PUBLIC HEALTH DIVISION, Center for Health Protection
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
Kate Brown, Governor

Oregon Health Authority

**Certificate of Need**
800 NE Oregon Street, Suite 465
Portland, OR 97232
Voice: (971) 673-0540
Fax: (971) 673-0556
TTY: 711
http://www.healthoregon.org/cn

**CERTIFIED MAIL**
**RETURN RECEIPT REQUESTED**

March 13, 2020

Kristen Smith
Post Acute Medical, LLC
1828 Good Hope Road, Suite 102
Enola, PA 17025

Re: Proposed Decision: Post Acute Medical (PAM Squared at Portland), CN #680

Dear Ms. Smith:

The Oregon Health Authority (OHA), Public Health Division, Certificate of Need Program is tasked with reviewing and making decisions on certificate of need applications. ORS 442.315(4).

On December 17, 2018, Post Acute Medical, LLC (PAM) filed an application with the required fee for a 50-bed freestanding inpatient rehabilitation hospital to be located at 13333 SW 68th Parkway in Tigard, Oregon. The application was determined to be complete on July 23, 2019 and review began on July 24, 2019. A public meeting was held on October 14, 2019. A proposed recommendation was issued on January 10, 2020. Following the release of the proposed recommendation, an informal hearing was requested by the Oregon Health Care Association (OHCA), an affected party, and was held on February 10, 2020. Following the adjournment of the informal hearing, the record was held open for 15 calendar days, in accordance with CN rules. On February 25, OHA notified affected parties and applicants that it was extending the open record date until March 2.

The CN process is governed by a number of rules adopted by OHA under ORS 442.315(2), found at Oregon Administrative Rules (OAR) 333, Divisions 545 through 670. The burden of proof for justifying the need and viability of the proposal rests with the applicant, PAM. OAR 333-580-0000(8). In order for a CN to be granted, OHA must find that PAM satisfied the criteria in OAR 333-580-0040 to 333-580-0060. The criteria incorporate the applicable service-specific methodologies and standards in OAR 333, Divisions 590 (Demonstrations of Need for Acute Inpatient Beds and Facilities) and applicable service-specific methodologies and standards in Division 645 (Demonstration of Need for Rehabilitation Services).

OHA makes findings and bases its decision on the extent to which the applicant demonstrates that the criteria and standards referenced in OAR 333-580-0030(1) are met. Criteria will be considered to have been met if the applicant can demonstrate that the questions posed in the criteria can be answered in the affirmative. OAR 333-580-0030(2).

## PROPOSED DRAFT DECISION

OHA proposes to approve the PAM application. OHA finds that PAM has met its burden of proof for justifying the need for a 50-bed inpatient rehabilitation facility. The proposed decision is based on the application and accompanying documents, the agency record, including information submitted by interested parties, affected parties, and staff analysis.

## Proposed Findings and Analysis

As stated above, in order to grant a CN application, the applicant must submit facts and documentation that support a finding that the criteria for a CN have been met. Only applicable criteria in the CN rules are called out in this summary.

### I. APPLICABLE REVIEW CRITERIA

#### A. Need: OAR 333-580-0040, OAR 333-590-0050, and OAR 333-645

This section combines the "need" criteria described in OAR 333-580-0040, OAR 333-590-0050, and OAR 333-645.

1. Criterion: Does the service area population need the proposed project? OAR 333-580-0040(1).

**OHA Findings: Yes, the service area population needs the proposed project.**

This criterion requires the applicant to use particular indicators and specific standards and methodologies to determine the appropriate service area and to determine whether there is a need for rehabilitation beds within the service area. Applications for inpatient rehabilitation facilities (IRFs) are required to address the criterion above through the specified methodologies if OAR 333-645[1] and OAR 333-590-0030 to 333-590-0060.

a. Service Area

The applicant has identified the service area that will be served by its proposed project as well as the population to be served. The applicant has identified a service area that includes Washington, Multnomah, Clackamas, Clatsop, Columbia, Tillamook, and Yamhill Counties[2]. In summary, OHA finds that there is a sufficient population-based unmet need for inpatient rehabilitation services among discharges from general inpatient hospitals in Northwest Oregon to support the proposed facility. From their proposed site, it is expected that the proposed facility will serve a combination of local and regional inpatients. IRFs draw their patient population from the discharges of other inpatient facilities. In turn, Portland metropolitan and surrounding area hospitals draw their general inpatient population from a wider swath of Oregon. Therefore, OHA has determined that the appropriate population base and service area for an IRF should be based on discharges from the inpatient facilities within larger geographic units, though not statewide. Under OAR 333-590-0030, such a regional service area is represented by a Health Service Area. OHA has determined Health Service Area 1, as defined in OAR 333-545-0000(15)(a), is the appropriate service area for the proposed facility as it encompasses the larger geographical unit from which the facility may reasonably be expected to draw from based on the above analysis. *See also* OAR 333-580-0040 and 333-645-0030(1)(a).

---

[1] The definitions in OAR 333-645-0010 are incorporated by reference.

[2] Post Acute Medical Application. Page 7.

b. Bed Need Calculation

While the applicant in, an abundance of caution, provided a bed need methodology that included an assessment of general acute care bed need, OHA had determined that the rules do not require a finding of general acute care bed need. CN rules for rehabilitation services state that a determination of hospital service area must be consistent with OAR 333-590-0040 or with historical use patterns for rehabilitation services if these are demonstrably different from a defined service area. OAR 333-645-0030(1)(a). CN rules are intended to promote rational decisions about balancing the allocation of resources across different categories of inpatient care. A central assumption behind the demonstration of inpatient need for CN purposes is that on a local basis, there should be a fixed pool of licensed beds relative to population size and composition, and out of this bed total, providers can make decisions about the allocation of beds for various and specialized purposes.

There are two crucial components in the CN rules for assessing IRF bed need. The first component is that total need shall not exceed seven beds per 100,000 general population. OAR 333-645-0030(1). This means that the applicant and OHA must determine the total number of IRF beds currently available, and that will be available if the proposed project is approved, against the service area population. If the total bed need calculated is more than seven beds per 100,000, the application cannot be approved. If the total bed need calculated is less than seven beds per 100,000, the review can proceed. This does not mean that extra beds must be approved when the available total is below seven beds per 100,000. Rather, it indicates that extra beds may be needed, and allows the consideration of the application to continue. The applicant has demonstrated to OHA that if the project is approved there will not be more than seven IRF beds per 100,000 general population in Health Service Area 1.

