1. **Please provide Cedar Hills Financial Statements for last 3 years (Operations if no B/S is available) as significant assumptions for proposed project are based on actual experience of this entity.**

Please see attached Appendix 1.

2. **Projected Balance Sheet is needed, wouldn't there be assets (building, land, accounts receivable) related to the proposed projects tracked at the subsidiary level?**

Please see NEWCO's Balance Sheet projection below.

NewCo					
Balance Sheet (Thousands of dollars)					
	Year 1	Year 2	Year 3	Year 4	Year 5
Cash	-	-	-	-	-
Patient Accounts Receivable, net	207	517	905	1,222	1,320
Fixed Assets					
Land	2,800	2,800	2,800	2,800	2,800
Building	31,059	31,059	31,059	31,059	31,059
Equipment	2,015	2,139	2,356	2,649	2,965
Less Accumulated Depr	(1,841)	(1,859)	(1,890)	(1,931)	(1,977)
Fixed Assets, net	34,034	34,140	34,326	34,577	34,847
Inventory	75	75	75	75	75
Prepaid Expenses	125	125	125	125	125
Total Assets	34,440	34,857	35,430	35,999	36,367
Accounts Payable	500	500	500	500	500
Accrue Payroll & WH payables	700	700	700	700	700
Intercompany Payable	37,233	35,762	29,645	19,611	8,269
Retained Earnings	(3,993)	(2,105)	4,586	15,188	26,898
Total Liabilities & Equity	34,440	34,857	35,430	35,999	36,367

3. **Applicant indicates that no financing will occur for the project, but will be cash flowed from operations—impact of $36 M for construction.**

Universal Health Services routinely funds capital projects, including new hospitals from working capital. As stated on page 52 of our Application, total estimated capital expenditures are $35,834,324 (Form CN-3). UHS has more than sufficient cash reserves to fund the requested project and provide working capital, as required. We also provided a letter from

UHS' Chief Financial Officer committing funds to the project. Further, based on UHS' audited financial statement for calendar year 2015, included as part of its 10-K filing with the Security and Exchange Commission. It had $1.021 billion in net cash provided by operating activities in 2015 alone. This is a very strong measure of its liquidity.[1] Further, on its consolidated balance sheet, in 2015 UHS had $61,228,000 in cash and cash equivalents and a total of $1,718,304,000 Current Assets.[2]

We have included the Universal Health Services 2015 Annual Report and its 10-K filing with the Securities and Exchange Commission. This document includes 2015 audited financials that demonstrate the above statements of UHS' very strong financial position. Please see Appendix 2, included.

a. What is their expected impact on cash flow (greater than ½ of existing cash), debt and are there other construction projects that also necessitate cash flow in the next 6 months (this is overall impact on UHS as it was noted this would be the parent Company related to the proposed project).

There would not be any impact. Please see the above response.

b. Please include a commentary on the ratios of the parent company, UHS, to ensure viability in the market to sustain operations since they are committing to funding the proposed project.

Please see UHS' 10-K Report, included as part of Appendix 2. This 10-K Report includes audited financials, and specifically, it includes percentage operating margin, return on equity and percentage of debt to capitalization.[3] Please also see response to #3, above.

4. Page 36 of application Table 21 does not show a significant change in use of psychiatric beds in the service area – essentially average daily census of 141 to 144 over a 6-year period. Can you comment on why an increase in utilization has not been seen at these facilities, but NEWCO expects a dramatic increase in utilization.

Table 21 did not incorporate Cedar Hills' utilization. Presented below in Table 1 is a revised table of planning area hospitals with adult inpatient psychiatric beds, including Cedar Hills Hospital. Please note that Cedar Hills opened in late 2009; therefore, its utilization has been provided in the table below from 2010 forward. In addition to the inclusion of Cedar Hills, the table also includes utilization figures for Tuality Healthcare that include MS-DRG 056 & 057 in accordance with their March 2, 2016 letter.[4] As shown below, there has been a significant increase in utilization of inpatient psychiatric care over the 6-year period, starting from an average daily census ("ADC") of 151 in 2009 and increasing to an ADC of over 228 in 2014.

