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(OAR 333-580-0080)
STATE OF OREGON
CERTIFICATE OF NEED APPLICATION FORM

Facility Name: Oregon Network, LLC dba Timber Springs Springfield Behavioral Health Hospital

Tax lot # **1703153000400,** located on

Street Address: International Way City/Zip: Springfield, 97477

Applicant/ Licensee:

Licensee Address (if different):

Facility Administrator: TBD Phone: TBD

Medicare Provider No.: TBD Medicaid Provider No.: TBD

PERSON AUTHORIZED TO ANSWER QUESTIONS, ACT AND RECEIVE SERVICE ON BEHALF OF THE APPLICANT
(if other than the facility administrator)

Name: Alicia Beymer, MBA, CPHRM, CPHQ Phone: 541-870-1059

Title: Chief Administrative Officer (CAO)

Firm: PeaceHealth Sacred Heart RiverBend

Address: 3333 RiverBend Drive City/Zip: Springfield, OR 97477

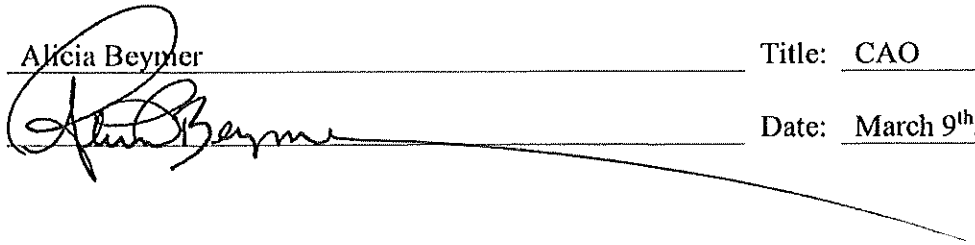
Have you previously submitted an application for this or a similar project? YES ☐ NO ☒

If yes, date submitted: _____ Application ID No. _____

CERTIFICATION BY APPLICANT

I hereby attest that I reviewed the application and have knowledge of the content of information contained in this application. I therefore declare under penalty of perjury, that the project described and each statement, amount and supporting documents included are true and correct to the best of my knowledge and belief.

Name: Alicia Beymer Title: CAO

Signature:  Date: March 9th, 2026

CERTIFICATE OF NEED APPLICATION
OREGON NETWORK, LLC, dba
TIMBER SPRINGS SPRINGFIELD
BEHAVIORAL HEALTH HOSPITAL

March 2026

Table of Contents

Section A: Introduction

PeaceHealth has proudly served the medical needs of Eugene, Springfield, and surrounding communities since 1936. As the only integrated health system in Trauma System Area 3 (TSA 3), PeaceHealth delivers care across the full continuum—from primary and specialty care to emergency services, imaging, advanced cardiac and stroke programs, inpatient and post-acute care, and behavioral health services.

Today, Oregon faces an unprecedented behavioral health crisis. Nearly one in three adults experience mental illness, and the state ranks 51st nationally for both prevalence of mental illness and access to care.[1] Lane County, the population center of TSA 3, reports some of the highest rates of psychiatric need within Oregon.[2] These high incidence rates, coupled with a historically limited number of residential and crisis care options, have left thousands of residents untreated or undertreated each year. In response, PeaceHealth, in partnership with others, actively supported and advocated to the State Legislature and the Oregon Health Authority (OHA) for funding and programming of alternative care settings and has worked closely with Lane County to plan a crisis stabilization center.

Despite recent growth in alternative behavioral health services, there remains a critical need for a full-service psychiatric hospital to address urgent regional demand from adolescents, adults, and seniors, and to strengthen the continuum of care across the TSA. This application reflects a deliberate effort to provide right-size inpatient capacity while accounting for expanding alternatives.

Lane County, the population center of TSA 3, has more patients waiting seven or more days for an inpatient psychiatric bed than any other county in Oregon, including counties within the Portland metropolitan area. In June 2024, OHA projected a need for 66 additional inpatient psychiatric beds in the TSA by 2029, with the current supply at 10.7 beds per 100,000 population, which is well below the literature-supported benchmark of 60 beds per 100,000, and well below the current national average of 28 beds per 100,000. In response and following a multi-year effort with Lifepoint Health (Lifepoint), this Certificate of Need application proposes the establishment of Timber Springs Springfield Behavioral Health Hospital (Timber Springs). Co-located with the Lane County Behavioral Health Crisis Stabilization Center on a new behavioral health campus, Timber Springs will result in an increase in the inpatient psychiatric bed ratio to 20 per 100,000.

When opened, Timber Springs will offer 96 beds, including a dedicated adolescent unit. Timber Springs will also include:

- The transition of 35 existing adult acute behavioral health beds from PeaceHealth Sacred Heart Medical Center.
- Approval of up to 24 new adolescent psychiatric beds, which can be safely and securely flexed between populations, depending on census needs.
- Approval of additional new adult and senior inpatient psychiatric beds.

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[1] Reinert, M, Nguyen, T & Fritze, D. (October 2025). "The State of Mental Health in America 2025." Mental Health America, Alexandria, VA.
[2] Lane County, OR. (July 2025). "Many People in Lane County are Struggling With Mental Health Concerns." Live Healthy Lane Issue Profile.

Upon Timber Springs' opening, PeaceHealth will close the 35 adult beds located at PeaceHealth Sacred Heart Medical Center RiverBend Behavioral Health Unit at University District (UD BHU), resulting in a net 61 new beds in the TSA. We have determined that this bed addition, with a dedicated adolescent unit, is the smallest, most efficient approach to meet the region's need.

Background

PeaceHealth's commitment to behavioral health spans over five decades, beginning in 1969 with the Johnson Unit at Sacred Heart in Eugene. In 2014, PeaceHealth replaced the Johnson Unit with the 35-bed UD BHU. While this unit continues to deliver high-quality care, its physical infrastructure and limited capacity no longer meet the escalating behavioral health demand in the region.

Prior to the closure of Sacred Heart University District Hospital in 2023, PeaceHealth evaluated options to expand to 100 psychiatric beds. However, renovation was deemed unfeasible due to infrastructure limitations, cost, and the inability to safely construct while actively serving patients. After thorough analysis, the best alternative was found to be development of a new, standalone psychiatric hospital. This model offers the most cost-effective, timely, and clinically appropriate approach to delivering modern, therapeutic, inpatient psychiatric care. Timber Springs will accept all major insurance plans, including CCO-managed Medicaid and Medicare, and will honor PeaceHealth's charity care policy.

The Growing Need

Oregon's behavioral health system is in crisis:[3]

- Nearly 1 in 3 Oregon adults experience mental illness.
- Twenty-seven percent (27%) of adults and 33% of youth report feelings of anxiety or depression.
- Lane County residents average 4.8 self-reported poor mental health days per month.

More than 922,000 Oregon adults have a mental health condition, and 291,000 report needing treatment but not receiving it.[4] Because of the historic lack of care alternatives, too many residents' behavioral health needs have gone unmet. As a result, individuals experience escalating crises, self-harm, aggressive behaviors, and worsening physical health conditions.

The consequences of inadequate access to behavioral healthcare extend across communities and beyond the healthcare system, manifesting as:[5]

- Approximately 40% of Oregon's unhoused population has a serious mental illness.
- Increased emergency department utilization.
- Greater involvement with law enforcement, child welfare, and the judicial system.
- Higher rates of Oregon State Hospital admissions.
- Disruptions to education, employment, housing stability, and family systems.

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[3] McMullen, M & Kirsch, S. (October 2025). "Oregon's Mental Health Crisis." Common Sense Institute.
[4] Fact Sheet. (March 2025). "Mental Health in Oregon." National Alliance on Mental Illness.
[5] McMullen, M & Kirsch, S. (October 2025). "Oregon's Mental Health Crisis." Common Sense Institute.

As discussed in later sections of this CN application, PeaceHealth Sacred Heart's Emergency Department routinely boards patients in psychiatric crises for 24 to 72 hours, or longer, often without access to specialized behavioral healthcare. These delays exacerbate patient suffering, strain hospital capacity, and increase system-wide costs.

A Public-Private Partnership

This public-private partnership brings together PeaceHealth, Lane County, Connections Health Solutions, and Lifepoint to create a coordinated and sustainable behavioral health system.

Timber Springs is proposed to open in January of 2029 and will serve adults and adolescents who qualify for inpatient treatment. Common conditions at admission will include acute safety risks (harm to self or others), severe depression (especially with suicidal intent), psychotic episodes (hallucinations, delusions), and manic episodes (bipolar disorder), often requiring immediate stabilization when individuals cannot care for themselves or pose a danger to others. Mood disorders, schizophrenia spectrum, substance use disorders, anxiety, and post-traumatic stress are also common conditions for inpatient treatment. As the PeaceHealth beds do today, the new Timber Springs hospital will serve complex and high-needs patients.

The hospital will be co-located with the new 42-bed Lane County Behavioral Health Crisis Stabilization Center, projected to serve approximately 8,200 patients annually. Together, these two facilities will operate as a fully integrated Behavioral Health Campus, designed to deliver:

- Immediate access to the appropriate level of care 24/7.
- Inpatient psychiatric services.
- Crisis stabilization.
- Peer support and case management.
- Psychiatric assessment, therapy, and medication services for all ages.
- Note that the full continuum of care currently offered to BH patients by PeaceHealth, detailed in **Appendix 3**, will remain, although the site of the care for the inpatient, intensive outpatient (IOP) and partial hospitalization (PHP) programs will transition to the new hospital.

