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

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

January 2, 2023

Alicia Beymer
PeaceHealth Riverbend, LLC
1255 Hilyard Street
Eugene, OR 97401

Re: Proposed Decision, PeaceHealth Riverbend, LLC
Certificate of Need Application No. 699

Dear Ms. Beymer:

The Oregon Health Authority (OHA), Public Health Division's Certificate of Need Program is tasked with reviewing and issuing Proposed Decisions on Certificate of Need (CN) applications. ORS 442.315(5)(a).

On June 8, 2023, PeaceHealth Riverbend, LLC ("PeaceHealth") filed a CN application with the required fee for a 50-bed freestanding inpatient rehabilitation hospital to be located at 123 International Way in Springfield, Oregon. The application was determined to be complete on June 23, 2023, and review began on June 26, 2023. A public meeting was held on August 29, 2023.

The CN process is governed by 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 PeaceHealth under the criteria applicable to the project. OAR 333-580-0000(8).

On November 15, 2023, OHA issued a Draft Recommendation finding that PeaceHealth met its burden of proof for justifying the need for a 42-bed inpatient rehabilitation facility.

No request for an informal conference was received by the agency and the time for such a request has now passed. Consequently, OHA issues this Notice of Proposed Decision pursuant to ORS 442.315(5)(b).

The Proposed Decision is based on the application, supplemental documents from

applicant, and the entirety of the agency record.

Need for inpatient rehabilitation beds in the Applicant's service area.

This review is conducted under OAR 333-645-0030 (Elements in Calculating Need for Rehabilitation Services) which requires that the below four criteria are evaluated:

(1) Total need for inpatient rehabilitation services is such that inpatient facilities shall not exceed seven beds in 100,000 general population:
(a) Determination of hospital service area is to be consistent with OAR 333-590-0040, or with historical use patterns for rehabilitation services if these are demonstrably different from a defined hospital service area;
(b) Adjustments to this standard can be made where a specialty rehabilitation service is proposed, if the applicant submits information demonstrating the sizes of populations at risk in the proposed service area; the current and historical rates of hospitalization in Oregon for those groups; and the availability, accessibility, quality, and levels of utilization of existing inpatient services addressing the needs of those groups in Oregon. An example of a specialty rehabilitation unit would be a unit specializing in strokes.

(2) Expansion of existing rehabilitation units shall be given priority over creation of new rehabilitation units for comparable services, unless it can be demonstrated that the applicant is offering the least costly service.

(3)(a) Rehabilitation units must have an annualized occupancy rate of at least 85 percent prior to expansion of any bed capacities, and expansion should be such that the unit can maintain a minimal occupancy rate of 75 percent on unit capacity, within 1-1/2 years of certificate of need approval;
(b) A new rehabilitation unit must demonstrate that it will be able to achieve and maintain a minimal annual occupancy rate of 75 percent of unit capacity within three years of certificate of need approval.

(4) Bed need calculation and minimal occupancy rate for rehabilitation services is to be consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060.

Determination of hospital service area. OAR 333-645-0030(1)(a).

Per OAR 333-590-0040 "Determination of Service Area for Existing Hospitals," the service area for an existing general hospital will be defined as including those zip codes from which either ten percent or more of the hospital's discharges originate, or in which the hospital has at least a 20 percent market share. Minor adjustments to the boundaries of the hospital service area may be made to create a contiguous service area or to conform more closely to the boundaries of demographic units for which census data are reported (county, county census division, enumeration district, or zip codes if conversion has been done). An applicant shall provide a

comprehensive market share analysis for the proposed service area of the proposed facility using relevant and recent data. This market analysis shall describe the estimated geographic area the facility will draw patients from and assess the impact to patients and like facilities within that region.

The service area was updated and defined by the applicant in the CN filing to include these five counties: Benton, Coos, Douglas, Lane, and Linn. Utilizing data requested from the Oregon All Payer All Claims Reporting Program (APAC), OHA isolated the admission data for the last three years (from 2020 to 2022), for patients originating from the abovementioned five counties to:

- Place of Service (POS) code 61 specific to professional claims and
- Revenue Code 24 specific to institutional claims for Comprehensive Inpatient Rehabilitation Facility.

Admissions by Patient County of Origin	2020	2021	2022	Three-year average
Lane	80.7%	69.2%	66.1%	71.6%
Linn	5.6%	9.8%	11.9%	9.2%
Coos	2.5%	6.3%	6.5%	5.2%
Benton	1.2%	3.6%	5.4%	3.4%
Douglas	5.6%	4.9%	2.4	4.3%
Josephine	1.9	0.4%	2.4%	1.4%
Jackson	0.0%	0.9%	1.8%	0.9%
Lincoln	1.9%	2.7%	1.2%	2.0%
Polk	0.0%	0.0%	0.6%	0.2%
Umatilla	0.0%	0.0%	0.6%	0.2%
Crook	0.0%	0.0%	0.6%	0.2%
Klamath	0.0%	0.0%	0.6%	0.2%
Marion	0.0	1.3%	0.0%	0.5%
Curry	0.0%	0.4%	0.0%	0.2%
Multnomah	0.6%	0.0%	0.0%	0.2%
Columbia	0.0%	0.4%	0.0%	0.2%
Grand Total	100%	100%	100%	100%

The applicant proposed there would be additional demand for inpatient rehabilitation beds because they would be offering a specialty stroke and TBI program.

Per OAR 333-590-0040, the service area for an existing general hospital will be defined as including those zip codes from which either ten percent or more of the hospital’s discharges originate, or in which the hospital has at least a 20 percent market share. The five identified counties made up 92.3% of the total population of

Oregon Rehabilitation Center (ORC) patients in Year 2022; therefore, the data provided supports the applicant's determination of hospital service area under the definitions of OAR 333-590-0040.

Hospital service population Demographic factors

With the consideration that the total need for inpatient rehabilitation services is such that inpatient facilities shall not exceed seven beds in 100,000 general population (OAR 333-645-0030(1) "Elements in Calculating Need for Rehabilitation Services"), OHA reviewed the demographic factors that made up the hospital service population. Utilizing census data for the abovementioned five counties, the service population from ages 15 and up[1] that would fit the scope of practice as stated by the applicant is approximately 669,000 in 2023, growing to 693,000 in 2027. At seven beds in 100,000 general population, the data would support 49 inpatient rehabilitation beds by 2027.

By Age Band	2023 Population	%	2027 Population	%
Pop age 0-4	36,538	4.6%	41,728	5.10%
Pop age 5-9	40,888	5.2%	40,092	4.90%
Pop age 10-14	43,748	5.5%	42,546	5.20%
Pop age 15-19	49,811	6.3%	51,546	6.30%
Pop age 20-24	65,344	8.3%	53,183	6.50%
Pop age 25-29	51,112	6.5%	54,819	6.70%
Pop age 30-34	49,919	6.3%	54,001	6.60%
Pop age 35-39	48,301	6.1%	51,546	6.30%
Pop age 40-44	47,419	6.0%	49,910	6.10%
Pop age 45-49	42,207	5.3%	47,455	5.80%
Pop age 50-54	44,553	5.6%	45,001	5.50%
Pop age 55-59	48,159	6.1%	45,819	5.60%
Pop age 60-64	53,940	6.8%	49,092	6.00%
Pop age 65-69	55,240	7.0%	51,546	6.30%
Pop age 70-74	48,531	6.1%	49,910	6.10%
Pop age 75-79	30,295	3.8%	40,092	4.90%
Pop age 80-84	18,559	2.3%	27,000	3.30%
Pop age 85+	15,923	2.0%	22,091	2.70%
Total Population	790,487		817,378	
IRF Eligible Population (>= Age 15)	669,313		693,011	

Data Source: Advisory Board's AGS modeling of several sources e.g. 2020 Census, latest American Community Survey, and Current Population Survey

[1] Applicant has indicated in their application that the proposed IRF will not serve patients under the age of 15.

