Fairfax
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September 16, 2019

Mr. Matthew Gilman, MPPA
Facilities Planning and Safety Program Manager
Health Care Regulation and Quality Improvement | Certificate of Need
Oregon Health Authority
800 NE Oregon Street, Suite 465
Portland OR 97232

Dear Mr. Gilman:

RE: Responses to Oregon Health Authority Questions Regarding NEWCO's Request to Establish a 100-Bed Inpatient Psychiatric Hospital in Washington County (CN #682)

On behalf of Fairfax Behavioral Health and Universal Health Services, I am pleased to provide responses to the Oregon Health Authority ("OHA") questions included in your letters dated July 25, 2019.

I would be happy to answer any questions you have on the above responses. I can be reached at ron.escarda@uhsinc.com or at 425.821.2000.

Sincerely,

Ron Escarda
CEO & Group Director of the Pacific Northwest
Universal Health Services

10200 NE 132ND ST | Kirkland, WA 98034 | 425.821.2000

OHA Application Completeness Questions

1. **On page 39 of the application, you state that you have met with healthcare organizations in the Service Area. With the exception of Providence St. Vincent, which refers to an agreement with Cedar Hills Hospital, have you met with any providers of inpatient psychiatric care? Please identify the organizations that you have met with.**

UHS executives have met with the healthcare organizations Providence Health & Services-Oregon, Kaiser Permanente, and HealthSource. There have also been meetings with local planning and regulatory agencies and elected officials in the course of obtaining site plan approval in Wilsonville. This has included the Wilsonville Mayor, City Council, and the Wilsonville Planning Commission.

2. **The applicant has stated that in 2018, their existing facility as Cedar Hills "deflected" 180 referrals a month; and for the first five months of 2019, "deflected" 337 referrals a month. The applicant needs to supply further information regarding these deflections - including source of referral or location of client at time of referral (such as ED or jail), potential payor, age if available, reason for deflection, and disposition of referral if not admitted to Cedar Hills.**

We will provide the requested information for Cedar Hill Hospital deflections as soon as we are able to compile it.

3. **The Inpatient Medical Exclusionary Criteria policy reflects if seclusion restraint was required in referring agency, patient must have demonstrated at least six hours free of seclusion restraint prior to transfer. Please describe how this policy is inclusive of the needs of the patient population being served.**

Cedar Hills Hospital staff have revised and renamed the policy in June 2019 to be the 'Admission and Exclusionary Criteria for Inpatient Treatment' P&P. The use of seclusion / restraint as an admission exclusionary condition has been removed. Staff do inquire about the use of seclusion / restraint during the clinical nurse-to-nurse communication with the referring hospital, but do not use this information to exclude the patient from admission; it is merely clinical information about the patient's recent behaviors and helps prepare CHH staff for what might be issues to expect upon the patient's arrival. Please see new Appendix 14 for the revised CHH Admission and Exclusionary Criteria for Inpatient Treatment Policy

4. **Oregon Certificate of Need rules do not account for out of state migration effects. Please amend the application to reflect this.**

We are unclear what this question refers to and request clarification. Within our application we incorporated migration effects into the acute care bed need model and qualitatively discussed migration effects in the context of the inpatient psychiatric bed need model. However, the psychiatric bed need model does not include migration.

Out and in-migration to the Washington County Service Area is applied within the acute care bed need models described in Appendix 11 on pages 425 and 426 and presented in Table M on page 427 of our application. As we discuss in the application, since the acute care bed need models show a surplus of 254 beds in Year 5 and 158 beds in Year 10, exclusion of out-of-state in-migration in these models will not affect our conclusions regarding bed need.

We discussed out-of-state migration on pages 93 and 94 of the application and presented migration statistics for Cedar Hills Hospital in Table 37, page 94. As stated above, migration was not used in the need models for inpatient psychiatric bed need. We included the qualitative discussion as supplementary evidence of need for additional inpatient psychiatric beds.

Form 10k

5. **On page 271 of the application, you state that you have partnered with local physicians in the ownership of certain facilities. Will the proposed facility have similar partnerships?**

The proposed facility will not have similar partnerships.

6. **On page 283 of the application, you state the "real property ownership interest" is owned, however, endnote #8 (page 290) states that the property for Cedar Hills Hospital is leased. Please comment on what, if any, impact this will have on Willamette Valley Behavioral Health (WVBH).**

There would be no impact on our proposed hospital. As stated in the application, UHS owns the proposed site for WVBH, an 8.7 acre vacant lot in the City of Wilsonville, allowing sufficient space for the hospital and necessary parking, as required by zoning regulations. Appendix 7 on page 218 of our application presented the property tax statement for WVBH's proposed site, billed to UHS for the period July 1, 2018-June 30, 2019, demonstrating ownership.

CN-5: Income Statement

7. **CN-5 - Outpatient revenue is growing at a slower rate than inpatient and other revenues. As the national trend is growth in outpatient services, please comment why WVBH expects inpatient revenues to grow faster than outpatient services.**

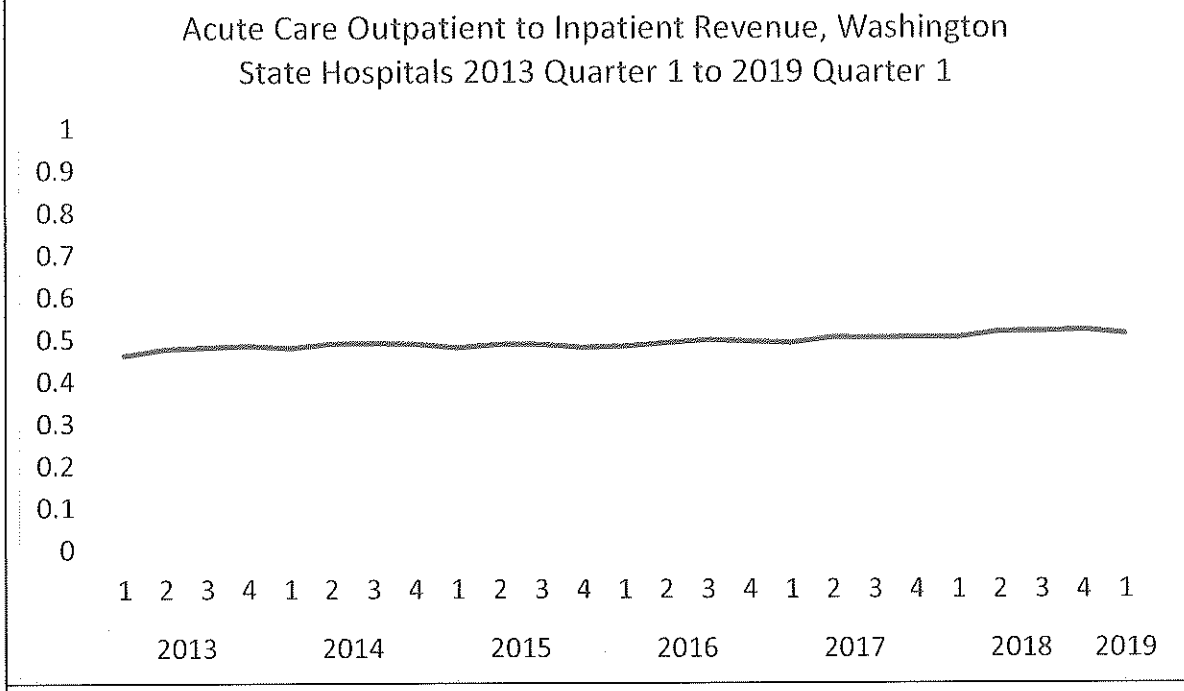
Willamette Valley Behavioral Health is first and foremost an inpatient psychiatric hospital, but outpatient services are an important part of its care continuum. We agree there may well be patients who do not require inpatient care and can be treated purely on an outpatient basis. There will also be inpatients, who upon discharge, will need follow-up care provided in an outpatient setting. In this regard, inpatient and outpatient services are essential complements to each other.

In general, UHS, through its extensive experience, assumes, where it has a psychiatric hospital, that its inpatient care will drive demand for outpatient services. We have modeled utilization and expected financial performance based on that assumption. For the months January to May 2019, the ADC for outpatient visits at Cedar Hills Hospital was 43% of the ADC for inpatient admissions; this percentage statistic has been applied to model projected utilization and financial performance for WVBH and assumed constant across all years of the forecast period. Outpatient revenue is calculated by multiplying the estimated ADC for outpatient services by outpatient revenue per visit (also drawn from January to May 2019 Cedar Hills Hospital actuals), and then multiplying that product by 254, which is the number of working days in a year. The slower growth rate identified by the OHA was due to a calculation error for the four months in 2021, where OP revenues were calculated assuming a full year rather than only four months of operations. This error has been corrected and is reflected in the revised income statement and accompanying CN forms CN-5, CN-8, CN-9, and CN-10 in Appendix 10, as well as Tables 11,13, and 14 in Appendix 15. Both Appendixes are included with our responses.

The OHA notes the national growth in outpatient services relative to inpatient services. While possibly true, it can be due to either growth in dedicated outpatient facilities, such as ambulatory surgery or rehabilitation centers, or a change in care delivery models where care shifts from inpatient to outpatient care. Given the need for inpatient psychiatric services, and based on UHS' experience, generally, and Cedar Hills Hospital, specifically, forecast models that tie outpatient to inpatient utilization, based on CHH actuals, should be very reasonable.

It should be also noted that in the case of Cedar Hills Hospital, there has actually been a compositional shift towards the provision of inpatient services. In September 2015, the ratio of outpatient to inpatient ADC was about 58%. This decreased to about 43% in May 2019. For a broader perspective, in Washington, the Washington State Department of Health publishes quarterly reports which provide outpatient and inpatient revenue statistics for hospitals providing acute care services. The ratio of outpatient to inpatient revenue for hospitals providing acute care services is plotted below in Figure 1.

Figure 1: Ratio of Acute Care Outpatient to Inpatient Revenue, Washington State Hospitals: 2013 Q1 to 2019 Q1



Sources:
Washington State Department of Health: Quarterly Reports 2013-2019
https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalFinancialData/QuarterlyReports

The ratio of outpatient to inpatient revenues for acute care providers in Washington State has increased slightly, from about 46% in the first quarter of 2013 to about 51% in the first quarter of 2019. This reflects an annual growth rate of about 1.5%. If we were to apply an annual growth rate of 1.5% to outpatient ADC within the WVBH financial model, this would result in an additional 93 outpatient visits, associated with about $550,000 in gross revenue from outpatient services in Year 5 of that model.

8. **CN-5 – Other expenses include utilities and plant maintenance. Total expenses in this category do not increase although volumes will increase dramatically over time. Please comment on the expectation that other expenses will not change regardless of inpatient volumes.**

Expenses for utilities and plant maintenance were calculated based on their estimated cost per square foot, where the estimated cost per square foot for these expenses was determined based on actual expenditures by Cedar Hills Hospital between January and May 2019. Since Cedar Hills was operating at capacity during these months, these expenses thus assume a full hospital and will slightly overstate actual expenses during the first few years of operations at WVBH.

In the interest of conservatism, we have added an expense growth factor of 5% per year, every year after the start-up in September 2021, for costs related to energy use, bank fees, postage, marketing, and collections. The revised income statement and CN forms CN-5, CN-8, CN-9, CN-10, along with revised versions of Tables 11, 13, and 14 reflect these increases in annual costs.

Please see revised Appendix 10, CN Forms and new Appendix 15-Revised Tables, included with these responses.

9. **CN-5 – Income Statement shows contractual adjustments of 54% for all future years except 2022, which is 36%. Why would 2022 have a substantially better collection rate than future years? Generally, the expectation is that contractual adjustments would stay consistent over the years. Please comment.**

This Income Statement shown in CN Form 5 was in error. It incorrectly calculated inpatient revenue for partial year 2021 and year 2022. We have included a revised income statement (CN-5), as well as corrected versions of CN Forms CN-8, CN-9, and CN-10 and Tables 11, 13, and 14 in Appendix 10 and Appendix 15, respectively. Based on the correction, inpatient contractual adjustments are calculated at a constant 42.7%, and overall contractual adjustments are calculated at 83.9% for the last four months of 2021, 55.1% for 2022, and 54.2% thereafter. The higher percentages in 2021 and 2022 reflect additional adjustments for Medicare during the first 5 months of operations.

10. **CN-6 - Balance Sheet – Consideration of ratios on company profitability. As the Balance Sheet was not completed due to consolidation, it would be helpful to see liquidity ratios and debts ratios on CN-9 based on the consolidated balance sheet to provide a complete picture of the ratios required. Please include this information.**

Based on the UHS Consolidated Balance Sheet, published on page 93 of the UHS 10-K (page 350 of the application), we calculate current liquidity ratios of 1.33 in 2017 and 0.97 in 2018.[1] Thus, current assets are approximately equal to current liabilities, which means UHS is able to cover its obligations. Debt ratios based on the UHS Consolidated Balance Sheet are equal to 51% in 2017 and 53% in 2018, so UHS assets are approximately double that of UHS debt.[2]

11. **CN-6 - Balance Sheet – Regarding cash flow impact of $48M financed for construction on the consolidated company. Please comment on other expansion and/or construction projects that also necessitate cash flow in the next 6 months, as the application included consolidated statements.**

Universal Health Services spends about $500 million per year on capital expenditures for behavioral health projects, including several current BH de-novo projects either underway or about to start construction. This would include the $47 million planned for WVBH. It is UHS policy and practice to fund all capital projects from cash flows from operations. In fact, UHS has historically not used debt-financing for project development.[3]

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[1] As of December 31, 2018, current assets were $1,937,802,000 and current liabilities $1,448,738,000. As of December 31, 2017, current assets were $1,798,002,000 and current liabilities, $1,848,034,000.
[2] As of December 31, 2018, total assets were $11,265,480,000 and total debt, $5,799,687,000. As of December 31, 2017, total assets were $10,761,828,000 and total debt, $5,710,392,000.
[3] It was not feasible to obtain a comprehensive list of all UHS expansion/construction projects underway or planned, since, given the sheer size of UHS, that list constantly changes.