The Applicant

The applicant for this CN is Oregon Network, LLC (the LLC or Applicant). Members of the LLC include PeaceHealth and Lifepoint. The LLC is a newly formed joint venture between the members. The LLC does not currently have any business operations. The only anticipated business operations of the joint venture will relate to the ownership and operation of the proposed 96-bed Timber Springs inpatient behavioral health hospital, the subject of this CN application. More detail on each member is included below:

PeaceHealth:
PeaceHealth is a not-for-profit healthcare system that owns and operates medical centers, critical access hospitals, medical group clinics, and laboratories located in Washington, Oregon, and Alaska. PeaceHealth's Oregon hospitals include PeaceHealth Sacred Heart Medical Center at RiverBend in Springfield, PeaceHealth Harbor Medical Center in Florence, and Cottage Grove Community Medical Center in Cottage Grove. These Oregon facilities and clinics have a total of 419 licensed inpatient beds. They provided care for over 270,000 outpatient clinic visits and close to 110,000 emergency department visits in the last fiscal year.

Lifepoint:
Through its wholly owned special purpose subsidiary, LPN BH Development 10, LLC, Lifepoint is a member of the LLC. Lifepoint operates acute care, rehabilitation, and behavioral health hospitals in 30 states. It currently operates one facility in Oregon: Willamette Valley Medical Center, located in McMinnville.

PeaceHealth and Lifepoint have also broken ground on a new 42-bed inpatient rehabilitation facility (IRF) in Springfield, which received CN approval in 2024. The legal applicant of that CN is PeaceHealth RiverBend, LLC. The new IRF is under construction and expected to open in August of 2026.

Regional Impact and System Benefits
The Timber Springs Behavioral Health Campus will:

- Improve geographic access to inpatient and urgent behavioral health services across Lane County and the TSA.
- Provide a direct alternative to emergency departments for individuals experiencing behavioral health crises.
- Reduce emergency department boarding by redirecting patients to a dedicated, specialized behavioral health campus.
- Deliver 24/7 local access to inpatient psychiatric care not currently available, including a dedicated adolescent unit.
- Offer a preventive, trauma-informed approach with timely intervention to avoid escalation to higher levels of care.
- Provide meaningful alternatives to Oregon State Hospital admissions and incarceration.
- Allow individuals and families to remain closer to home for treatment and recovery.
- Support first responders with reliable, clinical alternatives for individuals in crisis.
- Deliver modern therapeutic environments, including:
    - Private and spacious patient rooms,
    - Secure outdoor spaces, and
    - Community and activity rooms for all ages.

- Ensure continuity of care through coordinated discharge planning and referrals to:
    - Lane County Behavioral Health,
    - PeaceHealth outpatient services, and/or
    - Community-based partners.

In addition, as noted above, Timber Springs will include Intensive Outpatient Treatment (IOP) and Partial Hospitalization Programs (PHP). The programming of these options mirrors the inpatient programs. The IOP and PHP include vocational training to reestablish patients more seamlessly back into their community. These programs will be tailored to adolescent, adult, and geriatric patient populations. The intent of these programs is to provide a continuum of options that either serve in lieu of hospitalization or shorten the hospital length of stay.

Alignment with State Priorities, Policy, ORS, and OAR

The Oregon statute (ORS 430.610 - Legislative Policy) reads:

> *(3) To the greatest extent possible, mental health and developmental disabilities services shall be delivered in the community where the person lives in order to achieve maximum coordination of services and minimum disruption in the life of the person;*

The Oregon Health Authority (OHA) has adopted temporary rules related to the demonstration of need for new psychiatric inpatient beds. These rules temporarily amend rules in OAR chapter 333, divisions 590 and 615, temporarily suspend OAR 333-615-0020, and temporarily adopt OARs 333-615-0025, 333-615-0035, 333-615-0060, and 333-615-0070. This application is being reviewed under these rules.

OAR 333-615-0025 specifically includes the criteria for approval for a new psychiatric hospital. A Certificate of Need for a psychiatric hospital may be granted if OHA determines that an applicant can show, by a preponderance of the evidence, among other factors, that each of the following criteria is met:

(1) Within the proposal's Health Service Area, access to care is tailored to the specific demographic needs, including appropriate:
(a) Access to public transportation;
(b) Access for individuals with disabilities;
(c) Availability of adequate staffing; and
(d) Accessibility to other care providers.

(2) The number of beds needed to provide an anticipated range of patient days in a given psychiatric hospital's Health Service Area will not exceed 36 beds per 100,000 individuals in the Health Service Area.

(3) Applicants must describe how the proposed project will improve access to care for all individuals in the Health Service Area, with particular attention to vulnerable populations, including those who are uninsured, underinsured, on high-deductible plans, or enrolled in Medicaid.

(4) All other criteria in OAR chapter 333, division 615 are met, including analyses of:
(a) Need;
(b) Quality;
(c) Cost; and
(d) Availability of Alternatives in the Health Service Area.

This application is consistent with each criterion in the OHA's 2025 temporary rules. The requested number of beds has been sized to provide TSA 3 residents, and, through some modest in-migration assumptions, those in underserved contiguous TSAs, increased access to psychiatric care. It also addresses the lack of adolescent beds statewide with the inclusion of a dedicated adolescent unit, which will increase statewide supply by more than 33%. Specifically, this project establishes a right-sized, regionally appropriate inpatient psychiatric hospital that considers the growing number of alternative beds (including crisis stabilization), enhances local access, avoids unnecessary and oversized development, strengthens the overall mental health system, and provides a dedicated sub-specialty regionalized adolescent inpatient unit.

The project also advances the OHA's strategic goal to transform behavioral health statewide by expanding access, reducing emergency department congestion and backlogs, and ensuring coordinated, person-centered care.

Conclusion

Due to pressing factors unique to, and urgent in, TSA 3, Timber Springs represents a bold, necessary investment in behavioral health infrastructure. By expanding inpatient capacity, reducing emergency department boarding, providing timely alternatives to Oregon State Hospital admissions, and integrating crisis stabilization with inpatient treatment, the applicants putting forth this proposal, along with the support of our community partners depicted in **Graphic 1**, affirm a commitment to patients, families, first responders, and the broader community.

Graphic 1: Community Support and Partners

Section B: Narrative Discussion

Service Area Need (OAR 333-580-0040)

Note: OAR states that, in the event that the temporary rules do not contain standards in sufficient detail, then *nationally recognized standards from professional organizations; Standards developed by professional organizations in the State of Oregon; Federal Medicare and Medicaid certification requirements; State licensing requirements; and Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to inpatient psychiatric care and treatment* may be cited.

In several places throughout the application, we have cited external standards. These standards serve to support and refine the methodology described in the rules.

(1) Criterion: Does the service area population need the project?

This application requests approval for a 96-bed inpatient psychiatric hospital. Timber Springs will be created by transferring the 35 existing acute behavioral health beds from PeaceHealth's BHU UD, adding 37 new adult and senior inpatient psychiatric beds, and creating a new up-to-24-bed adolescent psychiatric unit, the size of which can safely flex between adolescent and adult, depending on demand.

(a) The applicant must identify the service area's need for the proposal in the past, present, and future;

By rule, the service area is TSA 3. The use rate, as calculated by historical resident discharges or days/population, is understated for several reasons, including:

- There is no publicly available data for the state's sole freestanding inpatient psychiatric hospital (Cedar Hills) by zip code of residence, age, or length of stay. As such, its use by TSA 3 residents cannot be confirmed. The Applicant is aware that a number of TSA 3 adult residents seek care at Cedar Hills every month.

- Other than for a limited period in neighboring Washington State, we do not have data on TSA 3 residents who were discharged from a Washington hospital with a psychiatric DRG included in MDC 19 (Mental Diseases and Disorders).[6] The data is, unfortunately, limited to the pre-COVID period because, starting in 2022, to comply with 42 CFR Part 2 (substance use disorder), Washington State began redacting patient zip code, county of residence, and age if the patient had substance use identified in any of the ten diagnosis codes or six procedure codes that are included with each inpatient discharge. Many psychiatric admissions have substance use as a secondary issue. With these noted limitations, Washington's inpatient data set shows the following:

[6] DRGs 876-887.

- In 2020, there were 15 residents of TSA 3 admitted, accounting for 193 days.
- In 2021, there were 23 residents admitted, accounting for 253 days.
- In 2022 and thereafter, the admissions are 9 or less each year and represent the sub-set of patients without a co-occurring or underlying substance disorder.

- To be conservative, we have limited our Apprise and Washington State inpatient data set (CHARS) queries to persons with a discharge coded to MDC 19. We reviewed actual discharges at the 35-bed UD BHU and found that nearly 12% of the patients were coded at discharge to MDC 1 (Diseases and Disorders of the Nervous System), which includes conditions causing severe behavioral, emotional, or cognitive symptoms and neuropsychiatric manifestations that cannot be safely managed in a medical unit and require 24-hour psychiatric monitoring, stabilization, or diagnosis. In addition, we found that another 3% were coded to MDC 20 (Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders). This finding is supported by the fact that the actual census in the unit through Q3 2025 was 29.5; in Apprise, applying MDC 19 to the hospital identified an average daily census (ADC) of 26.

Additional information is included in response to OAR 333-615-0025. This information provides data on rates of deflection, patient boarding in hospital Emergency Departments (ED) while awaiting placement, the inability of the Oregon State Hospital to admit patients in a timely fashion, and the OHA's June 2024 report identifying that even with the growth in alternatives, additional inpatient psychiatric beds are needed in TSA 3. For all these reasons, in a later section of this application, we have elected to modify the use rate.

Finally, while the service area is defined as TSA 3, about 7% of patients served in PeaceHealth's current behavioral health inpatient unit are from outside of TSA 3, and predominantly from adjacent TSAs 5 and 7, where there are even fewer inpatient beds available. TSA 5 includes 24 beds at Rogue Valley Medical Center for a population of approximately 327,398 (including 18,451 age 13–17, and 266,082 age 18+). TSA 7 has 15 beds, all located at St. Charles Medical Center, for a population of approximately 361,091 (including 19,923 age 13–17, and 292,966 age 18+).