Adjustments to this standard can be made where a specialty rehabilitation service is proposed. OAR 333-645-0030(1)(b).

The applicant proposed there would be additional demand for inpatient rehabilitation beds because they would be offering a specialty stroke and TBI program.

OHA first analyzed the historical volume of admissions for IRF from the service area. OHA utilized All Payer All Claims Data (APAC) admission data from 2020 to 2022, filtered to claims submitted by the facility Sacred Heart University District for patients originating from the proposed service area.

Table 1: Historical IRF admission volumes for ORC from 5 Counties, years 2020 through 2022.

Admissions by Patient County	2020	%	2021	%	2022	%	Total
Benton	2	1.3%	8	3.8%	9	3.5%	19
Coos	4	2.6%	14	6.7%	11	4.5%	29
Douglas	9	14%	11	5.2%	4	10.3%	24
Lane	130	84.4%	155	73.8%	111	67.7%	396
Linn	9	5.8%	22	10.5%	20	14.1%	51
Grand Total	154	100%	210	100%	155	100%	519

(source: APAC)

Per CMS guidelines, when a patient is registered as inpatient status and they are present in a physician's office, they should be reported with place of service for whatever the status they are inpatient, in this case, Comprehensive Inpatient Rehabilitation Facility – place of service (POS) – 61. Therefore, professional claims submitted by IRF providers would serve as a proxy for services provided to an inpatient patient when there is not an associated institutional/hospital claim.

Conversely, revenue code 24 is specific to IRF facility claims, and reflects services occurring in the IRF. The combination of data queried from POS 61 and Revenue Code 24 provides a clearer picture of the historical use patterns for rehabilitation services from a defined hospital service area. This methodology is commonly utilized by analytics and data aggregators to perform data cleansing and explain gaps in volumes for healthcare market and predictive analytics.

Admissions by Patient County of Origin	2020	%	2021	%	2022%	%	Total
Benton	27	4.9%	28	2.0%	57	3.7%	112
Coos	29	5.3%	77	5.5%	74	4.8%	180
Douglas	71	12.9%	150	10.8%	170	10.9%	391

Lane	321	58.3%	962	69.2%	1,048	67.3%	2,331
Linn	103	18.7%	173	12.5%	209	13.4%	485
Grand Total	573	100%	1,390	100%	1,558	100%	3,499

Table 1: Historical IRF admission volumes for 5 Counties, years 2020 through 2022 utilizing a combination of Revenue code 24 and POS 61. (source: APAC)

OHA then examined the population of such diagnoses in the service area by isolating to the principal diagnoses of TBI (ICD-10 CM code S06X) and Stroke (ICD-10 CM code I63X).

Admissions by Patient County of Origin	2020	%	2021	%	2022	%	Total
TBI							
Benton	0	0%	0	0%	1	3.3%	1
Coos	3	9.4%	2	4.2%	1	3.3%	6
Douglas	4	12.5%	5	10.4%	2	6.7%	11
Lane	23	71.9%	41	85.4%	17	56.7%	81
Linn	2	6.3%	0	0%	9	30%	11
Subtotal	32		48		30		110
Stroke							
Benton	0	0%	14	5%	0	0%	14
Coos	3	5.5%	18	6.4%	11	3.2%	32
Douglas	1	1.8%	20	7.1%	46	13.3%	67
Lane	10	18.2%	209	74.4%	221	63.7%	440
Linn	41	74.5%	20	7.1%	69	19.9%	130
Subtotal	55		281		347		683

Table 2: Historical IRF admission volumes for 5 Counties, years 2020 through 2022 utilizing a combination of Revenue code 24 and POS 61 with principal diagnoses of TBI and Stroke. (source: APAC)

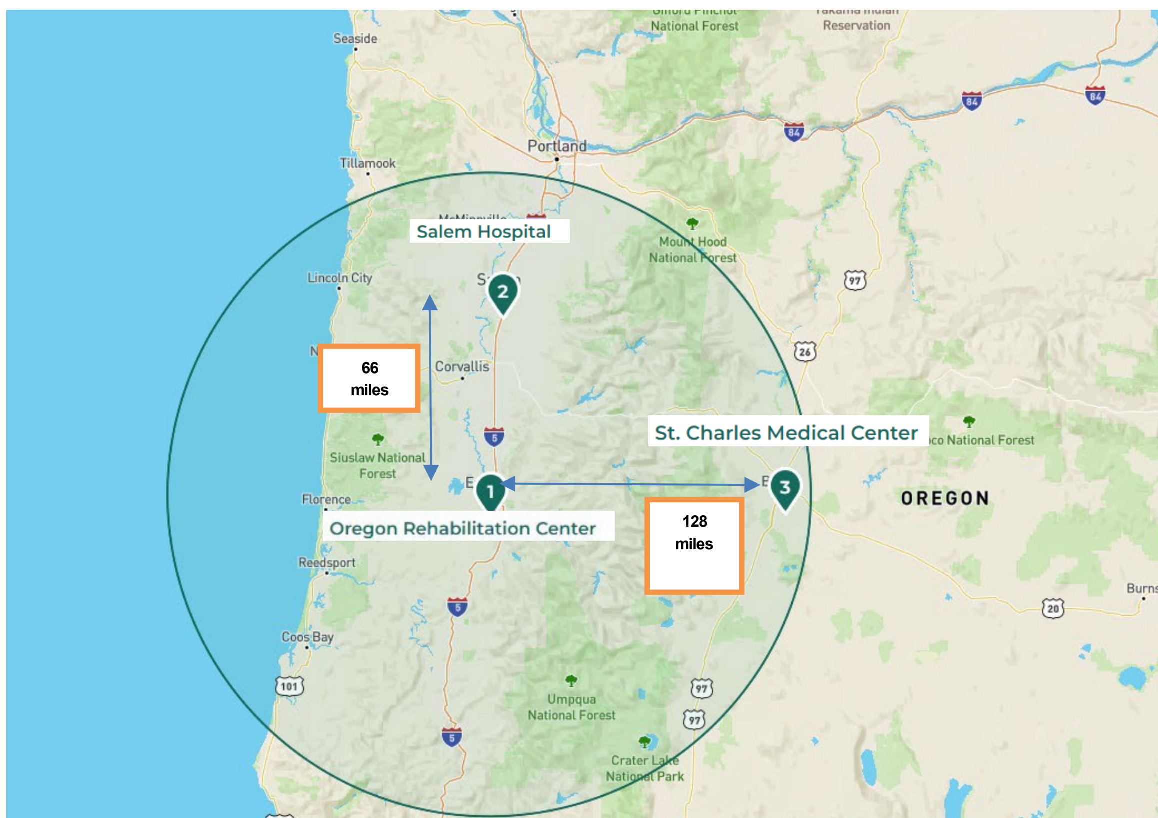
For TBI patients, a book published in 2022 on Traumatic Brain Injury: A Roadmap for Accelerating Progress, only about 13 to 25 percent of patients who survive moderate, severe, or penetrating TBI receive comprehensive, interdisciplinary inpatient rehabilitation, and even fewer receive TBI-specialized rehabilitation care (source: National Library of Medicine).

Per the Shirley Ryan Ability Lab, formerly the Rehabilitation Institute of Chicago, a not-for-profit nationally ranked physical medicine and rehabilitation research hospital based in Chicago, Illinois, stroke survivors are scored using the National Institutes of Health Stroke Scale (NIHSS) score. Scores of <5; 80% of stroke survivors will be discharged to home. Score between 6 and 13 typically require inpatient rehabilitation. Scores of >14 frequently require long-term skilled care. When OHA further filtered the data with the ICD-10 CM code R29X, the stroke patient population reduced to just one patient across the 3-year time span. This may be indicative of data integrity issue. An American Heart Association (AHA)/American Stroke Association journal published in August 2021 referenced a large percentage of patients discharged from the hospital after stroke receive care and rehabilitation in an inpatient rehabilitation facility (IRF; 19%), skilled nursing

facility (SNF; 25%), or home care services (12%).

