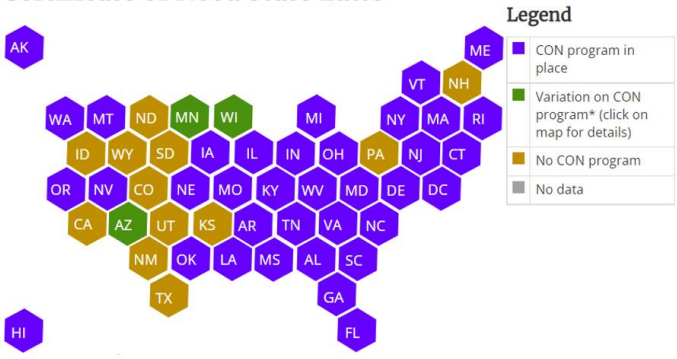
The NCSL provides the following map reflecting each states' current position on Certificate-of-Need laws. Recognize, each of the states Selectis currently operates in have applicable CON laws:

Table 8.

Interactive Map of State CON Laws

Currently, 35 states and Washington, D.C., operate a CON program with wide variation state to state. The following interactive 50-state map lists the health care facilities and proposed activities covered under the CON law for each state as of December 2021. It also includes enacted CON legislation for the past three legislative sessions (2019, 2020 and 2021) as well as whether a state has a moratorium on certain health care facilities or activities.

Certificate of Need State Laws



Certificate of Need (CON) State Laws (ncsl.org)

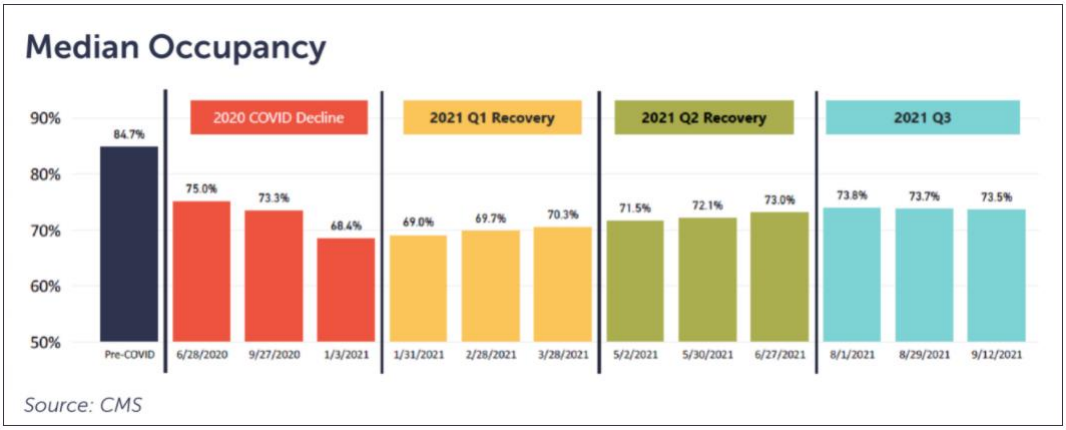
Succinctly, we think it is fair to suggest that existing CON laws create a barrier to entry for enterprises or other organizations attempting to enter regulated markets with new healthcare facilities. On the flipside, that same dynamic may boost the competitive posture and ostensibly the value of *existing* facilities. Obviously, if that logic is accurate, that would be favorable to the intrinsic value of Selectis' current footprint, especially since all of its current facilities exist in CON regulated states. On the other hand, as we will demonstrate later in this report, we believe the Company is poised to add to some of the existing facilities so they will need to address those additions through those same CON regulations. From a "big picture" lens, we think CON laws have likely curtailed the supply of new facilities and by extension will likely continue to do so in the future. To reiterate, we find that counterintuitive given what we have laid

out above in terms of the anticipated increases in demand for elderly care facilities in the coming years. Granted, CON laws have recently been suspended or otherwise set aside at least temporarily to deal with Covid19, so it is not inconceivable to us that changes/exemptions in CON laws may very well be made to accommodate rising elderly care demands in the future. However, as we sit today, we continue to view the existing CON landscape as a net benefit for existing players like Selectis.

Second, Covid19 has negatively impacted the industry. Clearly, this issue (the impact of Covid19 on the long term care side of the industry) includes many moving parts and associate complexities and as such would be more appropriately addressed by a business school study than by this document, but we will try to hit a few of the high (low) points.

The Centers for Disease Control and Prevention (CDC) reports that as of 2016, there were 1.7 million beds in 15,600 licensed nursing homes in the United States and (as of 2015) approximately 1.3 million occupants. More recent data from the Kaiser Foundation notes that "*as of 2019, there were 1,246,079 nursing facility residents in the US*". The reality is that like many industry statistics, exact numbers are hard to come by and specific studies are often few and far between (ala the above CDC statistics that are by now over 5 years old). That said, we do not know how many nursing home residents remain today but considering the high death toll Covid has exacted on nursing homes coupled with the reluctance of people to return or to be admitted given pandemic trajectories, we suspect those numbers are lower. That number is topical because lower occupancy rates mean greater financial challenges for operators, which may in turn lead to closures and fewer facilities. To that end, a recent report from CliftonLarsonAllen suggests that "*the median occupancy rate for nursing homes in the U.S. has fallen from 85% in January 2020, to 68% in January 2021*".

Table 8.



Initial Observations of SNF Trends Data Illustrates COVID-19 Challenges : 2021 : Articles : Resources : CLA (CliftonLarsonAllen) (claconnect.com)

In addition to occupancy issues, Covid has provided additional challenges for operators, many of which are well documented *on an ongoing basis*. Recall, at the start of the pandemic access to PPE was topical while more recently staffing shortages, vaccine protocols, retrospective operating scrutiny and several others continue to challenge operators. The question is perhaps, "how much more can operators take before they shut the doors"? Succinctly, when it is said and done, we think the pandemic will likely have caused a number of facility closures, which (all other things remaining unchanged) will put further pressure on the supply side of the industry.