Unfortunately, PeaceHealth data does not capture the number of requests for admission from outside of its system by location or zip code, nor the full number of patients not admitted at the time of need/request. In the new hospital, we will be able to accommodate an increasing percentage of these patients. We also note that our adolescent beds will provide the state's third dedicated program for youth, and we fully expect, and have designed the new hospital to accommodate, referrals from beyond our region.

(b) In establishing the magnitude of present and future need for each service element, the applicant will:

(A) Use appropriate indicators of a population's need (i.e., population-based use rates, population-based "medical necessity" rates, or established productivity standards);

(B) Use the standards and need methodologies specified in divisions 585 through 645 of OAR chapter 333 applicable to the services or facilities being proposed;

(C) Consider industry standards and historical experience as appropriate comparisons where plans are silent;

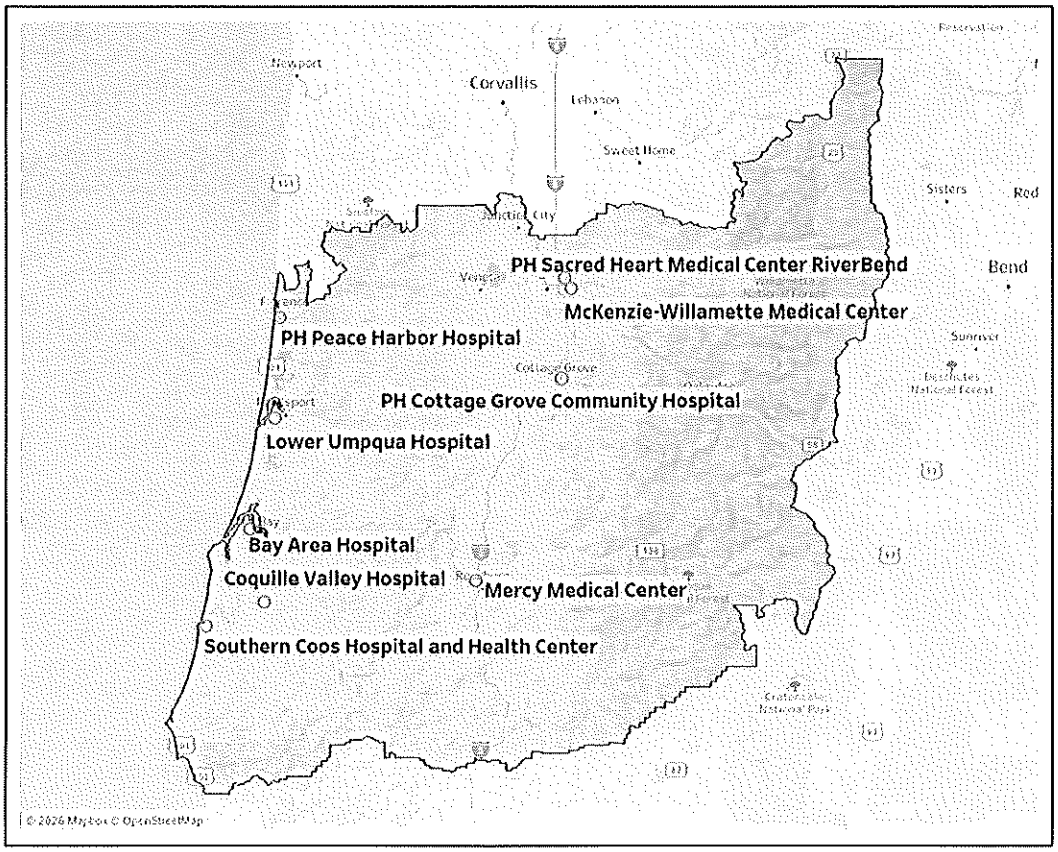
Service Area Definition

Consistent with OAR 333-615-0010(3), the Health Service Area for a psychiatric hospital is the TSA in which the proposed hospital will be located. For the purposes of this application, this is TSA 3, which is defined as:

> *"...all of Coos, Douglas, and Lane counties and the following zip codes in Curry County: 97450, 97465, and 97476 only."*

Map 1 identifies Trauma System Area 3.

Map 1: Trauma System Area 3



Source: Applicant

Service Area Inpatient Psychiatric Beds
Currently, within the TSA, there are 60 inpatient psychiatric beds located at three hospitals. One hundred percent (100%) of these beds care for adults only. The beds include:

- PeaceHealth Sacred Heart, Springfield (Lane County): 35 adult beds
- Bay Area Hospital, Coos Bay (Coos County): 13 adult beds
- Mercy Medical Center, Roseburg (Douglas County): 12 adult beds

Magnitude of Current Unmet Need
There is significant unmet need for behavioral healthcare in TSA 3. The proposed new hospital will directly address this deficit. The TSA has a documented an undisputed need for Timber Springs. Documentation of unmet needs are detailed below:

- **High Rate of Not Being Able to Admit Patients Needing Placement (Patient Deflections)**: Data for the period of November 2024 to October 2025 identifies the volume of patients from PeaceHealth's three emergency departments, the PeaceHealth Medical Group, as well as several other hospitals that regularly attempt referrals (e.g., Providence, McKenzie Willamette Hospital, the Asante Hospital System, and Good Samaritan Regional Medical Center). During this 12-month period, more than 700 individuals requesting admission were deflected, or not admitted. Using the sub-set of January–October of 2025, the deflection data shows 1,769 individuals referred for admission. Of this, 668 individuals in need were deflected due to lack of an available bed. The deflection rate, in three out of ten months reviewed in 2025, exceeded 42%, and, in one month, exceeded 45%. Data confirming these statistics is included as **Appendix 1.** PeaceHealth confirms that the 10-month period referenced above is reflective of continued, ongoing experience.

- **Boarding Days**: PeaceHealth has tracked boarding days (days a patient awaits a psychiatric admission from the emergency room) for several years at each of our three TSA 3 hospitals (Sacred Heart RiverBend, Cottage Grove, and Peace Harbor). Patients often board in the ED with 1:1 staffing, and, as depicted in **Table 1**, on an average day, the system has more than ten patients in the ED awaiting a bed for mental health needs. Boarding means the patient is not being actively treated in a therapeutic environment for their psychiatric needs. It also disrupts the flow of the ED and is costly for the hospitals and payers. PeaceHealth's experience has likely been replicated at every hospital in TSA 3 and surrounding areas. This is not a local phenomenon. Hospitals across the entire country face this challenge as mental illness incidences increase and we continue to rely on the emergency department system to treat such ailments. The emergency room is not suited, staffed, or equipped to provide appropriate behavioral healthcare, especially at the volumes that currently flood it.

Table 1: Average Number of Patients Boarding Per Day at PeaceHealth ED Facilities			
Year	**Child**	**Adolescent**	**Adult**
2024 Patients per Day (PPD)	0.12	1.3	9.1
2024 Average Length of Stay (ALOS) – hours	27	28	17
2025 PPD	0.13	1.3	9.5
2025 ALOS – hours	25	27	15

Source: Applicant, Internal PeaceHealth data

As shown in the **Table 1** boarding data above and detailed further in subsection (d.) below, this unmet need is particularly impactful in children and adolescents. The literature documents that there has been a sharp rise in child and adolescent psychiatric emergencies, leading to an increase in patient volume in EDs. National trends in mental health show that between 2009 and 2015, mental health-related ED visits increased 56.4% for pediatric patients, and another recent study demonstrated a 329% increase in ED visits from 2007 to 2016 for deliberate self-harm.[7,8] Primarily designed to address urgent physical health problems, emergency departments lack the resources and staffing to adequately address this rising need.[9] At the same time, availability of community-based services and psychiatric inpatient beds has decreased, leaving fewer options for disposition and transfer to necessary care.[10]

Both nationally and in Oregon, children face increasingly prolonged delays in the emergency department while awaiting mental health care. Nearly half (49%) of patients presenting for psychiatric reasons in 2021 required a higher level of care (e.g., psychiatric inpatient care, intensive outpatient hospitalization, etc.). For psychiatric patients ages 12–18, the most common presenting problem was depression (54%). Over the past three years, patients awaiting psychiatric treatment have spent an average of three to four days in the hospital ED awaiting a psychiatric placement. From 2019 to 2021, there was a 61% increase in the average length of time patients spent in the ED awaiting mental health care.[11]

More specific to this project is boarding data collected by PeaceHealth for each of its hospitals located in the service area. For the period of July 2023 to June 2024, there were nearly 600 patients under the age of 18 who presented to the ED. Twenty-seven percent (27%) of these patients spent at least 24 hours in the ED. Of these patients, the average length of stay ranged from a low of 2.5 days to a high of 5.0; the longest length of stay was nearly 2.5 weeks.

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[7] Experiences of Child and Adolescent Psychiatric Patients Boarding in the Emergency Department from Staff Perspectives: Patient Journey Mapping, Adm Policy Ment Health. 2023; 50(3): 417–426. Published online 6 Jan. 2023.
[8] Lo CB, Bridge JA, Shi J, Ludwig L, Stanley RM. Children's mental health emergency department visits: 2007–2016. Pediatrics. 2020.
[9] Campbell M, Pierce J. A retrospective analysis of boarding times for adolescents in psychiatric crisis. Social Work in Health Care. 2018.
[10] Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. Emergency Medicine International. 2012.
[11] Crowe, A., et al. (2022). *Experiences of child and adolescent psychiatric patients boarding in the emergency department: A patient journey map.* Administration and Policy in Mental Health and Mental Health Services Research.

