



## Capital Project Reporting Form (CPR-1)

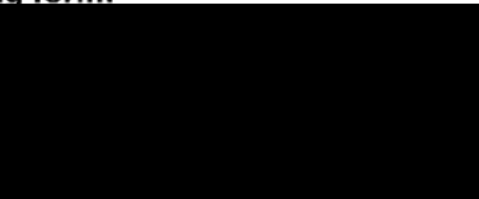
### Reporting Entity Identification and Contact

**Facility:**

**Name:** Salem Health  
**Federal Tax ID#:** 93-0579722  
**Address:** 890 Oak Street SE  
**City:** Salem **State:** OR **Zip Code:** 97301

**Individual completing form:**

**Name:**  
**Title:**  
**Email:**  
**Phone:**  
**Fax #:**



None

*If address is different than facility listed above, please provide:*

**Address:** 655 Winter Street SE  
**City:** Salem **State:** OR **Zip Code:** 97301

### Capital Project Qualitative Information

**1. Provide a brief description of the project.**

advanced radiation therapy system are end of life/support and must be replaced

**2. Proposed start date:** July 2025

**3. Date of approval by board:** July 2025

**4. Expected completion date:** January 2026

**5. What is the expected project cost?** 5,319,391

**6. Describe the expected benefits to the community that your facility serves. Include both direct financial benefits such as charity care as well as qualitative benefits such as access to care and quality improvements. Attach additional pages if needed.**

This is a replacement of the machines as it is end of life

**7. In what ways may this project negatively impact the community that your facility serves? Include direct cost such as bonds as well as indirect impacts such as service interruptions. Attach additional pages if needed.**

No, negative impacts are anticipated, and this project will not be funded with bond proceeds

**8. How has your facility evaluated the need for this project within the community that you serve?**

This is a replacement of a piece of equipment. Current volume supports replacement of this equipment

**9. Are the medical services created by this project already available in the community that your facility serves?**

This project is not creating new medical services, it is a replacement.

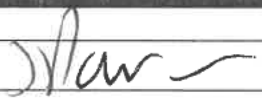
**Public Notice and Comment**

**1. Provide a link to the webpage where public notice of the capital project was posted. If your facility does not maintain a webpage provide the name of the newspaper where the public notice was made and date of publication. Attach additional pages if needed.**

<http://www.salemhealth.org/about/truebeam>

**2. Describe your facility's method of collecting and reviewing public comments on the capital project. Attach additional pages if needed.**

Salem Hospital is governed by a Board of Directors who considers community comments in their decision

|                    |                                                                                   |
|--------------------|-----------------------------------------------------------------------------------|
| <b>Signature:*</b> |  |
| <b>Date:</b>       | 7/22/21 ✓                                                                         |

*\*Entry of name connotes signature*

Please email the completed form to [HDD.Admin@dhsosha.state.or.us](mailto:HDD.Admin@dhsosha.state.or.us)

Hospital Reporting Program  
Research and Data Unit  
Health Analytics  
500 Summer St. NE  
Salem, OR 97301  
[HDD.Admin@dhsosha.state.or.us](mailto:HDD.Admin@dhsosha.state.or.us)