The second component is the instruction at OAR 333-645-0030(4) to assess bed need in a manner "*consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060.*" The rule makes it clear that the entire inpatient bed need methodology for general acute care beds found at OAR 333-590 need not be applied to IRFs. Instead, applicants are directed to calculate a population-based need for IRF services that takes into account existing capacity across a broad service area. General acute care bed need calculations are based on geographic populations and hospital admission rates for specific zip codes or other demographic units. In contrast, IRF need is based on hospital discharges, which reflect both location of hospitals and

geographic populations. Thus, service areas for IRFs must be substantially larger than for a general acute care bed need, and consideration of discharges is a more accurate method to calculate IRF need than analysis of need based upon zip codes.

The applicant has identified a net need in 2022 for 111 rehabilitation beds and a net need bed need in 2027 of 121 rehabilitation beds[3] in its proposed service area.

There is no historical CN precedent for the determination of the specific need for inpatient rehabilitation beds. Therefore, OHA used a combination of patient-level discharge data provided by the OHA's Health Policy and Analytics Division as well as information from peer-reviewed literature addressing the use of IRFs in the treatment of specific conditions. This literature indicates strong support for the use of IRFs, versus a skilled nursing facility (SNF) for the treatment of stroke, brain injury, and other neurologically related conditions[4].

To conduct its analysis OHA reviewed hospital discharge data for the five-year period of 2013 to 2017 for all licensed Oregon hospitals, including diagnosis related group (DRG) identifiers. OHA filtered out hospitals based on their geographical location, so only hospitals within the previously defined Health Service Area 1 remained. Sixteen hospitals fall within the geographical boundaries of Health Service Area 1. The discharges from these hospitals were analyzed, counting only DRGs related to stroke, brain injury, and other neurological conditions. The specific DRGs included in this calculation were: 61-66, 68-74, and 82-90. Data available from Healthcare Cost and Utilization Project (HCUP) support the selection of these stroke DRGs. Of the top ten conditions and procedures with discharges to a post-acute care (PAC) facility, 32.6 percent of stroke patients (DRGs 61-66) were discharged to an IRF and 40 percent were discharged to a skilled nursing facility[5].

Between 2013 and 2017, there were a total of 26,283 stroke, brain injury, and other related neurological hospital discharges by hospitals in Health Service Area 1. In order to determine the bed-need for these discharges, OHA made the following calculations:

---

[3] Post Acute Medical application. Page 39.

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4952961/;https://www.medicareadvocacy.org/inpatient-rehabilitation-facilities-and-skilled-nursing-facilities-vive-la-difference/

[5] Tian, W. Healthcare Cost and Utilization Project. Statistical Brief #205. Page 9.

- Total number of days as an inpatient, assuming an average length of stay (ALOS) of 12.7 days = 333,794.[6]
- Total bed need, assuming 100 percent occupancy and an ALOS of 12.7 = Average of 183 beds per year.

In order to ensure the availability of an IRF bed 95 percent of the time across the year, the 183 beds per year was adjusted. This adjustment resulted in an identified a need for 208 IRF beds. To account for current capacity, OHA subtracted all 57 inpatient rehabilitation beds at existing hospital-based facilities. This resulted in an identified need for 151 IRF beds. This number was further reduced, based on literature review that stated most, but not all, stroke, brain injury, and other related neurological condition diagnosed patients who would not qualify for nor benefit from IRF placement.[7] Therefore, the calculated need has been reduced by an additional 25 percent or 37 beds. With this reduction, OHA estimates a current unmet need of 114 IRF beds.

2. Criterion: Will the proposed project result in an improvement in patients' reasonable access to services? OAR 333-580-0040(3).

**OHA Findings: The proposed project will result in an improvement in patients' reasonable access to services.**

This criterion looks at issues related to accessibility of the facility, including traffic patterns, restrictive admissions policies, access to care for public-paid patients; and restrictive staff privileges or denial of privileges.

The applicant has identified several areas that demonstrates its project will result in patients' reasonable access to services. As required by OAR 333-580-0040(3), the applicant provides a broad discussion of access.

As required, the applicant has identified potential problems with traffic patterns and states that its proposed location will allow patients to avoid much of the traffic congestion that affects the downtown Portland area. The applicant cites data from Oregon Department of Transportation regarding the hours of "rush hour"

---

[6] ALOS cited by applicant.

[7] Deutsch A, Granger CV, Heinemann AW, et al. *Stroke.* 2006; 37:1477–1482; Langhorne P, Duncan P. *Stroke.* 2001; 32: 268 –274; Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE. *Stroke.* 2016 Jun;47(6): e98-169; Foley N, McClure JA, Meyer M, Salter K, Bureau Y, Teasell R. *Disability and Rehabilitation.* 2012 Dec 1;34(25):2132-8.

and states its location, at the corner of Interstate 5 and Highway 217, avoids much of this traffic.

The applicant discusses its admission policies and states that unlike existing hospital based IRFs, its proposed facility will benefit from "carefully developed admission protocols" that extend the benefits of IRF care beyond the 13 clinical criteria that CMS mandates must encompass 60 percent of admissions[8]. This will result in an increase in the number of patients who will potentially qualify for placement at an IRF.

Using Healthcare Cost and Utilization Project data published in 2016, the applicant states that approximately 75 percent of IRF patients were Medicare or Medicaid beneficiaries, which is consistent with the type of patient an IRF is intended to treat. Further, the applicant states that 78 percent of days will be Medicare by year 2 and bad debt will account for 1.2 percent of revenue.[9]

During the informal hearing process, affected parties expressed concerns regarding the applicant's payor mix, including their ability to contract with Medicare Advantage members and their ability to serve the Medicaid population. The applicant estimates eight to nine percent of their patients will be from the Medicaid-eligible population. OHA finds that this is consistent with available MedPac data and of the 41.7 percent of patients discharged to PAC, 8.1 percent were Medicaid[10], which further supports the applicant's estimates.

The applicant states it will provide patients with inpatient medical rehabilitation services, including nursing, physical, occupational and speech therapy and prosthetic services under the guidance of physician-led teams[11].

OHA finds that the applicant has sufficiently addressed this specified criterion.

## B. Availability of Resources and Alternative Uses of those Resources: OAR 333-580-0050.

---

[8] Post Acute Medical application. Page 54.

[9] Post Acute Medical application. Page 54.