The APAC data above showed approximately 24% IRF patients in 2021 and 2022 respectively had primary diagnoses of stroke or TBI. The applicant's proposal to build a designated 12-bed wing for both acquired traumatic brain injury (TBI) and spinal cord patients appears to be consistent with the data and research.
To understand if there is any regional draw for the TBI and spinal cord patients, OHA examined the APAC data for patients originating from outside the proposed service area. The data showed in 2022 that the stroke patients outside the proposed service area were mostly from Medford in Jackson County and were admitted to IRFs in the Medford area. The TBI patients in 2022's data were concentrated in the Portland area and were admitted to IRFs in Portland. The data did reveal some patients originating from Bend, Oregon who were admitted to IRFs in Bend, Oregon.

The data does not appear to support a regional pull of patients who may be diagnosed with stroke or TBI.



Existing bed inventory in the service area.

In the proposed service area, Salem Hospital has a 24-bed inpatient rehabilitation unit that also serves Benton, Coos and Linn Counties. For this reason, the bed inventory of Salem should be taken into consideration when determining the total

need for inpatient rehabilitation services (see map on page 7). The current inventory of beds is at 51 when you add 24 beds from Salem Hospital's and 27 beds from PeaceHealth's Sacred Heart University District's ORC together.

Based on Salem Hospital's FY2022 Medicare Cost Report, its 24-bed unit reported 375 discharges and 5,058 days in 2024, which equated to ADC of 13.9 (an occupancy rate of approximately 58%) and ALOS of 13.5 days. There appears to be idle licensed bed capacity, i.e., no lack of access.

While the applicant states that there is a shortage of inpatient rehabilitation beds, the data showed the total need for inpatient rehabilitation services per OAR 333-645-0030(1) is currently satisfied with the existing inventory of inpatient rehabilitation beds.

Expansion of existing rehabilitation units shall be given priority over creation of new rehabilitation units for comparable services, unless it can be demonstrated that the applicant is offering the least costly service. OAR 333-645-0030(2).

The applicant suggested that the facility in which these inpatient rehabilitation services are currently provided in PeaceHealth Sacred Heart University District's ORC is dated and is unable to be modernized in a cost-effective manner. According to applicant, not only is the current hospital campus infrastructure not able to support today's state-of-the-art equipment necessary for functional improvement of patients, but the patient rooms are also too small for rehabilitation patients. Additionally, the current units cannot be configured to support specialty care. The aging facility requires significant investments to meet seismic requirements and upgrading the existing generators and HVAC systems. OHA finds that the applicant has demonstrated it is offering the least costly service.

As of August 22, 2023, PeaceHealth announced the closing of the PeaceHealth Sacred Heart Medical Center University District hospital. The closing will transition Inpatient Rehabilitation, Emergency Department and related medical services to PeaceHealth Sacred Heart Medical Center at RiverBend, located less than 6 miles away in Springfield. Ambulatory Services, including PeaceHealth Medical Group clinics and Home & Community services, will remain open (source: PeaceHealth website).

Rehabilitation units must have an annualized occupancy rate of at least 85 percent prior to expansion of any bed capacities, and expansion should be such that the unit can maintain a minimal occupancy rate of 75 percent on unit capacity, within 1-1/2 years of certificate of need approval. OAR 333-645-0030(3)(a).

For this analysis, OHA utilized the following sources:

- APAC admission data from 2020 to 2022
- PeaceHealth Sacred Heart University District Medicare Cost Report for Fiscal Year (FY) 2022 report (July 1, 2021 to June 30, 2022)

As outlined above, the following historical volume analysis utilized APAC data that was filtered to claims submitted by the facility Sacred Heart University District for patients originating from the service area of the five counties. A combination of revenue code 24 and POS 61 was used.

Admissions by Patient County of Origin	2020	%	2021	%	2022	%	Grand Total
Benton	27	4.9%	28	2.0%	57	3.7%	112
Coos	29	5.3%	77	5.5%	74	4.8%	180
Douglas	71	12.9%	150	10.8%	170	10.9%	391
Lane	321	58.3%	962	69.2%	1,048	67.3%	2,331
Linn	103	18.7%	173	12.5%	209	13.4%	485
Grand Total	573	100%	1,390	100%	1,558	100%	3,499

OHA considered that the low volume of admissions in year 2020 was likely due to the impact of the COVID-19 pandemic. From 2021 to 2022, there was a 12% increase of patients from the service area admitted into IRFs. Although this historical utilization data is not specific to ORC but for all IRFs, there are only two IRFs within 75 miles driving distance radius of Eugene, OR -- Sacred Heart University District's ORC and Salem Hospital Inpatient Rehabilitation program. Patients typically receive inpatient rehabilitation at the acute care facility they are discharged from or at a facility near their home. It is reasonable to assume that a high percentage of the 1,639 admissions from these and traumatic brain injury patients are a unique cohort of patients known to travel farther to receive specialty care.

The applicant reported over the three-year period from 2019 to 2021, ORC had approximately 1,100 discharges, that is an annual average of 367 discharges. Utilizing a publicly available source of data, which is the PeaceHealth Sacred Heart University District Medicare Cost Report for Fiscal Year (FY) 2022 report (July 1, 2021 to June 30, 2022), there were 717 patients and 8,488 patient days reported from their IRF, i.e. ORC. (source: Medicare's Healthcare Cost Report Information System (HCRIS)). The Average Length of Stay (ALOS) was 11.8 days, and the ADC was 23.25. OHA noted that the number of licensed beds reported as available on the PeaceHealth Sacred Heart University District FY 2022 Medicare Cost Report was 20 beds, which is 7 beds less than the applicant's reported bed counts at the ORC. Additionally, the number of bed days available reported was 8,650, which appeared to be overstated for a 20-bed count. Based on the number of available days, the bed count would be 23.

Health Financial Systems	SACRED HEART MED CTR - UNIVERSITY		In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 38-0033	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Prepared: 1/22/2023 3:51 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	36	12,241	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	12,241	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		36	12,241	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	35	12,775		0	16.00
17.00	SUBPROVIDER - IRF	41.00	20	8,650		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00

A longer ALOS showed a negative association with functional gains among the mildly impaired patients as well as discharge to community for both mild and moderately impaired patients. It is probable that the ORC has a higher ALOS due to patient factors including a higher level of impairment.

TABLE 9–5

In 2019, the number of IRF cases and payments increased, while length of stay and users decreased

	2010	2015	2016	2017	2018	2019	Average annual change 2010–2019	Average annual change 2018–2019
Number of FFS cases	365,095	393,475	396,247	396,294	408,038	409,059	1.3%	0.3%
Cases per 10,000 FFS beneficiaries	101.3	103.4	103.2	102.7	105.7	106.9	0.6	1.6
Payment per case	$16,814	$18,527	$18,931	$19,481	$20,124	$20,417	2.2	1.5
ALOS (in days)	13.1	12.7	12.7	12.7	12.7	12.6	–0.4	–0.5
Users	330,774	354,343	355,390	354,618	363,753	363,285	1.0	–0.1

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), ALOS (average length of stay).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

Per the March 2021 Medicare Payment Advisory Commission (MedPAC) report, the average length of stay at IRFs has decreased while the number of IRF cases have increased as shown in Table 9-5.

However, the article concluded that the association of IRF Length of Stay (LOS) and patient outcomes varied by stroke impairment severity, positively for more severely impaired patients and negatively for mildly impaired patients. The Average

LOS (ALOS) was 8.9, 13.9, and 22.2 days for mild, moderate, and severely impaired stroke patients, respectively. The applicant's ALOS at 11.8 days, is better than industry average.

