January 6, 2022

Zacks Small-Cap Research

Sponsored – Impartial - Comprehensive

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Mitesco, Inc. (MITI-OTCQB)

MITI: Primary care that puts patients first

Our initial valuation for Mitesco, Inc. is $0.53 per share. Our target is based on a 10-year DCF with a 22% terminal EBIT margin and 12% discount rate. We believe the gap between current valuation and our target may reflect: uncertainty surrounding how quickly the company will open clinics beyond 2023, possible need to raise cash to support growth in working investment – under an aggressive new clinic opening scenario.

Current Price (01/05/22)	$0.19
Valuation	**$0.53**

OUTLOOK

Mitesco, Inc. is building a better model for primary care. Headed by veteran physician practice clinical and business leaders, Mitesco's "The Good Clinic" seeks to improve health disparities through a nurse-practitioner driven model emphasizing patient engagement and activation, frequent communication, continuity of care, an emphasis on wellness and convenience. The Company opened first clinic in February 2021, and by the end of the year had six clinics operating around Minneapolis. In 2022, the Company expects to open an additional 12 clinics in three states – Minnesota, Colorado and Arizona. By 2023, Mitesco plans to have 50 clinics in operation.

SUMMARY DATA

52-Week High	**$0.49**
52-Week Low	**$0.03**
One-Year Return (%)	**376.80**
Beta	**-1.45**
Average Daily Volume (sh)	**371,384**
Shares Outstanding (mil)	**213**
Market Capitalization ($mil)	**$39**
Short Interest Ratio (days)	**N/A**
Institutional Ownership (%)	**0**
Insider Ownership (%)	**3**
Annual Cash Dividend	**$0.00**
Dividend Yield (%)	**0.00**
5-Yr. Historical Growth Rates	
Sales (%)	**N/A**
Earnings Per Share (%)	**N/A**
Dividend (%)	**N/A**
P/E using TTM EPS	**N/A**
P/E using 2022 Estimate	**N/A**
P/E using 2023 Estimate	**N/A**
Zacks Rank	**N/A**

Risk Level	**High,**
Type of Stock	**N/A**
Industry	**Med Info Sys**
Zacks Rank in Industry	**N/A**

ZACKS ESTIMATES

Revenue
(in millions of $)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2020	0.0 A	0.0 A	0.0 A	0.0 A	0.0 A
2021	0.0 A	0.0 A	0.0 A		0.1 E
2022					17.9 E
2023					36.7 E

Earnings per share

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2020	$0.00 A	-$0.01 A	-$0.01 A	-$0.01 A	-$0.03 A
2021	-$0.01 A	-$0.01 A	-$0.01 A		-$0.03 E
2022					-$0.02 E
2023					$0.00 E

Zacks Projected EPS Growth Rate - Next 5 Years % **N/A**

INVESTMENT SUMMARY

COMPANY DESCRIPTION: Mitesco, Inc. is building a better model for primary care. Headed by veteran physician practice clinical and business leaders, Mitesco's "The Good Clinic" seeks to improve health disparities through a nurse-practitioner driven model emphasizing patient engagement and activation, frequent communication, continuity of care, an emphasis on wellness and convenience.

Mitesco opened its first clinic in February 2021, and by the end of the year had six clinics operating around Minneapolis. In 2022, the Company expects to open an additional 12 clinics in three states – Minnesota, Colorado and Arizona. By 2023, Mitesco plans to have 50 clinics in operation.

Importantly, the Company doesn't seek to be everything to everyone. The strategy simply to build new clinics, attract a panel of patients who want primary care that emphasizes prevention and wellness, and repeat the process again and again. Longer-term, the Company may diversify its core strategy, but in our view, it will differentiate itself from the competition by sticking to basics.

We believe that Mitesco's business plan is solid and straightforward. It addresses important deficiencies healthcare delivery, while hitting on the 4 "Cs" of primary care: first-contact care that is comprehensive, continuous, and coordinated. It is building out a platform for delivering care in a convenient, patient-focused way, that encourages patients to be active participants in their health. If successfully executed, it's an elegant solution to a long-standing challenge to improving healthcare delivery.

FINANCIALS: Our model is based on Mitesco opening 31 clinics by the end of 2023 and 98 by 2026. For 2023, we forecast sales of $36.7 million, growing to $124.9 million in 2026. We estimate average clinic-level operating margins of 19% in 2023, growing to 28% by 2026. Including corporate overhead, we look for operating margins of 5% in 2023 and 23% in 2026. We expect the company to reach breakeven in 2023, with earnings per share of $0.10 by 2026.

VALUATION: We value Mitesco at $0.53/share based on ten-year DCF for 300 clinics by 2031. Our model builds to $400 million in sales by 2031, with a terminal revenue growth rate of 2%. We model a terminal EBIT margin of 22%, 25% tax rate, and a 12% discount rate. Several factors provide upside to our valuation including: more modest working investment needs at the clinic level, faster time to cash flow breakeven at new clinics, reimbursement from insurers with risk-sharing upside for keeping patients healthy, and robust sales of ancillary products and services.

SENSITIVITIES: Mitesco, Inc. is at an early point of a vast market opportunity, in our view. Management has a very specific business plan, one built on collective wisdom and experience – which we believe will mitigate many of the risks typically associated with a startup. Mitesco owns and operates its clinics; practitioners are employees. Success comes from basic blocking-and-tackling. Importantly, as an owner-operator, Mitesco's interests are aligned with those of its practitioners. While results may be somewhat volatile in the next year or two, we expect this to stabilize as the business grows.

COMPANY OVERVIEW

Healthcare delivery in the US was undergoing a revolution well before COVID-19, driven by an influx of newly-insured patients from the Affordable Care Act, a shortage of primary care providers, the need for investments in technology to battle ever-rising administrative burdens, and changing reimbursement structures.

Barriers to access, and lack of continuity of care, particularly for those without chronic conditions, have been a long-standing hurdle to reduced disparities and better outcomes in healthcare. Over the past 25 years, many efforts have been made to improve access to medical care, and primary care in particular, such as mandatory insurance coverage for preventative care, rural healthcare initiatives and the expansion of Medicaid in many states. However, primary care in the US remains transactional and under-funded.

Improved access to high-quality primary care is a multi-factorial challenge in the US; however, a team of clinical and business physician practice industry veterans is working to address this issue by opening primary care clinics focused on improving access and continuity of care to the 70% of the population that who use < $2,000 in care each year, and therefore are less likely to have a strong primary care relationship.