In 2018, the Comprehensive Income Attributable to UHS, Post-Provision for Taxes was $775,219,000 and $784,897,000 in 2017.[4] It uses these operational cash flows to fund projects like WVBH.[5]

The most recent audited financial statements included in UHS' 2018 Form 10-K report[6] for calendar year 2018 were provided in Appendix 9 (beginning on p. 227, Application). It showed UHS had $1,937,802,000 in Current Assets as of December 31, 2018, all of which were cash or near-cash equivalents except $148 million in supplies.[7] UHS has more than sufficient cash reserves to completely fund the requested project.

12. CN-6 - No Balance Sheet is provided as numbers are consolidated – please comment on commitments/construction/project needs of UHS over the next 12 months that would impact cash flow of the consolidated organization.

Please see response to question 11, above.

13. Many of the tables and references apply to Cedar Hills and operations at Cedar Hills. Please provide 3 years of financial statements (income statement) for Cedar Hills.

Please see new Appendix 16, Cedar Hills Hospital, Income Statement, 2016-2018, included with these responses.

Need models

14. Table 8 (Page 26) Inpatient Bed Need Summary by Age Group – How is the target bed ratio of 32.5 calculated? Page 25 indicates that it came from 2016 data from northwestern states, including Oregon, Alaska, Idaho, Washington and Montana on the SAMHSA website. We could not recalculate this number; Please provide detail. Please also comment why the West Coast data was not used (which included Nevada and California) and why the 2017 report was not utilized?

To calculate the number of inpatient beds per 100,000 persons for each state in the U.S., we used data from the 2016 N-MHSS as referenced in our application. Although the N-MHSS is published every year, it is only every second year that facilities are asked the number of inpatient psychiatric beds they operate. The most recent year of inpatient psychiatric bed data is thus 2016, and is published in Table 4.7 of the N-MHSS 2016 report.[8] Using population data from the U.S. Census, we then calculate the number of beds per 100,000 persons. In Table 1, below, we present, for every state part of the Western Census Region, bed counts, population, and bed-to-population ratios for 2016. We chose the northern states part of U.S. Census Region West, as those were most comparable on a population-density basis.

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[4] Please see p.92, Universal Health Services. Inc and Subsidiaries Consolidated Statements of Comprehensive Income, 2016, 2017 and 2018.
https://ir.uhsinc.com/static-files/c921b88d-f35c-46f5-a27b-5e52ecbcd523

[5] We stated that all funds required for the proposed project will be provided by UHS cash reserves. We also provided a letter from our Mr. Filton, EVP and Chief Financial Officer, Universal Health Services, Inc., committing UHS reserves to this project (Appendix 8, p. 226, Application).

[6] https://ir.uhsinc.com/static-files/c921b88d-f35c-46f5-a27b-5e52ecbcd523

[7] Please see p. 93, Universal Health Services. Inc and Subsidiaries Consolidated Balance Sheets, 2018.

[8] This report can be obtained online at:
https://www.samhsa.gov/data/sites/default/files/2016_National_Mental_Health_Services_Survey.pdf

Table 1: Inpatient Psychiatric Beds to Population Ratios, U.S. States in the Western Census Region

State	IP Beds, 2016	2016 Population	IP Beds per 100,000
NW Average	3,440	14,851,381	32.6*
West Average	12,822	56,980,280	30.6*
West Census Region Average	18,267	76,614,450	31.6*
Alaska[1 2]	310	741,504	41.8
Arizona	1,817	6,945,452	26.2
California[2]	8,516	39,209,127	21.7
Colorado	1,149	5,540,921	20.7
Hawaii	361	1,428,105	25.3
Idaho[1 2]	560	1,682,930	33.3
Montana[1 2]	501	1,040,863	48.1
Nevada[2]	866	2,919,772	29.7
New Mexico	668	2,092,789	31.9
Oregon[1 2]	1,080	4,091,404	26.4
Utah	1,127	3,042,613	37.0
Washington[1 2]	989	7,294,680	13.6
Wyoming	323	584,290	55.3

Sources:
2016 N-MHSS Table 4.7,
https://www.samhsa.gov/data/sites/default/files/2016_National_Mental_Health_Services_Survey.pdf

U.S. Census Annual Estimates of the Resident Population, April 1, 2010 to July 1, 2018
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2018_PEPANNRES&prodType=table

Notes:
*Averages are not weighted by population counts.
[1] State is counted as part of the NW Average.
[2] State is counted as part of the West Average.

The average number of inpatient psychiatric beds per 100,000 persons across the Northwest states of Alaska, Idaho, Montana, Oregon, and Washington is 32.6, which we rounded down to 32.5 in our inpatient psychiatric bed need models. The impact of including California and Nevada in the average, as asked by the OHA, would reduce this average to 30.6, and slightly lower our estimates of bed need in 2019 from about 130 beds to about 110 beds. However, under the revised average there remains current net need for more psychiatric beds than our 100-bed application.

The average number of inpatient beds per 100,000 persons across all states part of U.S. Census Region West is 31.6. Use of this number would also reduce our estimates of bed need (to about 120 beds), but again, there would *still* be more net need currently than our request.

In summary, use of either the Northwest average, the Northwest plus California and Nevada average, or the West Census Region average would not significantly affect our estimates of net need, and would not affect our conclusion that need exists for our proposed hospital.

15. **Table 30 (Page 88) Occupancy Rates at Adult Psychiatric Inpatient Providers, Clackamas and Washington Counties, 2017 – Providence reflects an occupancy rate of 65.9%, wouldn't that indicate that there is capacity at Providence St. Vincent? Please comment.**

From Table 30 on page 88 of our application, Providence St. Vincent has a calculated ADC of 21.7, which would be sufficient to fill about 2/3s of their 33 beds. This suggests some available capacity at Providence St. Vincent. If a hospital is "full" when their ADC is 80% of more of their available bed capacity, this indicates an available capacity at Providence St. Vincent of about five inpatient psychiatric beds. Deducting this figure from our bed need calculations, we calculate a net need of 75 adult inpatient psychiatric beds and a total net need of 125 inpatient psychiatric beds for adolescents, adults, and older adults in 2019. These numbers would then grow to net needs of 80 adult beds and 141 adult, adolescent, and older adult beds in Year 3. Thus, even allowing for use of an additional five beds to fill the idle capacity at Providence St. Vincent, has no material effect on net need for our proposed hospital.

16. **Table P (Page 431) Service Area, Net Acute Care, Inpatient Bed Need, 5-year (2024) and 10-Year (2029) projections – Table shows a 357-bed surplus. Shouldn't these surplus beds be considered available for psychiatric care and indicate that the bed shortage calculated by WVBH is overstated? Please comment.**

Table P on page 431 of our Application shows a 357-bed surplus for acute care beds in Washington County. After ten years, we predict there will be a surplus of 158 Acute Care beds. As we stated in our Application, the OHA has traditionally been of the position that inpatient acute care beds are convertible to inpatient psychiatric care beds. Using that logic, a surplus of acute care beds, from the OHA's perspective, would negate any argument for additional inpatient psychiatric care beds. In point of fact, the data shows that existing acute care providers have been unable or unwilling to convert their persistent excess capacity in inpatient acute care beds to inpatient psychiatric care beds despite demonstrated need for additional psychiatric beds. Based on the OHA approval of the Lifeways Certificate of Need request, we understand the importance of "unusual circumstances," including nonavailability, access, and less costly alternatives.

The inability of existing acute care providers to convert idle acute care inpatient beds to psychiatric inpatient beds has led to an overburdened mental healthcare system in Clackamas, Multnomah, and Washington counties, and contributed to the current mental health crisis facing Oregon. Lack of access to inpatient psychiatric beds has pushed Oregon to the bottom of the national rankings in mental healthcare, with a fourth of Oregon adults with mental illness reporting an unmet need.[9] Furthermore, Oregon continues to report unacceptable rates of ED

[9] http://www.mentalhealthamerica.net/issues/mental-health-america-adult-data

boarding, as well as the incarceration of individuals who would be more appropriately handled in psychiatric hospitals. The Unity Center for Behavioral Health was intended to help solve these problems, but instead it has exacerbated the problems of nonavailability, access, and less costly alternatives facing the mentally ill in Clackamas, Multnomah, and Washington Counties. The Unity Center opening coincided with the closure of mental health facilities at four other hospitals in the Portland area, and it has not improved access or reduced wait times for patients. Furthermore, to date, it has failed to provide a safe and stable environment. Three patients have so far died at the Unity Center, at least two of which were apparently preventable and resulted from poor quality care by Unity Center staff. It is presently unclear what circumstances surround the most recent death at the Unity Center. [10]

These unusual and extenuating circumstances are strong evidence of the need for additional inpatient psychiatric bed capacity and the failure of any higher priority methods to meet this need. We have described these unusual circumstances in detail in our Application on pages 10 through 13 and pages 60 through 72. As a result of these unusual circumstances, it is clear the 357 surplus acute care beds are not available for psychiatric care and do not indicate that the shortage of inpatient psychiatric beds we have calculated in our Application is overstated.

17. **Table 8 (Page 26) Inpatient Bed Need – In various tables, WVBH considered only two service areas for its Adult Bed Need. For adolescents, the bed need and growth in bed need is modest. For geriatrics, the anticipated bed need and growth is nearly 70% over a 10-year period from 2019 to 2029. Please comment why the bed need should not be for the entire 3 service areas for all age groups and why it is reasonable to expect the need for geriatric beds to increase so dramatically, when the growth the last few years has not led to an increase in bed need.**

Adult Service Area of Clackamas-Washington counties vs. Clackamas-Multnomah-Washington counties

In our original January 2016 application, we calculated adult inpatient psychiatric bed need for the tri-county service area of Clackamas, Multnomah, and Washington counties. This was reduced to the counties of Clackamas and Washington in our present Application in light of the decision by the OHA to deny our prior Application. In the CN decision letter dated July 6, 2017, OHA staff stated: "With regard to the service area for psychiatric beds, the proposed tri-county area of Multnomah, Washington and Clackamas Counties is also too large and the more appropriate service area would be a single county service area." [11] The tri-county service area may be the most appropriate service area (and its usage would have simplified our current Application), however given the previous decision by the OHA, we reduced our proposed service area to Clackamas and Washington Counties. If we recalculate our bed need models using the 32.5 target bed ratio for the tri-county area, we show a current need for nearly 142 adult inpatient psychiatric beds, or about 60 beds more than the Clackamas-Washington Service Area. Our recalculated bed need model under the original assumptions for the tri-county area is presented in Table 2.

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[10] https://www.oregonlive.com/health/2019/07/patient-dies-at-portland-mental-health-facility-months-after-safety-issues-said-to-be-resolved.html, Accessed August 1, 2019

[11] OHA July 6, 2017 NEWCO Oregon, Inc., Final Decision on CN Application #675, pp. 3.

Table 2: Inpatient Psychiatric Bed Need, Adults age 18 to 64, Clackamas, Multnomah, and Washington County Service Area

18 to 64 Year Old Inpatient Psychiatric Bed Need Model

Clackamas, Multnomah, Washington County Service Area	Base Year 2019	Year 1 2020	Year 3 2022	Year 5 2024	Year 10 2029
Service Area Resident Population, 18 to 64	1,190,316	1,197,676	1,221,211	1,245,470	1,305,163
Total Planning Area Psychiatric Beds (Clackamas, Multnomah, and Washington)	245	245	245	245	245
Existing Psych Bed Ratio (Per 100,000 Residents)	20.6	20.5	20.1	19.7	18.8
Forecast Psychiatric Bed Need--Proposed Ratio--2016 NW Average					
Target Bed Ratio Per 100,000 Residents	32.5	32.5	32.5	32.5	32.5
Gross Bed Need at Target Ratio	386.9	389.2	396.9	404.8	424.2
Current Supply	245	245	245	245	245
Psych Bed Net Need, Clackamas, Multnomah, and Washington County Service Area	**141.9**	**144.2**	**151.9**	**159.8**	**179.2**
Psych Bed Net Need, Clackamas and Washington County Service Area (Table 8)	**79.7**	**81.0**	**85.3**	**89.7**	**100.7**

Older adult (65+) growth question

The OHA has asked why it is reasonable to expect the need for older adult beds to increase by nearly 70% when the growth the last few years has not led to an increase in bed need. We presume that the OHA is referring to the growth in net bed need between 2019 and 2029, which we estimate to increase by about 31 beds. This represents a change from an initial net need of 47 beds in 2019 to a net need in 2029 of 78 beds, for an increase of about 67%. This increase in net need reflects the following factors:

1. A constant population-based use rate of 32.5 beds per 100,000 persons across all 10 years.

2. Total population growth for older adults of about 35% from 271,161 persons to 367,827 persons 65+ years old between 2019 and 2029.

3. An existing number of older adult beds at Tuality Healthcare and Providence Milwaukee Hospital totaling 42, which is assumed to remain constant between 2019 and 2029.