Taking only the Medicare Cost Report into consideration, the occupancy rate of ORC can be calculated in the following way:

- Occupancy Rate = ADC of 23.25 / 27 beds = 86.3% OR
- Occupancy Rate = Total Inpatient Days 8,488 / Total Available Days of 27 beds x 365 days a year = 86.1%

Taking a combination of the Medicare Cost Report and the APAC data into consideration, one can project that 51.6% of 1,558 of the APAC 2022 IRF admissions would seek IRF services at the ORC, that is approximately 804 admissions/discharges. The 50% projection was derived by dividing 717 IRF discharges in PeaceHealth Sacred Heart University District Medicare Cost report 2021 from the 1,390 IRF admission volumes from APAC data in 2021. Assuming there are no major changes in admission trends, the projected occupancy rate of ORC can be calculated in the following way:

- Occupancy Rate = 800 x 11.8 ALOS / Total Available Days of 27 beds x 365 days a year = 96.3%

The data supports annualized occupancy rate of at least 85 percent was achieved prior to expansion of any bed capacities.

A new rehabilitation unit must demonstrate that it will be able to achieve and maintain a minimal annual occupancy rate of 75 percent of unit capacity within three years of certificate of need approval. OAR 333-645-0030(3)(b).

For an IRF of 50 bed capacity and assumed increase of ALOS from 11.8 to 13.9 days as literature suggested for moderate stroke impaired patients, OHA recalculated the number of patients needed to meet the occupancy rate of 75% as follows:

Number of Patients = 50 beds x 365 days a year x 75% occupancy / 13.9 days ALOS = approximately 985 patients.

This represents a 37.7% increase in admissions or a 61% increase in patient days than the applicant's report of historical patient days as seen below. From 2020 to 2021, there was a significant increase of patient days by almost 60%. However, the applicant experienced labor shortages that resulted in a reduction of almost 19% of patient days in the following year.

Table 3
PeaceHealth Sacred Heart Medical Center at University District's Oregon Rehabilitation Center (ORC)
Patient Days and Occupancy, 2018-2022

Year	Patient Days	Percentage Change in Patient Days	Occupancy
2018	3,882		59.1%
2019	4,121	6.1%	62.7%
2020[1]	5,337	29.5%	67.7%
2021	8,514	59.5%	86.4%
2022	6,921	-18.7%	70.2%

Source: Applicant

Impact of COVID-19 Public Health Emergency (PHE), temporary flexibilities/waivers on IRF Census

During COVID-19 Public Health Emergency (PHE), temporary flexibilities/waivers were issued as of March 30, 2020 for IRFs and other post-acute care providers serving Medicare beneficiaries to respond effectively to the serious public health threats to ensure that Medicare patients can continue receiving services without jeopardizing patients' health or the health of those providing services during the PHE. Below are three examples of the waivers in effect for IRFs:

- **Medicare Telehealth:** May be used to fulfill the requirement for physicians to conduct the required face-to-face visits at least 3 days a week for the duration of a Medicare Part A FFS patient's stay in an IRF.

- **Flexibility for IRFs Regarding the "60-Percent Rule":** CMS is allowing IRFs to exclude patients from the freestanding hospital's or excluded distinct part unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60-percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, OHA would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

- **IRF – Intensity of Therapy Requirement ("3-Hour Rule"):** The Coronavirus Aid, Relief, and Economic Security (CARES) Act requires the Secretary to waive § 412.622(a)(3)(ii) (commonly referred to as the "3-hour rule"), the criterion that patients treated in IRFs generally receive at least 15 hours of therapy per week. The waiver of this requirement for all beneficiaries treated in a hospital based or freestanding IRF provides flexibility for IRFs to provide care for patients during the PHE.

Notably some IRFs that are a part of a hospital system had staff and beds repurposed to serve the acute care population when the acute care hospital exceeded their surge capacity. Other IRFs expanded the population they served to include patients with COVID-19, some with dedicated COVID-19 units and negative pressure rooms. (Eddy, 2020). Most IRFs across the country have admitted "COVID-19 recovery patients" (tested positive for COVID-19 but are no longer infectious) who are diagnosed with debility as a result of severe symptoms—many following a prolonged hospitalization. This was made possible by a waiver of the "60% rule" by CMS.

Impact of US healthcare labor shortages on IRF census

The United States healthcare industry is facing severe shortages of staff at every level. The American Hospital Association estimates that the industry will face a shortage of up to 124,000 physicians by 2033. Meanwhile, it will need to hire at least 200,000 nurses a year to meet rising demands. A study projected that if US workforce trends continue, more than 6.5 million healthcare professionals will permanently leave their positions by 2026, while only 1.9 million will step in to replace them, leaving a national industry shortage of more than 4 million workers. (McKinsey).

Per the applicant, this is the major contributor to its volume decrease in 2022 (CN Application page 8). Considering that the threat of labor shortages and skyrocketing costs is expected to continue, OHA must consider that the applicant may not experience similar growth as they did in 2021.

Bed need calculation and minimal occupancy rate for rehabilitation services is to be consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060. OAR 333-645-0030(4).

In calculating the projected bed need, OHA reiterates that the service area has two IRFs: PeaceHealth ORC and Salem Hospital's. There are two counties in the service area that are served by both facilities. To accurately understand the current bed inventory, which is used towards projecting the bed need, OHA separated the population count into 3 segments:

1. PeaceHealth 3 Counties: Coos, Douglas & Lane
2. Salem 3 Counties: Lincoln, Marion, Polk
3. Overlapped Counties: Benton & Linn

1. PeaceHealth 3 Counties: Coos, Douglas & Lane				
2023 Population:		562,719		
2027 Population:		579,210		
Age Group	**2023**		**2027**	
Pop age 15-19	5.90%	33,200	6.00%	34,753
Pop age 20-24	7.60%	42,767	6.10%	35,332

Pop age 25-29	6.30%	35,451	6.40%	37,069
Pop age 30-34	6.20%	34,889	6.40%	37,069
Pop age 35-39	6.10%	34,326	6.30%	36,490
Pop age 40-44	6.10%	34,326	6.10%	35,332
Pop age 45-49	5.40%	30,387	5.90%	34,173
Pop age 50-54	5.70%	32,075	5.60%	32,436
Pop age 55-59	6.20%	34,889	5.70%	33,015
Pop age 60-64	7.00%	39,390	6.10%	35,332
Pop age 65-69	7.30%	41,078	6.50%	37,649
Pop age 70-74	6.50%	36,577	6.40%	37,069
Pop age 75-79	4.10%	23,071	5.20%	30,119
Pop age 80-84	2.50%	14,068	3.50%	20,272
Pop age 85+	2.10%	11,817	2.90%	16,797
Total Eligible Population	478,311		492,908	
7 per 100K population Bed Need	34		35	
PeaceHealth Bed Inventory	27		27	
Net Need/(Surplus)	7		8	

2. Salem 3 Counties: Lincoln, Marion, Polk 2023 Population: 491,234 2027 Population: 517,295				
Age Group	2023		2027	
Pop age 15-19	6.70%	32,913	6.70%	34,659
Pop age 20-24	6.60%	32,421	6.50%	33,624
Pop age 25-29	6.60%	32,421	6.30%	32,590
Pop age 30-34	6.70%	32,913	6.40%	33,107
Pop age 35-39	6.60%	32,421	6.40%	33,107
Pop age 40-44	6.30%	30,948	6.30%	32,590
Pop age 45-49	5.70%	28,000	6.00%	31,038
Pop age 50-54	5.80%	28,492	5.70%	29,486
Pop age 55-59	5.90%	28,983	5.60%	28,969
Pop age 60-64	6.30%	30,948	5.70%	29,486
Pop age 65-69	6.10%	29,965	5.70%	29,486
Pop age 70-74	5.10%	25,053	5.30%	27,417
Pop age 75-79	3.30%	16,211	4.20%	21,726
Pop age 80-84	2.00%	9,825	2.80%	14,484
Pop age 85+	1.70%	8,351	2.40%	12,415
Total Eligible Population	399,864		424,182	
7 per 100K population Bed Need	28		30	
Salem Health Bed Inventory	24		24	
Net Need/(Surplus)	4		6	

Although there is a net need of 4 beds, Salem's ADC of 13.9 means there are 10 underutilized beds in their IRF that patients in the overlapped counties of Benton and Linn can access.