With six primary care clinics in the Minneapolis area, Mitesco, Inc. is rethinking the model for primary care. Headed by veteran clinical and business leaders, Mitesco's "The Good Clinic" seeks to improve health disparities through a nursing-driven medical model. The Good Clinic seeks to take the best of traditional primary care – continuity of care, emphasis on wellness, patient-provider engagement – and marry it with the convenience and services that patients value – same-day visits, long-hours, telehealth, and ancillary services, such as nutrition and skincare.

The Company seeks clinic sites in residential concentrations of population to enhance the convenience, which we believe will be well received by customers due to the changes in community travel patterns resulting from the pandemic. Initially it will target locations in partnership with larger national residential developers and narrow network insurance providers. The clinics will generally be smaller than most standalone clinics, yet will offer a full range of services. Most clinics will be 1,500 – 3,000 square feet, with four to six exam rooms, and three to five nurse practitioners delivering care.

Most clinics will offer a full range of services:

- Family practice services including vaccinations, diagnostic testing and monitoring (EKG, pulmonary function)
- Behavioral health screenings
- Laboratory services including on-site testing and referral testing to major outsource lab companies;
- Occupational health services including treatment of work injuries, pre-employment exams, drug testing, company sponsored flu shots and education programs for workers.
- Wellness programs and lifestyle education including nutritional counseling, weight control programs and supplements
- Simple cosmetic treatments and dermatologic procedures (including skin care products)
- Advanced Electronic Medical Records (EMR) that enables rapid, accurate and consistent medical documentation and protocols, safety features, follow-up planning and billing information;

Over time, the company may include on-site generic medication dispensing and potentially other services.

THE IMPORTANCE OF PRIMARY CARE

Although many have gained access to medical care as a result of the ACA, in the US, we spend less than half as much on primary care than many other countries. Healthcare in the US emphasizes treatment of acute and chronic disease, not prevention. Like public health, primary care is focused on distal (or upstream) determinants of health, such as prevention, screening, early detection and intervention or management of chronic conditions. The formal definition of primary care is determined by the 4"Cs": first-contact care that is comprehensive, continuous, and coordinated.

A 2021 study by the US Centers for Disease Control (CDC) found that 85% of adults and 96% of children report having a "regular place to get care." However, it's worth noting that going to the same site, does not necessarily mean that the person is receiving regular care. According to a 2018 poll by the Kaiser Family Foundation, 26% of adults (and 45% of those aged 18-29) do not have a regular primary care provider. Patients receiving primary care generally receive more high value care and report better access and experience than those who do not (Levine et al., 2019). High value care includes certain cancer screenings (colorectal cancer and mammography), preventative care (blood pressure checks, flu vaccination), medication management and wellness counseling. However, those with primary care also received slightly more low-value care (antibiotics for viral illness, cervical and prostate cancer screenings for elderly adults.) Those without primary care were more likely to receive more low-value care (opioids for headaches) and less high-value care (ACE inhibitors and beta-blockers for heart failure) at a statistically significant degree.

Primary care was once the center of healthcare delivery in the US. However, the center shifted to hospitals and specialists through the twentieth century. Studies often cite low reimbursement as the key driver behind a shift towards specialty care, in our view, it fails to tell the whole story. Primary care never attracted the educational, institutional or research emphasis of specialties, where medical advances made more conditions curable, treatable or manageable. In 2016, primary care (which includes pediatrics, internal medicine, general/ family practice) accounted for fewer than half of all office visits (46%), while 54% of visits were to a specialist or subspecialist.

In many ways, primary care is like traditional Chinese medicine (TCM), where diagnosis and treatment are based on the whole person, and rely heavily on the practitioner's instincts and clinical experience. For many years, being a primary care practitioner meant regular office hours with a focus on patient engagement, management and diagnosis. In addition, a significant part of primary care practice occurs outside the exam room, reviewing and following up on patients recovering from hospitalization for acute conditions, managing patients with chronic illness and co-morbidities or complex disease, as well as consulting with specialists and other physicians about patient diagnoses. Often physicians are not reimbursed for these activities, which one study conservatively estimated constituting 17% or more of a primary care practitioner's workload. A 2019 report by the National Academy of Sciences, suggests that primary care is suffers under managed care because primary care is about "teams caring for people, not doctors delivering services" and that good primary care "defies management."

As managed care's influence grew, primary care physicians not only saw their reimbursement rates squeezed, under the popular gatekeeper model, primary care physicians faced growing administrative demands as "referral factories" for their patients. This increase in administrative workload, coupled with a constantly changing stream of new patients (as people switch insurers and insurers "optimize" their panels), all in the face of declining reimbursement has led to a decline in primary care practitioners.

In addition, as certain conditions have been hyperspecialized, it is often difficult for primary care physicians to keep up with all of the changes, making it more likely that they will refer out. From 1999-

2009, primary care referrals to specialists doubled from 5% to 10%. A 2011 Milbank study found that 1/3 of non-elderly patients received a specialist referral each year, and among the elderly, most were referred to two specialists each year. Finally, regulations enable many patients to self-refer to specialists (ophthalmology, dermatology, OB/gyn, etc.), circumventing further diminishing the primary care relationship.

Loss of patient continuity following diagnosis of chronic conditions may also occur. Chronic conditions such as diabetes or heart disease require frequent rechecks (anywhere from two to four times a year). Some of these patients focus on their chronic disease and essentially migrate to their specialist for primary care and skipping routine checkups. This shift can also happen following acute disease, where the patient has healthcare "fatigue" and postpones or cancels regular care. This can lead to unnecessary missed diagnoses of early comorbidities, or unwanted medication side effects.

Opportunity for nurse practitioners in primary care

NPs have provided care since the 1960s**.** The creation of Medicare and Medicaid programs in 1965 created a shortage of qualified physicians to treat the influx of people newly-eligible for care. In its first year, 19 million people enrolled in Medicare alone. Nurse practitioners (NPs) are registered nurses (RN) with additional graduate education (masters or doctoral) and clinical training. NP training emphasizes health promotion, disease prevention, and health education and counseling. NPs are nationally certified and often specialize in areas such as acute care, pediatrics, gerontology, women's health, or psychiatry/mental health. NPs are similar to primary care physicians with a "whole patient" philosophy, focusing on overall health and wellness. An NP can diagnose and treat patients with routine and complex medical conditions, and increasingly also prescribe medication.