Given a population-based use rate of 32.5 beds per 100,000 persons and a population of 271,161, we calculate a total need of about 89 beds for older adults. If this population grows as forecast to 367,827 in 2029, total bed need grows proportionally by about 35% to 120 beds.[12] Subtracting out the existing 42 beds results in an initial net need of 47 beds, which is projected to then increase to 78 beds in 2029. This near 70% growth is a function of applying an increase of 31 beds to the number of 47 beds of net need. In other words, *the 67% increase is driven entirely by forecasted changes in population.*

With regards to demand for psychiatric beds by older adults, from Table 21 on page 78 of our Application, we calculate psychiatric use rates for older adults from 2008 to 2017, and show a declining use rate in discharges but an increase in patient day use rate. These trends control for changes in population. On the other hand, estimates of demand which do not control for changes in population show increases in utilization. In Clackamas, Multnomah, and Washington Counties, patient days for older adults have respectively grown by about 5.6%, 6.4%, and 2.7% between 2008 and 2017.[13] Growth in utilization of inpatient psychiatric beds for the older adult age group is further evidenced when looking at Service Area providers. The average daily census for older adults treated at providers in the Clackamas, Multnomah, and Washington county area has grown from 25.9 in 2013 to 44.2 in 2017. Extrapolated over 10 years this would represent a change of 36.7 beds, a change greater than that predicted by the population growth rates described above. From our review of available data, our estimated growth in inpatient psychiatric bed need for older adults is consistent with expected population growth and changes in historical utilization from this age group.

18. **Table 8 (Page 26) and other tables involving Bed Need – Was consideration of Tuality Hospital reopening their geriatric facility considered in the calculations? Please indicate how those 22 beds were considered in the bed need. If not, please comment on impact.**

Our bed need models for older adults (age 65+) assume the 22 beds that are part of the Tuality Healthcare geriatric facility are fully operational and available for older adults. As listed in Table 22 on page 80 of our Application, we included geropsychiatric beds operated by Providence Milwaukie Hospital and 22 beds operated by Tuality Healthcare. This then reflects 42 geropsychiatric beds in the Clackamas-Multnomah-Washington county service area available for older adults. In Table 8 on page 26 of our Application, these 42 beds are deducted from gross bed need of 98.3 to obtain a net bed need of 56.3 in Year 3 (Table 8, pg. 26, Application).

19. **Table 12 (Page 47) and throughout application – Length of Stay (LOS) at Cedar Hills has decreased from 11.2 to 10.57 over the last few years. Can you comment on the decrease? Was the overall trend for decreased length of stay considered in these calculations?**

We recognize there have been observed modest reductions in average length of stay at Cedar Hills Hospital over the last few years. However, since there have been no demonstrated shifts in patient demographics, payor mix, inpatient care complexity, or other factors reasonably expected to affect ALOS going forward, we think the most reasonable approach is to utilize the most recent actual LOS from Cedar Hills Hospital, a 2019 figure, and hold it constant.

[12] This reflects a change of about 31 beds, where 31=0.35*89
[13] Oregon Inpatient Data, 2008-2017.

20. **Table 12 (and other tables throughout Application,) Page 47 – Future needs is projected on LOS of 10.57. As described above, Cedar Hills has seen a decline in LOS from 11.2. Why is it not reasonable to expect a further decrease in LOS in the future for WVBH's inpatient volumes over the next 10 years?**

Please see our response to question 19 above.

Payer data

21. **Page 49, Payer Mix Projection – Medicaid is estimated to be 12.8% of Gross Revenues. What data or assurances are there to support the increase in Medicaid over Cedar Hills (Table 10) of 8.7%?**

In all cases, patient admissions are based on medical necessity. Cedar Hills Hospital has operated in Oregon for a number of years where federal regulations, commonly referred to as the IMD ("Institution for Mental Diseases") exclusion, are in place. The IMD exclusion prohibits the use of Medicaid funds for free-standing psychiatric inpatient services if there are more than 16 individuals in the facility. However, this exclusion does not apply to child/adolescent psychiatric care or to psychiatric care provided to older adults.

We fully expect that WVBH will be able to be reimbursed by Oregon Medicaid fee-for-service and managed care for adolescent and older adult patient care, but not for patients 18-64 years of age. However, as stated above, WVBH will have admissions policies based on medical necessity, just as Cedar Hills Hospital has now.

It is not possible to precisely forecast payer mix, but we fully expect WVBH will provide at least 12.8% of its gross revenues in care to Medicaid-sponsored patients. As further evidence of the reasonableness of this expectation, please note that the three UHS Fairfax hospitals in Washington treat a very large percentage of Medicaid-sponsored patients, over 51% of total patient services revenues in 2018, as detailed in the table below.

Fairfax Behavioral Health Hospitals in Washington State, 2018	**Total Patient Service Revenues, by Payer ($)**			
Totals	**Medicare**	**Medicaid**	**Commercial**	**All other**
Fairfax, all	**29,187,200**	**99,738,800**	**25,177,600**	**38,085,600**
Fairfax Behavioral Health Everett	4,477,200	16,486,400	3,155,600	3,500,000
Fairfax Behavioral Health Kirkland	16,576,000	75,157,600	16,646,000	30,514,400
Fairfax Behavioral Health Monroe	8,134,000	8,094,800	5,376,000	4,071,200
	Percent of Total Patient Service Revenues, by Payer			
Fairfax, all	**15.2%**	***51.9%***	**13.1%**	**19.8%**
Fairfax Behavioral Health Everett	16.2%	*59.7%*	11.4%	12.7%
Fairfax Behavioral Health Kirkland	11.9%	*54.1%*	12.0%	22.0%
Fairfax Behavioral Health Monroe	31.7%	*31.5%*	20.9%	15.9%

Source: WA DOH Payer Census & Charge Comparison From 01/01/2018 To 12/31/2018

22. **Table 14 (page 52) WVBH Selected Financial Statistics, Revise (Gross Revenue per Patient Day) – Please comment why the gross revenue per patient day on this table is approximately $2,522, while the table Figure 5 (Page 33) for the UHS Fairfax WA facilities that list Washington Per Diem Charges are around $2,800. Does WVBH expect to charge at a lower rate than its Washington Facilities?**

In Figure 5 on page 33 of our application, we report per diem charges of about $2,800 for our Fairfax facilities in Monroe, Kirkland, and Everett, and per diem charges of about $1,800 for our facility in Spokane, based on 2018 inpatient statistics available from the Washington Department of Health CHARS (Comprehensive Hospital Abstract Reporting System) database. The average across all of these facilities in Washington State is about $2,551, which is approximately equal to the expected per diem charges for WVBH.

CHH Service Area

23. **Table 37 (Page 94) – Table shows that Cedar Hills only has 44% of its patients' volumes coming from the three service areas. Does this indicate there is a shortage in the three service areas or in other parts of Oregon or other states? Please comment on the need calculated in this application contrasted with the flat (or slightly declining) volumes from the three service areas at Cedar Hills.**

In Table 37 on page 94 of our Application, we document an increasing proportion of inpatient psychiatric discharges from patients residing in Oregon counties outside the Clackamas-Multnomah-Washington county area. Discharges from Oregon residents outside these counties rose from 313 in 2013 to 753 in 2018. These out-of-area Oregon residents, which in 2019 have accounted for over a third of Cedar Hills Hospital's patients, have served to both displace out-of-state patients and constrain the utilization of residents of Clackamas, Multnomah, and Washington counties. This is evidence of undersupply and shortages across other Oregon counties, and illustrates the need for additional mental health facilities across the state, not just in Clackamas, Multnomah, and Washington counties. We applaud the OHA's recent decision to award a Certificate of Need for Aspen Springs Hospital in Umatilla County, and hope for future expansions in inpatient psychiatric capacity throughout the state. Until that happens, the proposed WVBH is well situated on the I-5 corridor south of Portland to serve Oregon residents in those counties to the south.

Investigations into UHS and CHH

24. **The 10-K Annual Report in Appendix 9, Page 292, indicates several investigations into UHS practices, including several DOJ investigations. In addition, there have been news articles in various publications related to patient concerns that have been raised at several UHS facilities. Please comment on steps and processes UHS has taken to address these serious allegations.**

On page 292 of the 10-K annual report in Appendix 9, we describe the investigations of the DOJ into UHS' billings submitted to government payers in relation to services provided at UHS behavioral health hospitals. We have been advised by the DOJ Civil Division that the focus of their investigation was on medical necessity issues and billing for services not eligible for payment.

UHS has consistently denied any wrongdoing or improper conduct in its billings with government payers. The announcement of our preliminary settlement with the DOJ in July 2019 does not change that position. Given the significant amount of government reimbursement received by providers, Civil False Claims Act cases are an unfortunate but increasingly common reality in the health care provider industry. As indicated in the information released by UHS, following a lengthy and comprehensive investigation by the Government, the criminal investigation was closed with no charges filed against UHS or any of its facilities. Universal Health Services has a strong commitment to quality, operates a mature Compliance program, and is well regarded in the industry, with high quality scores as reported by independent accrediting authorities and multiple earned distinctions.

25. **Page 8 of the application states UHS has "successfully operated Cedar Hills Hospital in Washington County". However, Cedar Hills Hospital has had significant compliance issues in 2018 and 2019. Cedar Hills Hospital is currently in the process of returning to compliance following the most recent investigations. In addition, HCRQI substantiated complaints or compliance issues at this facility in May and August 2011, November 2012, June 2016, and December 2017. Please explain how WBHS will be managed differently to make it successful.**

We recognize there were a small number of compliance issues at CHH, but they have been successfully resolved. Further, we wish to emphasize CHH and WVBH are separate entities and would be managed separately.

In the interest of transparency, there were two issues in 2018 / 2019 that triggered multiple site surveys, an Elopement / Suicide incident in October 2018 and an EMTALA complaint in February of 2019.

<u>2018-2019</u>

- OHA and CMS surveyed us for the Elopement / Suicide incident. Surveys continued until July of 2019. CHH staff submitted Plans of Correction (POC), which were accepted and approved by both OHA and CMS. We have been cleared by OHA and are no longer being monitored. Although we are no longer being monitored by CMS, we are still in the process of self-auditing and monitoring our compliance with our POCs that were submitted.
- CMS received an anonymous complaint about not following EMTALA regulations (alleged we were taking funded patients as transfer requests over unfunded patients). Although the allegation could not be substantiated, the surveyors did find noncompliance with several requirements under EMTALA. We submitted our Plan of Correction; it was accepted and approved. We are no longer being monitored by CMS, but are still in the process of self-auditing to ensure our on-going compliance.

<u>2016-2017</u>

- 2016. Findings related to the use of seclusion / restraint, including the following issues: not updating the patient Master Treatment Plan following a restraint; a physician not authenticating his seclusion / restraint order; and the one-hour RN evaluation was late. Plan of Correction was accepted and approved by CMS; CHH is no longer being monitored by CMS.

- 2017. Findings related to CHH not preventing a patient-to-patient altercation in which a patient suffered knee pain as well as documentation of deficiencies related to nursing care for patient medical problems. Plan of Correction was accepted and approved by CMS. CHH completed the plan and is no longer being monitored by CMS.

2011-2012

- May and August of 2011, November 2012
    - The May and August incidents occurred under previous ownership; UHS acquired CHH in October of 2012 and has since implemented new processes and procedures.
    - The November 2012 site survey was likely for an incident that occurred prior to the acquisition of CHH in October of 2012.
    - We are unable to find any electronic record of a complaint and/or site survey issue in November 2012. The closest we could find is a site survey related to nurse staffing in December of 2012. There were findings related to noncompliance with OR's Nurse Staffing Law. A Plan of Correction was accepted and approved by OHA. CHH is no longer being monitored by OHA for this matter. Again, with UHS' acquisition of CHH in October of 2012, many changes have occurred related to staffing and policy / procedure.

Project feasibility

26. Page 35, OAR 333-580-0050 – Please provide information regarding sufficient, qualified personnel, adequate land, and adequate financing being available to develop and support the proposed project?

On pages 35 and 36 of our Application we outline our response to OAR 333-580-0050(2) regarding sufficient, qualified personnel, adequate land, and adequate financing available to develop and support the proposed project.

In Appendix 8 of our Application, we provided a letter from UHS' Chief Financial Officer committing funds to the project, and the consolidated balance sheet on page 350 shows 2018 cash reserves of nearly $75 million. Adequate funding thus exists for the proposed $47 million project.

UHS has already identified and purchased a site in the City of Wilsonville. Appendix 7 in our Application presented the property tax statement for WVBH's proposed site, billed to UHS for the period July 1, 2018-June 30, 2019. The proposed site location is currently an 8.7 acre vacant lot, allowing sufficient space for the hospital and necessary parking, as required by zoning regulations.

Given its existing presence in the Portland-Vancouver-Hillsboro MSA, UHS can leverage its experience to successfully recruit, train and employ staff for its Willamette Valley Behavioral Health operations. Although it is not possible to know the existing "idle" capacity of needed workers in this area, it is possible to infer relative changes in labor supply and labor demand for certain occupation groups. The Bureau of Labor Statistics reports employment and wage statistics by occupation on their Occupational Employment Statistics website, and we present this data for selected occupations in the Portland-Vancouver-Hillsboro Metropolitan Statistical Area in Table *3*.

Table 3: Trends in employment and wages for selected healthcare occupations in the Portland-Vancouver-Hillsboro MSA

Occupation	Employment					Avg. Hourly Wages				
	% annual growth	2015	2016	2017	2018	% annual growth	2015	2016	2017	2018
All occupations	2.33%	1,088,700	1,133,350	1,157,060	1,190,180	1.92%	25.07	25.94	26.6	27.0
Occupational Therapists	10.83%	600	710	890	860	2.30%	39.86	40.96	43.04	43.5
Physical Therapists	3.62%	1,450	1,510	1,570	1,660	0.92%	40.28	40.9	41.47	41.7
Registered Nurses	2.58%	20,140	22,690	22,500	22,220	2.47%	40.95	42.67	43.78	44.9
Nurse Practitioners	1.94%	860	1,050	910	Unkn.	-0.20%	53.65	54.74	55.3	53.2
Health Technologists and Technicians, All Other	-2.40%	1,250	1,100	1,050	1,130	4.87%	22.62	25.26	24.69	27.0
Healthcare Support Occupations	4.97%	25,710	28,620	28,760	30,820	2.67%	16.88	17.42	18.24	18.6

Sources:
BLS Occupational Employment Statistics, 2015 through 2019: https://www.bls.gov/oes/tables.htm. Real wages are calculated using the BLS Portland-Vancouver-Hillsboro MSA CPI for the years 2012 through 2017. https://www.bls.gov/regions/west/news-release/2018/pdf/consumerpriceindex_portland_20180112.pdf

Assuming a basic labor market supply and demand model, increases in the supply of workers will tend to push wages down and levels of employment up. Decreases in the supply of workers will generate the opposite effects. On the demand side, increases in the demand for workers will tend to push both wages and employment up while decreases in the demand for workers will tend to push both wages and employment down. For the Portland-Vancouver-Hillsboro MSA overall, real wages have been stagnant while employment has increased. This suggests that the supply of workers in this area has roughly kept pace with their demand. Similar effects can be seen in the labor markets for Healthcare Support Occupations, Nurse Practitioners, Registered Nurses, Physical Therapists, and Occupational Therapists. For the occupational category of Health Technologists and Technicians, All Other, employment has declined while wages have increased substantially. This suggests either a decrease in the supply of workers in these occupations coupled with increasing demand, or negotiated wages above the market wage, which then depresses demand for these workers.

