Post Acute Medical (PAM) is focused on providing high-quality post-acute care in both medical rehabilitation and long-term hospitals. PAM owns and operates 41 hospitals and 22 outpatient clinics across the country. CEO and executive team collectively possess over a century of experience and knowledge running successful LTACHs, start-up rehabilitation hospitals, and outpatient clinics. Corporate headquarters in Enola, PA. Over 8,000 employees across the United States.
Common Diagnoses*

- Stroke
- Brain Injury
- Spinal Cord Injury
- Neurological Conditions
  - Parkinson’s
  - Multiple Sclerosis
- Amputation
- Major Multiple Trauma
- Orthopedic

*Medical condition requiring close medical supervision, 24/7 nursing, and ability to tolerate three hours of therapy a day (Physical, Occupational, and/or Speech therapy)
Advantages of Our Rehabilitation Programs

• Commitment to best-in-market therapy technology
  – Hospital Design
    ▪ Ceiling mounted hoist tracks to support patients anywhere in the therapy gym
  – Clinical Innovation
    ▪ Exoskeleton, UE and LE robotics, integration of clinical technology

• Outdoor areas designed to accelerate outdoor functioning

• One-on-one therapy sessions, limited group therapy

• Entire staff, from administrators, to nurses, to therapists specifically trained for acute rehabilitation patients
  – Certified Rehabilitation Registered Nurses (CRRN)
  – Neurologic Clinical Specialists (NCS)
  – Orthopedic Clinical Specialists (OCS)

• Partner with local health care communities for optimal care coordination
Clinical Innovation

- Exoskeleton
- Upper Extremity Robotics
- Virtual Reality
- Vital Stim
Quality Data
CY 2018

REDEFINING THE PATIENT EXPERIENCE

Source: eRehabData.com
Discharge Indicators: CY 2018

Community Discharges
- PAM: 75%
- National Ave: 71%

Within Stay Acute Re-Admissions
- PAM: 8%
- National Ave: 10%

SNF Discharges
- PAM: 15%
- National Ave: 18%

30-Day Acute Re-Admissions
- PAM: 12%
- National Ave: 13%

Source: eRehabData.com & CMS
QRP Data for 30 day re-admissions
<table>
<thead>
<tr>
<th>Required by Medicare</th>
<th>IRH/Unit</th>
<th>SNF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close Medical Supervision by Rehab Trained Physician</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>24-Hour Rehabilitation Nursing</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Patients must require hospital-level care</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3 hours of intensive therapy per day; 5 days per week</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Medical care &amp; therapy provided by a physician-led multidisciplinary team</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Discharge rate to community (MedPAC, 2015)</td>
<td>75%</td>
<td>38.8%</td>
</tr>
<tr>
<td>Readmission rate to acute (CMS, 2016)</td>
<td>13.06%</td>
<td>23.5%</td>
</tr>
</tbody>
</table>
Goodbye RUG-IV, hello Patient-Driven Payment Model

Beginning on October 1, 2019, Medicare will reimburse skilled nursing facilities (SNFs) under a new payment system: the Patient-Driven Payment Model (PDPM). This system departs from the current RUG-IV system by changing the primary factor that influences reimbursement:

RUG-IV
Payment determined by the number of therapy minutes performed

PDPM
Payment determined by the primary clinical characteristics of the patient

Payment components expand under PDPM

Reimbursement under RUG-IV is primarily dependent on two factors: therapy utilization and functional ability. By contrast, payment under PDPM is dependent on a patient’s clinical characteristics across five categories. Each individual category has its own base rate, which is then multiplied by a rate dependent on a patient’s needs within that component.