[1] Page 36. UHS 2015 Annual Report and 10 K Report. See https://www.last10k.com/sec-filings/uhs#fullReport. We have included these financial documents as Appendix 1.
[2] Appendix 2, p. 87.
[3] Appendix 2, p. 60.
[4] Letter from Tuality Healthcare CEO, Manuel Berman, to OHA – Certificate of Need Program. March 2, 2016

Table 1. Average Daily Census at Adult Psychiatric and Geropsychiatric Inpatient Providers in the Service Area, 2009-2014

Planning Area Hospitals With Adult Beds	Average Daily Census, Adults 18 Years and Older, Inpatient Psychiatric Care						
	2009	2010	2011	2012	2013	2014	Average Annual Growth, 2010-2014
Legacy Emanuel Hospital & Hlth Ctr	10.2	10.7	10.0	10.5	10.3	9.9	-2.0%
Tuality Healthcare	16.2	16.6	17.3	16.8	15.9	16.2	-0.7%
Legacy Good Samaritan Medical Center	15.1	16.2	15.8	15.5	15.4	16.0	-0.2%
Adventist Medical Center	39.1	39.7	38.8	38.1	38.9	38.7	-0.6%
Providence Portland Medical Center	23.1	23.4	23.6	22.4	20.8	23.2	-0.3%
Providence St Vincent Medical Center	31.4	31.9	30.9	31.1	30.6	31.6	-0.2%
OHSU Hospital	16.0	15.4	15.3	15.0	14.7	15.6	0.3%
Cedar Hills		54.4	75.1	74.7	76.4	77.6	
Service Area Provider Total	**151.1**	**208.2**	**226.8**	**224.1**	**223.1**	**228.8**	**2.4%**

*Psychiatric DRGs 876 & 880-887, as well as 056-057 for Tuality Healthcare in accordance with their March 2, 2016 letter

Source: Oregon Inpatient Discharge Data, 2009-2014; Internal Cedar Hills Data

Further, to answer the question of why no increase has been seen at the facilities featured in Table 21 of our application, it is important to identify how the ADC translates to an individual psychiatric provider's occupancy rate. Provided below in Table 2 are both the bed counts and occupancy rate for planning area providers over the 6-year period. Every adult inpatient psychiatric provider has consistently shown occupancy rates between 70 to 90% of total occupancy. These occupancy rates are very high for units with relatively few (<50) beds as they are aggregate averages and do not factor surges in demand or seasonality that may reach total occupancy and limit access at intermittent periods. The combination of the rapid growth experienced by Cedar Hill with the consistently high occupancy rates of planning area hospitals shows that Cedar Hills has not "cannibalized" utilization away from other providers. The high occupancy rates also suggest that the reason why there has been little change in ADC utilization over the 6-year period in Table 21 [which did not include Cedar Hills Hospital] is because the inpatient psychiatric providers are effectively at full occupancy---and have been for some time. Findings of this quantitative analysis provides overwhelming support not only the theoretical justification for the approval of NEWCO, but also provides recent, actual quantitative evidence of the significant occupancy constraints facing current planning area psychiatric providers. This all translates into very significant access shortfalls for planning area residents.

Table 2. Bed Count and Occupancy at Adult Psychiatric and Geropsychiatric Inpatient Providers in the Service Area, 2009-2014

Planning Area Hospitals With Adult Beds	Bed Count, Adults 18 Years and Older, Inpatient Psychiatric Care					
	2009	2010	2011	2012	2013	2014
Legacy Emanuel Hospital & Hlth Ctr	10	10	10	10	10	10
Tuality Healthcare	21	21	21	21	21	21
Legacy Good Samaritan Medical Center	17	17	17	17	17	17
Adventist Medical Center	43	43	43	43	43	43
Providence Portland Medical Center	33	33	33	33	33	33
Providence St Vincent Medical Center	34	34	34	34	34	34
OHSU Hospital	20	20	20	20	20	20
Cedar Hills		78	78	78	79	89
Service Area Provider Total	**178**	**256**	**256**	**256**	**257**	**267**

Planning Area Hospitals With Adult Beds	Occupancy (%), Adults 18 Years and Older, Inpatient Psychiatric Care					
	2009	2010	2011	2012	2013	2014
Legacy Emanuel Hospital & Hlth Ctr	102%	107%	100%	105%	103%	99%
Tuality Healthcare	77%	79%	82%	80%	76%	77%
Legacy Good Samaritan Medical Center	89%	95%	93%	91%	91%	94%
Adventist Medical Center	91%	92%	90%	89%	90%	90%
Providence Portland Medical Center	70%	71%	71%	68%	63%	70%
Providence St Vincent Medical Center	92%	94%	91%	92%	90%	93%
OHSU Hospital	80%	77%	76%	75%	73%	78%
Cedar Hills		70%	96%	96%	97%	87%
Service Area Provider Total	**85%**	**81%**	**89%**	**88%**	**87%**	**86%**

*Psychiatric DRGs 876 & 880-887, as well as 056-057 for Tuality Healthcare in accordance with their March 2, 2016 letter

**There are no facility identifiers distinguishing between utilization inside or out of a hospital's designated psychiatric unit. This may result in occupancies near or even above 100%.