3. Overlapped Counties: Benton & Linn 2023 Population: 227,768 2027 Population: 238,986				
Age Group		**2023**		**2027**
Pop age 15-19	7.30%	16,627	7.20%	17,207
Pop age 20-24	9.90%	22,549	7.30%	17,446
Pop age 25-29	7.00%	15,944	7.40%	17,685
Pop age 30-34	6.50%	14,805	7.00%	16,729
Pop age 35-39	6.10%	13,894	6.50%	15,534
Pop age 40-44	5.70%	12,983	6.00%	14,339
Pop age 45-49	5.30%	12,072	5.60%	13,383
Pop age 50-54	5.60%	12,755	5.40%	12,905
Pop age 55-59	5.80%	13,211	5.40%	12,905
Pop age 60-64	6.30%	14,349	5.60%	13,383
Pop age 65-69	6.20%	14,122	5.80%	13,861
Pop age 70-74	5.30%	12,072	5.40%	12,905
Pop age 75-79	3.30%	7,516	4.30%	10,276
Pop age 80-84	2.00%	4,555	2.80%	6,692
Pop age 85+	1.70%	3,872	2.40%	5,736
Total Eligible Population		191,325		200,987
7 per 100K population Bed Need		14		15
Bed Inventory*		6		6
Net Need/(Surplus)		8		9

To arrive at the bed inventory for the overlapped service area, OHA subtracted the four beds needed in Salem's three counties service area from the 10 underutilized bed inventory of Salem. The remaining six beds would be available to serve the overlapped service area.

Per the projection methodology prescribed by OAR 333-645-0030:

- 7 per 100K population Bed Need 48
- Current Bed Inventory 33
- Net Need/(Surplus) 15
- Total Bed Need 27 + 15 = 42

The data supports 42 inpatient rehabilitation beds with the following considerations:

1) The applicant is able to improve utilization metrics, i.e. ADC to achieve 75% by Year 3.
2) The applicant is able to overcome staffing shortages and labor challenges.

Availability of resources and alternative uses of those resources. OAR 333-580-0050

Criterion: Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs? OAR333-580-0050(1).

The applicant must demonstrate that the best price for the proposal has been sought and selected. OAR333-580-0050(1)(a).

The applicant provided a cost estimate for the proposed project and indicated that their selected development partner has extensive experience in end-to-end project management. The applicant indicated that the developer and the LLC will qualify all contractors, review all bids and negotiate best pricing. Contractor selection will be carried out by the developer. OHA finds that applicant has met its burden.

The applicant must demonstrate that proposed solutions to identified needs represent the best solution from among reasonable alternatives: OAR 333-580-0050(1)(b).

Internal alternatives.

Prior to evaluating their internal alternatives, the applicant states that they developed evaluation criteria to guide the process. Their criteria included:

1. Ability to address unmet need for beds and specialty programming in a timely fashion.
2. Ability to incorporate design features that facilitate best practice

clinical protocols and functional goals.

3. Adequate spaces to support the emotional needs of patients and families, including patient spaces and amenities that are motivating, welcoming, safe, accessible, and prepare the patient for ideally returning to home.
4. A mix of private and community spaces.
5. Can be efficiently operated (e.g., low-cost heating/cooling, easy distribution of supplies, appropriate distance from nursing station and therapy areas to patient rooms, etc.)
6. Ability to incorporate advanced technology.
7. Geographically accessible to patients, families, and staff.

Using these criteria, the applicant considered four internal alternatives for providing these services:

- Alternative 1: Expand the existing ORC at Peace Health University District Hospital.

  The applicant states that a study[2] undertaken by the facility showed that expansion of the existing ORC was not economically feasible and that a new, freestanding project would be more cost efficient. A number of shortcomings in the existing physical plant and spaces were listed.

- Alternative 2: Relocate the ORC to the Peace Health Riverbend Hospital. The applicant indicates that this option would require displacement of existing programs and services. The applicant further indicates that the phasing and displacement would result in higher cost than a greenfield project due to added relocation and phasing demands. The applicant submitted a Letter of Intent (LOI) on September 6, 2023, proposing to move the 27-bed ORC from PeaceHealth University District's campus to PeaceHealth Riverbend. This move would be temporary pending approval of this Certificate of Need application.

- Alternative 3: Add beds to one of two Critical Access Hospitals owned and operated by Peace Health.

OHA finds that Alternative 3 is not feasible because a CAH may not provide more than 10 specialty beds. A proposal that cannot be implemented for regulatory reasons does not qualify as an alternate solution.

- Alternative 4: Build a freestanding 50-bed facility, operated as a joint venture with Lifepoint Health Inc. on the PeaceHealth Riverbend Campus.

[2] PeaceHealth application at p. 8.

Alternatives one and two have been dismissed as financially infeasible. However, OHA notes that no data was provided to support that conclusion. Alternative three is not viable for regulatory reasons. Alternative four, the preferred selection, was covered in more detail.

Notwithstanding the shortcomings of the data and analysis provided by the applicant, OHA concurs that the proposed project is the most effective and least costly alternative, considering all appropriate and adequate ways of meeting identified needs. In reaching this conclusion, OHA also considered the information provided at the public hearing regarding the suitability of the existing facility for renovation and its shortcomings for disability access.

The applicant must demonstrate that the selected architectural solution represents the most cost effective and efficient alternative to solving the identified needs. OAR 333-580-0050(1)(A)(iv).

The applicant states their proposed solution can achieve efficiencies and economies not available to the existing 27-bed unit that carries acute hospital overhead. OHA agrees the proposed project scale will likely bring efficiencies to delivery of the proposed services based on its experience administering health programs.

External alternatives.

OHA considered several possible external 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, it must meet 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. 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 nurse, a social worker or case manager, and a licensed therapist from each therapy discipline. And as described above, the facility must meet compliance thresholds for the “60-percent rule” and the “3-hour rule.”

By contrast, SNFs are designed to focus more on long term care for patients that are less likely to quickly regain functioning and less likely able to endure the more extensive rehabilitation requirements provided in an IRF. For this reason, the requirements for admission to a SNF are significantly 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.[3] In a SNF, the requirement is for one or more therapies per day for an average of one to two hours per day.

There are differences in the type of licensure required of an IRF versus a SNF that also guides OHA's analysis. In Oregon, IRFs are licensed by OHA as Special Inpatient Care Facilities (SICFs), which are required to follow physical environment, licensing, and nurse staffing rules for hospitals. SNFs are licensed by the Oregon Department of Human Services and required to follow rules specific to nursing facilities. Unlike IRFs, SNFs cannot provide hospital-level services.

OHA also considered that higher short-term costs of IRFs correlate to lower long-term costs due to increased functionality of patients.

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

The applicant has proposed to open and operate a 50 bed, 67,400 square foot Inpatient Rehabilitation Facility in Springfield, Oregon. These beds include the transfer of their existing 27 beds currently located in University District.

The applicant indicates that all current UD acute rehabilitation personnel will be offered the opportunity to transfer to the new facility and acknowledges that workforce challenges are like those facing other health care organizations.