Evaluation of employment statistics by occupation suggests the proposed hospital will be well positioned to fill its open positions. The majority of positions within the proposed hospital will be nursing positions, and the occupational statistics for the Portland-Vancouver-Hillsboro MSA indicate that nursing supply has kept pace with nursing demand.

Industrial zoning

27. **The Wilsonville site is within the Planned Development Industrial – Regionally Significant Industrial Area zone and has been submitted for zoning review. Please comment on whether or not there has been a determination that the project will meet the mandatory industrial zoning requirements for the significant area?**

See attached as new Appendix 17 the City of Wilsonville's approval on March 14, 2019 granting a second 1-year extension of land use approvals for WVBH. This decision recognizes the site is located within the Planned Development Industrial-Regionally Significant Industrial Area and meets zoning requirements.

Alternatives to proposed project

28. OAR 333-580-0300(5) requires the applicant to demonstrate to the Division that a proposal is approvable. The application considers alternative means of providing additional services at the existing Cedar Hills Hospital. Please provide information about what other alternatives were discussed.

Given (1) the unusual circumstances outlined in our response to Question 16 and discussed in our Application on pages 10 through 13 and pages 60 through 72, and (2) the very high estimated net need for additional inpatient psychiatric beds, we see only three alternatives to the construction of a new hospital. These include:

- Additional expansion of existing facilities at Cedar Hills Hospital;
- Redirection of care to other facilities; and/or
- Redirection of care to other non-inpatient care modalities.

In the case of Cedar Hills, further expansion is not an option as we have achieved full occupancy of the building envelope, and there is no additional space for further building out the site. In terms of inpatient care at other inpatient facilities, there has been little indication or response by any other of the existing providers of inpatient psychiatric care.[14] Redirection of care to non-inpatient modalities has been taking place in Oregon, as evidenced by the development/use of the Unity Center for Behavioral Health. However, all available evidence shows these actions have not eliminated or even reduced the need for additional inpatient psychiatric beds as originally presumed. As documented in the Oregon media and the community response to Senate Bill 140 A for an Emergency Department Boarding Pilot Project in OHA, the longstanding shortage of inpatient psychiatric beds and consequent ED boarding is a crisis that continues to persist.[15]

Some psychiatric care must be delivered in an inpatient environment, and some patients are sufficiently ill to warrant involuntary inpatient care under NMI rules. The construction of a new hospital thus represents the best solution among these alternatives.

In principle, another alternative would be the construction of a smaller hospital, such as the facility included in the recent CN approval for Lifeways Inc. However, based on our net bed need estimates, there is current net need for a larger facility than the one we have requested, let alone a facility the size of the Lifeways project.

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[14] As referenced in our Application on pages 71 and 72, since 2015 there has been no increase in the number of adult inpatient psychiatric beds, an increase of one geropsychiatric bed at Tuality Healthcare, and an increase of six adolescent inpatient psychiatric beds (closure of the 16 adolescent beds at Legacy Emanuel Medical Center and opening of 22 adolescent beds at the Unity Center for Behavioral Health).

[15] For references in the Oregon media, see for example, Jessica Floum. "Boarded in the ER: Oregon's mental health crisis." The Lund Report | Salem Reporter. Apr. 18, 2019., https://www.thelundreport.org/content/boarded-er-oregon%E2%80%99s-mental-health-crisis, Accessed August 6, 2019. For community testimony to referencing ED boarding, see Oregon State Legislature – 2019 Regular Session – SB 140 A - Meeting Materials/Exhibits., available at https://olis.leg.state.or.us/liz/2019R1/Measures/Exhibits/SB140, Accessed August 6, 2019

There is also a theoretical alternative of multiple, small-sized hospitals, not a single large one, as we have requested. However, based on its experience, UHS has found small hospitals are not cost effective, given the inability to capture economies of scale.

Architecture

29. **UHS has purchased three tax lots that combine to make 8.7 acres at 9500 SW Day Road. Application includes comment about parking being required per zoning requirements, yet the development depicted on drawing L100 leaves minimal potential for future expansion of either building or parking. Please provide additional information regarding how the requirement related to OAR 333-580-0050(2) will be met.**

The OAR regulations require the capability for further expansion of either the building or parking for the proposed hospital. Theoretically, UHS could expand either the building size, the parking capacity, or both, but doing so would be economically and operationally costly. For example, a parking garage could be constructed in the western area of the campus, and building expansion could occur in areas currently designated as parking. If the OHA requires a single-line drawing for confirmation of this option, we can meet this request.

30. **Excluding the adolescent wing, there are 84 beds assigned for adult and older adults. OAR 333-535-0061(4) requires noisy and quiet social activity spaces to totaling 40 square feet per patient. This would calculate as 84 X 40 = 3,360 square feet required. Our review of the plans noted that only 3,064 square feet of activity space was provided for the adults. Please comment on how this space will meet the requirements set forth in the OAR above.**

This is an architectural question that relates to the current architectural standards. Based on discussions with OHA staff in early August, it is our understanding that the conversion to FGI architectural rules (Facility Guideline Institute)[16] in Oregon will occur January 1, 2020. Under FGI standards, our single-line drawing that shows 3,064 square feet of activity space for adults is sufficient. Please see the SRG Partnership architectural memorandum, attached to CN-Form CN-3, included on page 406 of our Application.[17]

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[16] https://www.fgiguidelines.org/guidelines/2018-fgi-guidelines/

[17] SRG Partnership's memorandum, June 27, 2019, states: "The proposed hospital will include spaces that conform to 2018 FGI Guidelines. The combined area of the Social Spaces serving Adult Unit 1B (32 Beds) includes 30 SF per bed which exceeds the minimum requirement of 25 SF per bed (FGI 2.5-2.2.10.2(2)(a)). The combined area of the Social Spaces serving Adult Unit 1A (28 Beds) and Older Adult Unit 2B (24 Beds) exceeds the 40 SF per bed requirement for inclusion of dining activity (FGI 2.5-2.2.10.2). The combined area of Social Spaces serving the Adolescent Unit 2A (16 Beds) exceeds the 50 SF per bed requirement for inclusion of dining activity (FGI 2.5-2.3.3.1). The operational protocol for patient dining in the facility will be to encourage all patients to dine in the main Dining Room as scheduled. The sole exception will be newly admitted patients that have yet to be interviewed by the Hospital Psychologist. This interview is typically completed within the first 24-hours of a patient's stay. If necessary, meals for these patients will be served in the Quiet Activity Room or Patient Room."

We request that OHA staff confirm our understanding that FGI will be the applicable architectural standard against which our application will be reviewed, and further that our response to Question 30 is appropriate.

31. **Per OAR 333-535-0061(5)(l)(C), patient therapy spaces are required to be 300 square feet minimum. Based upon review of plans submitted, therapy spaces are below this minimum. Please describe how WVBH will comply with this rule.**

In discussions with OHA staff August 2, 2019, we confirmed that the allocated 368 square feet of patient therapy space between the gymnasium and kitchen in the northeast area of the WVBH campus is adequate. We have relabeled that space to clearly identify it in revised single line drawings, which is included with our responses as Revised Appendix 13.

32. **Per OAR 333-535-0061(8)(a), child and adolescent psychiatric units require additional space to accommodate family and other caregivers. The current adolescent wing makes no accommodation for this rule. Please describe how WVBH will comply with this rule.**

Our single-line drawings for the adolescent inpatient psychiatric space located in the southeast area of the WVBH campus identify a number of age-appropriate spaces. These include a consultation room, patient rooms, and two activity rooms. In our discussions with OHA staff August 2, 2019, it is our understanding that family and other caregivers can use these designated spaces within the adolescent area to meet with inpatients.

We request that OHA review staff confirm our understanding of this regulation and our conformance with it.

33. **A "timeout room" was not found within the adolescent wing as required in OAR 333-535-0061(8)(b). Please provide information that demonstrates how compliance with this rule will be achieved.**

Our single-line drawings for the adolescent inpatient psychiatric space included a "comfort room." We have revised the label on that room to "timeout" room. The revised single line drawings are included in our responses as Revised Appendix 13.

We request that OHA review staff confirm our revised drawings conform to this requirement.

34. **OAR 333-535-0061(8)(d) requires visual separation of outdoor activity areas of adolescent and adult patients. Drawings submitted do not elaborate on how visual separation will be provided. Please comment on how this requirement will be achieved.**

We understand there must be visual separation of outdoor activity areas for adolescent and adult inpatients. We have revised our single-line drawing in Revised Appendix 13 to clearly identify a fence separating these two areas that will be visually obscuring.

We request that OHA review staff confirm the revised single line drawings meet this OAR requirement.

35. **Because the terms geropsychiatric patients and "older adults" are used interchangeably within the application, it is uncertain if OAR 333-535-0061(9)**

Geriatric, Alzheimer and Other Dementia Units will need to be reviewed. Please clarify.

Within our application, we use the broad age-based definition of "geriatrics" as adults over the age of 65. We do not plan for the proposed hospital to treat patients with Alzheimer, Dementia or persons significantly disabled by the aging process. Our definition of "older adults" or "geriatrics" are older persons over the age of 65 who can both benefit from inpatient psychiatric care and are able to participate in their treatment. These patients tend to include older adults with diagnoses of chemical dependencies, schizophrenia and schizoaffective disorders, bipolar disorders, depression, and anxiety.

36. **Per OAR 333-535-0035(2)(a), at least one Airborne Infection Isolation (A.I.I.) room is required for a patient care unit An A.I.I. room was not found on the drawings. Please demonstrate how compliance with this requirement will be achieved at WVBH.**

Based on discussions with OHA staff August 2, 2019, it is our understanding that FGI rules will be implemented on January 1, 2020. Under FGI rules, an airborne infection isolation room is not required for facilities not treating infectious patients. UHS does not intend to treat medically compromised patients at WVBH. Therefore, it is our understanding our current single-line drawings are FGI compliant in this regard.

We request that OHA review staff confirm our understanding.

37. **Page 9 provides a listing of nine Outpatient programs to be provided and the Outpatient Clinical Care Plan lays out a multidisciplinary approach to those services. The floor plan provided includes only 892 square feet dedicated to outpatient treatment. Please provide additional information on how program, patient, and staff spatial need will be meet within this limited area.**

We understand the question regarding the number of outpatient programs listed in our Application and the limited space designated for outpatient treatment. It is our intent to gradually expand outpatient care over time. Thus, we would not intend to offer all listed outpatient programs at the outset. However, as has also been the case at Cedar Hills Hospital, as the utilization of outpatient programs grows, we may need to find and utilize additional space, which may not necessarily be located within the WVBH hospital itself. That would be our intent over time. Please confirm that this addresses the OHA staff question.

38. **The Cedar Hills Hospital's policies and procedures related to discharge included in the application materials do not reflect the standards of current hospital discharge laws and rules. Please describe how WVBH will meet current standards.**

We reviewed the 'Routine Discharge Process' P&P which was last revised in 2017. Although the P&P had most of the components for Oregon's 'Lay Caregiver' law and met its requirements in spirit, it did not spell out all the specifics of the law in the actual policy. We have revised the P&P with the specifics taken directly from the law, and have attached a revised version in new Appendix 18, included with these responses. This revised P&P should better fit the Oregon Lay Caregiver Law. For Cedar Hills Hospital, we have the revised and clarified the P&P, which was approved by CHH PI Committee meeting, August 15, 2019. We had already changed and approved the forms and the discharge process described in the P&P, but should have been more specific in the P&P.