Source: Oregon Inpatient Discharge Data, 2009-2014; Internal Cedar Hills Data

5. **Page 59 of application – Shouldn't the applicant include depreciation in viability of entity as well as management allocated costs to show viability as a stand-alone?**

These expenses were included in our Application in Form CN-5, NEWCO Income Statement.

6. **Page 61 of the application – States that ramp up in volumes is based on Cedar Hills experience – it would be helpful to see Cedar Hills' actual experience since increases are fairly dramatic over the first 5 years.**

Please see Table 3 below.

Table 3. Cedar Hills Hospital and NEWCO, Utilization Statistics, Selected Years

Admissions	2010	2011	2012	2013	2014
Cedar Hills Hospital	1,511	2,290	2,177	2,263	2,537
Annual Change		779	(113)	86	274
Patient Days	19,871	27,421	27,267	27,887	28,337
Annual Change		7,550	(154)	620	450
Length of Stay	13.2	12.0	12.5	12.3	11.2
Available Beds	78	78	78	79	89
Occupancy	69.8%	96.3%	95.8%	96.7%	87.2%
	Year 1	Year 2	Year 3	Year 4	Year 5
NEWCO	415.6	1039.5	1824.2	2457.7	2654.4
Annual Change		623.90	784.70	633.50	196.70
Patient Days	4,574	11,435	20,066	27,035	29,198
Annual Change		6,861	8,631	6,969	2,163
Length of Stay	11.0	11.0	11.0	11.0	11.0
Available Beds	100	100	100	100	100
Occupancy	12.5%	31.3%	55.0%	74.1%	80.0%

Table 3 indicates that Cedar Hills has effectively been at maximum occupancy since its opening in late 2009. It opens with 37 beds, then added 44 additional beds in May 2010 for a total of 78 beds. With additional capacity, it grew in admits by 779 and in patient days by an additional 7,550 over 2010-2011, then effectively became full once again. In NEWCO's case, we stated it would be based on Cedar Hills' experience, which as seen in Table 3, was very rapid until the hospital became completely full at 96% occupancy 2011-2013, when it added more beds. NEWCO would also be expected to grow very rapidly, given what occurred at Cedar Hills, and very importantly, given the very large unmet need (Table 26, Application). As seen in Table 3, NEWCO would have fewer admits and patient days than Cedar Hills until Year 4 (2013 Cedar Hills figures). As Table 3 demonstrates, the increase in NEWCO's occupancy percentage is relatively modest on an annual basis.

a. The application also states that a slower ramp up rate will be used for the new proposed project, however, it appears the increase in adjusted patient days will be 150%, 75%, 35%, and 8% starting with year 2, and further, per the report, Cedar Hills had an increase of only 38% in patient days for year 1. Please explain.

Please see Table 3, above and the response provided to #6.

7. Should projections be by Pediatric/Adult/Geriatric – or at least discuss why reimbursement rates for these classes are consistent as well as the deductible? We would assume the pediatric population would have higher deductibles as more kids would have Medicaid and Cedar Hills does not see this population.

Payor mix was not specifically modeled in the pro forma. Instead, we used the average reimbursement per patient day ("PPD") from Cedar Hills and applied it to NEWCO.

We do expect more Medicaid volume with adolescents, but we also expect to get higher contracted rates from managed care since we will be offering adolescent services not currently provided at Cedar Hills. We believe these will offset and expect reimbursement PPD to be about the same at NEWCO as at cedar Hills. UHS experienced a very similar situation in Phoenix in 2015, when it opened a new 102-bed hospital serving adolescents. The reimbursement PPD at the new hospital has been slightly higher than the existing hospital that had been open for several years and served

only adults.

a. How much of the anticipated business is expected to be Medicaid broken out by age cohort?

As stated above, we did not model at the payor level, nor by age cohort, thus, it is unknown how much of the expected patient population, by age, will be Medicaid.

8. Page 61 of application Table 27:

a. Length of stay on table 26 for other local facilities is closer to 10 – Table 27 uses 11 and it is stated this is consistent with Cedar Hills 11.2. It appears a large increase in the length of stay at Cedar Hills is based on military inpatients, therefore, would the proposed project be expected to a similar mix of military inpatients to increase the length of stay or would be more relevant to use closer to 10? Would this be dependent upon referrals from Joint Base Lewis McChord, which is out of state/out of service area?