-Access to Capital

Along with being driven largely by government reimbursements for covered services, the industry also has an additional symbiotic relationship with government agencies that is topical. Specifically, the U.S. Department of Housing and Urban Development ("HUD"), provides FHA mortgage insurance to finance the construction and/or

upgrade of healthcare facilities including nursing homes and SNF's. Access to that type of mortgage insurance is a considerable leg up in terms of accessing mortgage based capital. As we will delineate, Selectis has been able to take advantage of that access recently, and we suspect they may be able to do so in the future. Further, we believe the opportunity represents one of the *hidden values* in the story.

Below is some addition color from HUD regarding the program:

> *"The Office of Healthcare Programs (OHP) is located within the Department of Housing and Urban Development ("HUD") and administers FHA's healthcare programs, the Section 232 Mortgage Insurance for Residential Care Facilities program and the Section 242 Mortgage Insurance for Hospitals program. Both programs enable the affordable financing and refinancing of healthcare facility projects nationwide.*
>
> *FHA's healthcare programs are integral to HUD's community development mission. By reducing the cost of capital needed by hospitals and residential care facilities to finance the construction, renovation, acquisition, or refinancing of facilities, these programs improve access to quality healthcare and work to decrease overall healthcare costs. Since 1959, over 8,600 Section 232 mortgage insurance commitments have been issued in all 50 states".* Healthcare Facilities | HUD.gov / U.S. Department of Housing and Urban Development (HUD) .
>
> *"Section 232 loans help finance nursing homes, assisted living facilities, and board and care facilities. FHA mortgage insurance provides lenders with protection against losses as the result of borrowers defaulting on their mortgage loans. The lenders bear less risk because FHA will pay a claim to the lender in the event of a borrower's default. Loans must meet certain requirements established by FHA to qualify for insurance. Proposed projects are evaluated on the basis of whether the proposal is an acceptable insurance risk for the FHA Insurance Fund. It is not a competitive process. Section 232 may be used to finance the purchase, refinance, new construction, or substantial rehabilitation of a project. A combination of these uses is acceptable - e.g. refinance of a nursing home coupled with new construction of an assisted living facility".*
> https://www.hud.gov/federal_housing_administration/healthcare_facilities/residential_care/fha_insurance

-Industry Fragmentation

Lastly, while it has been some time since we have covered a name in the assisted living/ elderly care space, this particular bit of research has reminded us that over the years, some industry characteristics have remained largely unchanged. Among other things, one of those characteristics is the fragmented makeup of the industry's providers. According to the National Center for Assisted Living, Facts & Figures (ahcancal.org), 42% of the industry's facilities are independently-owned, meaning those owners operate just a single facility. Further, we believe a meaningful potion of the remaining 56% of "chain-affiliated" owners still operate only a handful of facilities. In our view, that posture provides some interesting nuances to the analysis, but ostensibly we think that posture provides acquisitive opportunities for successful and/or well capitalized operators.

Facilities & Services Overview

Currently, the Company has 12 properties in three states, and the facilities are predominantly Skilled Nursing Facilities. The table below reflects the current property roster and some particulars of each. We would add, we blocked the Southern Hills facilities which collectively represent the Company's first Continuing Care Retirement Community. Also, referring back to Table 8, Oklahoma and Georgia are both Certificate of Need states, so their supply of licensed beds are regulated by local authorities.

Table 9.

	Facility Type	Current # of Beds	Potential # of Beds	Avg. Medicaid Rates	Avg. Medicare Rates
OKLAHOMA					
Higher Call Nursing Center	SNF	44	86	$ 170.06	$ 430.00
Southern Hills Retirement Community	ILF	60	90	N/A	N/A
Southern Hills Assisted Living	ALF	-	24	N/A	N/A
Southern Hills Rehab Center	SNF	92	106	$ 185.33	$ 500.00
Park Place Healthcare & Rehab	SNF	106	106	$ 183.27	$ 420.00
Maple Healthcare (Fairland)	SNF	29	29	$ 174.92	$ 420.00
GEORGIA					
Glen Eagle Healthcare & Rehab	SNF	72	101	$ 212.45	$ 500.00
Warrenton Health & Rehab	SNF	95	110	$ 184.48	$ 500.00
Providence of Sparta Health & Rehab	SNF	62	71	$ 215.11	$ 500.00
Eastman Healthcare & Rehab	SNF	96	110	$ 168.90	$ 500.00
Archway Transitional (Leased)	SNF				
ARKANSAS					
Lonoke Health & Rehab (Leased)	SNF	106	141	N/A	N/A

-Reimbursements, Census, Occupancy

Again, Selectis predominantly operates SNFs. That being the case, the table above provides some notable information that we think provides the basis for some of the Company's opportunity. Reviewing the table, notice the reimbursement rates from Medicare are on average over 250% of the Medicaid reimbursement. Recall, Medicare, especially in the context of SNFs, is a temporary arrangement wherein patients can utilize specific applicable therapies provided by the SNF to address medical needs. For instance, a patient receiving a hip replacement may go from a hospital to a SNF for a period of time so they can rehabilitate and have access to services like physical therapy. In short, while the Medicare rate at a SNF is higher than the corresponding long term Medicaid reimbursement, it is also lower than the rate Medicare would pay to keep that same patient in a hospital. That being the case, the typical progression might be that the patient enters a hospital for a procedure where Medicare pays a high relative rate for post procedure hospital days. As a result, Medicare will work to get that patient out of the hospital setting to a lower reimbursement SNF but will in turn only cover 100 days at the SNF after which time the patient will need to be discharged from the SNF or seek long term arrangements with the SNF. In the case of the latter, the patient will either need to have some sort of private pay arrangements or will need to qualify for Medicaid. Whatever the case, Medicare will "pass the patient on" where a different payor will ultimately be responsible for a long term arrangement, ostensibly at a lesser rate.

Given the progression above, it should be clear that for SNF operators like Selectis, the calculus entails trying to balance the patient mix ("census") between higher paying short term Medicare patients, with long term lower paying Medicaid patients. It also entails decisions between focusing on attracting long term Medicaid patients versus long term private insurance patients. For instance, while again Medicaid typically provides the lowest reimbursement rates, it is generally more predictable than private insurance payors that may dispute specific charges and generally take longer to pay. Again, there are advantages and disadvantages associated with the different payors and finding the "optimal" mix is paramount to the success of SNF operators.