- **Oregon State Hospital's Ability to Admit in a Timely Manner**: Several decades ago, several organizations, including Disability Rights Oregon and several hospitals, filed a lawsuit against the Oregon Health Authority (OHA) and Oregon State Hospital (OSH) for failing to facilitate the admission of a forensic patient to OSH in a timely manner. The Ninth Circuit ruled in *OAC v. Mink* that the state psychiatric hospital must accept, within seven days, people found to not have the mental capacity to stand trial because they are unable to help their attorney defend them in court—what is called "aid and assist." Oregon has struggled to meet this requirement, and, 23 years later, data provided in subsequent litigation shows that, of all the counties in Oregon, Lane County regularly experiences the greatest number of days (beyond seven) for patients waiting for a civil commitment bed. As shown in **Table 2**, collectively, in a recent one-month sample, the TSA had more than 62 individuals with waits greater than seven days, with Lane County having the highest wait time in the state. This high rate has persisted for several years, demonstrating the urgency of need in the region.

Table 2: Summary of Patients Waiting for More than Seven Days for Placement July 15, 2025 – August 14, 2025

County of Commitment	Number of Individuals with Waits Greater than Seven Days
Benton	7
Clackamas	32
Clatsop	5
Columbia	8
Coos	**5**
Curry	**9**
Deschutes	4
Douglas	**2**
Hood River	7
Jackson	24
Josephine	13
Klamath	3
Lane	**46**
Lincoln	0
Linn	4
Malheur	7
Marion	12
Multnomah	29
Polk	4
Tillamook	2
Umatilla	6
Washington	22
Yamhill	4
Total	**255**

Source: Case No. 3:21-cv-01637-AN (Member Case), DEFENDANTS' THIRD FINE CALCULATION REPORT, p. 9–11

- **Adolescent Demand Is Growing and the Need for Beds Is Urgent**: As referenced in the above Boarding data, recent studies, both on the local and national level, discuss the overall insufficient supply of dedicated inpatient psychiatric beds for children and adolescents. Recent publications from the Journal of American Medical Association (JAMA) and the American Psychiatric Association have noted the increase in need for inpatient psychiatric services for children and adolescents and the general decrease in supply of beds. Specifically, the APA found that:
    - Currently, less than 50% of children with an identified behavioral health condition receive any treatment, resulting in increased costs and acuity of clinical presentation (Bostic and Hoover, 2020).
    - While demand for inpatient services has increased, the supply of inpatient psychiatric beds has decreased.[12]

Not only is demand for psychiatric care high for children and adolescents, but there is also documented variability in the need for inpatient psychiatric beds, which requires a lower target occupancy rate than is typical for adult populations. Several studies have demonstrated the extent of this variation. For example, one study of youth presenting with suicidality found clear seasonal fluctuations in presentation rates.

In 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association jointly declared a state of emergency in child and adolescent mental health, noting:[13]

> *This worsening crisis in child and adolescent mental health is inextricably tied to the stress brought on by COVID-19 and the ongoing struggle for racial justice and represents an acceleration of trends observed prior to 2020. Rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020, and by 2018 suicide was the second leading cause of death for youth ages 10–24. The pandemic has intensified this crisis: across the country we have witnessed dramatic increases in Emergency Department visits for all mental health emergencies, including suspected suicide attempts.*
>
> ***METHODS:***
> *Data were collected between January 2015 and December 2019 by a child and adolescent psychiatry consultation-liaison service in a pediatric ED and hospital. Descriptive analysis and multiple linear regression were performed to assess volume over time, seasonal trends, and associated diagnoses.*
>
> ***RESULTS:***
> *A total of 2,367 patients were included, with an average age of 13.9 years and female predominance (62.3%). During the study period, annual ED*

[12] The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions, Section 7 Child and Adolescent Psychiatric Beds, May 2022, psychiatry.org, p. 86-111.
[13] Cummings JR, Wilk AS, Connors EH. Addressing the Child Mental Health State of Emergency in Schools–Opportunities for State Policy Makers. JAMA Pediatrics. 2022 Jun 1;176(6):541–542.

consultations increased 87.5% and hospital consultations increased 27.5%. Consultations revealed seasonal trends, with highest volumes during January, April, May, October, and November ($P < .001$; adjusted $R^2 = 0.59$). The most frequent diagnostic categories were depressive disorders and trauma- or stressor-related disorders. Thirty-six percent of patients presented after a suicide attempt, with the highest rates in spring ($P = .03$; adjusted $R^2 = 0.19$). Boarding rates revealed significant seasonality, with higher instances in February, March, April, May, and October ($P = .009$; adjusted $R^2 = 0.32$).

CONCLUSIONS:
Mental health presentations to a pediatric ED and hospital reveal seasonal trends, with the highest volumes in fall and spring and the most common diagnoses being depressive and trauma-related disorders. Suicide attempts are highest in late spring. Knowledge of these trends should inform hospitals, mental health services, and school systems regarding staffing, safety, surveillance, and prevention.

While much of the recently published literature notes an increased need for inpatient psychiatric services for children and adolescents while the bed supply has decreased, there have not been definitive bed-to-population ratios published for these groups. However, an August 2024 review of the pediatric psychiatric bed supply did find that the median bed-to-population ratio in the US was 15 beds per 100,000 population (age 18 and under).[14] The study provided a map of the US in which the Pacific Northwest (Oregon and Washington) was found to have ratios well below the national median.

Using Oregon-specific data, the estimated bed-to-population ratio for the under 18 population (**Table 3**) is about 5 per 100,000 statewide.

Table 3: Oregon Bed-to-Population Ratio for 0–17

	2019	2020	2021	2022	2023
Oregon Beds	44	44	44	44	44
Oregon 0–17 Population	866,055	865,005	861,027	826,403	819,607
Oregon Bed-to-Pop. Ratio	5.08	5.09	5.11	5.32	5.37

Source: Oregon beds: Legacy Unity (22 adolescent beds) and Willamette Falls (6 child beds and 16 adolescent beds); population from Portland State University

The new hospital is designed to specifically meet the needs of the underserved adolescent population. The design can accommodate fluctuating demand across patient populations while maintaining strict safeguards for adolescent patients. Up to 24 beds may be designated as an adolescent unit at any given time, based on

[14] Pediatric Inpatient Psychiatric Capacity in the US, 2017–2020, *JAMA Pediatrics*, October 2024, Volume 178, Number 10, p. 1080–1082.

community need, referral patterns, and census volumes. The 24-bed adolescent unit is configured as a fully self-contained psychiatric nursing unit with controlled access points (through badge-controlled doors and staffing patterns that prevent adult patient entry), supervision standards, and structured program scheduling to prevent interaction with adult populations, dedicated noisy/quiet activity and group therapy spaces, consult rooms, staff work areas, and a dedicated exterior activity space—all of which are physically and operationally separate from adult units within the hospital. Further, circulation paths, sightlines, and common areas are designed to eliminate shared spaces, ensuring adolescents are never co-mingled with adults.
This flexibility provides the ability to respond to changing community demand, maximize utilization of licensed capacity, and remain fully aligned with regulatory expectations regarding patient safety, separation of populations, and delivery of age-appropriate behavioral health services.

- **The Impact of Homelessness and Behavioral Health Conditions is Well Established In the Literature:** Homelessness is associated with higher acuity at presentation, increased emergency department utilization, and longer inpatient lengths of stay. TSA 3 continues to experience persistently high levels of homelessness, concentrated in Lane County and, specifically, within the Eugene–Springfield urban core (which comprises 87% of the unhoused population in the county). In 2025, 10,822 individuals in Lane County met the US Housing and Urban Development definition of homelessness ("lacking a fixed, regular, and adequate nighttime residence"), and the January 2025 Point-In-Time (PIT) count identified 3,509 individuals experiencing homelessness on a single night—a 24% increase since 2023. The January 2025 PIT count identified a total of 4,371 people experiencing homelessness across the entirety of TSA 3.

  A 2024 systematic review and meta-analysis published in the *Journal of American Medicine* found that approximately 67% of individuals experiencing homelessness have a current mental health disorder and 77% have a lifetime prevalence of mental illness, with high rates of substance use disorders (44%), major depression (19%), schizophrenia (7%), and bipolar disorder (8%).

  In TSA 3, where homelessness is concentrated in the same urban areas proposed to be served by Timber Springs, these data underscore the continued need for accessible inpatient psychiatric capacity capable of stabilizing individuals experiencing acute mental health crises in the context of ongoing housing instability.

- **Significant Need for Better and More Timely Access to Inpatient Psychiatric Care for the Geriatric Community Exists:** Older adult Oregonians have a 26% prevalence of anxiety disorders, a 12% prevalence of serious mental illness, and Oregon has the 4th highest rate in the nation for older adult deaths due to intentional self-harm[15].

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[15] *Building the Older Adult Behavioral Health Workforce: Oregon's Cener of Excellence for Behavioral Health & Aging.* Innovation in Aging, Volume 8, Issue Supplement_1, December 2024, Pages 1294–1295.

- **OHA Identified a Need in TSA 3 for More Inpatient Beds**: In June of 2024, OHA issued a final report entitled *Behavioral Health Residential+ Facility Study*. The report focused on assessing behavioral health facility capacity across the state, identifying gaps in mental health residential space, substance use disorder (SUD) programs, and withdrawal management services by TSA. The report found that TSA 3 had a need for 66 additional adult psychiatric beds, beyond its current capacity, by 2029 to meet demand.

(3) Criterion: Will the proposed project result in an improvement in patients' reasonable access to services? The applicant will identify any potential problems of accessibility including traffic patterns; restrictive admissions policies; access to care for public-paid patients; and restrictive staff privileges or denial of privileges.

The proposed hospital will improve access to behavioral healthcare and mitigate the problems referenced in Criterion1 above. Related to adolescents, recent publications from the Journal of American Medical Association (JAMA, 2024) and the American Psychiatric Association (APA, 2022) document continued, post-pandemic increases in demand for inpatient psychiatric services for adolescents. The APA found that less than 50% of those with an identified behavioral health condition receive any treatment, resulting in increased costs and acuity at clinical presentation.