Revised Appendix 10

- CN Form 5 Income Statement (Replaces CN Form 5, page 408-409)
- CN Form 8 Debt Service Coverage (Replaces CN Form 8, page 410, Application)
- CN Form 9 Ratio Analysis (Replaces CN Form 9, page 410-411, Application)
- CN Form 10 Volume Adjusted Expenses and Revenues (Replaces CN Form 10, page 413, Application)

INCOME STATEMENT ($)

YEAR	PROJECTED				
	September-December 31, 2021	**Year 1-2022**	**Year 2-2023**	**Year 3-2024**	**Year 4-2025**
OPERATING REVENUE:					
Inpatient Revenue	2,225,120	22,114,004	49,756,510	57,219,986	63,114,429
Inpatient Physician Revenue	145,206	1,443,104	3,246,983	3,734,031	4,118,687
Outpatient Revenue	244,103	2,432,621	5,473,397	6,294,407	6,923,847
Patient Service Revenue	3,102,633	25,989,729	58,476,890	67,248,424	74,156,963
School Revenue	6,000	18,000	36,000	54,000	54,000
Total Revenue	**2,620,428**	**26,007,729**	**58,512,890**	**67,302,424**	**74,228,963**
DEDUCTIONS FROM OPERATING REVENUE					
Medicare Impact Pending Survey	779,507	232,385			
Provision for Medicare, Welfare & Other Contractual Adjustments -Inpatient	1,118,612	11,117,148	25,013,584	28,765,622	31,728,875
Physician	85,416	848,889	1,910,001	2,196,501	2,422,770
Provision for Medicare, Welfare & Other Contractual Adjustments -Outpatient	148,021	1,475,109	3,318,996	3,816,845	4,198,530
Charity Care	44,502	442,280	995,130	1,144,400	1,262,289
Denials	5,563	55,285	124,391	143,050	157,786
Bad Debt	16,688	165,855	373,174	429,150	473,358
Total Deductions	**2,198,309**	**14,336,952**	**31,735,275**	**36,495,567**	**40,243,607**
NET OPERATING REVENUE	**422,119**	**11,670,777**	**26,777,615**	**30,806,857**	**33,985,356**
OPERATING EXPENSES:					
Salaries &Wages	1,645,357	6,589,121	10,914,739	12,627,873	13,770,605
Employee benefits	304,281	1,222,269	2,019,159	2,336,079	2,547,477
Professional Fees	241,194	1,453,488	2,760,415	3,113,263	3,391,953
Supplies	43,585	433,166	974,624	1,120,818	1,236,277
Travel/Education	38,000	114,000	186,112	216,746	235,360

Maintenance	4,220	116,675	267,776	308,069	339,854
Purchased Services	133,178	550,352	820,392	894,129	951,950
Other Expenses	202,769	608,306	638,722	670,658	704,191
Insurance	7,168	71,146	160,506	184,112	202,505
Non-Allocated	52,565	157,694	165,579	173,858	182,551
Lease Expense	32,000	96,000	96,000	96,000	96,000
TOTAL OPERATING EXPENSE	**2,704,318**	**11,412,218**	**19,004,024**	**21,741,603**	**23,658,722**
OPERATING INCOME	**(2,282,199)**	**258,559**	**7,773,590**	**9,065,254**	**10,326,634**
NON-OPERATING EXPENSE					
Depreciation	819,345	2,458,034	2,458,034	2,458,034	2,458,034
Allocated Costs	12,664	350,123	803,328	924,206	1,019,561
TOTAL NON-OPERATING EXPENSES	**832,008**	**2,808,157**	**3,261,362**	**3,382,239**	**3,477,594**
EXCESS REVENUE OVER EXPENSES (Pre-Tax)	**(3,114,207)**	**(2,549,598)**	**4,512,228**	**5,683,015**	**6,849,040**

DEBT SERVICE COVERAGE ($)

YEAR	PROJECTED ($)				
	September-December 31, 2021	**Year 1-2022**	**Year 2-2023**	**Year 3-2024**	**Year 4-2025**
INCOME FOR DEBT SERVICE COVERAGE:[1] Excess of Revenue Over Expense, or Net Income	(3,114,207)	(2,549,598)	4,512,228	5,683,015	6,849,040
Depreciation and Amortization	819,345	2,458,034	2,458,034	2,458,034	2,458,034
Interest Expense	0	0	0	0	0
TOTAL DEBT SERVICE COVERAGE	**(2,294,862)**	**(91,564)**	**6,970,262**	**8,141,049**	**9,307,073**
DEBT SERVICE REQUIRMENTS: Interest Expense	0	0	0	0	0
Principle Payments	0	0	0	0	0
TOTAL DEBT SERVICE REQUIREMENTS	**0**	**0**	**0**	**0**	**0**
RATIO:[2] Income for Debt Service Coverage to Debt Service Requirements	NA	NA	NA	NA	NA

[1] Forecast debt service coverage on accrual basis.
[2] Ratio calculation = (net income + depreciation + interest) ÷ (principle + interest).

RATIO ANALYSES[1]

YEAR	PROJECTED				
	September-December 31, 2021	Year 1-2022	Year2-2023	Year 3-2024	Year4-2025
PROFITABILITY RATIOS: Operating Margin	-540.7%	2.2%	29.0%	29.4%	30.4%
Operating Ratio	6.407	0.978	0.710	0.706	0.696
Deductibles Ratio	0.839	0.551	0.542	0.542	0.542
Bottom Line Ratio	(7.378)	(0.218)	0.169	0.184	0.202
Return on Total Assets - A	NA	NA	NA	NA	NA
- B	NA	NA	NA	NA	NA
Return on Equity - A	NA	NA	NA	NA	NA
- B	NA	NA	NA	NA	NA
DEBTS RATIOS: Equity Financing - A	NA	NA	NA	NA	NA
- B	NA	NA	NA	NA	NA
Debt Service as a Percentage of Gross Patient Revenue	NA	NA	NA	NA	NA
Cash Flow to Total Debt	NA	NA	NA	NA	NA
Total Debt to Total Assets	NA	NA	NA	NA	NA
Peak Debt Service Coverage by Historical Net Revenue	NA	NA	NA	NA	NA

[1]Calculate ratios using formulas in Table 1 of OAR 333-580-0100(4)

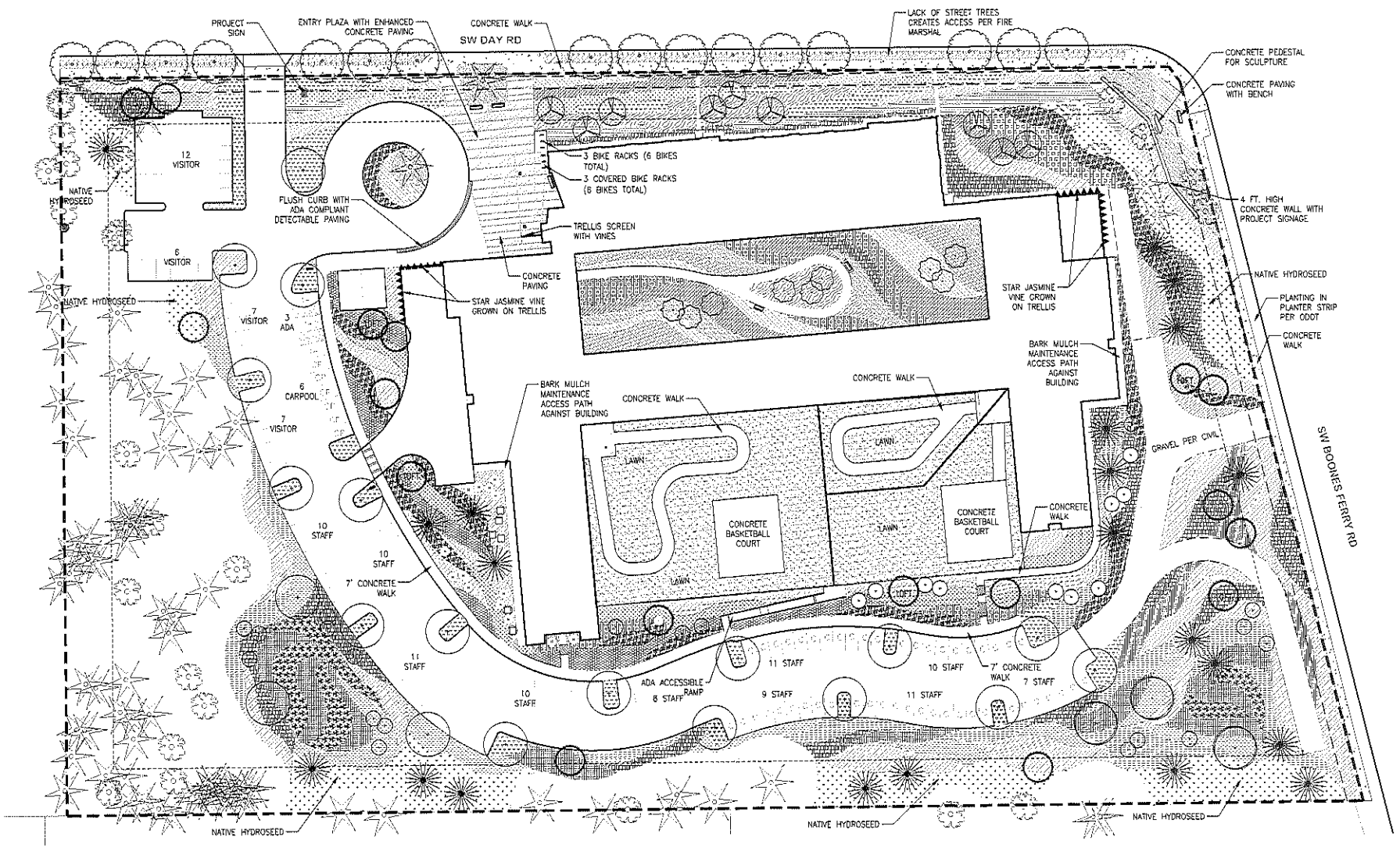
YEAR	PROJECTED				
	September-December 31, 2021	**Year 1-2022**	**Year2-2023**	**Year 3-2024**	**Year4-2025**
Debt Service Safety Margin	NA	NA	NA	NA	NA
Debt to Plant	NA	NA	NA	NA	NA
LIQUIDITY RATIOS: Current Ratio	NA	NA	NA	NA	NA
Days Revenue in Accounts Receivable	NA	NA	NA	NA	NA
Average Payment Period	NA	NA	NA	NA	NA
Days Cash on Hand	NA	NA	NA	NA	NA
Quick Ratio	NA	NA	NA	NA	NA
OTHER RATIOS: Adjusted Patient Days	1,220	12,124	27,279	31,370	34,593
Adjusted Admissions	115	1,147	2,581	2,968	3,273

VOLUME-ADJUSTED EXPENSES AND REVENUES

YEAR	PROJECTED				
	September-December 31, 2021	Year 1-2022	Year 2-2023	Year 3-2024	Year 4-2025
Number of Patient Days	1,038	10,316	23,211	26,693	29.442
Operating Expense per Patient Day	$2,605.32	$1,106.26	$ 818.75	$814.52	$803.56
Amount Attributable to Proposal	All	All	All	All	All
Gross Revenue per Patient Day	$2,524.50	$2,521.11	$2,520.91	$2,521.38	$2,521.16
Amount Attributable to Proposal	All	All	All	All	All
Number of Adjusted Patient Days	1,220	12,124	27,279	31,371	34,594
Operating Expense per Adjusted Patient Day	$2,217.36	$941.29	$696.65	$693.05	$683.90
Amount Attributable to Proposal	All	All	All	All	All
Gross Revenue per Adjusted Patient Day	$2,148.58	$2,145.15	$2,144.98	$2,145.38	$2,145.74
Amount Attributable to Proposal	All	All	All	All	All
Number of Admissions	98	976	2,196	2,525	2,786
Operating Expense per Admission	$27,537.64	$11,692.97	$8,654.02	$8,609.27	$8,493.47
Amount Attributable to Proposal	All	All	All	All	All
Gross Revenue per Admission	$26,683.40	$26,647.56	$26,645.51	$26,650.50	$26,648.15
Amount Attributable to Proposal	All	All	All	All	All
Number of Adjusted Admissions	115	1,147	2,581	2,968	3,273
Operating Expense per Adjusted Admission	$23,437.07	$9,949.26	$7,363.49	$7,325.41	$7,228.72
Amount Attributable to Proposal	All	All	All	All	All
Gross Revenue per Adjusted Admission	$22,710.04	$22,673.73	$22,671.99	$22,676.23	$22,680.04
Amount Attributable to Proposal	All	All	All	All	All

Appendix 13

Revised Single Line Drawings

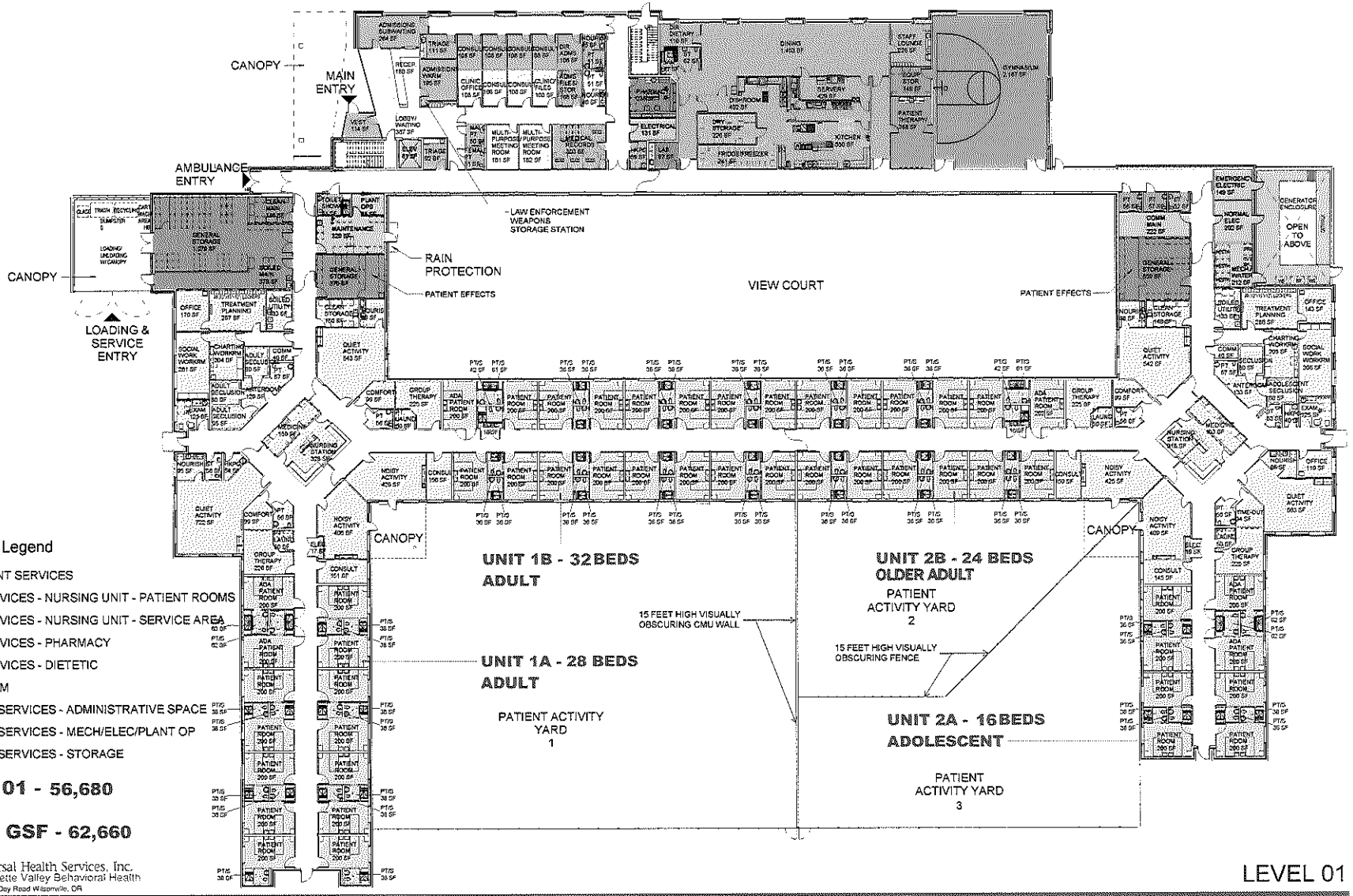


LANDSCAPE PLAN
L-100

Universal Health Services, Inc.
Willamette Valley Behavioral Health
9470 SW Day Road Wilsonville, OR