In addition to standard reimbursement rates, different SNF's offer different services and as such, they may also collect additional fees for administering those services. For example, in Table 9 above, while Selectis may collect $500 for a particular Medicare patient, they may collect additional amounts as that patient receives applicable therapies. To reiterate, the disparity in the reimbursements creates challenges for operators in terms attracting an optimal mix of occupants, and that "optimal mix" is a function of several variables that operators need to assemble. Those variables often include issues like working with a limited number of licensed beds, deciding which specific healthcare services they can provide (which is always a function of being able to staff the right skilled personnel to deliver them), developing and maintaining facilities and personnel that attract both short term and long term occupants, maintaining

appropriate industry ratings that will also help attract occupants, and a host of others elements that run the gambit from finance, marketing, quality of care, safety and many others. In short, it is a challenging business. We will address the Company's occupant mix in the Operating Overview below.

-**Expanding Capacity**

Recall, in the Industry Overview above, we discussed Certificate-of-Need laws and their implications in terms of controlling (specific to Selectis) the supply of nursing home beds in a particular state or county within a state. Given that, both Oklahoma and Georgia are CON states and as such their bed counts are limited by those applicable laws. That said, notice from Table 9, one of the value drivers in the Selectis story is the fact that they have approximately 175 additional potential beds or about 27% additional capacity of CON approved beds that they can utilize if/when they choose to do so. As we will also discuss in the Operating Overview below, that additional capacity would likely entail considerable operating leverage that we think would drive marked incremental margin. Frankly, that "inventory" of licensed capacity is part of our enthusiasm for the story. To be clear, while we do not expect this to be the path they choose, we think they could potentially *today*, lease these extra beds to other applicable facilities and drop those payments to the bottom line. Again, the extra licensed capacity is a value element to the story that we do not believe is being accounted for in the current valuation of Selectis shares. We will defend that view further in the Summary and Valuation section of this report.

-Refinances and Upgrades

On September 28, 2021, Selectis made an announcement that was topical on the face, but also has suggests what we think is some added hidden value in the story. The announcements address a refinance of one of the facilities, and just to edify, the refinance was done under the HUD section 232 program we covered in the Industry Overview above.

> *GREENWOOD VILLAGE, Colorado, Sept. 28, 2021 (GLOBE NEWSWIRE) -- Selectis Health, Inc. (the "Company" or "Selectis"), (OTC: GBCSD) announced today that it successfully refinanced the mortgage on the Southern Hills Continuing Care Retirement Community ("CCRC") after completing several renovations and hiring a new Executive Director.*
>
> *"We couldn't be more pleased with these outcomes at our Tulsa Campus," stated Lance Baller, CEO and Chair of Selectis Health. "This has been a challenging process due to the weather damage and the deep freeze from the Winter, and other COVID roadblocks that we encountered. This could not have been done without the extra effort from our exceptional team. We are very proud of the effort that everyone gave to push this over the finish-line. The $8,029,800 refinance is exceptionally important to our business model and to ensure our Southern Hills campus remains profitable, and functional for the residents of the communities this facility serves. The terms are 2.38% fixed for 420 months is extremely favorable and will provide us the type of consistency and certainty for this campus, our cash flows, and our operations for 35 years. At closing, Selectis paid-off the remaining loan balances at the Tulsa Campus for the Assisted Living Facility ("ALF") and the Independent Living Facility ("ILF") and therefore owns both free and clear of all loans encumbrances that have remained on the facilities since our initial purchase. Today is a major milestone for the Campus, and for Selectis."*
>
> *Selectis Leadership hired the new Executive Director of the Southern Hills SNF in August. He has overseen the completion of the renovations and hiring of additional and improved staff.*
>
> *"Not only have we hired on an exemplary new Executive Director, but we have also finished the renovations in the Skilled Nursing Facility, which include updated porcelain flooring that should last for many years, work to the fire suppression system, remediating the damage caused by the weather events in late-February, new painting of the interior, concrete repair around the exterior, and have been continuously implementing various improvements to the ILF as we grow our census. In fact, our ILF*

now houses 22 residents and counting, thanks to our new leaders and their focus on increasing the number of residents and delivering quality care across our entire campus."

"The Company is continuing to work on our next refinance of our Eastman facility. We expect to have this refinance closed in the coming months. This will afford us the same type of consistency that our Southern Hills campus just realized. We are working through the process with our current and future lenders, and expect more positive news coming, about this refinance, soon," said Randy Barker, President and COO of Selectis.

As we suggested in the Industry Overview above, we view the industry's access to government sponsored programs like Section 232 as a positive construct for operators in the industry that also own their facilities. As most who follow the microcap space can attest, one of the more topical risks in assessing small companies is their access to capital and by extension the often onerous cost of that capital. In that regard, Section 232 is a clear advantage. We would submit that there are not many microcap companies that can borrow $ 8 million at a 2.38% rate for 35 years. Granted, one needs to own a facility to do that in the first place, but regardless, the ability to access low cost capital in a non-dilutive format is not a typical path for most small companies. Moreover, as the release above alludes, the Company is currently working on an additional refinance at their Eastman (Georgia) facility, and we believe the Company has at least two additional properties that may be conducive to refinance as well. To revisit the notion, that (potential) refinance capital could for instance (but not necessarily), be used to upgrade facilities to deploy the excess licensed capacity we noted above. Again, while we could be wrong, we do not think many public companies with sub-$25 million market caps have the option to add 25% to their capacity by adding non-dilutive capital at 3% rates for 35 year terms. That said, the announcement above also includes another reference that we think is worth addressing in terms of the Company's facilities and associated services.

Aside from the refinance narrative, we would highlight the following line from the release above: "*Selectis Leadership hired the new Executive Director of the Southern Hills SNF in August. He has overseen the completion of the renovations and hiring of additional and improved staff"*. Anyone who has listened to one of Selectis management's presentations and/or has had the opportunity to discuss the Company with them directly will likely recognize that management is quite committed to the idea that there are particular things they can control in terms of making their facilities more attractive to potential occupants. For instance, upgrading the aesthetics and function of physical facilities as well as increasing the breadth of professional therapies they offer are obvious examples. However, management is also acutely focused on the importance of attracting high quality directors/administrators to run the individual facilities.