The shortage of beds for adolescents means that the nation's emergency departments have typically become where these youth are held for extended periods of time (days and sometimes weeks), while awaiting appropriate psychiatric placements. These children too often receive inadequate psychiatric intervention during these holds due to limited resources at the hospitals where they are awaiting transfer.

Boarding data collected by PeaceHealth for its Oregon hospitals for the period of July 2023 to June 2024 identified that of almost 600 patients under the age of 18 who presented to the ED, 27% (162) spent at least 24 hours in the ED. Of these patients, the average length of stay ranged from 2.5–5.0 days, with the longest length of stay being nearly 2.5 weeks. Importantly, even if a bed is available, these hospitals, both located in the Portland metro area, are more than a 2.5-hour drive from Eugene and Springfield, and as far as 4.75 hours from the outer reaches of the TSA, making access exceptionally challenging.

PeaceHealth's admission and charity care policies do not discriminate and do not restrict access based on payer. The Timber Springs admission and charity policies will be the same as the current PeaceHealth policies. There will be no restrictive staff privileges; the selected site enjoys suitable traffic access and good public transportation. The issue today is a lack of beds, and the proposed new hospital will directly address that issue.

Estimation of Numeric Bed Need (OAR 333-615-0030)

Note: OAR outlines a multi-step process for calculating numeric need. Each step is calculated and reported separately in **Appendix 2.** Where relevant, within the methodology, we separated adults from adolescents age 13–17, and estimated need separately before re-combining. We did this because we are asking that the adolescent beds be treated as a sub-specialty unit and they have different use rates. We have also estimated a higher in-migration for these beds.

> ***Step 1: Define the Population, 10 years historical and 10-year forecast.***
>
> ***(1)(a) Determine the estimated population for the Health Service Area identified in OAR 333-615-0010(3) for the prior 10 years in five-year increments, and five- and 10-year forecasts as a basis for estimating the population for previous years and forecasting future years. Applicants shall use Portland State University's Population Research Center (PRC) Intercensal Estimate reports, and when available, United States Census Data. If the applicant uses an alternate data source, the applicant must provide justification for the alternate data source.***
>
> ***(b) Age and sex specific forecasts and changes over time in the age and sex composition of the Health Service Area population shall be examined, and the implications for use-rates taken into consideration.***

Timber Springs was unable to exclusively use Portland State University's Population Research Center (PRC) data because that data is produced only at the county level and only a portion of Curry County is in the TSA, thereby requiring zip code-level data. As such, PRC data was used for the full three counties (Coos, Douglas, and Lane), and Claritas, a national demography source that uses actual US census data and provides annual updates to population data at the zip code level, was used for Curry County. The historic and projected population by age cohort for the TSA is depicted in **Table 4.** As this project proposes to become operational in 2029, population estimates have been developed through the tenth year, or 2038, as required in Step 8 of the methodology.

According to the most recent 10-year population data published by PRC and Claritas, the total population of TSA 3 is about 564,000. **Table 4** provides the data for both the 13–17 and the 18+ cohorts. As shown, the population age 13–17 has remained relatively flat and is expected to grow only slightly after 2025.[16] We also reviewed the changes over time in the age and sex composition of the TSA, but did not report them, as they did not seem relevant to the analysis.

[16] Please note that PRC data does not specifically include a 13–17 age cohort but includes 10–14 and 15–19. To determine the 13–17 age cohort, it was assumed that the population is evenly distributed between the ages within each age cohort.

Table 4: Service Area Population – 2010, 2020, 2025, 2030, and 2038					
	2010	**2020**	**2025, Est.**	**2030, Proj.**	**2038, Est.**
Combined Coos, Douglas, and Lane Counties					
Total Population (PRC)	522,660	559,985	561,019	574,738	588,788
Population 13–17	33,388	32,579	32,593	34,184	33,154
Population 18+	416,463	454,844	460,602	475,008	494,416
Curry County, Portion Located in TSA 3					
Total Population (Claritas)	3,007	3,160	3,123	3,183	3,256
Population 13–17	125	99	111	119	121
Population 18+	2,644	2,775	2,732	2,787	2,846
Total TSA 3 Population	**525,667**	**563,145**	**564,142**	**577,921**	**592,038**
Population 13–17	**33,513**	**32,678**	**32,704**	**34,303**	**33,275**
Population 18+	**419,107**	**457,619**	**463,334**	**477,795**	**497,262**

Source: PRC Forecasts for Coos, Douglas, and Lane counties; published in 2025 with the exception of Lane County, which was published in 2024; Claritas for Curry County Zip Codes (for the years beyond 2030, it was assumed that Curry County Zip Codes represented 13.3% of the PRC Curry County forecasts)

Step 2: Calculate TSA 3 Discharge and Patient Day Use Rates
Determine current year proposed Health Service Area and historical Health Service Area population-based discharge and patient day use-rates utilizing relevant and recent data. Future use-rate deviations must be explained.

(a) Determine current year and historical utilization by the Health Service Area population of existing facilities. For this step, the applicant shall use the Medicare Cost Reports and All Payer All Claims (APAC) data and may elect to use other relevant data. For the current year, and each of the prior 10 years, the applicant shall explain factors which may have affected identified trends. Factors to be addressed include, but are not limited to, changes in: population, public health needs (including any public health emergency), hospital location, service mix, age mix, reimbursement mix, transportation patterns, locations of physicians, specialists, unmet need, and the intensity or types of services delivered;

APAC data was not used due to extensive wait times and difficulty in accessing the data. Inpatient data from both Apprise and WA State CHARS (which contains inpatient utilization data by hospital and patient zip code of residence and is comparable to Apprise) were used to identify TSA 3 residents securing care in a Washington hospital, though the data since 2022 has been redacted. Using the available data, use rates by both discharges and patient days for the past ten years were calculated for residents of TSA 3. The same data for three TSA hospitals providing inpatient psychiatric care were also collected.

The temporary OAR did not offer a DRG level or other definition of a psychiatric admission, so as stated elsewhere in the application, we conservatively limited our definition to MDC 19 (Mental Diseases and Disorders) and refer to it throughout this CN application as the "baseline use rate."

For all the reasons noted earlier in this application, we chose to adjust the use rates to reflect the undercounting of discharges as a result of using only MDC 19. The use rate adjustment also recognizes that the baseline use rate is deflated because it does not include persons going to Cedar Hills, nor does it fully account for all Oregon residents using hospitals in Washington. Additionally, it undercounts residents going to other states beyond Washington and those who are currently foregoing care because of limited access. The calculated historical use rate only includes the sub-cohort of those in need who were able to receive inpatient care in Oregon (excluding the private psychiatric hospital in Portland) and were coded as MDC 19. It does not capture those who sought care elsewhere or were otherwise deflected. The adjusted use rate is intended to capture "new utilization" once access is enhanced.

At the time this application was being prepared, the most recent full year of data available was 2024. However, data through Q3 2025 (annualized) is also included both for comparison purposes and because it is the most recently available data.

Table 5 provides discharge use rates for the 13–17 and 18+ age cohorts. Selected years are provided in the table, with all years included in **Appendix 2.** The selected years represent the general trend.

Table 5: Residents of TSA 3 Aged 13–17, Historical and Current Psychiatric Discharges and Use Rates per 1,000

	2015	2018	2020	2022	2023	2024	Q3 2025 Annualized
Age 13–17							
Discharges	89	143	94	113	141	128	117
Use Rate	*2.69*	*4.35*	*2.88*	*3.46*	*4.31*	*3.91*	*3.58*
Age 18+							
Discharges	1,353	1,647	1,470	1,466	1,580	1,543	1,691
Use Rate	*3.09*	*3.66*	*3.21*	*3.19*	*3.43*	*3.34*	*3.65*
Combined 13+ Use Rate	*3.06*	*3.71*	*3.19*	*3.21*	*3.49*	*3.38*	*3.64*

Source: Oregon Apprise data and WA CHARS data, MDC 19 only

As discussed earlier, the data in **Table 5** is understated because of the limitations of MDC 19, the lack of visibility into patients cared for out-of-state, and because of the shortage of inpatient psychiatric beds for both age cohorts—meaning some patients do not receive care when needed, or sadly, do not receive care at all.

We also reviewed data to understand in-migration and market share. As **Table 6** indicates, the existing data demonstrates that adolescents overwhelmingly travel outside the TSA to

the Portland area for care. **Table 6** provides discharges and market share by hospital for TSA residents age 13–17.

Table 6: Residents of TSA 3 Aged 13–17 Psychiatric Discharges and Market Share by Hospital								
	2018		2022		2024		2025 Annualized (Q3)	
Hospital	**Disch.**	**Market Share**	**Disch.**	**Market Share**	**Disch.**	**Market Share**	**Disch.**	**Market Share**
Unity Behavioral Health	61	42.7%	71	62.8%	73	57.0%	97	67.1%
Providence Willamette Falls Hospital	48	33.6%	32	28.3%	48	37.5%	64	25.0%
OHSU	4	2.8%	5	4.4%	4	3.1%	5	4.6%
Sacred Heart, RiverBend	7	4.9%	2	1.8%	2	1.6%	3	3.4%
Legacy Emanuel Hospital	0	0.0%	1	0.9%	1	0.8%	0	0.8%
Rogue Valley Medical Center	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Providence St. Vincent Medical Center	4	2.8%	1	0.9%	0	0.0%	0	0.0%
Mercy Medical Center	0	0.0%	1	0.9%	0	0.0%	0	0.0%
McKenzie-Willamette	3	2.1%	0	0.0%	0	0.0%	0	0.0%
Bay Area Hospital	16	11.2%	0	0.0%	0	0.0%	0	0.0%
Total	**143**	**100.0%**	**113**	**100.0%**	**128**	**100.0%**	**169**	**100.0%**

Source: Oregon Apprise and Washington CHARS databases, MDC 19 only

The 18+ age cohort's volume, market share, and out-migration information are provided in **Table 7**. This table indicates that, while PeaceHealth has a significant market share of the MDC 19 discharges, out-migration to non-TSA 3 hospitals has increased in the past few years, such that more residents seeking access to care are required to travel relatively long distances to obtain that care.