CERTIFICATE OF NEED APPLICATION - JUNE 27, 2019

WALKER|MACY SRG
111 SW OAK, SUITE 200
PORTLAND, OR 97204
503-326-3137



Department Legend

- OUTPATIENT SERVICES
- BASIC SERVICES - NURSING UNIT - PATIENT ROOMS
- BASIC SERVICES - NURSING UNIT - SERVICE AREA
- BASIC SERVICES - PHARMACY
- BASIC SERVICES - DIETETIC
- GYMNASIUM
- SUPPORT SERVICES - ADMINISTRATIVE SPACE
- SUPPORT SERVICES - MECH/ELEC/PLANT OP
- SUPPORT SERVICES - STORAGE

LEVEL 01 - 56,680

TOTAL GSF - 62,660

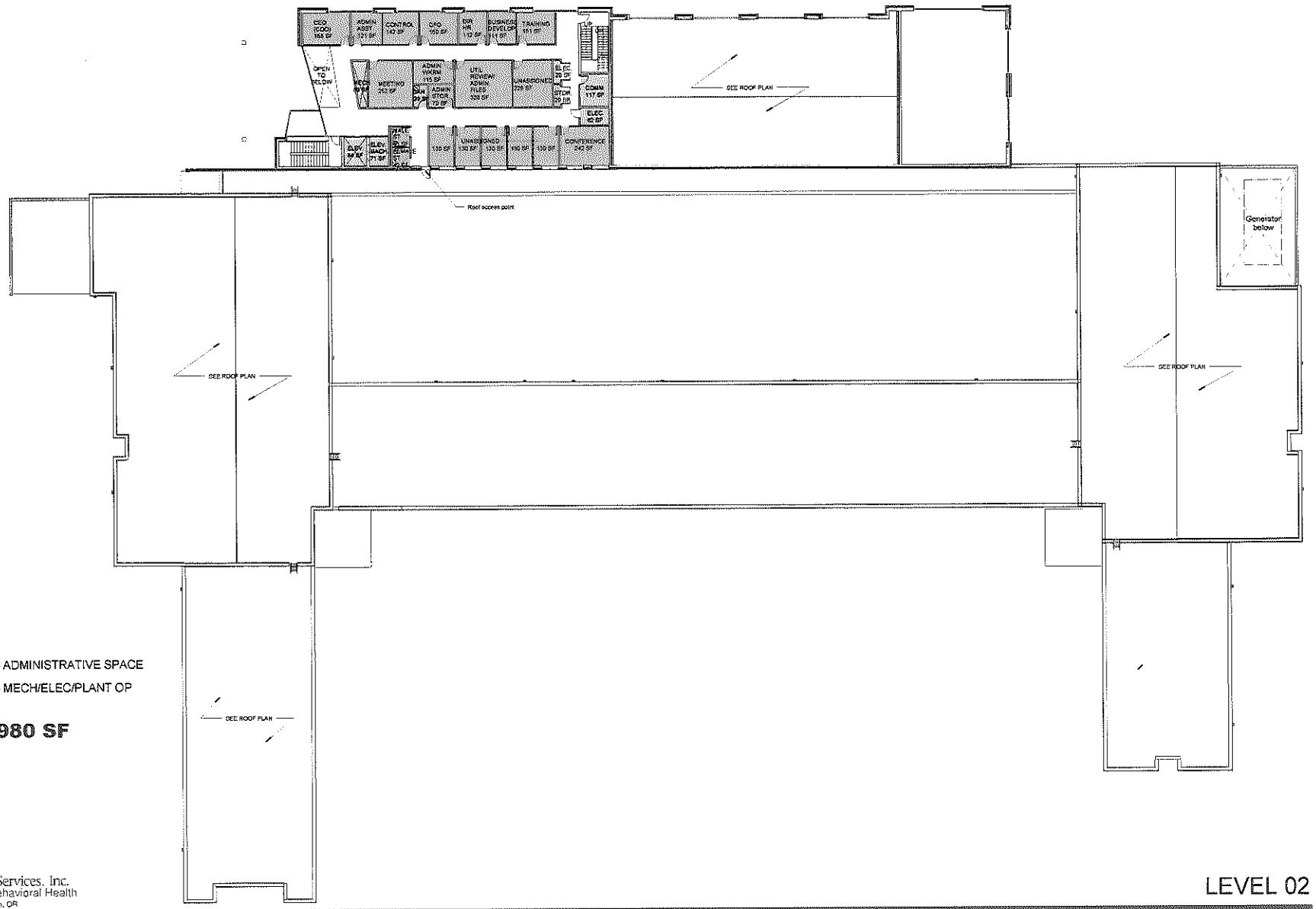
UHS Universal Health Services, Inc.
Willamette Valley Behavioral Health
9500 SW Day Road Wilsonville, OR

LEVEL 01

CERTIFICATE OF NEED APPLICATION - AUGUST 6, 2019

0' 8' 16' 32' 64'

SRG
A-101



Department Legend

- SUPPORT SERVICES - ADMINISTRATIVE SPACE
- SUPPORT SERVICES - MECH/ELEC/PLANT OP

LEVEL 02 - 5,980 SF

Universal Health Services, Inc.
Willamette Valley Behavioral Health
6500 SW Day Road Wilsonville, OR

CON APPLICATION - JUNE 27, 2019

LEVEL 02

0' 8' 16' 32' 64'

SRG

A-102

Appendix 14

Cedar Hills Hospital

Admission and Exclusionary Criteria for Inpatient Treatment Policy

Admission and Exclusionary Criteria for Inpatient Treatment

Original Policy Date: 06/13/19
Revision Date(s):
Last Review Date: 06/13/19

Responsible Department: Medical Staff

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words: exclusionary, admission, treatment, red flag

SCOPE

It is the policy of Cedar Hills Hospital to provide the most appropriate level of psychiatric care in the least restrictive and age appropriate environment utilizing medical necessity criteria. Treatment is offered without regard to race, color, religion, sex, national origin, age, handicap or ability to pay.

POLICY

Acute Inpatient Admission Criteria:

A. Serious and imminent risk of harm to self or others due to a behavioral health condition, or substance use as evidenced by, for example:
   1. Recent and serious suicide attempt(s) as indicated by the degree of intent, impulsivity, and/or impairment of judgment.
   2. Current suicidal/homicidal ideation with intent, realistic plan and/ or available means, or other serious life threatening, self-injurious behavior(s).
   3. Recent self-mutilation that is medically significant and dangerous.
   4. Recent assaultive behaviors that indicate a high risk for recurrence and serious injury to others that are due to a psychiatric disorder. These behaviors cannot only be due to conduct disorder or anti-social behaviors.
   5. Recent and serious physically destructive acts that indicate a high risk for recurrence and serious injury to self and/or others that is due to a psychiatric disorder. These behaviors cannot only be due to conduct disorder or anti-social behaviors.

6. Severe delusional and psychotic behavior that places a person at risk for harm to self or others.
7. Acute deterioration in normal level of functioning that significantly interferes with the patient's ability to safely and adequately care for themselves.
8. Patient has a Behavioral Health Diagnosis.
9. Severe disturbance of affect, behavior, thought process, or judgment that cannot be managed safely in a less restrictive environment.
10. The patient with a documented psychiatric history of unpredictability and/or impulsivity, with recent displays of similar behavior thereby putting themselves or others at risk.
11. Imminent risk of deterioration in functioning due to the presence of multiple and/or complex psychosocial stressors that are so severe that they cannot be managed in a less restrictive environment.
12. Functional I.Q. of 70 or above and ability to benefit from program content.
13. Able to perform ADL's with minimal assistance including ability to perform self-care ostomy bag.
14. Patients admitted must be a minimum of 18 years of age.

Acute Inpatient Exclusion Criteria:

A. Significant medical condition which cannot be safely treated in a psychiatric hospital setting (e.g. medically unstable in vital signs, lab results, level of consciousness, requiring medical or surgical intervention which cannot be provided in a psychiatric hospital.) This includes but is not limited to:
    1. Active TB (Tuberculosis, Chicken Pox, Influenza)
    2. Recent convulsive episode within last 72 hours in a patient with no seizure history or uncontrolled seizure in a patient with a documented seizure disorder.
    3. PICC Line, Port-a-Cath, Hickman or Sub-Clavian
    4. Individuals receiving or requiring blood transfusion.
    5. Intubation
    6. Traction
    7. "Stage 3 or 4 Decubitis Ulcers or Stasis Ulcers"
    8. Cardiovascular disorders requiring monitoring (acute heart attack, stroke.)
    9. Complicated, high risk pregnancy complications other than psychiatric symptoms, regardless of trimester.
    10. Active GI Bleed
    11. Patients currently receiving Dialysis, or are in Renal Failure, or End Stage Renal Disease.
    12. Non-ambulatory and unable to perform ADL's.
    13. Critical Lab Values
    14. Serious overdose presenting with abnormal laboratory information or required IV treatment
    15. Indwelling Catheters (Foley, supra-pubic)
    16. Peg or NG Tube (Tube Feeding)
    17. Eating Disorder as primary problem

18. Fentanyl Patch
19. Insulin Pump
20. Substance Use Disorder as primary problem including patients who are currently prescribed or are deemed to be in need of methadone treatment
21. Blood Alcohol Level of .25 or above
22. O2 of less than 90% on room air

RED FLAG CRITERIA:

A. <u>These conditions require specific consultation with the attending or on call psychiatrist.</u>
The following list of medical red flags may include but are not limited to:
1. Patients who have been incarcerated for violent crimes including life threatening or sexual assault offences within one year of current date.
2. Registered or adjudicated sex offenders
3. Patients who present intoxicated or in active withdrawals will have an assessment performed including breathalyzer/results of Breathalyzer. That information will be related to the on call physician for consultation.

B. Cardiovascular
1. Recent chest pain, heart attack/MI, and cardiac surgery or post CVA with functional deficits
2. Temperature greater than 100 even if origin known / treatment begun
3. Systolic blood pressure equal to or greater than 120; Diastolic blood pressure equal to or greater than 80
4. Pulse equal to or greater than 100
5. O2 of less than 95% on room air

C. Diabetic
1. Blood sugar > 300 or < 50 needs to be reviewed with attending or on call psychiatrist.

D. Other Medical
1. Stage 1 or 2 Decubitis or Stasis Ulcers
2. Wound drains / special wound care (burns)
3. Patient's prescribed any medical device, including C-PAP machine that they will not have on their person when they arrive at the facility.
4. Subcutaneous Anticoagulant Therapy (have recent lab values available)
5. Current Bone Fractures
6. Patients requiring frequent laboratory and/or radiology services
7. Temperature equal to or greater than 100 with unknown origin and/or not being treated
8. Blood in urine/sputum
9. Patient taking Coumadin (have recent lab values available)
10. Patient currently receiving chemotherapy or radiation treatment
11. Medical Detox with severe symptoms such as syncope/diaphoresis, sudden confusion/weakness, vomiting or other neurological changes
12. Heparin use
13. Hep-locks

14. Autism Spectrum Disorders
15. Dementia (Alzheimers and other types)

E. Medications/Medication: Consult with medical if the patient is OUTSIDE OF THE RANGES below:
   1. Lithium level — Above 1.4
   2. Tegretol level — Above 12.0
   3. D lantin level — Above 20
   4. Depakote level — Above 120
   5. Methadone — review if used for maintenance or pain
   6. Clozaril — review White blood cell count (WBC) with nursing and evidence of recent (within 7 days) lab values

F. Gait Dysfunction — frequent falls, identify special needs including the use of prosthetic limbs, canes, wheelchairs, casts, immobilizer or other special apparatus that may pose a safety concern.