[10] Tian, W. An All-Payer View of Hospital Discharge to Postacute Care, 2013. Healthcare Cost and Utilization Project – Statistical Brief #205.

[11] Post Acute Medical application. Page 5.

This section addresses available resources and reasonable alternative resources, as required by OAR 333-580-0050 and OAR 333-645.

1. Criterion: Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs? OAR 333-580-0050(1).
   **OHA Findings: Yes, the proposed project is the most effective and least costly alternative, considering all appropriate and adequate ways of meeting identified needs.**

This criterion requires an applicant to, in short:

- Demonstrate that the best price for the proposal has been sought and selected;
- Demonstrate that proposed project represents the best solution from among reasonable alternatives, both internal alternatives and external alternatives[12].

The applicant has provided documentation in its application that it has consulted with an architect registered in the state of Oregon who is familiar with the costs of building health care facilities in the state[13]. OHA has determined that the applicant's cost estimates are consistent with industry standards.

OHA considered several possible alternatives to the proposed IRF. First, OHA looked at skilled nursing facilities (SNF). While SNFs and the services they provide are similar to an IRF, there are important differences.

For an IRF to qualify for Medicare reimbursement, they must satisfy specific criteria. First, patients must have a preadmission screening to determine if they are likely to benefit significantly from an intensive rehabilitation program. Second, to be reimbursed, the facility must ensure that the patient receives close medical supervision and must provide rehabilitation, nursing, physical therapy, and occupational therapy services. Third, facilities must have a medical director of rehabilitation who provides services in the facility on a full-time basis. Next, the facility must use an interdisciplinary team to coordinate the treatment of each patient. This team is led by a rehabilitation physician and includes a rehabilitation

[12] OAR 333-580-0050(1)(b).
[13] Post Acute application. Form CN-3.

nurse, a social worker or case manager, and a licensed therapist from each therapy discipline. Finally, the facility must meet compliance thresholds that state no less than 60 percent of all patients admitted to their facility have a primary diagnosis within the 13 conditions specified by the Centers for Medicare and Medicaid Services (CMS).

By contrast, SNF's are designed to focus on long term care for patients that would not recover quickly nor be able to endure the more extensive rehabilitation requirements provided in an IRF. For this reason, the requirements for admission to a SNF are different from those of an IRF. As described above, patients admitted to an IRF require active and ongoing intervention of multiple therapy disciplines (physical therapy, occupational therapy) and require an intensive rehabilitation program of three hours per day at least five days per week[14]. In a SNF, the requirement is for one or more therapies per day for an average of one to two hours per day.

In reviewing the data, OHA also found that IRFs have fewer patients readmitted to a general, acute care hospital, then SNFs. According to an Oregon State University study published in September 2018, one in four SNF patients in Oregon required readmission to an acute care hospital[15]. In comparison, the CMS national average for IRFs was 13 percent in December 2016. Given the lower rate of hospital readmissions and fewer services needed later, there is adequate evidence that IRF placement can be more cost-efficient for some patients, such as patients who have had a stroke, brain injury, and suffer from other neurological conditions[16]. In addition to national statistics, OHA received written testimony and letters of support that highlight the advantages of IRF placement over SNF placement for some patients[17].

It is also important to note the differences in the type of licensure required of an IRF versus a SNF. In Oregon, IRFs are licensed by OHA as Special Inpatient

---

[14] Centers for Medicare and Medicaid Services

[15] CA Mendez-Luck, J Luck, AE Larson, GB Dyer. The State of Nursing Facilities in Oregon, 2017. Corvallis, OR: OSU College of Public Health and Human Sciences, 2018. Page 24. Exhibit 4.5.

[16] OHA is not suggesting that patients are provided a lower standard of care at SNFs or that SNF patients have bad outcomes. Rather, OHA recognizes that based on its research, certain patients at IRFs have better outcomes given the different level of care provided.

[17] These letters were submitted by the Oregon Rehabilitation Center, Tuality Orthopedic, Sports, Spine, and Rehabilitation Center, Pacific University School of Physical Therapy and Athletic Training, Oregon Health Sciences University Department of Orthopedics and Rehabilitation, SpineCare Chiropractic, and Northwest Functional Neurology.

Care Facilities (SICFs), which are required to follow physical environment, licensing, and nurse staffing rules for hospitals. On the other hand, SNFs are licensed by the Department of Human Services and required to follow rules specific to nursing facilities. Unlike IRFs, Skilled Nursing Facilities cannot provide hospital-level services. With regard to cost arguments, it is likely that higher short-term costs of IRFs are related to lower long-term costs due to increased functionality of patients.

OHA also looked at the expansion of existing capacity at the two inpatient rehabilitation units currently in use. The applicant contacted these facilities to discuss a joint venture expansion, but neither facility was interested[18]. Additionally, the applicant interviewed orthopedic surgeons, patient support groups, and managed care entities regarding its proposal for a new IRF. The applicant states that these interviews confirmed its assumption for the need for additional IRF capacity in the proposed service area. During the PAM public meeting, one of the inpatient rehabilitation units stated it only had a 60 percent occupancy rate. There are many factors that may influence occupancy at hospital based IRF units. A 2016 MedPac report to Congress stated that, "hospital-based IRFs are typically smaller and have lower occupancy rates compared to freestanding IRFs,"[19] Additionally, an individual facility's occupancy and utilization patterns commonly are not related to underlying population need[20].

The applicant provided analysis and discussion on the following options[21]. These options include:

- Maintain the status quo and do not develop an IRF
- A joint venture with an existing provider
- Alteration of the proposed facility size and layout; number of beds and site design

- <u>Maintain the status quo</u>

The applicant states it has rejected the first alternative as, according to its data, Oregon has a low ratio of certified inpatient rehabilitation facility (CIRF) beds

[18] Post Acute Medical application. Page 63.
[19] Report to Congress: Medicare Payment Policy. March 2016. Page 257.
[20] Stein J, Bettger JP, Sicklick A, Hedeman R, Magdon-Ismail Z, Schwamm LH. Use of a standardized assessment to predict rehabilitation care after acute stroke. **Archives of Physical Medicine and Rehabilitation**. 2015 Feb 1;96(2):210-7.
[21] Post Acute Medical application. Page 62.

per population, compared to the national average, indicating a need for the service. OHA agrees with this analysis.