Aside from managing the day-to-day operations of the facility, successful Directors tend to be entrenched in the medical communities in the areas they serve. Keep in mind, having relationships with facilities that can ultimately help refer short term Medicare patients to the facilities is paramount to the success of the Medicare census of each facility. That notion applies to attracting long term occupants as well (some of whom become long term patients following their short term Medicare stays). In addition, as staffing continues to rank high on the industry's list of challenges, the ability of Directors to source and maintain high quality professional and non-professional staff is becoming an increasingly paramount element to the success of operators. As a result, Selectis has focused resources on that end, which includes the development of internal processes to identify, mentor and retain effective Director candidates in order to optimize the performance of each facility.

Projected Operating Model

In terms of our analysis around these variables, we have modeled occupant mixes for Selectis that we believe are congruent with their historic numbers. First, in terms of the Company's SNFs, we think they generally prefer to focus the census on Medicare and Medicaid patients/occupants. We think that approach stems from some of our prior

narrative regarding the collectability (albeit at lower rates) of government payor billings versus private payor alternatives. As a result, we have limited our model assumptions to those two payor groups. The exception to that would be their Southern Hills ILF, which involves individual private payors. That will likely apply to the Southern Hills ALF as well.

As we suggested, managing the mix of the census between (in the case of Selectis) Medicare and Medicaid occupants encompasses a good part of the challenge. More specifically, finding the mix between high reimbursement but short term Medicare patients versus longer term but low reimbursement Medicaid occupants is much of the challenge.

In a perfect world, we assume the Company would like to see the Medicare census represent a measurable portion of the total census with the balance being Medicaid. However, from a practical standpoint, keeping beds consistently filled with Medicare patients is difficult and probably not likely. As a result, we are modeling a Medicare to Medicaid mix of 15% to 85% respectively. While we think they could do better than that, we will stick with that until we get some visibility to the contrary.

Beyond the census mix, the greater goal is to approach full utilization of the available census, perhaps even regardless of mix. Again, as we understand it, we believe the Company exited 2021 with total SNF occupancy of about 64%. (This number does not include the census for the Southern Hills ILF, which we believe exited the year at occupancy of about 43%). As we discussed in the Industry Overview above, SNF's across the nation have seen marked census declines as a result of Covid, and while those numbers improved through calendar 2021, they remain well under pre-covid numbers. Selectis' occupancy rates have not escaped that compression, and at first glance their 64% overall occupancy rate exiting 2021 is probably below the current national average, however, that requires some color because it also embodies part of the catalyst we believe is building in the stock.

To edify, if our math is correct, the Company currently has 3 SNFs that ended 2021 with 90%+ occupancy rates. Conversely, the remaining 5 ended the year operating at occupancy rates ranging from just under 10% to just over 73%. Further, one of the facilities, Southern Hills Assisted Living, is in the process of opening but has not contributed as of yet. More specifically, the Company only recently took control of two of these properties, Warrenton Health & Rehab and Providence of Sparta Health & Rehab. The abbreviated version of their acquisition of these facilities is that the Company technically took over the properties from the failing operators in mid-2021 but only began operating them in earnest in December 2021. These facilities ("Warrenton" and "Providence" ended 2021 with occupancy rates of 54% and 72% respectively. We believe (and we are modeling) these facilities to ultimately approach the 85% to 90% occupancy rates that are more congruent with the normalized performance of their more mature facilities. We do not see that as a big leap of faith, but that added contribution would provide marked operating leverage to the business.

In addition to Warrenton and Providence, the other current "outlier" in terms of facility performance is Park Place. Recognize, the Company completed the refurbishment and *recertification* of Park Place in late 3Q-F21/early 4Q-F21. As result, the facility made no measurable contribution to Q3F21 and we are modeling just a modest contribution for 4Q-F21. That said, this is a newly refurbished 106 bed facility, and we think it will provide a basis for marked sequential growth if they are successful growing the census as we believe they will.

To summarize some of the above, for Q3F21 the Company reflected Operating Income of $737,000 ($.26 per share) and associated EBITDA of nearly $1.2 million ($.42 per share). However, as we just delineated, that number was generated with 3 facilities that in our view are largely in the midst of internally generated growth/momentum (as opposed to growth associated with the waning of the pandemic). By extension, we are projecting sequentially improving census success from these facilities, as well as the startup of Southern Hills Assisted Living. We also see continued census improvement from Southern Hills Retirement Community (ILF). In short, if our projections are reasonably accurate, the Company ended 2021 with something around 420 beds filled, but an additional 239 available. That represents an opportunity for 50%+ growth by filling existing beds. Further, as we addressed above, they also have an additional 175 licensed beds that they could add through facility reconfiguration and/or buildout, providing what we view as the next (organic) growth leg to the story.

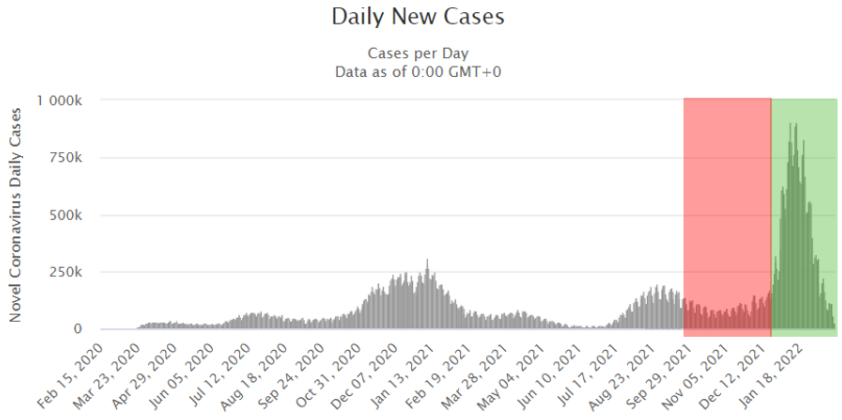
On the expense side, it is important to recognize that there is considerable operating leverage in the business. That is, owning and operating the facilities entails considerable fixed costs associated with the buildings, taxes etc. As a result, incremental revenues (read: occupancy) drive earnings momentum as fixed costs are spread out over more occupied beds. In the case of Selectis, we think that leverage may prove particularly pronounced because some of the (emerging) facilities we addressed above have to this point represented cash drains on the enterprise but will begin making measurable contributions. While we submit, we may have to make some adjustments to the model since we are anticipating occupancy and revenues to accelerate beyond anything we can historically back test. That is another way of saying the resulting operating leverage may be less robust than we are anticipating. On the other hand, we think we have applied appropriate discounts to our target assumptions to account for some of that variability.