The demand for nurses, physicians, and allied health workers currently exceeds supply, but the applicant asserts success with targeted marketing efforts, flexible work schedules, consistent messaging of their employment brand, and resourceful and creative sourcing. PeaceHealth points out it is one of the largest employers in Lane County and has historically been an attractive employer, although recruiting to healthcare organizations outside of Portland have been difficult the past few years. PeaceHealth indicates that it hires more than 2,500 positions annually.

The applicant states that they will incorporate elements known to be vital to a successful employment recruitment program, including:

1. Strategic workforce planning;
2. Employer branding and culture;
3. Thorough sourcing and screening of candidates;
4. A rigorous interview process that narrows the talent pool to the very best; and,
5. A fine-tuned onboarding process that improves employee retention.

[3] Centers for Medicare and Medicaid Services

To enhance retention, the applicant will offer comprehensive benefits and flexible hours and scheduling.

Staffing is identified as a significant challenge by OHA. Both PeaceHealth and Lifepoint state they have made considerable investments in growing the workforce, and partner with educational institutions to serve as a training site for students from various disciplines who wish to prepare themselves for a future in a healthcare related field. These training programs provide a large pool of new healthcare professionals to the community and serve as an ongoing source for recruitment. Specific to Oregon and other Northwest states, PeaceHealth and Lifepoint have established clinical education agreements with several universities and schools to provide clinical rotations for medical education, physical therapy, occupational therapy, speech therapy, and nursing students. The applicant lists the schools they have worked with in the past for recruiting which include schools along the west coast.

Adequate land available to support project and future expansion.

The applicant is proposing to use property near its Riverbend campus which is sufficient to support a 50-bed hospital. This location is located minutes from I-5 and easily accessible from the north and the south. The property/building will be leased through Capital Growth Medvest, the property owner of the campus. Medvest included a letter in the application that serves as a commitment to financially support the construction of the project with a lender commitment that is included from Servis 1st Bank.

Adequate Financing.

PeaceHealth and Lifepoint have committed to funding the project. Funding will primarily be related to the costs of constructing the building and purchasing equipment to outfit the IRF. Capital expenditures for land, building construction, and equipment have been certified by an architect. Sources and uses of cash have been prepared based on the cash available by the applicant. Sources of cash to fund the project are from the two owners, PeaceHealth and Lifepoint. (Form CN-12).

Based upon the Company’s financial statements of both PeaceHealth and Lifepoint submitted, OHA finds the applicant has adequate financing available to develop and build the new facility.

<u>Criterion</u>: 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)(a-d).

OHA addressed the service area and patient need within the service area above. As outlined, particularly for patients who have had a stroke, brain injury, or who

suffer from other neurological conditions 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.

OHA finds that the proposed project will have an appropriate relationship to its service area and will limit unnecessary duplication of service and negative financial impact.

Criterion: Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standard, compared to other similar services in the area? (a) The proposed project must comply with state licensing, architectural and fire code standards; (b) If the proposal is already being offered in the defined service area, the applicant must describe, to the best of his or her knowledge, to what degree the existing service complies with state licensing, architectural and fire code standards. OAR 333-580-0050(4).

Applicant provided floor plans for the proposed facility. Subsequent to a Certificate of Need approval, and prior to licensure of the proposed facility, OHA's Facilities Planning and Safety (FPS) program will review stamped and signed architectural drawings.[4] Based on plans provided for the preliminary drawings, OHA notes the below nondeterminative deficiencies:

> **FGI 2.6-3.1.3.5:** Hand-washing stations that comply with Section 2.1-2.8.7.2 (Hand-Washing Station—Design requirements) shall be provided in each room where therapy or teaching is conducted. Not found in classroom.
>
> **FGI 2.10 Renal Dialysis Centers:** Dialysis treatment indicated single sink in the treatment area and a handwash station was not provided. The narrative does not indicate how these services are to be provided.

The preliminary drawings of the project provide the required spaces, with other minimum area requirements met. Because the plans that were submitted are schematic design drawings the Proposed Decision does not render any conclusions regarding equipment or equipment placement.

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

[4] The facility is required to adhere to the 2018 edition of the Facilities Guidelines Institute (FGI) physical environment standards.

The building schematics, floor plans, and additional information provided by the applicant demonstrate that the proposed project meets relevant physical plant standards. OHA finds that applicant has adequately addressed each of the factors in OAR 333-580-0030(4)(a-d).

Economic Evaluation. OAR 333-580-0060.:

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).

Any financial forecasts which deviate significantly from the financial statements of the five-year historical period presented in the application must be fully explained and justified. OAR 333-580-0060(1)(a).

The application is for a new 50 bed IRF with no historical data. Financial forecasts are appropriate.

An 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. OAR 333-580-0060(1)(b).

The applicant expects the project to meet the revenue and expense projections provided in the application. Should revenue shortfalls or operating expenses increase, both members (PeaceHealth and Lifepoint) have committed to providing funding.

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 OAR 333-580-0060(1)(c):

Applicants must describe their debt capability in terms of the required ratio analysis. OAR 333-580-0060(1)(c)(A).

The applicant plans to finance $72 million to build the new facility through a leasing arrangement with the landowner, Capital Growth MedVest. The absence of debt outstanding from the applicant distorts the debt ratios and causes them to not be applicable as debt is carried by a separate company.

The discussion of liquidity should include comments on the adequacy of cash, the collection period for patient accounts receivable, and the payment period for accounts payable. OAR 333-580-0060(1)(c)(B).

OHA finds that the Current Ratio is positive in Year 1 and improves each year thereafter. Days Revenue in Accounts Receivable is estimated to be between a

hospital’s days revenue in Accounts Receivable. According to Moody’s Not-for-Profit and Public Healthcare Report released in 2023 for 2022, the average days revenue in accounts receivable is 48 days for a hospital (down from 48.1 days the previous year). IRFs are typically more days than an average hospital based on the way they bill. Looking at various IRF’s in Washington and Idaho, an average day of 59 days was noted, which met OHA’s expectation of being within 10 days of the Moody’s Average.

Note that the application is projecting 56 days in Accounts Receivable after the first year. This is within the range of expectation in OHA’s assumptions above. The applicant projects days cash on hand is assumed to be about 82 days once the facility reaches 80% occupancy. While a hospital would have higher days due to the constant demands of a hospital and the need to ensure it has access to liquidity should the need arise, OHA typically expects a hospital to have at least 90 days’ worth of cash on hand – The IRF projecting 82 days is reasonable.

The profitability ratios required by OAR 333-580-0100(4) and Form CN-9 must be discussed. OAR 333-580-0060(1)(c)(C).

The applicant adequately addressed profitability ratios and the justification for certain forecasted results. Rental expense paid to the landlord for the leased building is one item of importance discussed by the applicant. With the debt held by the landlord, the risk is held at the landlord level and reduces the burden on the IRF. OHA did not note any ratios that were concerning or inconsistent with the financial information provided.

Operating Margin – The operating margin of the proposed facility is negative for the first year of operation but turns positive in Year 2. Given the owners and commitment to fund any potential losses, OHA is not aware of any negative impact from the margin not reaching a positive margin in Year 2.

Deductibles Ratio – A deductibles ratio of .48 is the estimated contractual. Depending on the gross rates established, the ranges for the deductibles ratio can fluctuate. OHA typically expects around 50% or slightly better so 48% is consistent with those expectations.

Other Ratios – The applicant asserts favorable ratios because of the debt load handled and managed by the landlord, rather than the entity itself. As a result, the ratios are favorable.

Board designated assets: The intended uses of this fund are to be discussed in general terms. Alternative uses or contingent availability of these funds, such as to meet a cash requirement, also need to be addressed. Additionally, the proportion (percent) of depreciation that was or is to be funded is to be identified for each financial period presented. OAR 333-580-0060(d).

Application indicates the debt will reside with the landlord.

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. OAR 333-580-0060(1)(e).