- Form a joint venture

The applicant rejected the second alternative due to a lack of interest from existing hospitals with inpatient rehabilitation beds. Additionally, the applicant states that in follow up discussions regarding the development of a freestanding IRF, several orthopedic surgeons, patient support groups, and managed care entities provided support for the applicant's proposal. OHA has received letters of support for this proposal from two organizations who specialize in the treatment and recovery of brain injury.

- Facility size and layout

The applicant evaluated the options of a 40-bed IRF and a 50-bed IRF and found that the costs to increase its bed capacity by ten beds was incremental[22]. Therefore, the applicant rejected the 40-bed option and opted to propose 50 beds.

2. Criterion: Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project? OAR 333-580-0050(2).

   **OHA Findings: This criterion is met. There will be qualified personnel, adequate land, and adequate financing.**

The applicant states that it will work with professional associations and recruiters for filling vacancies in its proposed facility. It will hire an executive team four to seven months before opening its proposed facility and that team will be responsible for the recruitment of all vacancies. The applicant sites existing residencies it has with university health systems and its experience in training Physical Medicine and Rehabilitation residents in its Texas and Kansas facilities[23]. The applicant states it is actively discussing with a medical school in Oregon opportunities for the proposed facility to become a clinical rotation site for Neurology, Family Medicine, Physical Medicine, and Rehabilitation.

---

[22] Post Acute Medical application. Page 63.
[23] Post Acute Medical application. Page 79.

Based on review and analysis of applicable criteria, the applicant has demonstrated that it has adequate land and adequate financing to support this proposal. See also Section C, below. The proposed site is within the City of Tigard and which supports this project in their community[24].

The applicant states that in alignment with its quality standards, it will pursue accreditation by the Joint Commission for rehabilitation facilities, including sub-specialty accreditation for stroke, brain injury, and cancer[25].

The applicant states that its facilities have high ratios of direct care per patient day. Additionally, the applicant states it will use "Navigator" staff[26] throughout the service area who will work with acute care hospitals in the service area.

3. Criterion: Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers? OAR 333-580-0050(3).

**OHA Findings: Yes, the proposed project will have an appropriate relationship to its service area and will limit unnecessary duplication of service and negative financial impact.**

This criterion requires the applicant to identify the extent to which the proposal and its alternatives are currently being offered to the identified service area population. The applicant must address any negative impact the proposal will have on those presently offering or reimbursing for similar or alternative services. The applicant must also demonstrate that all necessary support services and ancillary services for the proposal are available at acceptable levels to ensure that patients will have the necessary continuity in their health care.

OHA has addressed the service area and patient need within the service area above. As stated above, there is a population need, particularly for patients who have had a stroke, brain injury, or who suffer from other neurological

---

[24] Public comment from Kenny Asher, City of Tigard. October 14, 2019.
[25] Post Acute Medical application. Page 65.
[26] Post Acute Medical application. Page 65.

conditions. These patients benefit from earlier and more intense rehabilitation services than can be provided at alternative discharge options, such as discharges to home or to SNF. Early and intensive services could also be offered at existing general hospitals if they created new or expanded IRF units, using existing licensed bed capacity. These services would be the only comparable alternatives to the proposed freestanding IRF.

There is opposition to the applicant's proposal, centered on two main issues. First, that this need is currently being met at existing facilities, such as SNFs. Second, current utilization at one existing hospital based IRF is low in relation to its licensed capacity. As stated above, while services provided in a SNF are similar to those that would be provided in an IRF, additional resources available at IRFs for the treatment of stroke, brain injury, and other neurological conditions may lead to better outcomes, and long-term costs associated with IRF care can be more efficient because there is a reduced chance of readmissions[27]. As also stated above, OHA does not believe that underutilization at one hospital unit IRF is evidence that patient need in the service area is met. There is a need for IRF beds despite a localized pattern of limited admissions to the existing IRF.

4. Criterion: Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standards, compared to other similar services in the area? OAR 333-580-0050(4).

**OHA Findings: Yes, the proposed project does conform with relevant state physical plant standards.**

In compliance with this rule, the applicant has submitted building schematics for OHA review with applicable physical standards and fire code standards. Based on this review, the applicant's floor plans, and additional information provided in response to OHA questions, demonstrate that they meet relevant physical plant standards.

## C. Economic Evaluation: OAR 333-580-0060

[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4952961/

This section of the proposed decision assesses the economic viability of the proposed project and the economic impact the project would have on the cost of health care.

1. Criterion: Is the financial status of the applicant adequate to support the proposed project, and will it continue to be adequate following implementation of the project? OAR 333-580-0060(1).

   **OHA Findings: Yes, the financial status of the applicant is adequate to support the proposed project and it will continue to be adequate following the implementation of the project.**

OAR 333-580-0060(1)(b) states that the applicant must describe how it will cover expenses incurred by the proposal in the event the proposal fails to meet budgeted revenues in any forecasted year.

In its analysis, OHA finds that the company will fund any shortfalls with the following sources in the following order:

- Cash on hand at the entity level
- Parent company's cash on hand (average approximately $4.5M)
- Parent company's revolving LOC (Average approximately $12.9M)
- Parent company's term loan ($13M)
- Based on the parent's revolving line of credit and operations, any deficits sustained could be sustained by the parent company.

Applicants must discuss the results of ratio analysis required by Form CN-9 and OAR 333-580-0100(4), explaining strengths and weaknesses. The discussion should refer to each ratio as detailed in Table 1 of OAR 333-580-0100(4). Specifically, applicants must describe their debt capability in terms of the required ratio analysis.

OHA finds that the company's debt capability is a function of the parent companies EBITDA. Parent's maximum leverage is 4.25x EBITDA. Its current leverage is less than 2.3x. OHA agrees with the applicant's assessment that there is capacity to extend the line of credit should they need additional financing.

The company averages approximately 55-58 days in AR and varying AP lengths depending on the vendor payment terms. The company expects that AR collection period will start higher and then stabilize and become more in line with the parent company. The applicant explains that funds will come from 3 sources (cash, line of credit, loan from parent).

Operating Margin – The operating margin of the proposed facility is negative for the full year of operation. In the second and subsequent years, we expect operating margins to stabilize at 17%-18% of net revenue on an EBITDA basis and 15-17% of net revenue on a net income basis. This certainly is aggressive based on expected margins. Even if margins are half as much, the Company will produce sufficient margin to support ongoing operations.

Operating Ratio – At the project level are expected to improve over the projection period as the Project stabilizes. The ratio of Net Income plus depreciation, interest and amortization of net revenue is expected to stabilize at 17-18%. As fixed costs are covered and patient days' increase, the ratio of operating expenses to net patient revenue will improve. See comment on page 13 regarding operating margin.