The increase in out-migration from PeaceHealth likely results from the increased complexity of patients being cared for in the BHU, which requires, with increasing frequency, adjacent patient rooms to be taken off-line to prevent injury or exposure to violence as we experience more patients with a known history of violence to other patients. This results in the need to keep surrounding rooms vacant as a safety precaution; and the de facto outcome is fewer beds are available to admit a patient.

Table 7: Residents of TSA 3 Aged 18+ Psychiatric Discharges and Market Share by Hospital								
	2018		2022		2024		2025 Annualized (3Q)	
Hospital	**Disch.**	**Market Share**	**Disch.**	**Market Share**	**Disch.**	**Market Share**	**Disch.**	**Market Share**
Sacred Heart Medical Center RiverBend[17]	1,182	71.8%	1,127	76.9%	1,083	70.2%	1,056	62.5%
Bay Area Hospital	268	16.3%	96	6.6%	177	11.5%	187	11.0%
Mercy Medical Center	10	0.6%	6	0.4%	45	2.9%	219	12.9%
Tuality Healthcare	2	0.1%	29	2.0%	43	2.8%	27	1.6%
Providence St. Vincent Medical Center	16	1.0%	47	3.2%	34	2.2%	37	2.2%
Legacy Unity Behavioral Health	32	1.9%	27	1.8%	33	2.1%	20	1.2%
OHSU	18	1.1%	18	1.2%	25	1.6%	24	1.4%
McKenzie-Willamette Medical Center	18	1.1%	18	1.2%	19	1.2%	17	1.0%
Willamette Valley Medical Center	1	0.1%	13	0.9%	18	1.2%	21	1.3%
Providence Milwaukie Hospital	7	0.4%	15	1.0%	17	1.1%	9	0.6%
St. Charles Medical Center (Bend)	14	0.9%	11	0.8%	15	1.0%	13	0.8%
Rogue Valley Medical Center	28	1.7%	16	1.1%	8	0.5%	9	0.6%
Salem Hospital	3	0.2%	7	0.5%	6	0.4%	4	0.2%
Good Samaritan Regional Medical Center (Corvallis)	17	1.0%	5	0.3%	3	0.2%	7	0.4%
Portland Hospitals (Legacy Good Sam, Legacy Emanuel, and Providence Portland)	10	0.6%	10	0.7%	8	0.5%	27	1.6%
Other Oregon Hospitals	15	0.9%	12	0.8%	5	0.3%	5	0.3%
Washington Hospitals	6	0.4%	9	0.6%	4	0.3%	8	0.5%
Total	**1,647**	**100.0%**	**1,466**	**100.0%**	**1,543**	**100.0%**	**1,691**	**100.0%**

Source: Oregon Apprise and Washington CHARS databases, MDC 19 only

Table 8 provides ADC and occupancy for the three TSA hospitals with inpatient psychiatric services for 2018, 2022, 2024, and 2025 (annualized). This data is also likely understated as it only includes MDC 19 patient days, and we know that it understates the actual UD BHU ADC.

[17] Sacred Heart RiverBend data includes data in 2018 and 2022 for both the University District Campus and the RiverBend Campus. PeaceHealth consolidated reporting for University District Campus with RiverBend in 2023.

Table 8: TSA 3 Hospitals' Inpatient Psychiatric Units MDC 19 Days, ADC, and Occupancy 18+, 2018, 2022, 2024 and 2025 (annualized)													
		2018			2022			2024			2025, Annualized		
Hospital	**Beds**	**Total Days**	**ADC**	**Occ.**	**Total Days**	**ADC**	**Occ.**	**Total Days**	**ADC**	**Occ.**	**Total Days**	**ADC**	**Occ.**
PeaceHealth UD BHU and RiverBend (per Apprise)	35	11,990	32.8	93.9%	11,808	32.4	92.4%	10,136	27.8	79.3%	9,587	26.3	75.0%
Bay Area Hospital	13	2,092	5.7	44.1%	2,100	5.8	44.3%	2,382	6.5	50.2%	1,945	5.3	41.0%
Mercy Medical	12	90	0.2	2.1%	39	0.1	0.9%	316	0.9	7.2%	1,953	5.4	44.6%

Source: Apprise Data, MDC 19 only

As noted earlier, there was virtually no in-migration (discharges or days to the three TSA 3 hospitals from outside the TSA) for the 13–17 cohort. **Table 9** details the in-migration to TSA 3 hospitals for the 18+ cohort. Based on just deflection rates at PeaceHealth, we know this percentage does not accurately reflect demand.

Table 9: TSA 3 Hospitals, 2024 Beds, Occupancy, and Percent In-Migration, MDC 19 Only (Age 18+)			
Hospital	**2024 18+ Total Days**	**Days from TSA**	**Percent In-Migration**
PeaceHealth BHU and RiverBend	10,136	9,479	6.5%
Bay Area Hospital	2,382	1,716	28.0%
Mercy Medical	316	297	6.0%
Total	**12,834**	**11,492**	**10.5%**

Source: Apprise database, MDC 19 only

(b) Estimate future utilization rates by the Health Service Area population, based on population forecasts for age and sex breakdowns, including consideration of an explained range of age and sex adjusted use-rates specific to:

(A) The Health Service Area;

(B) The nearest facilities with service mixes most comparable to the proposed facility; and

(C) The nearest facilities with comprehensive service mixes.

Population forecasts prepared by PRC through 2038 were used to estimate the age cohort-specific populations for all four counties. As noted earlier, only a relatively small portion of Curry County is included in TSA 3. Using zip code-specific data developed by Claritas, the portion of Curry County that is included in TSA 3 was estimated separately. This portion/percentage by age cohort was then applied to the Curry County population estimates prepared by PRC.

Future discharge utilization rates for the service area were estimated for 2025, 2030, 2035, and 2038. No gender-specific breakdowns were used, as this project does not propose to provide any gender-specific programming.

Step 3: Use Rate Assumptions

Develop a consistent and reasonable set of well-documented assumptions regarding the appropriate use-rates reviewed in section (2) of this rule, including the extent to which utilization at the proposed psychiatric hospital will be new and the extent to which it will replace existing utilization at hospitals.

At step 3, the methodology converts from estimating just TSA 3 resident need to also estimating the proposed utilization of the new hospital. As previously indicated, the use rates are understated because they exclude those who sought care but were not admitted due to a lack of beds (see deflection, boarding data, and WA state use, above). This data suggests that more than one-third of referrals were not admitted. Further, the data also demonstrates that at least 13% of patients admitted to PeaceHealth's existing inpatient psychiatric unit are coded to an MDC other than MDC 19 at discharge. Given all these factors, we chose to adjust the historical use rate to correct for the underutilization (the adjustment is intended to reflect "new" utilization).

In evaluating the existing literature, data, and studies, we were not able to identify a consistent source of data on admission rates by state and/or a national average. We did identify studies, including one using CMS Healthcare Cost Report Information System (HCRIS) data, which evaluated data for the period of 2011–2023 and estimated inpatient beds per 100,000. The study used nationally representative HCRIS data for the period of 2011–2023. Per the report:[18]

[18] Bressman, E., et al. (2025). *Inpatient psychiatric bed capacity within CMS-certified U.S. hospitals, 2011–2023.*

- There is a shortage of inpatient psychiatric beds across the US, with only 28.4 beds per 100,000 population, on average. Per the report, the optimal level of beds is 60 beds per 100,000, more than double the current nationwide average.
- Given that inadequate numbers of inpatient psychiatric beds create additional challenges for people in need of mental health treatment, including longer emergency department wait times and higher rates of psychiatric readmissions, these results have important implications for individuals with mental illness across the US.

The current ratio of beds-to-population in TSA 3 is 10.7 per 100,000, a rate 165% lower than the report's average of 28.4 beds. Assuming that there is a direct correlation between beds and ability to admit, we conservatively increased the actual use rates experienced in the TSA by 50% (less than one-third of the variation between bed ratios for the TSA and from the CMS HCRIS data). The results are shown in **Table 10**. It is important to note that 100% are not technically all "new" discharges, as some represent cases not currently coded as MDC 19. However, between the two age cohorts, we estimate 48 new discharges of adolescents and more than 600 discharges for those age 18+.

Table 10: TSA 3 Unadjusted and Adjusted Use Rate and Impact on Discharges

Variable	Calculation
13–17 Use Rate (Unadjusted) Average 2022–2025, Annualized	3.82
13–17 Use Rate (Adjusted)	5.72
Population 13–17 (2025)	32,704
Unadjusted Discharges	125
Adjusted Discharges	187
"New" Discharges	62
18+ Use Rate (Unadjusted)	3.40
18+ Use Rate (Adjusted)	5.10
Population 18+ (2025)	463,336
Unadjusted Discharges	1,576
Adjusted Discharges	2,364
"New" Discharges	788

Source: PRC Forecasts for Coos, Douglas, and Lane counties; published in 2025 with the exception of Lane County, which was published in 2024, Claritas for Curry County Zip Codes; Apprise database, MDC 19 only

Step 4: Analyze the advantages and disadvantages of both new and replacement components of utilization, with respect to both the population to be served and to existing facilities. Address the legislative findings cited in ORS 442.310.

In summary, ORS 442.310 finds that the achievement of reasonable access to quality healthcare, including mental healthcare, at a reasonable cost is a priority of the State of Oregon, and that problems preventing reasonable access include:

- The inability of many residents to pay for necessary healthcare, lacking coverage from private insurance or publicly funded programs such as Medicare and Medicaid;
- Inadequate incentives for the use of less costly and more appropriate alternative levels of healthcare;
- Insufficient or inappropriate use of existing capacity, duplicated services, and failure to use less costly alternatives in meeting significant health needs;
- Insufficient primary and emergency medical care services in medically underserved areas of the state; and
- Lack of secure residential beds and Oregon State Hospital beds for civilly committed patients.