The scope of NP practice differs from state to state. In 23 states (and DC), NPs have full-practice authority, meaning that they can practice without physician oversight. NPs have "reduced" practice scope in 16 states; they can diagnose and treat patients, but require physician oversight to prescribe medication. NPs practice under physician supervision in 11 "restricted" states; however, in 2020, Florida loosened its restrictions and now allow NPs who have accumulated at least 3,000 hours of practice under physician supervision to practice independently.

According to the American Academy of Nurse Practitioners, there are currently over 325,000 licensed NPs in the US, and an additional 30,000 graduate each year. Almost three-quarters of NPs work in a primary care setting, the balance in hospitals.

Research consistently shows that NPs provide quality care that is equal to, and in some dimensions better than, primary-care physicians. A two-year study (Liu, 2020) of 800,000 VA (Veterans' Administration) patients found NP-assigned patients were less likely to use primary care and specialty care services and incurred fewer total and ambulatory care sensitive hospitalizations than physician-assigned patients. In addition, the study did not find statistically significant differences in cost, clinical outcomes, or diagnostic testing between NP-assigned patients and those assigned to a physician. Similarly, a five-year study of community health centers (Kurtzman and Barnow, 2017), found no statistical difference in seven of nine outcomes for NP- or PA-treated patients, compared to MD-treated patients. On the other two outcomes –NP-treated patients were more likely to receive recommended smoking cessation and health education counseling than MD-treated patients.

Notably, NPs are able to achieve these outcomes at lower cost than primary care physicians. A 2021 study looking at the drivers of costs for Medicare patients in different risk-strata, (Razavi, Jacob, et al., 2021), reported that physician cost of care was 34% higher than NP care for low-risk patients, and 21% higher for medium- and high-risk patients. The difference was driven primarily by higher service volume.

PHYSICIAN PRACTICE MANAGEMENT – VERSION 2.0

Physician Practice Management Companies (PPMs) attracted a lot of attention in the 1990s. Investors (and physicians) were lured by promises of practice growth, economies of scale and the ability to get higher reimbursements and upside from risk-sharing with insurers. In 1998, there were some 30 publicly-traded companies. However, by 2002, most had declared bankruptcy or dissolved.

Following passage of the ACA in 2010, and its influx of newly-insured patients and innovative value-based reimbursement, private equity and venture capitalists again began to accumulate healthcare providers. From 2013-2016, private equity scooped up 366 physician practice groups. The question to ask is whether or not the world and the business models will perform better this time around.

The first wave of PPMs made equity investments into physician practices in exchange for a management fee and share of profits. These companies did not employ physicians but rather created a de facto joint venture with physicians that avoided prohibitions in many states at the time against the corporate practice of medicine. The goal was to provide monetization for physicians, access to capital, professional management, better leverage with insurers and operating economies of scale, while maintaining provider autonomy.

Unfortunately, PPMs focused primarily on growth through acquisition and failed to provide clinic-level revenue growth and operating efficiencies they promised to most practices, at least at a level to sufficient offset the management fee. The math simply didn't work. In essence, the management companies benefitted, but the practices became less profitable as a result of the PPM management fee and increased administrative burden. As a result, once their interests were monetized, many physicians retired or otherwise reduced their workloads, which simply compounded problems.

The fast pace of acquisitions and accounting rules at the time that allowed pooling-of-interest mergers (often in stock), enabled companies to hide poor execution at the clinic level. There were signs of trouble, such as MedPartners decision to buy Caremark, for its clinics, but much more for its PBM in 1996, or the failed merger between MedPartners and PhyCor, two PPMs with diametrically-opposed approaches to practice management.

There have been changes in the past 20 years, which may result in better outcomes for the new crop of PPMs. First, many more physicians have worked as salaried practitioners rather than opening a practice. According to LEK Consulting, 75% of respondents preferred to work in a group or hospital-affiliated practice.

Second, there are many different business models in this latest iteration. A number of companies focus on managing the risk-sharing aspect for Medicare patients, both through owned and contracted physician networks. Some provide on-site and virtual primary care to employers with a clinic model, while others offer membership-based concierge medicine models as an employee benefit or for individual. Episodic treatment models such as urgent care and retail clinics, remain popular. Other companies are building mixed models with owned practices, contracted practices and software service clients. Hospitals and insurers continue to buy and build physician practices. Telehealth companies provide general or specialized care, and some are looking to move into in-person care. Finally, we have the newest players, DCEs (direct contracting entities). In 2021, CMS (Centers for Medicare and Medicaid Services), awarded exclusive contracts to 53 entities to participate in risk-sharing arrangements for Medicare FFS members. The goal is to bring value-based care to physicians and Medicare members who do not want to join a Medicare Advantage (HMO) plan. However, read the fine print for most of the new PPMs, and one

discovers that most of have eventual plans to expand into other types of services, populations or reimbursement models.

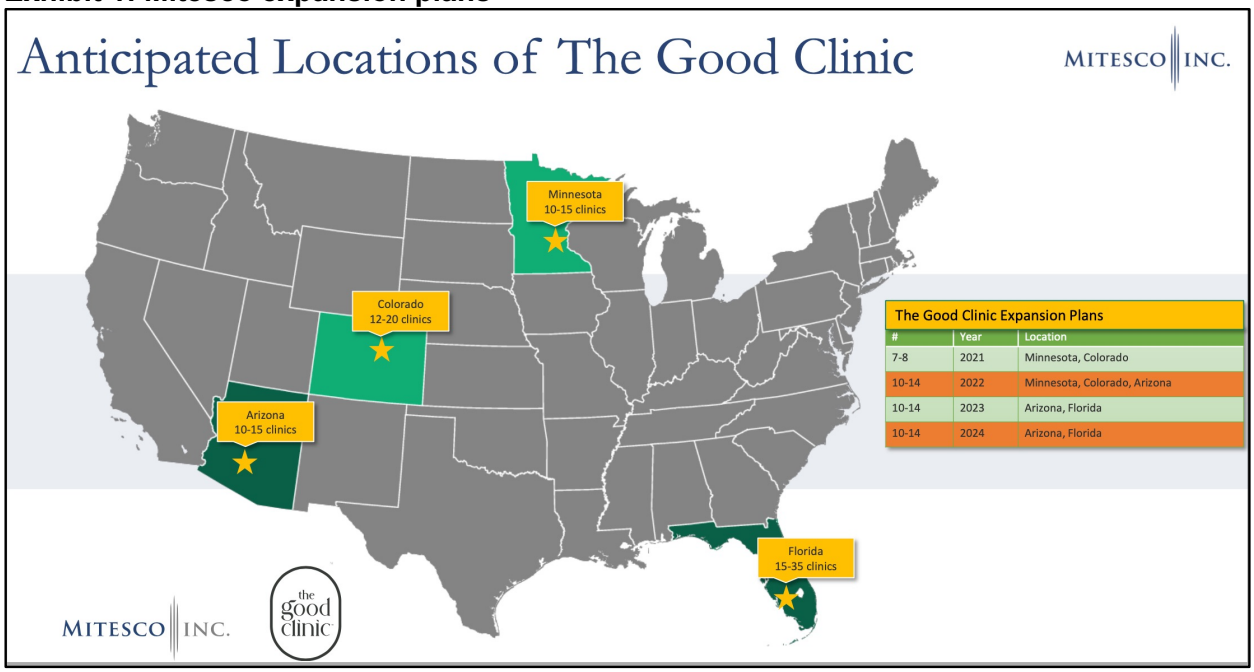
Add to this, too much money chasing what are likely too few viable opportunities, and investors run the risk of 2023 looking a lot like 2000. It's too early to say which ventures will thrive and which will wither. It's reasonable to say at this point that all expect to be successful, and most expect to be acquired in the next few years. This is the risk to investors. Each company is saying the right things, but in many cases, it seems like more sizzle than steak. In our view, the most successful companies will have a focused business strategy and the right talent and experience to execute on that plan.