Lastly, as we established above, we think Selectis' path to higher valuations is relatively simple, that is, they need to fill beds they already have licensed. While some of that extra capacity is the result of Covid's impact on the industry, some of it is also related to newly established capacity that they are just now in the throes of marketing. Obviously, our enthusiasm centers on the view that we believe they will indeed improve aggregate census and in turn drive improving top and bottom line results. That said, we submit, the next few quarterly results could include some volatility that would likely in turn cause our projections to miss actual results, perhaps even measurably. For instance, as the chart below reflects, for much of 4Q-F21 (the pink highlighted box in Table 10 below), U.S Covid cases were declining, which we think likely enhanced occupancy nationwide. Notice, our model reflects considerable revenue improvement for Q4-F21 over Q3-F21, even though for Q3, Selectis reported markedly improved sequential results. Succinctly, we are projecting that waning Covid cases through the quarter may have helped bump census, however, our projections therein are also related to the assumed ramp of new facilities we covered above.

On the other hand, as we exited 4Q-F21 and entered 1Q-F22 (the green highlighted box in Table 10 below), Omicron was gathering steam and reported cases exploded through what looks like will be the first half of 1Q-F22. To be clear, that development unfolded subsequent to our *initial* modeling, and our guess is that it may have once again negatively impacted census on multiple levels. Under that theory, we are a bit guarded about our projections for Q1-F22 and Q2-F22, but we are constructive on the aggregate path forward. We would add, while we are expecting 4Q-F21 to reflect strong revenue growth both YoY *and* sequentially, we fully expect to miss the bottom line. Specifically, these are Q4 *audited* results (which generally include a host of adjustments to prior quarter *unaudited* results in any case) and given the various new pieces/changes to the Company in fiscal 2021, there will likely be some measurable extraordinary adjustments that we have not attempted to model. However, we suspect adjustments of that nature will predominantly be non-cash charges.

Table 10.

Daily New Cases in the United States



https://www.worldometers.info/coronavirus/country/us/

Risks and Caveats

Today, any discussion regarding the risks of operating an assisted living or other long term care facility should probably begin with Covid19. Clearly, the pandemic has taken a marked toll on most facilities and that toll includes multiple elements. Of course, the most tragic of those elements is the suffering and loss of life associated with facility occupants and staff. To put that into perspective, the CDC recently reported that as of January 30, 2022 *"Long Term Care Facilities make up at least 23% of all COVID-19 deaths in the U.S. This share has decreased since the start of the pandemic, when LTCF deaths were nearly half of all deaths nationally".* Again, there are likely multiple implications for the industry that will stem from covid, and most of them are bad. Here are a few to consider.

As we also illustrated above, Covid19 has negatively impacted occupancy rates throughout the industry. Unfortunately, some of that is the result of occupants passing, but certainly other factors include facilities not accepting new enrollees with the pandemic still raging, facilities not accepting new enrollees due to short staffing, potential new enrollees being apprehensive about entering facilities dealing with all or parts of the aforementioned factors and a host of others. All those things considered, the reality for the industry might very well be that the "new normal" is lower overall occupancy rates, which would be decidedly negative for operators. We would add, while we would like to believe the industry has seen the worst of Covid, the fact remains that mutating variants and resulting new surges have continued to impair visibility and provide ongoing volatility. That could continue to impact results into the foreseeable future.

We submit, getting back to pre-pandemic occupancy rates will be the goal and the challenge for operators, no one knows for sure just how long that may take, and that lack of visibility will remain a topical risk until it improves. That said, we would offer a constructive observation in that regard. Regardless of the stigma Covid may have left on the industry, it does not change the aging demographic wave we noted above. We think it is probably fair to say, most people do not enter LTC facilities because they want to, but rather because they do not have an abundance of better options. We are not sure Covid has changed that.

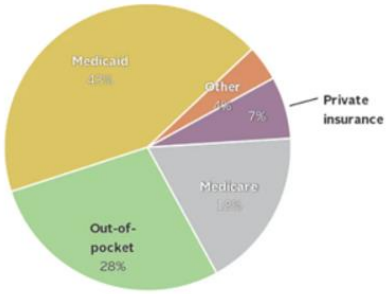
Aside from occupancy, Covid has also raised some issues in the industry that we believe will result in changes. For instance, we think it is likely that the pandemic will result in new protocols and other safety related regulations that could add to the operating costs of facilities. We are not opining that those changes/regulations will be good/bad or necessary/unnecessary, but we do think they will almost certainly be more expensive. To that point, as we addressed above, many of our nation's elderly are cared for through in-home settings as opposed to facilities like SNFs or nursing homes. The care givers of those individuals are most often other family members, but also include private enterprises that provide such services as well as other community outreach programs and others. Certainly, that in-home approach is driven in part by people's preference to live in their own homes (and to be cared for by relatives), but also by cost. In our view, payors (especially as the population ages and more aggregate care is required) will have to continue to search for ways to provide good care but at the same time reign in costs, and that may include more in-home type options as opposed to more facility based care. We would add, as we touched on previously, the distinction between facility types (is it a SNF or is it a "nursing home?") as well as among patients, ("what kind of care do they require and who will be paying for it?") provides more complexity to the industry than we have delineated here. That *definition* may impact how and by whom providers are reimbursed in the future, which would in turn impact facilities like the SNFs operated by Selectis.

As with many industries right now, the elderly care business, and perhaps most acutely, the SNF and/or nursing home sector(s) are struggling with staffing. We submit, a discussion regarding the genesis and continuation of domestic personnel shortages is beyond the scope of this publication, and if we are honest about it, while we like to think we have a good grasp of microeconomic issues, we are not sure we have a totally cogent explanation of the shortages anyway. Regardless, the personnel problems in the industry are real and we do not believe there is good visibility with respect to when they might improve. Here again, we are comfortable suggesting that staffing wages will likely provide additional pressure on the expenses of operators.