Deductible Ratio - The applicant estimated a deductibles ratio of 55% which is certainly within industry standards, contemplating Medicare rates as well as Medicaid.

Bottom Line Ratio – Same as operating margin.

Return on Total Assets – Applicant states that losses are recouped in year 3 of operations.

Return on Equity – Applicant states that losses are recouped in year 3 of operations.

Debt Ratios – As property will be rental payments, applicant anticipates being tax free within 4 years. This is reasonable as property will not be carried on the books as it will be leased to the applicant.

Equity Financing – it is assumed equity financing will not be needed to fund the project.

Debt Service to Gross Patient Rev – Applicant used net revenue, regardless of either ratio, this reduced to 0 by year 4 as a result of leased building.

Cash Flow to Total Debt – operating cash flow will be negative in the first year of operations as the project ramps up. This ratio will improve over the forecasted period as cash flow builds and total debt decreases

Peak Debt Service Coverage – As minimal debt, will be paid off by 4th year.

Under OAR 333-580-0060(1)(e), the applicant must discuss the availability of other sources of funding, including, but not limited to, donor restricted assets, assets of parent or subsidiary corporations, or a related foundation, which may be acquiring assets and/or producing income that is for the purpose of, or could be used for the purpose of, capital expenditure by the applicant.

OHA finds that the parent company will be monitoring cash flow needs and assist in financing shortfalls in funding with a line of credit. Construction will be funded through a loan with the parent and equipment purchases will be funded through a traditional loan. The parent has committed to assisting and funding requirements during the start-up phase of the project.

Under OAR 333-580-0060(1)(f), the applicant must discuss money market conditions in terms of their impact on project financing, including interim financing, if applicable. The estimated rate of interest must be justified by the applicant. If debt financing is secured before or during the review process, the actual rate of interest obtained should be reported within 30 days of securing financing.

OHA finds that funding for the project has been secured at an estimated rate of 5.78% (floating 30-day LIBOR + 350 bps). Project costs will be borne by Medistar, the developer, at a rate of interest of 9.50%.

Under OAR 333-580-0060(1)(f)(C), the financing term selected must be supported with evidence showing the benefits of its selection.

The applicant will not have a stand-alone line of credit. The applicant will borrow under the parent company's 4-year term line of credit. The applicant anticipates the line of credit would be renewed at the end of the 4-year term. The debt for the land and building will be held by the developer.

Patient days, admissions and other units of service used in forecasting projected expenses and revenues, both for the facility as a whole and for services affected by the proposed project, must be consistent with projections used to determine area need. All assumptions must be discussed;

The applicant has included patient days by type of service, information regarding the need based on the local region, and other considerations to forecast revenues for the facility.

An applicant must identify and explain all inflation assumptions and rates used in projecting future expenses and in completing the forms described in OAR 333-580-0100. It is important that the assumptions used by the applicant in preparing financial forecasts be carefully considered. All relevant factors pertaining to historical experience of the applicant, together with upcoming changes affecting the future, should be considered in forecasting the financial condition of the entity.

The applicant used a standard inflation rate of 2%, which is considered reasonable for annual salaries and benefits.

Under OAR 333-580-0060(1)(h)(B), projected deductions from revenues should be explained and justified. The applicant uses comparable data from four recently opened locations under the parent entity to project deductions of 55% of total revenues. Deductions from revenue at the other four locations ranged from 48% to 60%. The midway point is considered appropriate for use. Bad debt is in line with historical averages for similar services per the historical financial statements of the parent and are appropriate given the services to be provided.55% is consistent with industry standard.

Under OAR 333-580-0060(1)(h)(C), expected changes in the intensity and/or complexity of services provided must be considered in addition to the rate of inflation in arriving at an overall rate of increase in revenues or expenses. Services provided are expected to remain consistent over a larger sampling population. Individual services may vary in intensity but will remain consistent over a period of time. The applicant does not expect a change in payor mix nor in services provided.

Under OAR 333-580-0060(1)(h)(D)(i) through OAR 333-580-0060(1)(h)(D)(iv), the applicant's projected gross revenue must reflect:

- Patient day increases/decreases

- Outpatient activity increase/decrease
- All debt service coverage requirements
- Other significant impacts the proposal will make on revenue projections

Patient day increases/decreases: Medicare revenue and patient day increases are projected at 1.80%, which is consistent with Medicare's most recent annual increases for inpatient rehabilitation services. Non-Medicare patient days for individual payor contracts range from increases of 0% - 4%. An average of 2% was used, which is appropriate given the range and the industry.

Outpatient activity increase/decrease: Revenue increases for outpatient services are expected to increase similar to inpatient services as patients transfer from higher-intensive to less-intensive care. Additionally, the focus on neurological activity rather than sports medicine and injury provide services not as concentrated in the area.

All debt service coverage requirements: The joint borrowing between the applicant and the parent does not require specific debt service coverage covenants. The project will be expected to meet certain performance requirements from the parent. No concerns were identified by OHA in its review.

Other significant impacts the proposal will make on revenue projections: As the application is for a new facility, there is not historical performance to consider.

2. Criterion: Will the impact of the proposal on the cost of health care be acceptable? OAR 333-580-0060(2).

**OHA Findings: Yes, the impact of the proposal on the cost of health care will be acceptable.**

Under this criterion, the applicant must discuss:

- Impact of the proposal both on overall patient charges
- Proposal's impact on the gross revenues and expenses
- Impact the proposal will have on related patient charges and operating expenses
- Proposed or actual charges for the proposed service

- Projected expenses for the proposed service
- Architectural costs of the proposal

Under OAR 333-580-0060(2)(a), an applicant must discuss the impact of the proposal on both overall patient charges at the institution and on charges for services affected by the project.

OHA finds that the applicant has estimated gross charges based on several factors including:

- Medicare Fee-For-Service (CMG)
- Medicare Advantage – similar to Fee-For-Service rates
- Medicaid CCO rates – willing to agree to accept a negotiated rate for CareOregon Medicaid patients. Note the local CCO, HealthShare primarily contracts with CareOregon, Providence Health Plan and Kaiser to manage its population.
- Insurance companies' rates

The applicant estimates net patient revenue per patient day at $1,736. Data provided for Medicare reimbursement supports an average reimbursement from approximately $1,600 to $2,200 depending on the services provided. The estimate is reasonable as a result.