G. MRSA, HIV, C-DIFF presenting with open wounds, or other communicable disease.

H. Any patient currently receiving hospice care

I. Third trimester pregnancy

UNIT-SPECIFIC CRITERIA:

Cedar Hills Hospital is divided into 5 separate treatment units, each being designated to serve a distinct patient population with clinical programming specific to those populations. The following are criteria used to determine if a patient is clinically appropriate for the given units:

A. Crisis Stabilization Unit (CSU)
   a. Most acute psychiatric patients in the hospital
   b. Active psychosis or delusions that put the patient at risk of harm to self or others
   c. Active elopement risk
   d. Active / recent aggression episodes or behavior
   e. Active self-harm or suicidal behaviors
   f. Involuntary patients with active suicidal / self-harm behaviors

B. South / North Units
   a. Psychiatric disorders
   b. Co-Occurring disorders
   c. Suicidal / self-harm ideation with no active behaviors

C. West1 Unit
   a. Detoxification
   b. Substance Use Rehabilitation
   c. Co-Occurring disorders
   d. Overflow for Military Program

D. West2 Unit
   a. Military Program (Enlisted, Veteran, and Dependents).

Appendix 15

Revised Table 11 (page 45, Application), Table 13 (page 49, Application) and Table 14 (page 52, Application)

Table 11 - WVBH Oregon, Inc. Utilization Projections, Full Year 1 - Year 5. Page 45, Application (Revised August 2019)

Statistic	Partial Year	Year 1	Year 2	Year 3	Year 4	Year 5
	September 1, 2021- December 31, 2021	2022	2023	2024	2025	2026
Admissions	98	976	2,196	2,525	2,786	2,833
Adjusted Admissions	115	1,147	2,581	2,968	3,273	3,330
Adjusted Admissions (Table 1)	108	1,077	2,423	2,786	3,072	3,126
Total Patient Days	1,038	10,316	23,211	26,693	29,442	29,949
Equivalent Outpatient Days	106.90	1,065.28	2,396.88	2,756.41	3,032.05	3,092.69
Adjusted Patient Days	1,220	12,124	27,279	31,371	34,594	35,198
Adjusted Patient Days (Table 1)	1,145	11,381	25,608	29,449	32,474	33,042
Equivalent Outpatient Days	1,148	11,389	25,694	29,473	32,417	33,073
Average Daily Census (ADC)	8.5	28.3	63.6	73.1	80.4	82.1
Adjusted ADC	10.0	33.2	74.7	85.9	94.5	96.4
Average Length of Stay	10.6	10.6	10.6	10.6	10.6	10.6
Outpatient Visits	443	4,398	9,895	11,380	12,518	12,768
Outpatient ADC	3.6	12.0	27.1	31.2	34.3	35.0
Occupancy (ADC/Beds)	8.5%	28.3%	63.6%	73.1%	80.4%	82.1%
Available Beds	100	100	100	100	100	100
Calculations from Table 1, OAR 333-580-0100 (4)						

Note: Adjusted admissions and adjusted patient days, underlined and in italics in the table, are calculated by multiplying admissions or days by the ratio of total gross revenues divided by inpatient revenues. Table 1, OAR 333-580-0100(4) defines these adjusted figures differently; Table 11 includes these adjusted figures pursuant to OAR 333-580-0100(4). As noted, adjusted admissions figures are the same calculated either way, and adjusted patient days are virtually identical. For purposes of this application, adjustments made multiplying admits or days by the ratio of total gross revenues divided by inpatient revues will be used, since it is the standard measure.

Source: Applicant.

Table 13 - WVBH, Projected Number of Full-Time Equivalent Employees, Year 1 Through Year 5. Page 49, Application (Revised August 2019)

		Year 1	Year 2	Year 3	Year 4	Year 5
	September-December 31, 2021	***2022***	***2023***	***2024***	***2025***	***2026***
Schedule of FTE's (Full Time Equivalent) Employees						
Hours/FTE/Period	696	2,080	2,080	2,088	2,088	2,080
Orientation	8.3	3.8	4.0	6.0	7.0	8.0
Nursing Admin	8.6	8.6	9.6	9.6	10.0	10.0
Adult	9.8	30.7	69.3	79.7	87.7	89.4
Adult/Adolescent -- IOP/PHP	1.1	1.8	5.4	6.2	6.9	7.0
Recreation Therapy	1.1	1.1	3.2	3.7	4.0	4.1
Group Therapy	1.1	3.7	8.5	9.8	10.7	10.9
Social Services Admin	0.5	0.5	1.0	1.0	1.0	1.0
Pharmacy	1.4	1.4	1.4	2.2	2.4	2.5
Dietary	6.0	6.0	6.0	7.0	7.0	7.0
Plant Operations	2.0	2.0	2.0	3.0	3.0	3.0
Housekeeping	2.0	2.8	4.4	5.1	5.6	5.7
Patient Transport	-	-	1.5	2.5	3.0	3.5
Intake	9.6	9.6	10.6	11.5	12.5	12.5
Mobile Intake	2.0	2.0	2.0	3.0	3.0	3.0
Financial Counseling	1.0	1.0	1.5	2.0	2.0	2.0
Quality Assurance	1.0	1.0	2.0	2.0	2.0	2.0
Utilization Review	1.1	2.0	4.5	5.2	5.8	5.9
Medical Records	1.5	1.5	1.5	2.8	3.1	3.2
Communications	2.8	2.8	3.0	3.0	3.5	4.0
Patient Accounts	2.0	2.8	3.0	3.0	3.5	4.0
Fiscal Accounting-CFO & AP/Payroll	2.0	2.0	2.0	2.0	2.0	2.0
Purchasing	-	-	-	-	-	-
Data Processing	1.0	1.0	1.0	1.0	1.0	1.0
Administration-CEO & Admin Assist	2.0	2.0	2.0	2.0	2.0	2.0
Marketing	3.0	3.0	3.0	4.0	4.0	4.0
Personnel	1.0	1.0	1.5	2.0	2.5	2.5
Total	***71.8***	***94.2***	***153.8***	***179.1***	***194.4***	***199.0***

Table 14 - WVBH, Selected Financial Statistics. Page 52, Application (Revised August 2019)

Statistic		Year 1	Year 2	Year 3	Year 4	Year 5
	September 1-December 31, 2021	2022	2023	2024	2025	2026
Gross Revenue per Patient Day	$2,524.50	$2,521.11	$2,520.91	$2,521.38	$2,521.16	$2,521.77
Net Revenue Per Patient Day	$406.67	$1,131.33	$1,153.66	$1,154.13	$1,154.30	$1,154.51
Operating Expense per Patient Day	$2,605.32	$1,106.26	$818.75	$814.52	$803.56	$806.39
Gross Revenue per Adjusted Patient Day	$2,148.58	$2,145.15	$2,144.98	$2,145.38	$2,145.74	$2,145.71
Net Revenue Per Adjusted Patient Day	$346.11	$962.62	$981.62	$982.02	$982.42	$982.35
Operating Expense per Adjusted Patient Day	$2,217.36	$941.29	$696.65	$693.05	$683.90	$686.14
Gross Revenue per Admission	$26,683.40	$26,647.56	$26,645.51	$26,650.50	$26,648.15	$26,654.52
Net Revenue Per Admission	$4,298.37	$11,957.89	$12,193.95	$12,198.94	$12,200.72	$12,202.96
Operating Expense per Admission	$27,537.64	$11,692.97	$8,654.02	$8,609.27	$8,493.47	$8,523.42
Gross Revenue per Adjusted Admission (AA)	$22,710.04	$22,673.73	$22,671.99	$22,676.23	$22,680.04	$22,679.66
Net Revenue Per AA	$3,658.31	$10,174.67	$10,375.52	$10,379.77	$10,383.94	$10,383.19
Operating Expense per AA	$23,437.07	$9,949.26	$7,363.49	$7,325.41	$7,228.72	$7,252.36

New Appendix 16

Cedar Hills Hospital
2016, 2017, 2018 Income Statements

CEDAR HILLS HOSPITAL
Income from Operations
2016 - 2018

	2016 YTD	2017 YTD	2018 YTD
Inpatient A.D.C.	80.40	80.40	81.40
Total FTEs	192.80	195.70	200.90
PATIENT REVENUE			
Inpatient Revenue	65,963,929	65,675,214	66,914,319
Outpatient Revenue	7,954,937	7,234,019	6,790,575
Partial Revenue	1,156,050	1,211,600	1,129,530
TOTAL PATIENT REVENUE	**75,074,916**	**74,120,833**	**74,834,424**
REVENUE DEDUCTIONS			
Medicare Deductions	15,414,187	12,887,322	10,336,430
Medicaid Deductions	44,550	201,143	150,918
Blue Cross Deductions	2,637,312	2,579,266	2,275,990
HMO/PPO Deductions	14,913,359	15,317,540	15,196,549
Managed M/C Deductions	3,559,333	2,904,100	3,497,690
Managed M/D Deductions	1,217,829	2,113,960	4,114,654
Gov't Fund Non Medicaid Deductions	103,051	124,234	165,480
Miscellaneous Deductions	4,086,936	4,951,310	5,508,019
TOTAL REVENUE DEDUCTIONS	**41,976,556**	**41,078,875**	**41,245,730**
NET PATIENT REVENUE	**33,098,360**	**33,041,958**	**33,588,694**
Other Revenue	76,726	89,040	71,854
NET REVENUE BEFORE BAD DEBT	**33,175,086**	**33,130,998**	**33,660,548**
Bad Debt	692,671	1,111,091	713,507
NET REVENUE	**32,482,415**	**32,019,907**	**32,947,041**
CONTROLLABLE COST			
Salaries	11,419,512	12,144,645	13,376,985
Temp Help Agency	286,106	663,895	598,440
Employee Benefits	2,196,718	2,304,821	2,548,541
Professional Fees	3,368,406	3,302,887	3,378,527
Purchased Services	901,201	1,021,426	1,070,308
Maintenance	301,199	416,928	361,414
Supplies	1,099,145	1,104,740	1,149,616
Insurance	300,112	348,526	205,030
Lease/Rental	1,068,032	1,059,387	1,096,081
Travel/Educ/Dues	113,350	146,991	128,579
Other Expenses	653,262	677,985	639,957
Non-Allocated Expenses	94,547	127,198	148,020
TOTAL CONTROLLABLE COST	**21,801,591**	**23,319,429**	**24,701,498**
INCOME FROM OPERATIONS	**10,680,824**	**8,700,478**	**8,245,543**

New Appendix 17

City of Wilsonville Land Use Approval Extension

WILSONVILLE
OREGON

March 14, 2019

Ken Sandblast, AICP
Westlake Consultants, Inc.
15115 SW Sequoia Parkway, Suite 150
Tigard, OR 97224

Re: Case File AR19-0008 2nd Time Extension for UHS

Dear Ken:

Enclosed you will find the Administrative Review and Decision on your request for the second 1-year extension for time approvals for UHS. Please be advised that the decision is not final and effective until the appeal period, as spelled out on the attached Notice of Decision page, has passed. Please call us if you have any questions.

Sincerely,

Shelley White
Administrative Assistant

March 14, 2019

Notice of Administrative Decision

Project Name: Second 1-Year Extension of Land Use Approvals for Universal Health's Willamette Valley Behavioral Health at 9470 SW Day Road

Case File No.: AR19-0008

Owner/Applicant: Newco Oregon Inc.

Applicant: Universal Health

Applicant's Rep.: Westlake Consultants, Ken Sandblast

Location: Southwest corner of Day Road and Boones Ferry Road. The property is specifically known as Tax Lots 400, 500, 501, Section 2B, Township 3 South, Range 1 West, Willamette Meridian, City of Wilsonville, Washington County, Oregon.

Request: Class II Revision of Second 1-Year Extension of Land Use Approvals

On March 14, 2019 an administrative decision was rendered, granting approval of the above-referenced application:

The written decision is on file in the planning division. A copy of the applications, all documents and evidence submitted by or on behalf of the applicant and applicable criteria are available for inspection at no cost and will be provided at $.25 per page at the Wilsonville Planning Division, 29799 SW Town Center Loop E., Wilsonville OR, 97070.

Section 4.022(.01) of the Wilsonville Code provides that this decision may be appealed by any person who is entitled to written notice or who is adversely aggrieved. Appeal is processed under Wilsonville Code 4.022.

Note: Any appeal must be filed with the City Recorder within fourteen (14) calendar days of the notice of the decision. The notice of appeal shall be in writing and indicate the specific issue(s) being appealed and the reason(s) therefore. Should you require further information, please contact Daniel Pauly AICP, Senior Planner, with the City Planning Division at 503-682-4960. Last day to appeal: 4:00 P.M. on March 28, 2019

For more information, contact the Wilsonville Planning Division at 503-682-4960

WILSONVILLE
OREGON

Planning Division Staff Report
Administrative Decision

2nd 1-Year Extension of Land Use Approvals for Universal Health's Willamette Valley Behavioral Health at 9470 SW Day Road

Date of Report/Decision: March 14, 2019

Application No.: AR19-0008 Class II Revision of 2nd 1-Year Extension of Land Use Approvals

Request Summary: 2nd 1-Year Extension of Land Use Approvals for Universal Health's Willamette Valley Behavioral Health at 9470 SW Day Road. The extension changes the expiration date from March 7, 2019 to March 7, 2020.

Location: Southwest corner of Day Road and Boones Ferry Road. The property is specifically known as Tax Lots 400, 500, 501, Section 2B, Township 3 South, Range 1 West, Willamette Meridian, City of Wilsonville, Washington County, Oregon.

Owner/Applicant: Newco Oregon Inc.