Again, the majority of industry care is paid for via government reimbursements either in terms of Medicare for short term patients or Medicaid for long term occupants. Generally speaking, the good thing about government based reimbursements is that they pay what they agree to pay, but the bad thing about government based reimbursements is that they pay less (than private payors). As we described above, the reimbursements for Medicare patients in SNFs is considerably higher than the reimbursements for Medicaid occupants in the same facilities. From that vantage point, while we think most operators that provide services to each would suggest that Medicare reimbursements for short term occupants are generally reasonable, the Medicaid reimbursements for long term occupants do not cover the cost. Obviously, some operators are better than others so that is a broad statement that is likely true in some instances but false in others. The fact is, as we understand it, most facilities could likely perform reasonably well under existing Medicaid reimbursements if their facilities remained consistently at 80%+ occupancy rates. That is a difficult task. Given that the average LTCF occupant is in the facility for something around 2 years, maintaining consistent occupancy is a challenge. That leads us to the risks we see around Medicaid reimbursements.

Table 11.

Who pays for long-term care in the United States



Source: Commonwealth Fund,

https://www.vox.com/2014/12/14/7390315/long-term-care-medicaid

As we see it, there are two opposing realities that continue to rage around Medicaid reimbursements. Succinctly, as Table 11 illustrates, Medicaid bears an outsized responsibility for LTCF payments. By extension, many operators and other industry advocates suggest that metrics like quality of care, facility safety and other associated elements are directly related to the reimbursements provide by Medicaid. That is, they argue that generally, low Medicaid reimbursements contribute to poor LTCF care, a notion that has perhaps been illuminated by the pandemic. On the other hand, according to the Centers for Medicare & Medicaid Services, *"Medicaid spending grew 9.2% to $671.2 billion in 2020, or 16 percent of total National Health Expenditures ("NHE")*. To edify, the other side of the Medicaid reimbursement coin is that the federal and states governments that collectively pay the Medicaid reimbursements are all trying to figure out how to reign in growing healthcare costs, so *raising* Medicaid reimbursements is fiscally problematic. We do not pretend to know where reimbursements are headed, but they remain topical to operators and Selectis is certainly no exception. In that regard, their levels have always been and we suspect will continue to represent a cogent risk for operators.

The Industry Overview above included an additional element that we think could provide headwinds to the industry as it sits today. As we noted, 35 states (including Oklahoma and Georgia) are Certificate of Need states. In our view, (and we think Selectis management would agree with this assessment), Certificate of Need Laws generally provide value to the certified/licensed beds of incumbent players. That said, while CON laws were originated at the federal level but were later repealed, many individual states continued to uphold local CON laws, and that continues today. However, Covid19 has created new scrutiny of CON laws because some believe that these laws contributed to the overwhelming of hospital capacity as the pandemic peaked through multiple tranches. U.S. News recently included an article to that end, (https://www.usnews.com/news/best-states/articles/2021-07-09/on-the-heels-of-the-pandemic-states-should-get-rid-of-certificate-of-need-laws.), in which they noted that several states are currently considering changes to those laws. In fact, during the pandemic, we believe some facilities were granted temporary exemptions from CON laws to add temporary Covid wings and/or covert portions of facilities to Covid wards etc. In many instances, those changes were the types of events that would have ordinarily required CON application and acceptance by applicable local authorities. Inasmuch as CON laws may be viewed as advantageous for incumbent players in current CON states, then the repeal of CON laws in those same states should in contrast be viewed negatively. We do not know how to handicap the likelihood of a repeal of CON laws (specifically in Oklahoma and Georgia) but we do believe that the likelihood of that possibility is higher post-

covid than it was pre-covid, and we also believe we will see more (rather than less) discussion to that end as the pandemic is assessed going forward.

Recall, the Company recently transitioned its business from a healthcare facility Real Estates Investment Trust ("REIT") to a healthcare facility operator. Whereas in its REIT format, the Company had 5 employees, that number today is *closer to 550 employees*. However, those original 5 employees remain with the Company today and they have been responsible for the development of and the transition to the new business plan that we believe will prove prescient. We think it is reasonable to assume that the handful of original employees (and specifically Chairman and CEO Lance Baller, and President and COO Randy Barker) have been and continue to be integral to the direction and success of the Company. Consequently, their departure(s) for any reason, could be markedly negative for the share price and/or the Company in general.

Our operating projections reflect the Company transitioning to consistent and sequential cash flow and earnings growth. In that event, we would not expect to see the Company engage in equity financings to support working capital. (That by the way, does not mean that they would not entertain equity financings for the purpose of acquisitions and/or capacity expansion in existing facilities). If we are wrong about the timing and/or the breadth of that profitability, then it is certainly conceivable that they may need to sell additional dilutive equity capital to continue operating the business. On the other hand, as we alluded to above, in Q3-F21 the Company completed a facility refinance that provided them with non-dilutive capital and our sense is that they have other facilities they may be able refinance to provide them with additional non-dilutive capital. To be clear, we view that lever as one of our "hidden value" portions of the story, however, that assessment could prove wrong for any number of reasons, which could provide headwinds for our target assumptions.

While this may go without saying, for the reasons we addressed above, we think Selectis is aligned to begin posting sequentially improving results and we think those results will imply better valuations. While we have laid out a number of risks that could impeded that success of those results, perhaps the most germane (and most straightforward) risk is that they simply fail to raise their census/ occupancy as we have modeled. Succinctly, if they underperform in that regard, our target assumptions may prove aggressive.

Selectis trades in the OTC market and as such its shares are generally illiquid and subject to volatility that we would suggest may or may not be congruent with the fundamental characteristics of the Company. While our sense is that the Company will probably be able to up-list the shares in the foreseeable future, that up-listing may or may not improve the liquidity of the shares and or the related volatility.

These are just some of the more visible risks associated with Selectis and its shares. There are likely others we have overlooked or are as of yet unforeseen.

Summary and Conclusion

We submit, initiating coverage of a LTCF/SNF operator in the face of a worldwide pandemic that has been particularly devastating to the elderly with co-morbidities, especially those residing in LTCFs, SNFs and/or nursing homes is about as contrarian as it gets. We are good with that, as we often find ourselves on the contrarian side of things. In our experience, most *successful* microcap investors we know have at least a thread or two of contrarian woven into their fabric.