With all this said, we believe that Mitesco's business plan is solid and straightforward. It addresses important deficiencies healthcare delivery, while hitting on the 4 "Cs" of primary care: first-contact care that is comprehensive, continuous, and coordinated. It is building out a platform for delivering care in a convenient, patient-focused way, that encourages patients to be active participants in their health. If successfully executed, it's an elegant solution to a long-standing challenge to improving healthcare delivery.

SENSITIVITIES

Mitesco, Inc. is at the very beginning of its growth story, Management has a very specific business plan, one built on collective wisdom and experience – which we believe will mitigate many of the risks typically associated with a startup. Moreover, Mitesco owns and operates its clinics, practitioners are employees. This gives Mitesco more oversight of its business, it is not beholden to private equity or outside financiers. While results may be somewhat volatile in the next year or two, we expect this to stabilize as the business grows. Several factors may affect forecasts and results over the next several years.

Exhibit 1: Mitesco expansion plans



Source: Mitesco, Inc. investor presentation, 11/1/21.

- **Addressable market size and competition for patients**: Compared to other countries, the US has a surplus of healthcare insurers and health care services. The problem is that in the US neither is well-distributed according to need. There are markets where there are many insurance options and a wealth of providers, specialist and subspecialist. In other parts of the country, patients have few private insurance options and a trip to a provider may mean waiting several weeks (or longer) for an appointment and a drive of several hours or more.

  The market for healthcare is still highly fragmented, yet intensely competitive. The competition became only more intense during the pandemic where there was a significant mismatch between supply and need. Once a niche service in rural markets and certain specialties, telehealth was widely adopted during the pandemic; however, recent studies show that its reach is hampered, particularly for lower-income populations, by coverage, technology and tech literacy hurdles. A July 2021 report by McKinsey & Company shows that telehealth claims peaked in April 2020, and have stabilized at half the peak since, but still considerably above claims before the pandemic. We now see telehealth as a must have for providers, no longer a point of differentiation.

  It is important to recognize that there are myriad physician practice companies (public and private) with aggressive expansion plans. For example, VillageMD, which offers value-based primary care, has 38 standalone, physician-group partnership and retail-based clinics in Arizona, another 60 in Texas and a smaller presence in ten other states. We model for Mitesco to grow to 300 clinics over the next ten years. This translates to an average of ten clinics in each state where NPs have fully-independent, or largely independent scope of practice. So, while Mitesco is likely to be expanding in many of the same markets as its competitors, we believe that its ground-up strategy, coupled with strong execution at the corporate and clinic level, will be a sustainable competitive advantage.

- **Competition for labor:** Many companies are looking to NPs to deliver high-quality medical care in an overburdened primary care market. The question is to what extent will companies find themselves competing to hire NPs. We've used an average cost of $150,000 per NP (salary and benefits) in our model, and MITI will also offer its NPs stock compensation. Merritt Hawkins, a medical staffing firm, reported a 21% increase in demand for NPs in 2021, making NPs the most in-demand medical providers. Merritt Hawkins notes that NP average base salaries rose from $123,000 in 2017 to $140,000 in 2021, an average annual increase of 3%. Of course, average base salaries will vary by geography, specialty and experience, but labor costs are a line item to watch. Mitesco offers NPs much of the autonomy of opening a private practice, along with career progression, without the uncertainties, which should be an attractive package for most NPs.

- **Reimbursement changes:** Currently Medicare reimburses NPs at 85% of the physician rate for office visits. Reimbursement for Medicaid patients varies by state from 75%-100% of the physician rate. Reimbursement from commercial insurers varies. UnitedHealth Group (UNH – NYSE) stated policy is to reimburse NPs at 85% of the applicable physician fee schedule. While we believe that insurers want to encourage use of NPs and ancillary medical professionals where appropriate it's possible that contracted reimbursement rates could change over time.

- **Move to a risk-based model:** Mitesco plans to be an in-network provider for insurers in its markets as a way of attracting more patients. Initially, services will be billed at the contracted rate and Mitesco will collect any co-pays at time of service and then bill the patient's insurer for the balance. Many providers are looking to move to value-based reimbursements, where they can receive bonuses for good performance (such as reducing hospital readmissions), and where providers have little-to-no downside risk. In 2021, CMS took a big step to encourage providers to participate in value-based payments by establishing 53 DCEs (direct contracting entities) that will manage value-based payments to physicians for patients who do not want to participate in Medicare Advantage (HMO) plan. These shifts are important as they create a strong incentive to improve care coordination (which benefits primary care practitioners) and deliver high quality care at a lower cost. Through its

company-owned primary care clinics, we believe Mitesco is well positioned to move into value-sharing arrangements, either directly or by partnering with an ACO or other provider system.

- **Regulatory:** Mitesco is prioritizing clinic expansion in states that support near of fully independent practice by nurse practitioners. As noted, in 2020, Florida passed legislation allowing NPs with extensive experience to operate independently. If other states follow, it creates greater opportunity for Mitesco to open in additional geographies.

