PUBLIC HEALTH DIVISION
Office of Health Care Regulation and Quality Improvement
Kate Brown, Governor

Oregon Health Authority

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September 29, 2016

Ron Escarda
Fairfax Behavioral Health System
10200 N.E. 132nd Street
Kirkland Washington 98034

Re: NEWCO Oregon, Inc. (CN #675)

Dear Mr. Escarda:

As you know, we are engaged in reviewing the above captioned application for completeness. Our contracted accounting firm has now had the opportunity to review the application materials and your responses to our earlier screening questions. Based upon their input we have determined that the application still appears to be incomplete or requires an explanation in the following areas:

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.

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?

3. Applicant indicates that no financing will occur for project, but will be Cash flowed from operations – impact of $36M for construction.

    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).

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.

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.

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?

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.

   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.

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.

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

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?

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.

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

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

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

   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?

   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?

   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?

   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?

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:

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.

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.

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.

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.

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

Required Action: 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.

Thank you for your cooperation.

Sincerely,

Jana Fussell

Jana Fussell
Certificate of Need Coordinator

cc: Frank Fox, Consultant for NEWCO Oregon, Inc.
Manuel S. Berman, Tuality Healthcare, Affected Party
Steve Robison, Oregon Public Health Division
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