To be clear, we recognize the marked negative impact that Covid has had on the industry and as we addressed in multiple places above, that impact may well last beyond the end of the pandemic. Further, as some "experts" suggest, we may never see the actual end of Covid19, which means it may be an ongoing headwind for the industry. We accept that as well. In addition, per our Risks and Caveats section above, we also accept that there are other headwinds both old and new that will continue to present challenges for the industry and its associated operators.

On the other hand, in our view the aging demographic and resulting wave of elderly folks needing care appears unavoidable and perhaps even disruptive. It is difficult for us to consider that dynamic and not believe that part of the answer will be more demand for LTCFs. Moreover, as we alluded to above, we think one of the outcomes of the pandemic will be a reassessment of the flexibility, readiness and the capacity of the healthcare system to respond to changes, be they unforeseen shocks, or longer term trends. Again, we think that path may provide value to legacy operators.

The above macro views noted, there are a handful of bullet points that we think are topical to the story and are the basis for our enthusiasm for the shares and we believe support our thesis for higher valuations for Selectis.

To reiterate, our current valuations/targets are based on a simple premise. Selectis currently operates 9 facilities, with a 10th, Southern Hills Assisted Living, preparing to open in the current year (effectively completing the Company's first Continuing Care Retirement Community). From a practical standpoint 3 of these 9 facilities are relatively new to the story. Park Place (a 106 bed facility) was just renovated and recertified in September/October 2021 and essentially contributed nothing to the most recently reported quarter (3Q-F21). The other two, Providence/Sparta and Warrenton, did not begin full operations under the Selectis umbrella until into 4Q-F21. As a result, we think the Company exited 2021 with about 64% of their licensed beds occupied. Our view is that as we move forward, they will be (sequentially) successful filling these beds and ultimately reach system wide occupancies consistent with the 85%+ (normalized) rates currently experienced by their more seasoned facilities. Again, our targets are based on that basic premise. More specifically, our current target is based on both our DCF/NPV analysis of projected future cash flows (discounted significantly to account for volatility in terms of those projections), as well as our terminal value DCF approach. Each of those approaches yields a number similar to our target and we believe that target reflects the low end of industry comparable metrics like Enterprise Value to Sales as well as Enterprise Value to EBITDA.

Second, as we touched on prior, the Company has demonstrated an ability to refinance facilities through favorable government (HUD) programs. We believe that opportunity represents an attractive opportunity in terms of access to capital that few microcap companies have. Given the challenges that many small companies have in terms of access to capital, and the propensity for those needs to be addressed through the issuance of dilutive and discounted equity, **this is in our view a very attractive relative attribute of Selectis.** We often suggest that the specter of considerable future dilutive equity is one of the more cogent risks associated with small early stage companies. To reiterate, we believe Selectis has multiple properties that it can potentially refinance providing inexpensive access to growth capital that they could use to either enhance exiting facilities or perhaps acquire others. That brings us to our third bullet point.

We noted above that the Company currently has approximately 650 beds available, of which we estimate roughly 420 are occupied. However, we also noted that they have an additional (approximately) 175 licenses they can add if they enhance and/or ad-on to existing facilities. **We have not modeled that potential,** even though ostensibly, they could likely "rent" (for lack of a better term), those beds to others today and generate additional revenue. We think they are more likely to find ways to use them themselves, but again, we have not modeled that scenario or included it in our targets, so we view that potential as a second valuation leg in the story, and one with reasonable visibility.

Lastly, given some of the upgrades the Company has done and in connection with some of their potential new refinance activity, we think there is a growing underlying facility value angle that may become more apparent as they continue to upgrade facilities (and gather associated appraisals). For instance, our sense is that the current appraisal value of the Company's facilities likely exceeds the current Enterprise Value of the Company, and perhaps considerably. We believe that value will become more visible when (if) they continue to refinance facilities. In that case, we think even the collective refinance values will probably understate that actual appraisal value because presumably, refinance capital will be used to enhance facilities that will ostensibly be worth more once they are renovated than they were prior to renovation when the refinance was completed. Again, we think facility value visibility will improve as we move forward, and we think that value could in turn underpin the valuation of the shares at higher levels.

As a result of our analysis herein, we are initiating our coverage of Selectis shares with an allocation of 4 and a 12-24 month price target of $19.00 per share based on the valuation methodology described above. We will reassess our targets as additional information becomes available.