- **Financing needs:** At the end of November, the Company filed an S-1 to raise $16.5 million, including up to $5 million from selling shareholders. After this offering, management indicates a preference to finance new clinic construction and startup with short-term debt, as each clinic is forecast to be operating cash flow neutral in just over a year. This approach has incremental short-term interest expense, but minimizes shareholder dilution.

VALUATION

While it is tempting to use peer metrics (price-to-earnings or price-to-sales multiples) to value physician practice companies, for us, the methodology falls short as the publicly-traded peers differ considerably in terms of business model, strategic priorities, patient base, services, locations and reimbursement agreements. A key takeaway for those who invested in physician practice management companies in the late 1990s, is that operating cash flow is the best performance metric. For these reasons, we opt for a DCF model.

Our 10-year DCF model builds to sales of approximately $400 million by 2031 from 298 clinics. We model terminal sales with an EBIT margin of 22% and a 25% tax rate. We assume a terminal growth rate of 2% and an 12% discount rate. Under these assumptions, we arrive at an intrinsic value of $0.53 per share.

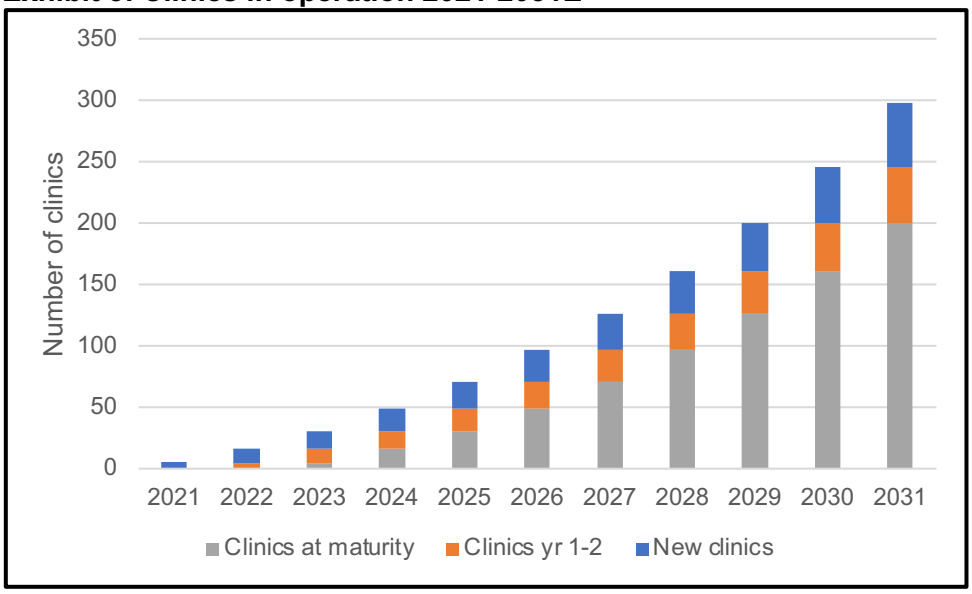
Exhibit 2: Valuation sensitivity

WACC	Terminal EBIT Margin				
	18%	20%	22%	24%	26%
10%	0.67	0.76	0.84	0.93	1.01
11%	0.56	0.64	0.71	0.79	0.86
12%	0.48	0.54	0.61	0.68	0.74
13%	0.41	0.47	**0.53**	0.59	0.65
14%	0.35	0.40	0.46	0.51	0.57
15%	0.30	0.35	0.40	0.45	0.50
16%	0.26	0.30	0.35	0.40	0.44

Source: Zacks Investment Research estimates.

We've modeled for rapid new clinic rollout, going from its current base of six (at 12/30/21) to 31 in 2023, and 50 by the end of 2024. This is somewhat behind management's stated goal of 50 operating clinics by 2023, and builds in what we believe is a reasonable cushion for possible delays arising from the continuing effect of the pandemic on business certainty and licensing approvals in expansion states. The Company has five clinics in development that it expects to open by spring 2022 and has announced additional planned locations.

Exhibit 3: Clinics in operation 2021-2031E



Source: Company filings, Zacks Investment Research estimates.

We approached our clinic revenue model in two ways. Our top-down model is based on patient census and staffing levels. Our bottoms-up approach considers facility utilization, operating hours, and other metrics.

Our top-down approach creates two scenarios for clinic revenue and sets the range for our bottoms-up modeling. Under the conservative scenario, we model each NP having a panel of 1,000 patients, each visiting twice a year – for a total of 2,000 annual visits. Our low-end reimbursement assumption is $70 per visit ($50 from the insurer and $20 in patient co-pays). Although this assumption is low, it is in-line with commercial insurance reimbursement for a 5- to 20-minute primary care visit. In general, commercial insurance reimbursement for medical office visits tracks closely to Medicare reimbursement. We include a separate assumption for patient out-of-pocket spending on non-covered products and services averaging $50 per year. Under this scenario, the average NP generates c. $200,000 in billings each year.

Our robust scenario models each NP having a panel of 2,000 patients, each visiting three times per year – for a total of 6,000 annual visits. This load is possible for an NP working full-time, seeing 2-3 patients per hour. We model $130 in reimbursement for each visit ($110 from the insurer and $20 patient co-pay). We include additional revenues of $250 by each patient per year for out-of-pocket spending on non-covered products and services. Under this scenario, the average NP generates c. $1.3 million in billings each year.

Exhibit 4: Top-down clinic revenue scenarios

Top-down clinic revenue scenarios		
Patient Revenues		
Patient count per NP	1,000	2,000
Avg visits per year per patient	2.0	3.0
Total visits per NP (annually)	2,000	6,000
Revenue per visit (in-person), $		
reimbursement	50	110
co-pay	20	20
	70	130
Annual patient revenue per NP	140,000	780,000
Additional patient spend (annually)	50	250
Total ancillary revenue per NP (annually)	50,000	500,000
Annual revenues by staffing ($):		
Per clinic with 3 NPs	470,000	2,840,000
Per clinic with 4 NPs	610,000	3,620,000
Per clinic w 5 NPs	750,000	4,400,000

Source: Zacks Investment Research estimates.

From these top-down scenarios, we estimate revenue scenarios based on clinic capacity and utilization. **Exhibit 4** calculates an estimate of in-person visit slots based on clinic size, operating hours, and average length of visit for a clinic with four NPs. It also includes an estimate of average weekly workload per NP, both in-person and telehealth visits.