Applicant: Universal Health

Applicant's Rep.: Westlake Consultants, Ken Sandblast

Comprehensive Plan Map Designation: Industrial

Zone Map Classification: PDI-RSIA (Planned Development Industrial-Regionally Significant Industrial Area)

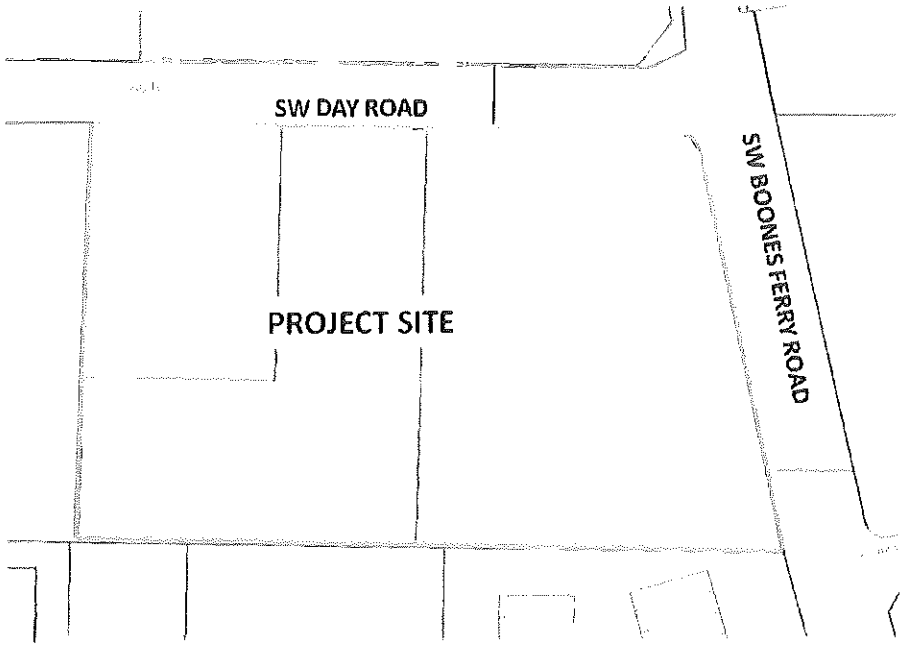
Staff Reviewers: Daniel Pauly AICP, Senior Planner

Action Taken: Approval of the requested 1-year time extension moving the expiration date to March 7, 2020.

Applicable Review Criteria:

Section 4.008	Application Procedures-In General
Section 4.009	Who May Initiate Application
Section 4.010	How to Apply
Section 4.011	How Applications are Processed
Section 4.014	Burden of Proof
Section 4.023	Expiration of Development Approvals
Section 4.030	Authority of the Planning Director
Section 4.140	Planned Development Regulations

Vicinity Map



Background/Summary:

The applicant proposed to extend, by 1 year, the land use approvals for Universal Health's planned Willamette Valley Behavioral Health facility at Day Road and Boones Ferry Road. The City granted land use approval valid for 2 years in March 2016. In January 2018 the City approve an extension (AR18-0001) moving the expiration date of the land use approvals from March 7, 2018 to March 7, 2019 to allow additional time for the applicant to pursue necessary state permissions for the project. The project has yet to obtain the necessary state permissions. The applicant thus requests a second 1-year extension moving the expiration date of the land use approvals from March 7, 2019 to March 7, 2020. This is the second of three potential 1-year time extensions.

Exhibit List:

The following exhibits are hereby entered into the public record by the Development Review Board as confirmation of its consideration of the application as submitted. This is the exhibit list that includes exhibits for Planning Case File AR19-0008.

Planning Staff Materials

A1. Staff report and findings

Materials from Applicant

B1. Extension Request Letter

Findings:

NOTE: Pursuant to Section 4.014 the burden of proving that the necessary findings of fact can be made for approval of any land use or development application rests with the applicant in the case.

General Information

Application Procedures-In General
Section 4.008

The processing of the application is in accordance with the applicable general procedures of this Section.

Who May Initiate Application
Section 4.009

Westlake Consultants submitted the extension request on behalf of the original applicant for the land use approvals, Universal Health Services.

Request

As described in the Findings below, the requests meets the applicable criteria.

Extension of Expiration of Development Approvals

Time Extension for Good Cause, Maximum Number of 3 1-Year Extensions.
Subsection 4.023 (.04)

1. As explained in the request letter the applicant continues to pursue legal remedies to obtain approval of a Certificate of Need from the Oregon Health Authority. The City does not expect development of the project without the Certificate of Need. The applicant anticipated a final decision on the Certificate of Need in 2018, but have not exhausted the available processes prior to the current expiration date of March 7, 2019. Needing additional time for land use approvals while continuing to pursue the Certificate of Need constitutes good cause consistent with this subsection.

Requests for Time Extensions Submission Prior to Expiration
Subsections 4.023 (.04) and 4.140 (.09) I.

2. The applicant submitted a written request received by the Planning Department on February 27, 2019 8 days before the expiration date of March 7, 2018 meeting the 8-day prior requirement of Section 4.023 which is less restrictive and deemed applicable over the 30-day prior requirement of Section 4.140.

Requirement for Time Extension: Good Faith Attempt to Develop or Market
Subsection 4.140 (.09) I.

3. Since obtaining land use approval from the City in 2016 the applicant has pursued state approvals needed for development of the facility. The applicant has incurred substantial expenses pursuing state approvals needed for development demonstrating a good faith attempt to develop the property as approved by the City.

Requirement for Time Extension: Development Expected Within Next Year
Subsection 4.140 (.09) I.

4. In the submitted request letter, the applicant states they anticipate a final exhaustion of their legal remedies to obtain their Certificate of Need within 2019. If approval of the Certificate of Need is granted the applicant would immediately pursue construction.

Requirement for Time Extension: Payment of Supplemental Street SDC's.
Subsection 4.140 (.09) I.

5. No supplemental street SDC's are applicable to this project.

Action Taken:

THEREFORE, based on Staff analysis and the above findings 1-5 above, the Planning Director hereby **approves** the application as requested moving the expiration date of the following Case Files to March 7, 2020:

DB15-0094 Stage I Preliminary Plan (Master Plan)
DB15-0095 Two (2) Waivers
DB15-0096 Stage II Final Plan
DB15-0097 Site Design Review
DB15-0098 Type 'C' Tree Removal Plan
DB15-0099 Class III Signs

Case File #:AR19-0008

Approved:

3/14/19

Daniel Pauly, Senior Planner for
Miranda Bateschell, Planning Director

Date

Section 4.022(.01) of the Wilsonville Code provides that this decision may be appealed by the Applicant and party entitled to notice or adversely affected or aggrieved or called up for review by the Development Review Board. The notice of appeal shall indicate the nature of the action or interpretation that is being appealed or called up. The appeal shall regard a determination of the appropriateness of the action or interpretation of the Code requirements involved in the decision.

Note: The decision of the Planning Director may be appealed by an affected party or by three (3) Board members in accordance with Section 4.017 except that the review shall be of the record supplemented by oral commentary relevant to the record presented on behalf of the Applicant and the Planning Director. Any appeal must be filed with the City Recorder within fourteen (14) calendar days of the notice of the decision. The notice of appeal shall be in writing and indicate the specific issue(s) being appealed and the reason(s) therefore. Should you require further information, please contact Daniel Pauly AICP, Senior Planner, with the City Planning Division at 503-682-4960. Last day to appeal: ***4:00 P.M. on March 28, 2019.***

For more information, contact the Wilsonville Planning Division at 503-682-4960.

Westlake
consultants, inc

February 27, 2019

Mr. Daniel Pauly, AICP
Senior Planner
City of Wilsonville
29799 SW Town Center Loop E
Wilsonville, OR 97070

Re: Universal Health Service, Inc. / Willamette Valley Behavioral Health
City of Wilsonville Case File AR18-0001

Dear Dan,

On behalf of Universal Health Services, Inc. ("UHS"), Westlake Consultants submits this request for a second 1-year extension of the City of Wilsonville land use approvals for Case Files DB15-0094, DB15-0095, DB15-0096, DB15-0097, DB15-0098, DB15-0099 as authorized by *Section 4.023.(01) and Section 4.023.(04)* of the City of Wilsonville *Community Development Code*.

As per the approval for Case File #AR18-0001, the current land use decision expiration date for the UHS approvals is March 7, 2019.

In accordance with the provisions of *Section 4.023.(01).B*, the Applicant is requesting a second 1-year time extension of the UHS approvals. Concurrent with the City of Wilsonville's land use review and approval process, this extension request is the continued legal proceedings associated with the State of Oregon Certificate of Need approval process to operate the Willamette Valley Behavioral Health facility on Day Road in Wilsonville. These ongoing efforts by UHS have been complicated by the Oregon Health Authority final decision making process. UHS appeal and legal efforts are currently pending a final decision in 2019.

In accordance with the provisions of *Section 4.023.(04)* the Applicant is requesting this 1-year extension in writing at least eight days prior to the current March 7, 2019 expiration date. With ongoing pursuit of State approvals, UHS continues to incur substantial legal, consulting and business expenses in their good faith efforts to develop their Day Road property not only over the preceding year, but over the entire three years since land use approvals in early 2016.

City of Wilsonville
Exhibit B1 AR19-0008

As all applicable provisions of *Section 4.023.* are satisfied, UHS respectfully requests a second 1-year extension for all above referenced Willamette Valley Behavioral Health case files resulting in land use approvals valid until March 7, 2020.

Thank you in advance for your time and consideration of this extension request.

Sincerely,

WESTLAKE CONSULTANTS, INC.

Ken Sandblast, AICP
Director of Planning

cc: Mr. Ron Escarda, UHS
Mr. Craig Tompkins, SRG Architects
File

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New Appendix 18

Cedar Hills Hospital

Routine Discharge Process Policy and Procedure
Revised August 2019

Routine Discharge Process

Original Policy Date:	5/2011
Revision Date(s):	3/6/2017; 7/30/19
Last Review Date:	8/15/19
Responsible Department:	Clinical Services

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

SCOPE

Cedar Hills Hospital Inpatient Services

POLICY

Cedar Hills Hospital will have a procedure to ensure a patient's timely, organized, and safe discharge from the hospital.

PROCEDURE(S)

1. Discharge planning begins during the admission process. Upon meeting with the patient, the Assessment Center Counselor asks the individual if they would like to identify a family member / friend / support person to be their identified Lay Caregiver who will provide assistance to the individual following their discharge from the hospital. If the individual identifies a Lay Caregiver, that person's name and contact information is documented on the Medical Screen Exam, Part II (Clinical / Psychiatric Screening) form.

2. Within 72 hours of admission and prior to discharge, a Social Services staff member completes the 'Discharge Needs Assessment', where information regarding existing providers is documented as well as information needed to understand the long-term needs of the patient. Information gathered should include the following:
    a. Income

b. Housing situation, including whether they will return to the place from which they resided prior to hospitalization or if step-down resources are needed
c. Insurance resources
d. Aftercare support
e. Access to and ability to pay for medications
f. The individual's capacity for self-care, including their risk for self-harm
g. Need for community-based services

3. The Assessment Counselor completes the 'Release of Information (ROI)' form with the individual adding existing providers, any family members participating in the patient's treatment, and the patient's identified Lay Caregiver. The 'ROI' form should be present in the patient's medical record and (minimally) allow the disclosure of the following protected health information:
    a. Discharge criteria;
    b. Patient diagnosis, treatment recommendations, and current safety issues;
    c. Risk factors for suicide and the securing of lethal means of committing suicide;
    d. Prescribed medications, dosage, potential side effects, and the process for obtaining refills;
    e. Available community resources for the individual's needs; and
    f. The circumstances under which the patient or lay caregiver should seek immediate medical attention.

3. Within 72 hours of the patient's admission, the assigned primary therapist meets with the patient and reviews the information that has been gathered on the patient. Additionally, the therapist calls the patient's identified Lay Caregiver and received input on the patient's risk of suicide / self-harm as well as their discharge needs once they leave the hospital. During the session with the patient, the therapist provides the patient with community resources and them to the 'My Crisis / Safety Plan' form.

4. Within 72 hours of admission, the therapist completes the Master Treatment Plan, which includes clinical findings and the patient's discharge needs.

5. The social services team documents on-going discharge planning efforts in the patient record. Discharge efforts that should be documented include collaboration with previous and existing providers, family members, and the Lay Caregiver.

6. On the day prior to the scheduled date of discharge, the primary therapist meets with the patient and reviews the patient's post-discharge plan with them, including appointments that have been arranged for the patient and how the next level of care will be different from hospitalization. The patient is given

contact information for their outpatient care providers as well as given education on suicide and relapse prevention. Finally, the therapist reviews the patient's 'Crisis / Safety Plan' with them and reviews any barriers that might be present related to the patient's discharge plan.

7. A call is placed to the patient's identified Lay Caregiver to review the discharge plan, risk assessment, and any applicable barriers to success in additional to receiving confirmation that any lethal means of suicide / self-harm have been secured for the patient's transition to home or the next level of care. The therapist recommends the safe removal of any dangerous items in the patient's home (to be conducted by someone other than the patient) and documents the family/friend's response to this intervention.

8. Also on the day prior to the scheduled date of discharge, the primary therapist will determine whether the patient is a candidate for 'Post-Discharge Follow-Up Program'. The therapist will offer this service to the patient and complete the enrollment process if the patient consents to participate.

9. On the day of discharge, the patient is seen by a physician and a 'Face-to-Face Risk Assessment' is completed.

10. On the day of discharge, the provider writes a prescription for medications, not to exceed a 30-day supply. If applicable, the provider will write an order specifying any home medications to be destroyed or returned to family. Education is provided to the patient / family regarding the emergence of symptoms associated with SSRI medications.

11. At the time of discharge, a nurse meets with the patient and completes the 'Medication Reconciliation' and 'Aftercare Plan' forms. The nurse will review all 'Property Inventory' forms with the patient to ensure that all personal belongs are accounted for. The patient is given a 'Patient Satisfaction Survey' to complete prior to exiting the hospital. When the patient is prepared to exit the unit, the completed 'Discharge Communication' form is given to the receptionist by staff escorting the patient to the lobby.

12. Medical Records staff will fax relevant collateral information, within 24 hours of discharge, to the identified aftercare providers. If the patient's aftercare appointments occur within 24 hours of discharge, Social Services staff is responsible for faxing these documents on the day of discharge and placing a copy of the fax confirmation sheet in the patient medical record.

13 The provider's 'Discharge Summary' will be faxed to aftercare providers within 30 days of discharge.