The current bed-to-population ratio in TSA 3 is 10.7, and we have documented both significant underuse and deflection of patients needing hospitalization throughout this CN application. Timber Springs is planned to reduce deflections, boardings, and residents needing to travel to Portland metro or out of state for care. Once opened, the bed-to-population ratio in TSA 3 will be approximately 20 beds per 100,000

The "new" discharges are calculated in Table 10. We do not assume that Timber Springs will realize 100% of all the new utilization, but rather, the new campus through crisis stabilization and inpatient, along with the increased alternatives in TSA will enhance the continuum and improve access and availability at every entry point. The advantage of this new utilization is significant and positive.

Temporary OAR 333-615-0025 (2) requires that the number of beds needed to provide an anticipated range of patient days in the TSA does not exceed 36 beds per 100,000 individuals. With a range of 36-bed-per-100,000, the population can support 213 beds by 2038. The 96 beds in this project result in TSA 3, coupled with the existing capacity at the other two results means that the TSA will have 57% of this ratio.

Timber Springs will continue the policies of PeaceHealth related to charity care. We have already had conversations with the local CCO and understand that it intends to use Timber Springs for its Medicaid patients who require hospitalization.

Further, Timber Springs is but one component of a larger private-public partnership with the county that will co-locate crisis services on the same campus. While primary care and emergency care are available in the TSA, especially in the Eugene–Springfield region, data provided in this application demonstrate that the high rates of deflections and ED boardings cause inefficiencies and increase costs for families, patients, payers, and providers. Further, offering more beds within TSA 3 reduces the need to travel to the Portland metro area or out of state. Again, Timber Springs would bring a significant and positive change for the TSA.

Step 5: Projection of Future Patient Days and ADC

Given all information from the preceding steps, and five- and 10-year population forecasts, compute the range of possible future patient days in five years and in 10 years at the proposed psychiatric hospital, allowing appropriate adjustments for out-of-area utilization and other identified and justified special factors or considerations relevant to the proposal.

AND

Step 6: Convert each computed value of forecasted patient days based on preceding sections of this rule to an average daily census (ADC).

Table 11 provides five- and ten-year estimates of TSA 3 patients, patient days, and ADC. The table provides this information separately for the adolescent sub-specialty regional unit and the adult (18+) unit.

Table 11: Five-Year and Ten-Year Estimates TSA 3				
	2025	**2030**	**2035**	**2038**
13–17				
Use Rate (Adjusted)	5.72	5.72	5.72	5.72
Population	32,704	34,303	34,068	33,275
Discharges	187	196	195	190
Patient Days @ 14.8 ALOS	2,770	2,906	2,886	2,818
ADC	7.6	8.0	7.9	7.7
18+				
Use Rate	5.10	5.10	5.10	5.10
Population	463,336	477,796	490,972	497,262
Discharges	2,364	2,438	2,505	2,537
Patient Days @ 10.6 ALOS	25,056	25,838	26,551	26,891
ADC	68.6	70.8	72.7	73.7
13+ Total				
Discharges	2,551	2,634	2,700	2,727
Patient Days	27,826	28,744	29,436	29,709
ADC	76.2	78.8	80.6	81.4

Source: PRC Forecasts for Coos, Douglas, and Lane counties; published in 2025 with the exception of Lane County, which was published in 2024, Claritas for Curry County Zip Codes; Apprise database, MDC 19 only

Step 7: Peak Census

Estimate the statistically expected peak daily census, the statistical variability, or standard deviation, of the daily census and provide the methodology used by the applicant and sufficient information to validate use of the applicant's statistical model.

Peak census for the TSA was calculated using a Poisson Distribution. A Poisson Distribution models the number of times a random, independent event occurs within a fixed interval of time or space. In healthcare bed planning, it is most commonly used to predict patient arrivals or demand and is most informing in estimating bed need in units where arrival time is not pre-planned, such as inpatient psychiatric care.

A Poisson distribution is relatively easy to calculate. The formula for a 95% confidence interval is: Bed Need = ADC + (1.65 x √ADC). The formula for the 99% confidence interval is: ADC + (1.96 x √ADC).

We used the 95% confidence level for the adult beds and the 99% confidence level for the adolescent beds. We chose a 99% confidence level for adolescent beds because the unit is relatively small (24 beds maximum) and the census has more seasonal/school year fluctuations than the adult unit. The results are included in **Table 12.**

Table 12: TSA 3 Bed Need Peak Census Analysis Maximum ADC

	2025	2030	2035	2038
	13–17 (99% Confidence Interval)			
Bed Need	14.0	14.5	14.5	14.2
	18+ (95% Confidence Interval)			
Bed Need	82.3	84.7	86.8	87.8
Combined Total	96.3	99.2	101.3	102.0

Source: Bed Need Methodology Step 7 with Poisson Applied

Step 8: Timber Springs Projected 10-Year Utilization

Using a 10-year projection from the anticipated opening date of the facility, the applicant shall identify supported mathematical estimates of appropriate utilization levels and patient days generated because of changes identified in prior steps. Applicant shall explain the degree to which the utilization will be "new" days for the health service area population, or will shift present health service area utilization patterns for the services. Applicant shall address whether this analysis supports the need for the proposed hospital.

Bed need for the TSA was calculated based on the findings of Steps 1–7, with the addition of in- and out-migration and provider market share specific to Timber Springs, allowing for bed need to be calculated for the new hospital. To be conservative, we did not use the peak census ADC, but rather the Step 6 ADC calculation for TSA 3 and then adjusted for in and out migration and occupancy to determine bed need at Timber Springs. Finally, we did not assume that all new capacity would happen at Timber Springs; rather we assumed that Timber Ridge along with the new crisis center will open capacity elsewhere that will provide more choice for residents. Key assumptions are provided in **Table 13** and the details on the projected Timber Spring census are included in **Table 14**. The complete OAR methodology is included in **Appendix 2.**

Table 13
Timber Springs Bed Need, Years 1-10

Factor	**13-17 Age Cohort**	**18+ Age Cohort**
Market Share of TSA 3 Discharges	60.0% in 2029, increasing to 80% by 2031	70% each year
Rate of In-migration (ADC)	0 in 2029, 4.5 ADC in 2030 and increasing to 8.0 by 2032	0 ADC in 2029, increasing to 11.5 by 2035
Patient Days ALOS = current actual	14.8	10.6
Occupancy Target	80% after start-up	

Table 14: Projected Timber Springs Census										
	2029	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
	13–17 Population									
TSA 3 ADC Based on Adjusted Use Rate	7.9	8.0	7.9	7.9	7.9	7.9	7.9	7.8	7.8	7.7
Estimated Market Share	60.0%	72.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Market Share Adjusted ADC	4.73	5.73	6.36	6.35	6.34	6.33	6.32	6.27	6.23	6.18
Discharges from In-Migration	0	111	173	197	197	197	197	197	197	197
ADC from In-Migration	0	4.5	7.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Total ADC (TSA 3 + In-Migration)	**4.7**	**10.2**	**13.4**	**14.4**	**14.3**	**14.3**	**14.3**	**14.3**	**14.2**	**14.2**
	2029	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
	18+ Population									
TSA 3 ADC Based on Adjusted Use Rate	70.4	70.8	71.2	71.6	72.0	72.3	72.7	73.1	73.4	73.7
Estimated Market Share	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Market Share Adjusted ADC	49.2	49.6	49.8	50.1	50.4	50.6	50.9	51.1	51.4	51.6
Discharges from In-Migration	0.0	223.8	344.3	344.3	344.3	344.3	396.0	396.0	396.0	396.0
ADC from In-Migration	0	6.5	10	10	10	10	11.5	11.5	11.5	11.5
Total ADC (TSA 3 + In-Migration)	**49.2**	**56.1**	**59.8**	**60.1**	**60.4**	**60.6**	**62.4**	**62.6**	**62.9**	**63.1**
	2029	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
	13+ Population									
ADC	54.0	66.3	73.2	74.4	74.7	75.0	76.7	76.9	77.1	77.2
Patient Days	19,703	24,194	26,712	27,172	27,269	27,366	28,012	28,073	28,134	28,196
Beds Needed @ 80% Occupancy	67	83	91	93	93	94	96	96	96	96

Source: OAR Bed Need Methodology with Applicant underlying assumptions defined in narrative

Step 9: Availability of Other Beds

If the result of the above analysis indicates that psychiatric inpatient beds are needed in the proposed Health Service Area, an applicant for a new facility shall weigh it against the availability of beds at other facilities within the Health Service Area. Applicants shall use inpatient psychiatric bed capacity for all facilities in the Health Service Area provided by the Oregon Health Authority. Conversion of existing beds to psychiatric inpatient beds will be presumed infeasible where a general hospital in the proposed Health Service Area has not increased their psychiatric inpatient bed capacity by 20 percent or greater over the has prior three-year interval from the date the applicant submitted their letter of intent.

PeaceHealth intends to close its existing BHU and, therefore, the entire campus to inpatient care as soon as the new hospital is fully operational. This is typically about 60–90 days after opening the new campus. While the psychiatric unit currently provides high-quality care, the facility in which these services are provided is dated and unable to be modernized in a cost-effective manner. The current location's design cannot support today's therapy milieu, making it challenging to accommodate all patients safely and appropriately. There are also no dedicated spaces or means to maintain separation between adolescent and adult patients, resulting in adolescents remaining in the ED until they can be transferred to appropriate placement.

There are infrastructure concerns at the current BHU caused by aging generators and HVAC systems that need to be upgraded and expanded, as well as seismic upgrade requirements to meet current safety codes.