Under OAR 333-580-0060(2)(a)(B), when a health service is affected by the proposal, an applicant must demonstrate what impact the proposal will have on related patient charges and operating expenses. Expenses and patient charges for individual health services will be compared to historical and forecasted rates of increase for the facility as a whole.

In its analysis, OHA finds that the applicant included modest increases in expenses based on historical experience. Concern generally surrounds the significant increase in volumes and business and whether the company can meet these aggressive targets.

Under OAR 333-580-0060(2)(b), the applicant must discuss both the proposed or actual charges for the proposed service and the profitability of the proposed service, compared to other similar services in the state (if any).

The applicant provided a summary of patient costs by facility and payor. The rate for payor beginning in 2022 are significantly less than the average cost per facility per payor. The data used to compare rates for existing facilities is from 2017 historical data, which will experience inflation by the starting date of patient care. The costs for the applicant are thus increasingly lower than those charged by current facilities. OHA considered the financial analysis, noting the balance of revenues and costs are using these rates and patient days used in the comparison.

While expenses are reasonable, the concern is the aggressive revenue growth anticipated and whether the Company can meet such aggressive targets. Regardless, the company have access to cash flow should it not meet its targets.

Under OAR 333-580-0060(2)(c), the applicant must discuss the projected expenses for the proposed service and demonstrate the reasonableness of these expense forecasts.

OHA analyzed the financial forecasts to identify areas where unreasonable assumptions or inappropriate financial relationships may occur, noting the assumptions discussed prior in this report are appropriately included as the basis for calculating the financial forecasts. Deductions, wages, and inflation are based on industry data and prior experience in operating similar IRF facilities. The assumptions are considered reasonable based on the market data and other figures presented. As indicated earlier, revenue targets are very ambitious. OHA notes that some expenses may be on the lower side but increasing those expenses does not impact profitability. The concern is the revenue growth and anticipated 85% full by the 4th year which seems very aggressive.

Under OAR 333-580-0060(2)(d), if the proposed service is currently not being provided in the area, the applicant should identify potential travel cost savings by:

- Establishing what the existing travel costs are to patients

OHA finds that existing costs are standard personal travel costs. Current hospital based IRFs units are located on the east side of Portland. There are no IRF facilities in Washington County on the west side of Portland. Therefore, it is anticipated that patients will be drawn from a large area around Portland to obtain services.

- Establishing what the travel costs will be to patients after implementation of the proposal

OHA finds that savings were presented by the applicant based on mileage from various Washington and Oregon cities, detailing the reduction in fuel costs and mileage at the IRS reimbursement rates. OHA agrees that savings in travel will result for those in closer proximity to the facility.

The applicant estimates cost savings based on mileage from the impacted cities and including the federal mileage reimbursement rate at about $16.35 per visit to the facility. The inclusion of the federal mileage reimbursement rate is not appropriate. The use of estimated fuel savings is appropriate for consideration as those on the west side of the river are expected to incur savings. The estimated savings are overstated as the reduction in mileage is the incremental distance from the new facility to the existing facilities from the detailed city centers.

Form CN-3 details the architectural estimates, which were prepared and estimated with the assistance of an architect registered in Oregon. The use of a local architect familiar with costing, estimation, and building requirements provides reasonable comfort the pricing and construction cost is appropriate. The applicant provides input into the cost of equipment necessary to outfit the building based on services to be provided, which is reasonable given its expertise in the industry. While the estimated useful life is 40 years, the building and internal fitting for patient service are expected to last far in excess of the depreciable life. The building facility incorporates designated areas for occupational and physical therapy, patient beds, kitchen, dining room, activity space, office space, etc. necessary to effectively treat patients.

## CONCLUSION/PROPOSED ORDER

For all the reasons cited above, OHA finds that PAM has met its burden of demonstrating that the CN criteria are met and proposes to grant a certificate of need as proposed, with the following condition:

1. IRF admissions must not be restricted based on patient insurance or ability to pay. The applicant must provide to OHA de-identified information for each patient identifying the patient's payor and principle reason for admission to the IRF. Applicant must provide these data to OHA on a quarterly basis for one year and annually for three years, in a manner prescribed by OHA.

Dated this 13th day of March 2020.

By: _____

Dana Selover, MD, MPH
Section Manager
Health Care Regulation and Quality Improvement
Oregon Health Authority

**NOTICE:** Pursuant to ORS 442.315(5)(b), an applicant or any affected person who is dissatisfied with this proposed decision is entitled to a contested case hearing before OHA. A request for hearing must be received by OHA within 60 days after service of the proposed decision. A request for hearing may be sent to:

Dana Selover MD, MPH
Section Manager
Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 465
Portland, OR 97232

An applicant or affected person who requests a hearing will be notified of the time and place of the hearing. Parties may be represented by legal counsel at the hearing. Legal aid organizations may be able to assist those with limited financial resources. Per ORS 413.041, a party that is not a natural person may be represented by an attorney or by any officer or authorized agent or employee of the party. Parties are ordinarily represented by counsel. OHA will be represented by an Assistant Attorney General. Parties will be provided information on the procedures, right of representation and other rights of parties relating to the conduct of the hearing before commencement of the hearing. Any hearing will be held by an administrative law judge from the Office of Administrative Hearings, assigned as required by ORS 183.635.

If a request for hearing is not received within this 60-day period, the right to a hearing under ORS chapter 183 shall be considered waived. If a hearing is not requested within 60 days, or if the request for hearing is withdrawn, or if the party notifies OHA or the administrative law judge that the party will not appear, or if the party fail to appear at a scheduled hearing, OHA may issue a final order by default. If OHA issues a final order by default, OHA designates the relevant portions of its

files on this matter, including all materials submitted by the applicant or affected persons relating to this matter, as the record for purposes of proving a prima facie case upon default.

**Notice to Active Duty Service members**. Active duty Servicemembers have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For more information contact the Oregon State Bar at 800-452-8260, the Oregon Military Department at 503-584-3571 or the nearest United States Armed Forces Legal Assistance Office through http://legalassistance.law.af.mil. The Oregon Military Department does not have a toll-free telephone number.

s noted in the initial application, the applicant projected the following proforma financial statements (Page 117).