Projected Operating Model

Selectis Health, Inc.											
Projected Operating Statement											
Prepared By: Trickle Research											
	(Actual)	(Actual)	(Actual)	(Estimate)	(Estimate)	(Estimate)	(Estimate)	(Estimate)	(Estimate)	(Estimate)	(Estimate)
	3/31/21	**6/30/21**	**9/30/21**	**12/31/21**	**Fiscal 2021**	**3/31/22**	**6/30/22**	**9/30/22**	**12/31/22**	**Fiscal 2022**	**Fiscal 2023**
Revenue											
Total Revenue	$ 5,762,843	$ 6,012,037	$ 7,319,055	$ 8,486,642	$ 27,580,577	$ 8,194,127	$ 8,608,848	$ 8,888,287	$ 9,085,565	$ 34,776,828	$ 37,883,492
Expenses											
Property Taxes, Insurance and Other Operating	$ 3,544,730	$ 4,655,236	$ 4,413,930	$ 5,176,794	$ 17,790,690	$ 4,706,592	$ 4,806,127	$ 4,873,193	$ 4,920,541	$ 19,306,453	$ 20,052,068
General and Administrative	$ 2,098,327	$ 912,496	$ 1,721,292	$ 2,476,519	$ 7,208,634	$ 1,805,989	$ 1,820,919	$ 1,830,979	$ 1,838,081	$ 7,295,968	$ 7,407,810
Provision for (Recovery of) Bad Debts	$ 24,134	$ (8,001)	$ 12,142	$ 7,319	$ 35,594	$ 8,487	$ 8,194	$ 8,609	$ 8,888	$ 34,178	$ 37,153
Acquisition Costs	$ -	$ -	$ -	$ -	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Depreciation and Amortization	$ 401,023	$ 450,243	$ 435,013	$ 435,925	$ 1,722,204	$ 435,053	$ 434,183	$ 433,315	$ 432,448	$ 1,734,999	$ 1,721,161
Total Expenses	$ 6,068,214	$ 6,009,974	$ 6,582,377	$ 8,096,557	$ 26,757,122	$ 6,956,121	$ 7,069,423	$ 7,146,095	$ 7,199,958	$ 28,371,597	$ 29,218,192
Income from Operations	$ (305,371)	$ 2,063	$ 736,678	$ 390,085	$ 823,455	$ 1,238,006	$ 1,539,425	$ 1,742,192	$ 1,885,607	$ 6,405,230	$ 8,665,300
Other (Income) Expense											
Gain on Warrant Liability	$ -	$ -	$ -	$ -	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Gain on Extinguishment of Debt	$ 543,543	$ -	$ -	$ -	$ 543,543	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Gain on Sale of Investments				$ -	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Interest Expense, net	$ (675,598)	$ 650,181	$ 486,816	$ 394,291	$ 855,690	$ 385,291	$ 376,291	$ 367,291	$ 358,291	$ 1,487,163	$ 1,343,161
Gain on Forgiveness of PPP Loan	$ (432,022)	$ -	$ -	$ -	$ (432,022)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Other Income	$ (564,077)	$ 30,662	$ (51,856)	$ (300,000)	$ (885,271)	$ (50,000)	$ (50,000)	$ (50,000)	$ (50,000)	$ (200,000)	$ (200,000)
Lease Termination Expense			$ 354,710	$ -	$ 354,710	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Total Other (Income) Expense	$ -	$ 680,843	$ 789,670	$ 94,291	$ 1,564,804	$ 335,291	$ 326,291	$ 317,291	$ 308,291	$ 1,287,163	$ 1,143,161
Net Income (Loss)	$ 258,706	$ (678,780)	$ (52,992)	$ 295,794	$ (177,272)	$ 902,715	$ 1,213,135	$ 1,424,901	$ 1,577,317	$ 5,118,067	$ 7,522,139
Net Loss Attributable to Noncontrolling Interests	$ (10,650)	$ -	$ -	$ -	$ (10,650)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Net Income (Loss) Attributable to Selectis Health, Inc.	$ 248,056	$ (678,780)	$ (52,992)	$ 295,794	$ (187,922)	$ 902,715	$ 1,213,135	$ 1,424,901	$ 1,577,317	$ 5,118,067	$ 7,522,139
Series D Preferred Dividends	$ (7,500)	$ (7,500)	$ (7,500)	$ (7,500)	$ (30,000)	$ (7,500)	$ (7,500)	$ (7,500)	$ (7,500)	$ (30,000)	$ (30,000)
Net Income (Loss) Attributable to Common Stockholders	$ 240,556	$ (686,280)	$ (60,492)	$ 288,294	$ (217,922)	$ 895,215	$ 1,205,635	$ 1,417,401	$ 1,569,817	$ 5,088,067	$ 7,492,139
Net Income (Loss) per Share Attributable to Common Stockholders:											
Basic	$ 0.01	$ (0.03)	$ (0.02)	$ 0.10	$ (0.07)	$ 0.31	$ 0.41	$ 0.48	$ 0.53	$ 1.75	$ 2.52
Diluted	$ 0.01	$ (0.03)	$ (0.02)	$ 0.10	$ (0.07)	$ 0.30	$ 0.40	$ 0.47	$ 0.51	$ 1.69	$ 2.40
Weighted Average Common Shares Outstanding:											
Basic	26,866,379	26,891,841	2,824,560	2,890,362	2,890,362	2,904,814	2,919,338	2,933,935	2,948,604	2,926,673	2,985,647
Diluted	27,605,688	26,891,841	2,824,560	2,890,362	2,890,362	2,976,814	3,010,120	3,041,050	3,069,922	3,024,477	3,134,068

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Rating System Overview:

There are no letters in the rating system (Buy, Sell Hold), only numbers. The numbers range from 1 to 10, with 1 representing 1 "investment unit" (for my performance purposes, 1 "investment unit" equals $250) and 10 representing 10 investment units or $2,500. Obviously, a rating of 10 would suggest that I favor the stock (at respective/current levels) more than a stock with a rating of 1. As a guideline, here is a suggestion on how to use the allocation system.

Our belief at Trickle is that the best way to participate in the micro-cap/small cap space is by employing a diversified strategy. In simple terms, that means you are generally best off owning a number of issues rather than just two or three. To that point, our goal is to have at least 20 companies under coverage at any point in time, so let's use that as a guideline. Hypothetically, if you think you would like to commit $25,000 to buying micro-cap stocks, that would assume an investment of $1000 per stock (using the diversification approach we just mentioned, and the 20-stock coverage list we suggested and leaving some room to add to positions around allocation upgrades. We generally start initial coverage stocks with an allocation of 4. Thus, at $1000 invested per stock and a typical starting allocation of 4, your "investment unit" would be the same $250 we used in the example above. Thus, if we initiate a stock at a 4, you might consider putting $1000 into the position ($250 * 4). If we later raise the allocation to 6, you might consider adding two additional units or $500 to the position. If we then reduce the allocation from 6 to 4 you might consider selling whatever number of shares you purchased with 2 of the original 4 investment units. Again, this is just a suggestion as to how you might be able to use the allocation system to manage your portfolio.

For those attached to more traditional rating systems (Buy, Sell, Hold) we would submit the following guidelines.

A Trickle rating of 1 thru 3 would best correspond to a "Speculative Buy" although we would caution that a rating in that range should not assume that the stock is necessarily riskier than a stock with a higher rating. It may carry a lower rating because the stock is trading closer to a price target we are unwilling to raise at that point. This by the way applies to all of our ratings.

A Trickle rating of 4 thru 6 might best (although not perfectly) correspond to a standard "Buy" rating.

A Trickle rating of 7 thru 10 would best correspond to a "Strong Buy" however, ratings at the higher end of that range would indicate something that we deem as quite extraordinary..... an "Extreme Buy" if you will. You will not see a lot of these.