In the smaller (four exam room) clinic model, open 60 hours per week (8AM - 7PM weekdays and 9AM - 2PM on Saturdays), we calculate approximately 96 appointment slots per week, based on a 30-minute average visit length and 1.5 room turns per hour. For the six-room clinic model with the same operating hours, but shorter average visit length and 2 room turns per hour, we calculate 192 appointment slots. However, patient traffic is not consistent throughout the day or week. Clinics are likely to be busier in the morning and late-afternoon/early evening during the week and generally busy on weekends. While a clinic may have anywhere from 100 to 200 available appointments in a week, not all of those slots will be filled. So, we model capacity at both 60% and 80% utilization, which generates in-person annual patient revenues of $210,000 at a smaller clinic with longer visits and lower utilization to just over $1.0 million for a six-room clinic, operating at 80% capacity (both calculations assume $130/visit). Under these assumptions, the average NP (assuming 4NPs per clinic) will see anywhere from 35-60 patients per week in person. This workload is lower than many large clinics where primary care practitioners may see up to 20 patients per day. However, Mitesco plans to utilize telehealth for many visits as a way to increase convenience and engagement for patients. We've modeled a range of 15 to 30 telehealth visits per week for each NP in our capacity calculation.

Exhibit 5: Clinic capacity and utilization calculation

AVAILABLE APPOINTMENT CALCULATION		
Visit time (hrs) - NP time	0.5	0.25
Room turns/hour	1.5	2
Hours of operation		
Weekdays	11	11
Weekends	5	5
Slots per week per room	24	32
Exam rooms	4	6
In-person exams/week	96	192
AVG CAPACITY UTILIZATION		
	60%	80%
In person exams/week	57.6	153.6
In person exams/year	2,995	7,987
Patient revenue	209,664	1,038,336
NP Workload (includes utilization assumption)		
In-person visits/week	35	60
Telehealth/week	15	30

Source: Zacks Investment Research estimates.

In Exhibit 5, we look at different revenue scenarios based on utilization, staffing and product mix For simplicity, we've modeled $130/visit for in-person appointments and $95/visit for telehealth. Telehealth visits are spread over four NPs. We also include ancillary revenues in our calculation. As shown in Exhibit 6, we then arrive at a range of clinic revenues from $1 million to $1.5 million. We apply these estimates to new clinics, clinics open approximately a year, and mature clinics and our clinic growth assumptions for the top-line in our DCF.

Exhibit 6: Clinic revenue scenarios based on utilization and staffing

	Utilization		
	60%	***70%***	***80%***
6 rooms, $130/visit	778,752	908,554	1,038,366
Telehealth visits 15/wk, 30 wk, 60/wk $95, at 4NPs	148,200	247,000	296,400
Ancillary revenues	50,000	75,000	125,000
Estimated clinic revenues	**$976,952**	**$1,230,554**	**$1,459,766**

Source: Zacks Investment Research estimates.

Our clinic-level gross margin ranges from 5% for clinics operating at 60% capacity to the low 30% range for clinics operating at 80% capacity. The overall gross margin will depend on the number of clinics and their maturity. We expect individual clinic costs to be largely fixed from year-to-year, varying only by supply and non-clinical personnel staffing levels. We model corporate overhead to grow by 5% per year, from our estimate of $4.7 million in 2021.

Capital expenditures will be driven primarily by new clinic openings. Management guides to an average start-up cost (including construction, staffing, licensing, etc.) of $1.1 million. We increase that to $1.25 million to account for potential delays and material and construction cost overruns. The Company indicates a preference for debt to fund clinic start-ups.

In addition to start-up costs, we model clinics to carry an accounts receivable balance equal to 25% of sales (90 days). This assumption is likely conservative, as the Company expects 30% of its revenues to come from co-pays and ancillary product/service fees. Provider reimbursement timeline regulations vary from state to state; however, most providers complain about slow payment from insurers and supports our DSO assumption.

FINANCIALS

Profit and loss

Mitesco launched operations in 2021, so results to date primarily reflect start-up costs. For the nine-months ended 9/30/21, Mitesco's revenue totaled $24,744 and gross profit of $16,690 from three clinics in operation at the end of the quarter. General and administrative costs came in at $4.1 million, reflecting corporate payroll, stock compensation, legal/professional costs and additional corporate operating costs.

Mitesco reported an operating loss of $4.1 million for the nine-months ended 9/30/21. Non-operating expense was $1.5 million, primarily from interest expense. The Company reported a net loss of $5.6 million for the period. After preferred stock dividends of $0.45 million, loss per common share was $0.03.

For the full-year 2021, we forecast revenues of $0.1 million, although given the recent launch of Mitesco's clinics, the actual number is likely to differ materially from our estimate. With the Company opening two new clinics right at year-end, it's possible that reported costs will also differ materially from our estimate. We expect general and administrative costs to total $4.7 million and other expense $1.7 million. After preferred stock dividends, we expect a net loss of $7.0 million, approximately ($0.03) per share.

For 2022, we look for revenues of $17.8 million, based on 17 clinics in operation at year end (12 clinics opened during the year). We model average clinic revenues of $1 million in the first year, based on 60% capacity utilization. For more mature clinics, we model revenues of $1.5 million, based on 80% utilization.

We assume that operating costs for each clinic are largely fixed at $0.9 million per year, excluding construction and start-up costs. For 2022, we model $15.7 million in COGs, a clinic level gross margin of 12%. We've modeled $4.9 million in general and administrative costs for 2022, interest expense of $0.8 million for clinic construction debt financing, and preferred stock dividends of $0.7 million. The net loss is likely to narrow significantly from our estimate of $7 million in 2021 to $4.3 million in 2022. Earnings are looked to improve slightly from our estimate of $(0.03) 2021 to $(0.02) in 2022.

We expect the Company to report breakeven net income in 2023, based on our revenue estimate of $36.7 million (32 clinics at year end), 19% gross margin, 5% operating margin and $0.2 million in net income to common shareholders.

Cash flow

Mitesco's business model is cash intensive, as are most physician practice companies. On the front end are new clinic construction costs, as well as clinic overhead until each reaches normalized revenue levels. In addition, is the need to fund accounts receivable, as the Company seeks to be a key provider to insurers in its markets. We are taking a conservative approach to modeling clinic accounts receivable averaging 90 days (DSOs). A clinic generating $1.0 million in revenue, would have $0.25 million in AR. This amount would grow to $0.38 million for a clinic with $1.5 million in revenue. The level of DSOs for each clinic will vary by revenue mix; clinics with a high level of ancillary product and service sales, will likely have lower DSOs as these items will be cash payment at time of service.