Please see Table 3, above, which shows Cedar Hills' and NEWCO's length-of-stay ("LOS") figures. Table 3 shows Cedar Hills actual LOS was 11.2 in 2014. It declined slightly in 2015. Through November 2015 year-to-date, Cedar Hills' LOS was 10.6 days. We did state NEWCO's LOS was modeled at 11 days, consistent with Cedar Hills' average 11.2 LOS in 2014 (i.e. the last full calendar year of data available at the time of this application).[5] It is the case that military inpatients have higher lengths-of-stay, which does drive LOS up somewhat. Excluding military inpatients, the Hospital's LOS was 8.9 days in 2015.

It may be LOS at NEWCO is lower than modeled but this has no impact on any modeling; patient days are the driving variable regarding NEWCO's patient population. If LOS was less, then more admits would occur, but patient days would not be expected to change from those modeled.

9. From CN-5 Income Statement:

a. How would the patient mix by age and payor group be different for NEWCO than for Cedar Hills? Please detail how this will affect patient service revenue and deductions.

As stated above, in response to #7, payor mix was not specifically modeled in the pro forma, nor was age mix. Instead, we used the average reimbursement per patient day ("PPD") from Cedar Hills and applied it to NEWCO. Based on our extensive experience developing and operating such hospitals, the methodology we used for NEWCO is reliable and an accurate predictor of expected financial performance.

b. Travel and education, this is a flat amount of $96,000, wouldn't this increase with FTEs?

[5] In 2015, Cedar Hills Hospital LOS was 10.6 days including all inpatients. It should be noted that military inpatients have much higher lengths-of-stay, driving the average figure up. Excluding military inpatients, the Hospital's LOS was 8.9 days in 2015.

Travel would not be materially impacted by number of FTEs or ADC, based on our experience operating comparable behavioral health hospital. All hospital functions would be available day one and FTEs travel the same whether we have 10 patients or 80 patients. Travel is mostly related to local marketing and specific corporate training programs. It is UHS' practice to hold travel expenses constant in its pro forma models.

c. How was the 6% of allocated cost determined and what does this expense represent?

When there is a relationship between subsidiary and parent, there are standard overhead, allocated costs not directly attributable to operations. The Management Fee, referenced above, has been calculated at 6% of net revenues, is intended to capture such anticipated costs, which at this time are not defined, but are nonetheless expected. Such costs might include costs of corporate staff activities for Human Resources, Legal, Financial Services, Planning/Marketing, etc.

d. What does the non-allocated expense represent and why would this remain flat year over year?

Non-allocated expense is an internal UHS classification to include audit fees, consulting fees, legal expense, sales tax, property tax, and other miscellaneous expenses not assigned to a cost center.

Most of the non-allocated expenses included in the model would be property tax as consulting and legal are assumed to be minimal.

We do not expect these non-allocated expenses to flex with volume, by definition of "fixed," and thus, such expenses are held constant over the forecast period in the pro forma model.

e. Depreciation is included as fixed costs however it was previously stated the assets would be on the parent company books therefore would the depreciation not be recorded on the subsidiaries' books?

Depreciation would be recorded at the hospital level. Fixed assets for the hospital would be maintained in the FAS ("fixed asset system") specific to NEWCO and recorded on the balance sheet.

f. What is the expected leased expense related to? Would there be other leases that would be required not included in the capital expenditure total?

Lease costs were modeled for copiers and other minor equipment not purchased.

g. There are no increases expected for inflation/cost of living for employees' salaries based on FTEs; has this been the practice of Cedar Hills that there are no "across the board" wage increases? If there have been increases year over year, what is the average wage increase?

We prepare pro formas without any inflation factors for both revenues and expenses. This is considered a conservative approach.

Our management practice is to provide merit increases in the 2.5%-3% range annually. If the

inflation environment were to change, this would be reviewed.

h. Maintenance expense is driven based on patient service revenue, what is the thought process around being driven based on revenue and not the age of the building, square footage or something similar?

Based on experience at numerous similarly-sized behavioral health hospitals, maintenance expense runs about 1% of net revenue. This is the figure used in the pro forma model.

OTHER CONCERNS – Facility Design and Construction

We have reviewed the revised plans that you submitted for the proposed hospital and your responses to my questions concerning them and their impact on hospital operations for the four age cohorts that you propose to serve. As you are aware, one of the criterion for approval is the OAR 333- 580-0050(4)(a) requirement that the project conforms to relevant state physical plant standards and must comply with state licensing, architectural and fire code standards. Additionally, OAR 333-580-0050(1)(A)(iv) requires the applicant to demonstrate that "the selected architectural solution represents the most cost effective and efficient alternative to solving the identified needs." A project that does not conform to licensing rules arguably would not satisfy this standard. It is the responsibility of the applicant to establish that the criteria set out in the CN administrative rules can be met.