**UNAUDITED (PROVIDED BY APPLICANT)**

| | PROJECTED- STAND ALONE (Income Statement) | | | | | | Percentage of Patient Revenue | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2022 | 2023 | 2024 | 2025 | 2026 | | 2022 | 2023 | 2024 | 2025 | 2024 |
| **Total Patient Revenue** | 27,275,628 | 53,585,664 | 60,176,646 | 63,406,023 | 64,541,812 | [a] | | | | | |
| Contractual Adjustments | 15,001,596 | 29,472,115 | 33,097,155 | 34,873,313 | 35,497,997 | | 55.00% | 55.00% | 55.00% | 55.00% | 55.00% |
| Charity Care | - | - | - | - | - | [b] | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| **Total Deductions** | 15,001,596 | 29,472,115 | 33,097,155 | 34,873,313 | 35,497,997 | [b] | 55.00% | 55.00% | 55.00% | 55.00% | 55.00% |
| | **0.55** | **0.55** | **0.55** | **0.55** | **0.55** | | | | | | |
| **TOTAL OPERATING REVENUE** | **12,274,032** | **24,113,549** | **27,079,491** | **28,532,710** | **29,043,815** | | | | | | |
| Salaries & Benefits | 6,948,083 | 11,767,608 | 13,248,654 | 13,990,118 | 14,269,920 | [c] | 25.47% | 21.96% | 22.02% | 22.06% | 22.51% |
| Professional Fees | 35,000 | 35,525 | 36,058 | 36,599 | 37,148 | [d] | 0.13% | 0.07% | 0.06% | 0.06% | 0.06% |
| Supplies | 585,680 | 1,131,360 | 1,248,160 | 1,292,000 | 1,292,000 | [d] | 2.15% | 2.11% | 2.07% | 2.04% | 2.04% |
| Purchased Services | 732,100 | 1,414,200 | 1,560,200 | 1,615,000 | 1,615,000 | [d] | 2.68% | 2.64% | 2.59% | 2.55% | 2.55% |
| Rental and Lease | 2,939,148 | 2,939,148 | 2,939,148 | 2,939,148 | 2,939,148 | | 10.78% | 5.48% | 4.88% | 4.64% | 4.64% |
| Insurance | 62,400 | 63,336 | 64,286 | 65,250 | 66,229 | [e] | 0.23% | 0.12% | 0.11% | 0.10% | 0.10% |
| Management Fees | 552,331 | 1,085,110 | 1,218,577 | 1,283,972 | 1,306,972 | [d] | 2.02% | 2.03% | 2.02% | 2.03% | 2.06% |
| Provisions for Doubtful Accounts | 184,110 | 361,703 | 406,192 | 427,991 | 435,657 | [f] | 0.67% | 0.67% | 0.67% | 0.68% | 0.69% |
| Interest | 419,355 | 424,620 | 93,843 | 25,486 | | | 1.54% | 0.79% | 0.16% | 0.04% | 0.00% |
| Depreciation & Amortization | 401,250 | 417,500 | 437,500 | 457,500 | 477,500 | [g] | 1.47% | 0.78% | 0.73% | 0.72% | 0.75% |
| Other Expenses | 1,065,400 | 1,527,469 | 1,682,808 | 1,740,154 | 1,737,809 | | 3.91% | 2.85% | 2.80% | 2.74% | 2.74% |
| **Total Operating Expenses** | **13,924,857** | **21,167,579** | **22,935,426** | **23,873,218** | **24,177,383** | | 51.05% | 39.50% | 38.11% | 37.65% | 38.13% |
| **Excess Revenue over Expenses, Pre tax** | **(1,650,825)** | **2,945,970** | **4,144,065** | **4,659,492** | **4,866,432** | | | | | | |
| Operating Margin | -13.45% | 12.22% | 15.30% | 16.33% | 16.76% | | | | | | |

**[a] Revenue analysis based on applicants project number of patient days**

| | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|
| Number of Adjusted Patient Days | 7,321 | 14,142 | 15,602 | 16,150 | 16,150 |
| Increase in Days | | 93.17% | 10.32% | 3.51% | 0.00% |
| | | | | | |
| Net Revenue per Patient Day | 1,677 | 1,705 | 1,736 | 1,767 | 1,798 |
| Operating expense per Patient Day | 1,902 | 1,497 | 1,470 | 1,478 | 1,497 |
| | | | | | |
| % of Capacity | 40.12% | 77.49% | 85.49% | 88.49% | 88.49% |

3 years exceed 85% which can be difficult to achieve and is considered full.

**[b] Deductions from revenue analysis**

Total deductions are consistent Year over Year at 55%. Charity care is 0 as costs of free care is included in the Provisions for doubtul accounts.

**[c] Salaries and benefits analysis**

| | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|
| Projected FTE | 127 | 155 | 165 | 169 | 168 |
| Salaries per FTE | 54,752 | 75,822 | 80,198 | 83,027 | 85,143 |
| Annual Increase | | 38.48% | 5.77% | 3.53% | 2.55% |

the applicant is projecting increases based on increase staffing - we note the staffing starts to slow down in the 2025, 2026 year at around 168 employees. Salaries are reasonable based on mix. Annual increases are reasonable (2-3% minimum in a stable year)

The applicant is projecting increases of approximately 2% each year.

**[d] Various expenses**

| | | | | | |
|---|---|---|---|---|---|
| **Supplies** | 585,680 | 1,131,360 | 1,248,160 | 1,292,000 | 1,292,000 |
| **Professional Fees** | 35,000 | 35,525 | 36,058 | 36,599 | 37,148 |
| **Management Fees** | 552,331 | 1,085,110 | 1,218,577 | 1,283,972 | 1,306,972 |
| **Purchased Services** | 732,100 | 1,414,200 | 1,560,200 | 1,615,000 | 1,615,000 |
| | 1,905,111 | 3,666,195 | 4,062,995 | 4,227,571 | 4,251,120 |
| **Total Patient Revenue** | 27,275,628 | 53,585,664 | 60,176,646 | 63,406,023 | 64,541,812 |
| **Supplies and Professional Fees as % of Revenue** | 6.98% | 6.84% | 6.75% | 6.67% | 6.59% |

These fees are falling just short of 7% as a percentage of gross revenues. It wouldn't be unusual for these fees to be closer to 10%. On the lower end of what we would expect.

| [e] | | | | | | |
|---|---|---|---|---|---|---|
| | **Insurance** | 62,400 | 63,336 | 64,286 | 65,250 | 66,229 |
| | **Total Patient Revenue** | 27,275,628 | 53,585,664 | 60,176,646 | 63,406,023 | 64,541,812 |
| | **Insurance as % of Revenue** | 0.23% | 0.12% | 0.11% | 0.10% | 0.10% |

Similar to rent and depreciation, some insurance costs may be embedded in the rental costs. The amount reserved for insurance may be low as expectation of .50 to 1.00%. As such, we would expect this number to be closer to $300,000 based on revenues.