Our model assumes six clinics at the end of 2021 (two clinics opened on December 30, 2021), growing to 98 by the end of 2026. Under these assumptions, we estimate that the Company will not generate positive free cash flows (after capex and working investment) until 2029. However, given our aggressive clinic roll-out and conservative working investment need assumptions, our timeline may be flawed. Mitesco's management guides to new clinics being operating cash flow breakeven at 14 months; for clinics tied to narrow network insurers, management believes operating cash flow breakeven will occur in about half that time.

Balance Sheet

At September 30, 2021, Mitesco had $0.4 million in cash and equivalents on its balance sheet and a pandemic SBA loan of $0.5 million. Management indicates a preference to finance clinic construction costs with short-term debt and a 12- to 18-month payoff, as a way of reducing dilution to existing shareholders compared to equity financing.

Exhibit 7: Mitesco income statement forecast

	2020A	2021E	2022E	2023E	2024E	2025E	2026E
$							
Revenue							
Service revenues	0	100,000	17,876,194	36,719,758	60,859,468	89,964,647	124,890,862
Cost of goods sold	0	(200,000)	(15,725,000)	(29,600,000)	(46,250,000)	(66,230,000)	(90,206,000)
Gross profit	0	(100,000)	2,151,194	7,119,758	14,609,468	23,734,647	34,684,862
Operating expenses:							
Corporate G&A	(2,533,569)	(4,700,000)	(4,935,000)	(5,181,750)	(5,440,838)	(5,712,879)	(5,998,523)
Total operating expenses	**(2,533,569)**	(4,900,000)	(20,660,000)	(34,781,750)	(51,690,838)	(71,942,879)	(96,204,523)
Net operating income (loss)	**(2,533,569)**	**(4,800,000)**	**(2,783,806)**	**1,938,008**	**9,168,631**	**18,021,768**	**28,686,339**
Other income (expense):							
Grant income	3,000	0	0	0	0	0	0
Interest expense	(1,515,902)	(1,600,000)	(840,000)	(1,050,000)	(1,260,000)	(1,512,000)	(1,814,400)
Misc gains/losses	1,185,877	0	0	0	0	0	0
Total other expense	**(327,025)**	**(1,600,000)**	**(840,000)**	**(1,050,000)**	**(1,260,000)**	**(1,512,000)**	**(1,814,400)**
Loss before provision of income taxes	**(2,860,594)**	**(6,400,000)**	**(3,623,806)**	**888,008**	**7,908,631**	**16,509,768**	**26,871,939**
Provision for income taxes	0	0	0	0	(921,863)	(1,809,337)	(4,317,579)
Net income (loss)	**(2,860,594)**	**(6,400,000)**	**(3,623,806)**	**888,008**	**6,986,767**	**14,700,431**	**22,554,360**
Preferred stock dividend	(75,535)	(600,000)	(660,000)	(726,000)	(798,600)	(878,460)	(966,306)
Preferred stock deemed dividends	0	0	0	0	0	0	0
Net income (loss) available to common shareholders	**(2,936,129)**	**(7,000,000)**	**(4,283,806)**	**162,008**	**6,188,167**	**13,821,971**	**21,588,054**
Net loss per share - basic (in Dollars per share)	$ (0.03)	($0.03)	($0.02)	$0.00	$0.03	$0.07	$0.10
Net loss per share - diluted (in Dollars per share)	$ (0.03)	($0.03)	($0.02)	$0.00	$0.03	$0.07	$0.10
Weighted average shares outstanding - basic (in Shares)	105,177,272	209,000,000	209,000,000	209,000,000	209,000,000	209,000,000	209,000,000
Weighted average shares outstanding - diluted (in Shares)	105,177,272	209,000,000	209,000,000	209,000,000	209,000,000	209,000,000	209,000,000

Source: Company filings, Zacks Investment Research estimates.

KEY MANAGEMENT

Lawrence Diamond – Chief Executive Officer and *Director*

Mr. Diamond has served as Chief Executive Officer November 2019 and Director since October 2019. He also serves as Chief Executive Officer and Principal of Diamond Consulting, a consulting firm focused on enhancing the performance for healthcare businesses. From 2018 to 2019, he served as CEO of Intelligere, Inc., a supplier of interpretation and translation for 73 languages to healthcare providers. From 2014 to 2017, Mr. Diamond served as the EVP and the COO of PointRight, Inc., a leading healthcare analytics firm specializing in long-term and post-acute care using predictive analytics for skilled nursing, home health, Medicare & Medicaid payers, hospitals, and ACOs. Additionally, Mr. Diamond served as the Vice President of Insignia Health from 2013 to2014, where he grew their business internationally and domestically providing population health engagement via their validated program (Patient Activation Measure, PAM) and SaaS-based population health-coaching. In addition to leadership roles in telemedicine, mobile technology, Mr. Diamond spent eight years UnitedHealth Group, where he also served as Vice President, driving their Medicare Advantage, pharmacy products, health plan operations, and mergers and acquisitions. He began his career at Merrill Lynch in private client banking in 1985 and earned his M.B.A. at the University of Minnesota, and his B.S., Business Administration, at the University of Richmond.

Phillip Keller – Chief Financial Officer

Prior to joining Mitesco in 2021, Mr. Keller, was the Chief Financial Officer, Secretary and Treasurer of First Choice Health Care Solutions, Inc. a $50 million integrated care platform of non-physician owned orthopedic and spinal care medical centers for four years. Previously he was Managing Director at Solution Management Corp, a financial and operational consulting firm and was Chief Financial Officer at RehabCare, a $1.5 billion provider of physical, occupational and speech-language rehabilitation services to hospital, nursing facilities and home care setting in 47 states. Mr. Keller has also held senior finance roles at PharMerica, Inc. and BioScrip. Mr. Keller received his Bachelor of Science in Accountancy from Loyola University of Chicago and is a Certified Public Accountant and Chartered Global Management Accountant.