The application proposes a leasing arrangement. The owners have funding available due to the balance sheets of both PeaceHealth and Lifepoint.

Money market conditions must be discussed in terms of their impact on project financing, including interim financing, if applicable. Include the month and year in which financing is to be secured in this narrative. OAR 333-580-0060(1)(f).

This project is being funded through member contributions and the lease.

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. OAR 333-580-0060(1)(f)(A).

There is no long-term debt and debt will be handled by the landlord.

When a bond rating report is issued before or during the review period in conjunction with a proposed bond issue to fund a certificate of need proposal, the applicant must submit a copy of the report to the division within 30 days of its issuance. OAR 333-580-0060(1)(f)(B).

Application indicates the debt will reside with the landlord.

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

Application indicates the debt will reside with the landlord.

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. OAR 333-580-0060(1)(g).

The applicant's assessment is that their owners, PeaceHealth and Lifepoint have sufficient experience and expertise to forecast results appropriately and meet

projections. OHA agrees that, based on other facilities owned and operated across the country, the applicant demonstrates experience in this field.

Forecasts have been created based on local jurisdiction data and local rates of labor, construction, etc. Revenue projections are developed based on local conditions, including expected utilization, reimbursement from insurance providers, the anticipated patient mix by payor, and the expected length of stay per discharge. PeaceHealth through its operation of ORC is familiar with the inputs and critical factors to include in financial forecasts to ensure they are achievable and realistic based on prior experience.

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. Specifically: OAR 333-580-0060(1)(h).

Projected changes in wages and salaries should be based on historical increases or known contractual obligations and planned future personnel increases. Considerations should include expected full-time equivalent staffing levels, including increases resulting from the proposal. OAR 333-580-0060(1)(h)(A).

The financial model forecasts a 2.0% wage increase each year, which is standard for cost of living and inflation nation-wide. OHA considers the inflation adjustment appropriate. With the improvement in the economy and scarcity of qualified health care staff, 3.0% may be seen as a current wage increase based on market forces, but the differences between this and the rate used by the applicant are not significantly different enough to create detrimental deviations.

Projected deductions from revenues should be explained and justified. OAR 333-580-0060(1)(h)(B).

Deductions from operating revenues are due to provisions for contractual adjustments. Deductions as a percent of revenues are between 44% to 45% over the 5-year forecast. This rate is in line with industry metrics.

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. OAR 333-580-0060(1)(h)(C).

Applicant’s financial forecasts do not expect changes to the payor mix for years two through five, and only slight changes from year one to year two.

Projected gross revenue must reflect patient day increases/decreases, outpatient activity increase/decrease, and all debt service coverage requirements. OAR 333-580-0060(1)(h)(D)(i) through (iii).

Patient day increases/decreases, and outpatient activity increase/decrease can be found in the financial results assessment below.

All debt service coverage requirements are not applicable. The entity does not plan to use debt to fund the project. The landlord will fund the project from equity and the entity will make lease payments to the parent company for rent of the property.

Other significant impacts the proposal will make on revenue projections. OAR 333-580-0060(1)(h)(D)(iv).

See the financial results assessment below.

Each applicant must submit within 30 days, a copy of the financial feasibility report if the applicant arranges for such a report and it becomes available before or during the review period. OAR 333-580-0060(1)(h)(D)(v).

See the financial results assessment below.

The applicant expects utilization of beds to exceed 80% by year three. MedPac data indicates that the national average is approximately 65-85%. The applicant has been above 85% in prior years although the past year (2022) was below 80% which they believed was a result of staffing shortages.

OHA finds that applicant demonstrated that its financial status is adequate to support the proposed project and it will continue to be adequate following the implementation of the project.

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

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

An applicant must show what the proposal's impact will be on the gross revenues and expenses per inpatient day and per adjusted patient day. OAR 333-580-0060(2)(a)(A).

The applicant states the impact on patients will benefit the population due to economies of scale that can be achieved by IRFs, particularly due to the relative portion of the population expected to be covered by Medicare.

OHA agrees this is a reasonable assumption and adds that the selection of patients based on their insurance providers would have an impact on the economies of scale which can be achieved if a lesser majority of Medicare/Medicaid patients covered.

The applicant must discuss 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). OAR 333-580-0060(2)(b).

Lifepoint currently operates the existing IRF in Eugene/Springfield under PeaceHealth. While the pandemic affected their utilization along with labor shortages, Applicant believes it will overcome these issues and continue to operate consistent with prior utilization.

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

See financial results assessment below. Contractual adjustments are based on those experienced by the ORC. Deductions are generally standard for major payors. Due to the expected concentration of large payors for the applicant, the standard deduction rate is considered appropriate for use in calculating expenses for margin calculations. Other expenses below the line are based on individual assumptions and projections.

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. OAR 333-580-0060(2)(d)(A).

The proposed facility location is six miles from the current ORC and less than ¾ of a mile from the Hospital campus. The applicant indicates that the new location will provide better parking and a regular bus line as compared to the old location in the University District. There is no expected increase in travel costs. The temporary move of the IRF beds to PeaceHealth Riverbend does not significantly impact this analysis given the short duration of the relocation.

Establishing what the travel costs will be to patients after implementation of the proposal. OAR 333-580-0060(2)(d)(B).

The costs of transportation are not expected to change by a measurable amount per patient. The applicant indicates that the new location will have better parking and will be served by the same bus line that currently services the Riverbend campus.

Showing what the difference is between the figures in paragraphs (A) and (B) of this subjection. OAR 333-580-0060(2)(d)(C).

OHA finds there is no significant change in travel cost savings for patients between the two locations.

The applicant must discuss the architectural costs of the proposal: OAR 333-580-0060(2)(e).

An applicant must demonstrate that the existing structure will last long enough to derive full benefits from any new construction or remodeling. OAR 333-580-0060(2)(e)(A).

Form CN-3 details the architectural estimates, which were prepared and estimated with the assistance of an architect registered in Tennessee (Kevin Harney, ESA Architects, https://esarch.com/people/kevin-harney/). The construction costs carry a contingency of close to $15 million which allows for increase in costs that have been seen the past few years. The applicant states the structural building design meets all requirements of the Oregon Building Codes and Life Safety Codes and the costs are consistent with the Doge Research report.

General construction costs must be within reasonable limits (within high/low range as described in the most current issue of the Dodge Research Report adjusted for location). OAR 333-580-0060(2)(e)(B).

OHA finds that the applicant has shown that the impact of the proposal on the cost of health care will be acceptable. There are potential risks which are ameliorated by the reduction of the beds granted pursuant to the bed need analysis. These include:

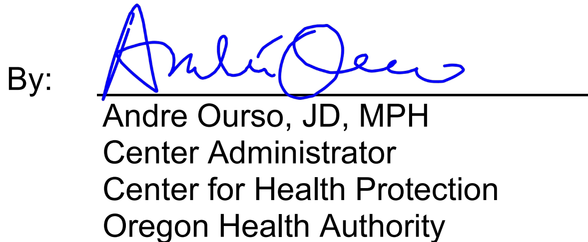
1. Utilization metrics
2. Staffing shortages and labor challenges
3. Increase in deductible percentage greater than expected
4. Cost of construction exceeding contingency amount

CONCLUSION/PROPOSED DECISION

OHA finds that applicant has met its burden of demonstrating that the CN criteria are met for a 42 bed IRF and proposes a certificate of need consistent with that finding, with the following condition:

1. The existing 27 IRF beds temporarily relocated to PeaceHealth Riverbend must cease operating within 30 days from the first calendar day the proposed facility can admit patients.

Dated this 2nd day of January 2024.

By: 

Andre Ourso, JD, MPH
Center Administrator
Center for Health Protection
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 the Office of Administrative Hearings. 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. An applicant or affected person 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 as the record for purposes of proving a prima facie case upon default. ORS 413.038.

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.