OAR 333-580-0300(5) requires the applicant to demonstrate to the division that a proposal is approvable. The previously requested "detailed functional description of how the four patient populations (child, adolescent, adult and geriatric) will share/use the hospital space" was not provided. The information that was provided was not detailed and did not provide adequate explanation. Specifically:

Regarding our response to questions #1 and #2, below, UHS has determined that inpatient care for children, persons 5-11 years old, will not be included at this time, due to space configurations and treatment modality requirements for the different age cohort groups.

1. **As we review your plans it is not clear how, as required by OAR 333-535- 0061(8)(d), child and adolescent care units are physically and visually separate from each other and from adult units. It does not appear that, without alterations to the plans, this requirement can be met.**

Please see attached memorandum from SRG Partnership, Inc., the architectural firm UHS engaged for the Wilsonville psychiatric hospital Appendix 3 includes detailed responses by SRG that address the Oregon Health Authority questions related to facility design and construction.

2. **Although you have designated Unit 2A as a 24-bed geriatric unit, the rest of the patient rooms are not labeled for the age population to be served in them. In order to establish need for the project, your application posits serving 20 child/adolescent patients, 60 adult patients and 20 geriatric patients. Given the design of the facility, it does not appear to us that it could successfully serve this patient mix**.

Please see attached memorandum from SRG Partnership, Inc., the architectural firm UHS engaged for the Wilsonville psychiatric hospital Appendix 3 includes detailed responses by SRG that address the Oregon Health Authority questions related to facility design and construction.

3. **Although your June 28, 2016 response references "window treatments" and "glass frosting", patient rooms must have visually functional windows as outlined in OAR 333-535-0025(1)(c). As presented, it does not appear that required visual separation will be achieved in the patient activity yards and at the nursing stations**.

Please see attached memorandum from SRG Partnership, Inc., the architectural firm UHS engaged for the Wilsonville psychiatric hospital Appendix 3 includes detailed responses by SRG that address the Oregon Health Authority questions related to facility design and construction.

4. **As we previously noted in our letter dated April 26, 2016, OAR 333-535- 0061(8)(a) requires that the environment of child and adolescent units reflect the age, social and developmental needs of children and adolescents, including spaces to accommodate family and other caregivers. Consequently, the environment for children and adolescents will differ from each other and will not be the same environment required for adults and geriatric patients. How will the shared seclusion, social work and exam rooms be made age appropriate? Without the requested "detailed functional description" cited above, it is not possible to see how the single dining room will adequately accommodate the needs of four different shifts for each meal three times a day. In addition, access to the single gym also seems problematic given the design of the facility.**

Please see attached memorandum from SRG Partnership, Inc., the architectural firm UHS engaged for the Wilsonville psychiatric hospital Appendix 3 includes detailed responses by SRG that address the Oregon Health Authority questions related to facility design and construction.

5. **OAR 333-535-0061 (7)(a) requires that five seclusion rooms be provided but we only see four.**

Please see attached memorandum from SRG Partnership, Inc., the architectural firm UHS engaged for the Wilsonville psychiatric hospital Appendix 3 includes detailed responses by SRG that address the Oregon Health Authority questions related to facility design and construction.

<u>Required Action:</u> Please provide the previously requested "detailed functional description" and identify which rooms will be used for the separate child, adolescent and adult units. Please do not combine child and adolescent into one group for this purpose, as they must be separate.

Please see Appendix 4 for a detailed functional description. We have outlined a preliminary detailed functional description for each hospital unit to explain how the different patient populations would utilize the shared spaces throughout the facility. The functional description shows how all activities that take place in the dining room, gymnasium, and outdoor activity yards will be staggered and each patient population will travel between these shared spaces at different times. Unit 1B will be the acute adult unit and these patients will not utilize the dining room or the gymnasium because their meals and exercise therapy will occur on the unit. The acronym "OB" represents outdoor breaks that will occur in the two separate patient activity yards.

Due to the flexibility of the architectural plans there are two halls that can be used to transfer patients between the hospital units and the shared spaces. Many activities will also take place on the unit throughout the day, which will ensure that each patient population is visually and physically separated from one another.

Appendix 1

Cedar Hills Financial Statements

Appendix 2

Universal Health Services
2015 Annual Report and 10-K Filing with Securities and Exchange Commission

Appendix 3

Memorandum from SRG Partnership, Inc, October 4, 2016

Appendix 4
NEWCO Detailed Functional Description