Tom Brodmerkel – Chairman

Tom Brodmerkel brings over twenty-five years of experience as a healthcare executive. He has a wealth of knowledge in operations, business development, marketing, and national sales management. Tom acquired majority interest and became CEO and Chair of Wave Global Services in 2016. (dba: Wave Health Technologies). Recently, Tom joined the board of CareSource Corporation, a not-for-profit $10B health plan, as well as PointRight, a privately held company, based in Cambridge, Massachusetts.
Mr. Brodmerkel's passion for the senior market is well chronicled in his stellar career with experiences including: President, Medicare Programs, a +$2 billion division of Coventry Health Care; nine years at UnitedHealth Group, where his positions included President of United Health Advisors and COO of United Healthcare's +$3 billion Medicare Programs division. Tom has also served as a senior executive in start-up healthcare companies including Matrix Medical Network, Definity Health and American Telecare. Earlier in his career, Mr. Brodmerkel held regional VP sales management positions with Principal Financial Group (ONA) and Mutual of New York (MONY). Tom is a graduate of the United States Naval Academy in Annapolis, MD, Mr. Brodmerkel served in both active and reserve duty in the U.S. Navy.

Michael C. Howe – CEO, The Good Clinic.

Michael C. Howe is the Chief Executive Officer of The Good Clinic, LLC. Mr. Howe has successfully grown consumer-facing businesses, including the business now known as MinuteClinic, acquired by CVS in 2006. As CEO of the new business unit, Mr. Howe brings 30+ years of consumer and healthcare experience including Minute Clinic, Arby's Restaurants, and Verify Brand.

Bradley Case – President, The Good Clinic.

Bradley Case has spent more than 28 years leading innovation in healthcare strategy, finance, and care delivery. He brings extensive experience in clinical model design, consumer engagement strategies, and the integration of technology into the practice of medicine. Previously, Mr. Case was in senior leadership roles for Estrella Health, Bright Health, and UnitedHealth Group. His most recent role was as chief strategy officer for SymphonyCare, a next-generation healthcare technology

Rebecca Hafner-Fogarty – Chief Medical Officer

Rebecca Hafner-Fogarty, MD, MBA, FAAFP is the Chief Medical Officer. Dr. Hafner-Fogarty brings valuable consumer health experience including senior roles at MinuteClinic as well as Zipnosis. She is an experienced primary care physician who served on the Minnesota Board of Medical Practice for many years and has deep expertise in regulatory and policy issues in telemedicine and other healthcare innovation.

Kevin Lee Smith – Chief Nurse Practitioner Officer

Kevin Lee Smith DNP, FNP, FAANP is the Chief Nurse Practitioner Officer with previous experience including helping to create the MinuteClinic model and providing early-stage informatics leadership at Zipnosis. Dr. Smith has also been an active primary care Nurse Practitioner and served in faculty positions at the University of Minnesota throughout his career.

Jim "Woody" Woodburn - Founder

Jim "Woody" Woodburn, MD, MS is a founder and has been key to the success of organizations including MinuteClinic, Applied Pathways and several other venture capital-funded companies. In addition to his experience as an Emergency and Occupational Medicine physician leader, he was Medical Director at BCBS of MN and led employee health and wellness programs for over 12 years. Dr. Woodburn led the successful clinical expansion for MinuteClinic including the provider ownership model and clinical quality management.

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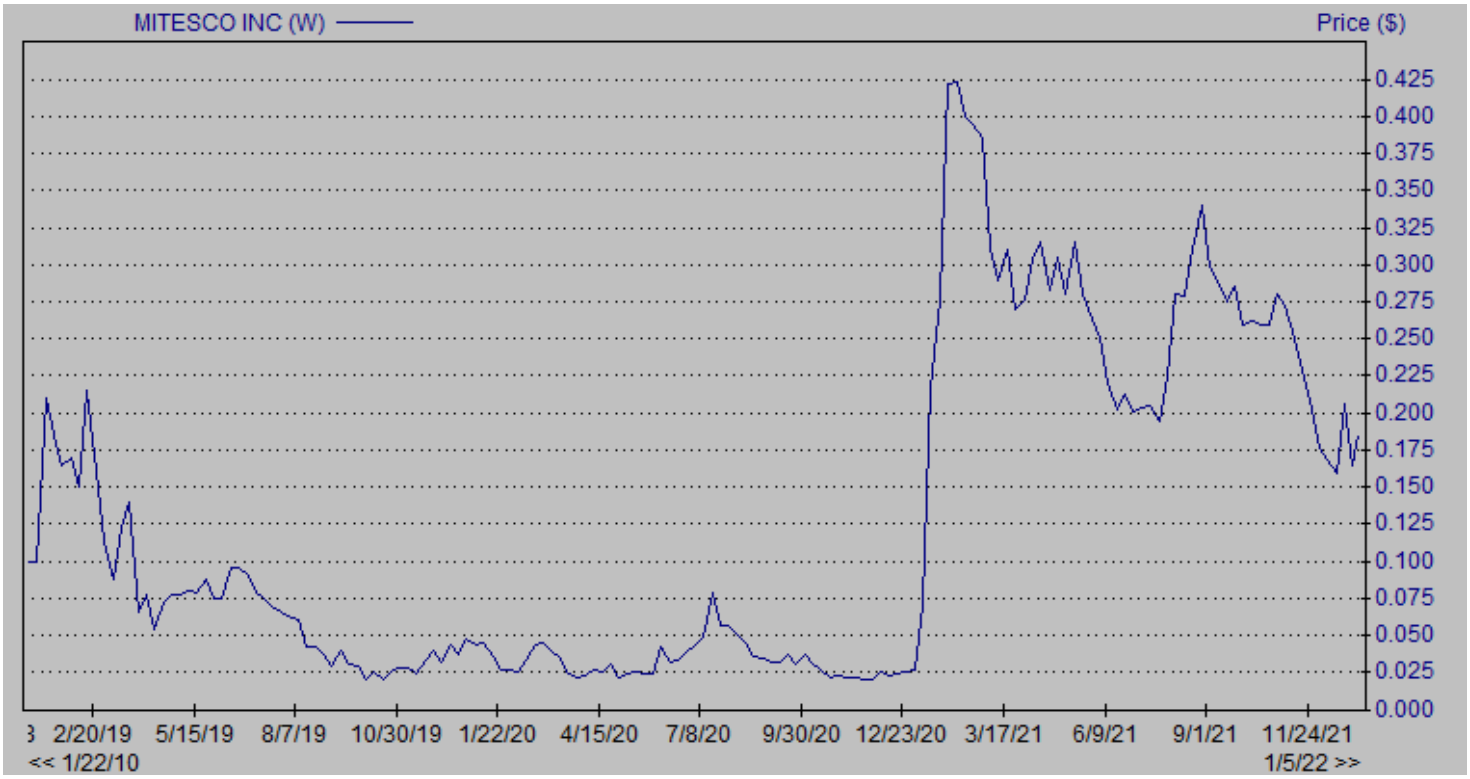

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