ATTACHMENT 1

Financial Analysis
(Unaudited Stand-Alone PeaceHealth)

	UNAUDITED (PROVIDED BY APPLICANT)										
	PROJECTED- STAND ALONE (Income Statement)						Percentage of Patient Revenue				
	Year 1	Year 2	Year 3	Year 4	Year 5		Year 1	Year 2	Year 3	Year 4	2024
Total Patient Revenue	41,033,031	61,193,379	71,139,095	72,561,877	74,013,114	[a]					
Other	493,405	762,500	886,428	904,157	922,240						
Charity	698,847	1,101,481	1,280,504	1,306,114	1,332,236						
Contractual Adjustments	18,465,126	27,392,416	31,844,486	32,481,375	33,131,003		45.00%	44.76%	44.76%	44.76%	44.76%
Total Deductions	19,657,378	29,256,397	34,011,418	34,691,646	35,385,479	[b]	45.00%	44.76%	44.76%	44.76%	44.76%
	0.48	0.48	0.48	0.48	0.48						
Other operating Revenue	106,878	159,685	185,638	189,351	193,138						
TOTAL OPERATING REVENUE	**21,482,531**	**32,096,667**	**37,313,315**	**38,059,582**	**38,820,773**						
Salaries, Wages & Benefits	11,882,938	14,111,167	16,089,536	16,427,909	16,773,414	[c]	28.96%	23.06%	22.62%	22.64%	23.12%
Professional Fees/Benefits	382,930	337,498	367,688	374,306	381,044	[c]	0.93%	0.55%	0.52%	0.52%	0.53%
Supplies	984,898	984,564	1,142,340	1,162,902	1,183,834	[d]	2.40%	1.61%	1.61%	1.60%	1.63%
Purchased Services	544,290	782,435	907,820	924,161	940,795	[d]	1.33%	1.28%	1.28%	1.27%	1.30%
Insurance	143,858	192,117	217,835	221,756	225,748	[d]	0.35%	0.31%	0.31%	0.31%	0.31%
Other	4,502,247	5,577,561	6,223,417	6,343,339	6,465,577	[d]	10.97%	9.11%	8.75%	8.74%	8.91%
Depreciation & Amortization	571,733	573,668	581,108	591,822	602,537	[e]	1.39%	0.94%	0.82%	0.82%	0.83%
Interest / Rent Expense	6,179,857	6,259,904	6,201,663	6,303,080	6,429,141	[d]	15.06%	10.23%	8.72%	8.69%	8.86%
Total Operating Expenses	**25,192,751**	**28,818,914**	**31,731,407**	**32,349,275**	**33,002,090**		61.40%	47.09%	44.60%	44.58%	45.48%
Operating Income	**(3,710,220)**	**3,277,753**	**5,581,908**	**5,710,307**	**5,818,683**						
Operating Margin	-17.27%	10.21%	14.96%	15.00%	14.99%						
Interest Income, Rental Income, etc.	-	-	-	-	-						
Excess Revenue over Expenses	**(3,710,220)**	**3,277,753**	**5,581,908**	**5,710,307**	**5,818,683**						

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

		Year 1	Year 2	Year 3	Year 4	Year 5
Number of Adjusted Patient Days		9,072	12,810	14,600	14,600	14,600
Increase in Days		N/A	41.20%	13.97%	0.00%	0.00%

The large increased was addressed by the applicant in the response to preliminary comments. The large increase in 2021 is a function of natural growth, but also artificial growth represented through mathematical presentation rather than gross increase in patients. Increase in patients expected over the 5-year forecast is generally more linear and consistent with the growth experienced in prior Encompass Health facilities.

		Year 1	Year 2	Year 3	Year 4	Year 5
Net Revenue per Patient Day		2,368	2,506	2,556	2,607	2,659
Expense per Patient Day		2,777	2,250	2,173	2,216	2,260
Net Revenue per Patient Day		(409)	256	382	391	399
Margin Percentage		-17%	10%	15%	15%	15%
Marginal Net Revenue YoY			260%	33%	2%	2%
% of Capacity		49.71%	70.19%	80.00%	80.00%	80.00%
Increases in Net Revenue per Patient Day	Year-over-year		5.5%	2.0%	2.0%	2.0%
Decreases in Expense per Patient Day	Year-over-year		-23.4%	-3.5%	1.9%	2.0%
Increases in Revenue per Patient Day	Yr. 1 thru Yr. 5					**12%**
Decreases in Expense per Patient Day	Yr. 1 thru Yr. 5					**-19%**
Increases in Net Revenue per Patient Day	Yr. 1 thru Yr. 5					187%

Gross revenue per patient day increases significantly in Year 2. Additionally, gross expense per patient day stays relatively flat in years 2-5 - Given the recent labor increases, this area may see larger increases to retain and attract qualified staffing.

The application assumes an 80% utilization rate which the previous location did demonstrate for several years but not the recent year when staffing shortages prevented the facility for achieving a higher utilization rate.

[b] Deductions from revenue analysis

Total deductions are relatively consistent YoY and range at approximately 48% which is within a reasonable range considering industry metrics. Deductions are based on payor, which is expected to be heavily from Medicare. Medicare uses standard payment rates, and as such the deduction percentages can be more heavily based on total revenues.

[c] Salaries and benefits analysis

	2020	2021	2022	2023	2024
Projected FTE	94	111	123	134	139
Salaries per FTE	126,414	127,128	130,809	122,596	120,672
Annual Increase		0.56%	2.90%	-6.28%	-1.57%
Benefits as % of Wages	3%	2%	2%	2%	2%

The applicant is projecting an increase of approximately 2% each year, which is consistent with a typical cost of living wage adjustment. Average salary per FTE is projected above the average in the area, which is a conservative and appropriate assumption. Benefits as a percent of salaries is lower than the expected average of 20-25%. Increasing benefits 15%, calculated below, does not change the status of the facility moving from net income to net loss in any year.

	2020	2021	2022	2023	2024
Current Benefits Expense	382,930	337,498	367,688	374,306	381,044
Increase in Forecasted Benefits Expense	57,440	50,625	55,153	56,146	57,157
Net Income (Loss)	(3,710,220)	3,277,753	5,581,908	5,710,307	5,818,683

[d] Various expenses

Rent/Interest Expense					
Total Interest & Rent Expense	6,179,857	6,259,904	6,201,663	6,303,080	6,429,141
Payment Escalation		1%	-1%	2%	2%

Rental expense is related to the lease payments, which are forecasted to begin at $2.494M per year, with annual lease payment escalators. Based on the expected lease term of 20 years (with 2 10-year extensions), rent expense each period is overstated depending on the total balance expected to be paid between intercompany entities to recoup the balance of the construction loan.

Supplies	984,898	984,564	1,142,340	1,162,902	1,183,834
Purchased Services	544,290	782,435	907,820	924,161	940,795
Total Supplies, Purchased Services	1,529,188	1,766,999	2,050,160	2,087,063	2,124,629
% of Revenue	4%	3%	3%	3%	3%

Insurance	143,858	192,117	217,835	221,756	225,748
Total Patient Revenue	41,033,031	61,193,379	71,139,095	72,561,877	74,013,114
Insurance as % of Revenue	0.35%	0.31%	0.31%	0.31%	0.31%

Additional Financial Information

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	PROJECTED- STAND ALONE (Balance Sheet)				
	2020	2021	2022	2023	2024
Accounts Receivable	2,379,865	3,867,194	3,173,689	3,690,381	3,942,548
PP&E	3,680,000	3,780,000	3,930,000	4,130,000	4,380,000
Accumulated Depreciation	(457,768)	(923,571)	(1,401,429)	(1,895,357)	(2,409,375)
	5,602,097	6,723,623	5,702,260	5,925,024	5,913,173
Accounts Payable	354,437	423,197	474,221	527,057	555,114