**Oregon Health Authority**
**Financial Analysis Calculations - PAM**
**November 2019**

## Additional Financial Information

| | PROJECTED- STAND ALONE (Balance Sheet) | | | | |
|---|---|---|---|---|---|
| | **2022** | **2023** | **2024** | **2025** | **2026** |
| Cash | (2,980,848) | (754,759) | 3,379,448 | 8,018,996 | 13,464,561 |
| Accounts Receivable | 2,609,412 | 3,938,785 | 4,200,254 | 4,372,660 | 4,450,987 |
| PP&E | 2,000,000 | 2,100,000 | 2,200,000 | 2,300,000 | 2,400,000 |
| Accumulated Depreciation | (401,250) | (818,750) | (1,256,250) | (1,713,750) | (2,191,250) |
| Right of use asset | 45,978,078 | 43,558,178 | 41,138,278 | 38,718,378 | 36,298,478 |
| | 47,205,392 | 48,023,454 | 49,661,730 | 51,696,284 | 54,422,776 |
| | | | | | |
| Accounts Payable | 185,367 | 273,323 | 284,838 | 290,942 | 290,551 |
| Accrued Compensation & Prof. Fees | 819,020 | 1,112,318 | 1,188,591 | 1,239,916 | 1,264,715 |
| Other Current Liabilities | 963,877 | 1,352,455 | 1,697,567 | 1,998,343 | 2,253,895 |
| | 1,968,264 | 2,738,096 | 3,170,996 | 3,529,201 | 3,809,161 |
| Lease Liability | 45,978,078 | 43,558,178 | 41,138,278 | 38,718,378 | 36,298,478 |
| Debt | 1,559,874 | 1,082,033 | 563,244 | | |
| Fund Balance | (2,300,824) | 645,147 | 4,789,212 | 9,448,705 | 14,315,137 |

| | PROJECTED- STAND ALONE (Changes in Financial Position) | | | | |
|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Net Income | (1,650,820) | 2,945,975 | 4,144,068 | 4,659,497 | 4,866,436 |
| Depreciation & Amortization | 401,250 | 417,500 | 437,500 | 457,500 | 477,500 |
| Working Capital from Operations | (2,339,700) | 445,930 | 4,408,706 | 8,862,455 | 14,106,387 |

| Capital) | | | | | |
|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Accounts Receivable | 2,609,412 | 1,329,373 | 261,469 | 172,406 | 78,327 |
| Accounts Payable and Accrued Expenses | 1,004,387 | 681,876 | 421,385 | 352,101 | 280,351 |
| **Increase (Decrease) in WC from Ops.** | 1,605,025 | 647,497 | (159,916) | (179,695) | (202,024) |
| | | | | | |
| Other Current Liabilities | 963,877 | 388,578 | 345,112 | 300,776 | 255,552 |
| | 641,148 | 258,919 | (505,028) | (480,471) | (457,576) |
| | | | | | |
| Repayment of Long-Term Debt | 440,126 | 477,841 | 518,789 | 563,244 | - |
| Additions to Plant & Equipment | 2,000,000 | 100,000 | 100,000 | 1,000,000 | 100,000 |

| DEBT SERVICE COVERAGE | | | | | |
|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Net Income | (1,650,820) | 2,945,975 | 4,144,068 | 4,659,497 | 4,866,436 |
| Depreciation and Amortization | 401,250 | 818,750 | 1,256,250 | 1,713,750 | 2,191,250 |
| Interest Expense | 938,603 | 943,867 | 613,091 | 544,734 | 519,248 |
| | (0.3) | 5.0 | 9.8 | 12.7 | 14.6 |

## DEBT SERVICE COVERAGE

| Profitability Ratios | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Operating Margin | -13% | 12% | 15% | 16% | 17% |
| Operating Ratio | -3% | 18% | 19% | 20% | 20% |
| Deductibles Ratio | 55% | 55% | 55% | 55% | 55% |
| Bottom Line Ratio | -13% | 12% | 15% | 16% | 17% |
| Return on Total Assets (A) | -3% | 6% | 8% | 9% | 9% |
| Return on Total Assets (B) | -3% | 6% | 8% | 9% | 9% |
| Return on Equity (A) | 72% | 457% | 87% | 49% | 34% |
| Return on Equity (B) | 72% | 457% | 87% | 49% | 34% |
| | | | | | |
| Debt Ratios | | | | | |
| Equity Financing | | | | | |
| Debt to Equity (A) | -68% | 168% | 12% | 0% | 0% |
| Debt to Equity (B) | -68% | 168% | 12% | 0% | 0% |
| Debt Service as % of Gross Patient Rev. | 5% | 3% | 2% | 2% | 1% |
| Cash Flow to Total Debt | -35% | 88% | 123% | 145% | 140% |
| Total Debt to Total Assets | 3% | 2% | 1% | 0% | 0% |
| Peak Debt Service Coverage by Historicall Net Rev. | -23% | 303% | 459% | 511% | 0% |
| | | | | | |
| Debt Service Safety Margin | 9% | 24% | 23% | 24% | 22% |
| Debt to Plant | 98% | 84% | 60% | 0% | 0% |
| | | | | | |
| Liquidity Ratios | | | | | |
| Current Ratio | -19% | 116% | 239% | 351% | 470% |
| Days Revenue in Accounts Receivable | 78 | 60 | 57 | 56 | 56 |
| Average Payment Period | 53 | 48 | 51 | 55 | 59 |
| Days Cash on Hand | (80.00) | (13.00) | 55.00 | 125.00 | 207.00 |
| Quick Ratio | -19% | 116% | 239% | 351% | 470% |
| | | | | | |
| Other Ratios | | | | | |
| Adjusted Patient Days | 7,321.00 | 14,142.00 | 15,602.00 | 16,150.00 | 16,150.00 |
| Adjusted Admissions | 610.00 | 1,179.00 | 1,300.00 | 1,346.00 | 1,346.00 |

## FINANCIAL ANALYSIS FOR INDIVIDUAL SERVICE

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Bed Units of Service/Day (365 days/year) | 20 | 39 | 43 | 44 | 44 |
| Units of Service per Year | 7,321 | 14,142 | 15,602 | 16,150 | 16,150 |