Source: Advisory Board
### SNF Staffing Changes Under PDPM

<table>
<thead>
<tr>
<th>Planned staff additions</th>
<th>Planned staff removals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>25%</strong> are adding nurses</td>
<td><strong>17%</strong> are removing OTs²</td>
</tr>
<tr>
<td><strong>22%</strong> are adding MDS coordinators</td>
<td><strong>14%</strong> are removing PTs³</td>
</tr>
<tr>
<td><strong>17%</strong> are adding SLPs¹</td>
<td><strong>8%</strong> are removing SLPs</td>
</tr>
</tbody>
</table>

Source: advisoryboard.com
Post-Acute Care Collaborative PDPM Preparedness Survey

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†1 Includes SLPs for Speech, Language, and Audiology
² OTs for Occupational Therapy
³ PTs for Physical Therapy

---
Proposed Service Area & Population Growth

<table>
<thead>
<tr>
<th>County</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clackamas</td>
<td>385,936</td>
<td>389,452</td>
<td>393,217</td>
<td>398,504</td>
<td>404,070</td>
<td>434,369</td>
<td>465,783</td>
<td>495,355</td>
</tr>
<tr>
<td>Clatsop</td>
<td>37,306</td>
<td>37,440</td>
<td>37,604</td>
<td>37,723</td>
<td>37,868</td>
<td>38,747</td>
<td>39,581</td>
<td>40,202</td>
</tr>
<tr>
<td>Columbia</td>
<td>50,470</td>
<td>50,878</td>
<td>51,319</td>
<td>51,888</td>
<td>52,490</td>
<td>55,808</td>
<td>59,222</td>
<td>61,273</td>
</tr>
<tr>
<td>Multnomah</td>
<td>754,862</td>
<td>761,564</td>
<td>768,634</td>
<td>775,731</td>
<td>783,119</td>
<td>821,615</td>
<td>858,518</td>
<td>879,988</td>
</tr>
<tr>
<td>Tillamook</td>
<td>25,500</td>
<td>25,609</td>
<td>25,732</td>
<td>25,911</td>
<td>26,102</td>
<td>27,133</td>
<td>28,128</td>
<td>28,998</td>
</tr>
<tr>
<td>Washington</td>
<td>553,948</td>
<td>562,152</td>
<td>570,673</td>
<td>580,338</td>
<td>590,323</td>
<td>643,194</td>
<td>697,715</td>
<td>750,746</td>
</tr>
<tr>
<td>Yamhill</td>
<td>102,318</td>
<td>103,394</td>
<td>104,525</td>
<td>106,198</td>
<td>107,940</td>
<td>117,492</td>
<td>127,688</td>
<td>137,386</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,910,340</strong></td>
<td><strong>1,930,489</strong></td>
<td><strong>1,951,705</strong></td>
<td><strong>1,976,293</strong></td>
<td><strong>2,001,913</strong></td>
<td><strong>2,138,356</strong></td>
<td><strong>2,276,634</strong></td>
<td><strong>2,393,947</strong></td>
</tr>
</tbody>
</table>

Source: OEA Long Term County Population Forecast 2010-2050 (2013 Data), interpolated Accessed October 2018

Source: Environics Analytics
## Acute Rehab Bed Need: Seven County Service Area

### Table F: Corrected Table 18. Calculating Oregon Bed Deficit, 2017, 2022, 2027, and 2032

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Service Area Population</td>
<td>2,241,784</td>
<td>2,394,576</td>
<td>2,549,422</td>
<td>2,694,843</td>
</tr>
<tr>
<td>b. CIRF beds per 100K Population (OAR 333-645-0030(1))</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>c. CIRF Beds Needed</td>
<td>157</td>
<td>168</td>
<td>178</td>
<td>189</td>
</tr>
<tr>
<td>d. Existing CIRF Beds</td>
<td>57</td>
<td>57</td>
<td>57</td>
<td>57</td>
</tr>
<tr>
<td>e. Bed Deficit (c – d)</td>
<td>100</td>
<td>111</td>
<td>121</td>
<td>132</td>
</tr>
<tr>
<td>f. Number of PAM Squared at Portland Beds Proposed</td>
<td>0</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Remaining Bed Need (e-f)</td>
<td>100</td>
<td>61</td>
<td>71</td>
<td>82</td>
</tr>
</tbody>
</table>
IRH Utilization Rates: Medicare FFS Beneficiaries

Source: CMS Public Use File
Why Tigard Triangle

• Proximity to major road and mass transit networks
• Easily accessible to likely referral sources
• Ease of development in an area prioritized for mixed use
• Desirable area for staff to live