After thorough analysis, PeaceHealth ruled out the option of expanding the current location due to the higher cost compared to new construction and the inability to safely construct upgrades while actively serving patients. All the issues associated with the aging building mean that the existing unit cannot be expanded economically.

Finally, per CMS requirements, neither of PeaceHealth's two Critical Access Hospitals (CAH) can operate more than ten psychiatric beds, and operating multiple units is inefficient and costly due to duplication of spaces, staff, and equipment. The two existing CAHs were ruled out for these reasons.

The best alternative was found to be development of a new, standalone psychiatric hospital. While this option may not be the best alternative in other TSAs, it is ideal for TSA 3 because this model offers the most cost-effective, timely, and clinically appropriate approach to delivering modern, therapeutic, inpatient psychiatric care. Timber Springs will accept all major insurance plans, including CCO-managed Medicaid and Medicare, and will honor PeaceHealth's charity care policy.

Because the current UD BHU unit will close, the result of the project is only a 61-bed increase, including a dedicated adolescent service that will meet the needs of TSA 3 residents and include capacity for in-migration from other TSAs.

Step 10: Protecting Existing Providers in the TSA

Applicants must document how the project will avoid adverse financial impact to existing psychiatric service providers, particularly those serving high-acuity or underserved populations. The analysis shall address whether the proposed project will contribute to continuity or conversely, fragmentation of psychiatric care in the Health Service Area.

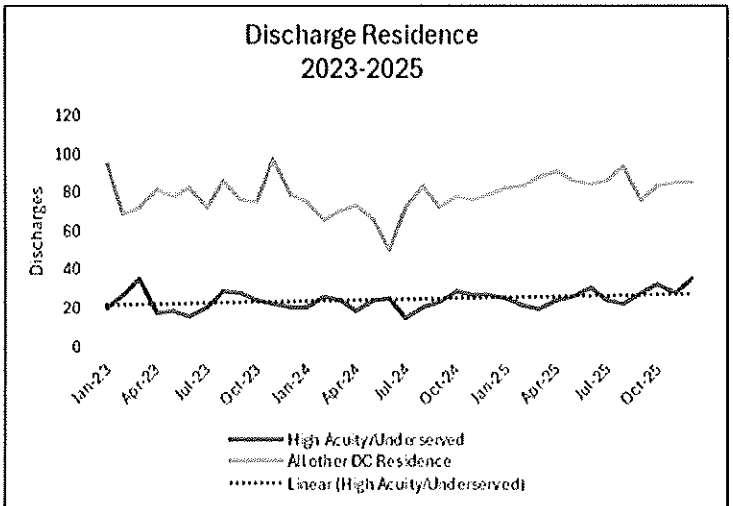
There are two other hospitals in the TSA that each serve their community by providing inpatient beds (one has 13 beds and one has 12). We are not familiar with their unit configurations and cannot discern if their census levels are due to space, room configurations, staffing, or programming. Our bed need assumptions assume that the market share and in-migration rates of these existing providers remain constant.

What we do know is that of all the counties in the state, Lane County sends the highest number of patients to Oregon State Hospital, and the data included earlier in the application demonstrates that access is terribly compromised. Without more beds in Lane County and TSA 3, we will not be able to change this dynamic and adequately serve the needs of our residents.

We also know that the UD BHU serves a very high-acuity patient, measured by severe and complex mental health conditions and symptoms posing a significant risk to overall safety and well-being.

Graphic 2 demonstrates that, since at least January of 2023, high-acuity behavioral health patients have accounted for 20–25% of all patients, and that between the period of January 2023–January 2025, there has been a 14% upward trend in complex or high-acuity patients. High-acuity patients often present with severe symptoms, such as acute psychosis, severe depression, or suicidal ideation, and may require a multidisciplinary approach to address both acute symptoms and underlying mental health issues. Complex patients also include some traditionally underserved cohorts, including those discharged to an adult family home, residential care facility, skilled nursing facility, or Oregon State Hospital. It also includes the unsheltered.

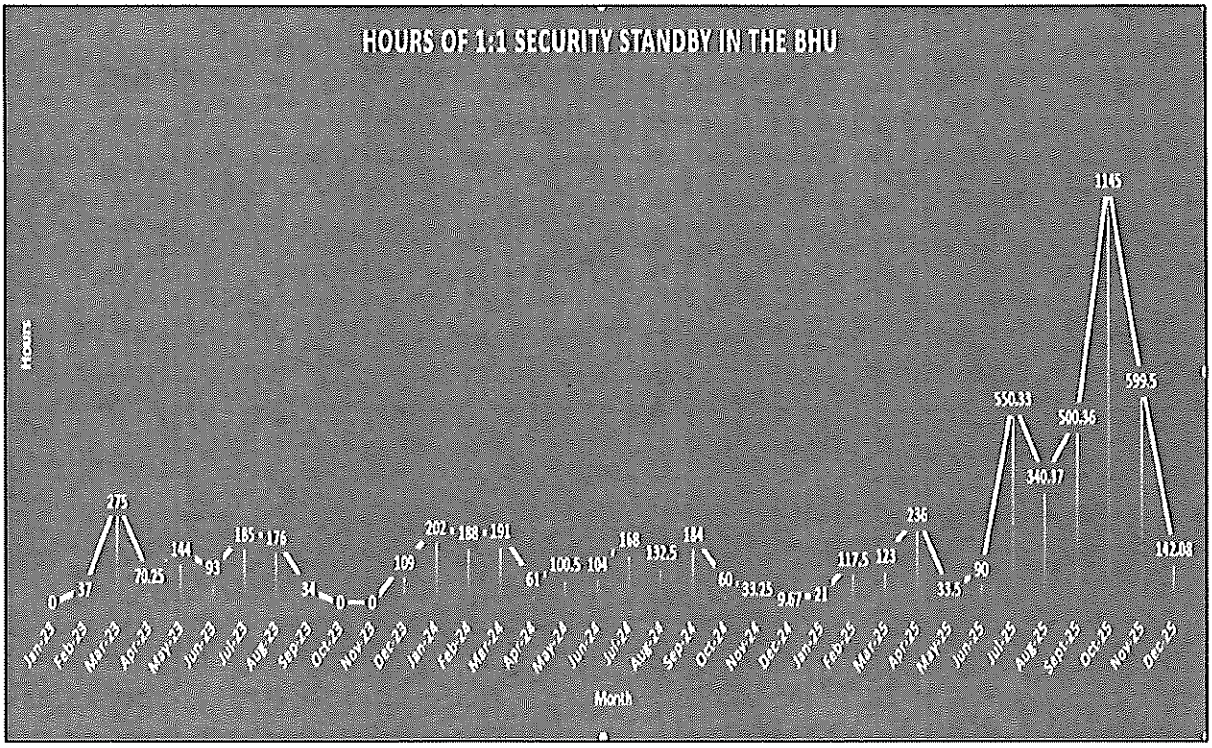
Graphic 2



Highy Acuity/Underserved include those dishcarged to an Adult Foster Home, Residential Care Facility, Skilled Care Facility, Oregon State Hospital, or Unsheltered.

Graphic 3 shows the hours of 1:1 security standby at the UD BHU since January 2023, required as a result of complex patients seeking treatment. The percentage of 1:1 security standby escalated significantly in the second half of 2025.

Graphic 3



This project is pivotal to the public-private partnership in TSA 3 and will result in crisis stabilization beds being co-located on the campus. We believe that, collectively, these two services will go far in mitigating current deficits in the TSA behavioral health delivery system. We also remind reviewers that **the adolescent unit will provide the only dedicated adolescent beds outside of the Portland metro area.** We have strong working relationships with Portland-area providers, and we know that they are eager to have these adolescent beds available in Lane County to help reduce census from Central and Southern Oregon and reduce their deflection rates so that they can serve more patients from the metro area.

PeaceHealth, and now the LLC, have the trust and support of both providers and payers. During public comment, we understand that the OHA can expect a large showing of support.

Availability of Alternatives in the HSA (OAR-333-615-0040)

(1) The applicant shall provide a complete description of all alternatives to inpatient treatment at a psychiatric hospital available in the Health Service Area. This includes an inventory with provider name, type of mental health services provided, address, and if relevant: bed capacity, occupancy, and utilization averages for each of the past five years in the Health Service Area.

Information regarding bed capacity and occupancy of three existing inpatient hospital psychiatric units in TSA 3 is included in **Table 8** earlier in the application.

For a cohort of patients, alternatives to inpatient hospitalization, including residential treatment facilities (RTF), residential treatment homes (RTH), adult foster homes (AFH), and residential substance use disorder facilities, can reduce the length of stay in an acute psychiatric hospital and eliminate, reduce, or shorten the need for inpatient hospitalization. **Table 15** details the supply identified in the TSA by the 2024 OHA report. While crisis beds are not currently available, they will be when the county completes its Behavioral Health Crisis Stabilization Center facility, which will be co-located on the same property with Timber Springs.

Despite outreach, we do not currently have the level of detail requested in the review criterion related to the inventory by provider name, bed capacity, occupancy, etc. We are glad to work with the OHA to compile.

We believe that the growing alternatives in TSA 3 should be encouraged and that an increase in alternatives will help temper the need for acute psychiatric hospitalization. For this reason, we elected to be conservative on the bed need.

Table 15: OHA 2024 Identification of Supply

Type of Facility/Unit		TSA 3	Total Statewide
Inpatient Psych Facility – FS	Beds	0	98
	Beds per 100K	0	2.31
Inpatient Psych Facility – Unit in Hospital	Beds	60	363
	Beds per 100K	10.39	8.57
Residential Treatment Facility (RTF)	Beds	88	641
	Beds per 100K	15.24	15.13
Secure Residential Treatment Facility (SRTF)	Beds	131	587
	Beds per 100K	22.69	13.86
Residential Treatment Home (RTH)	Beds	65	388
	Beds per 100K	11.26	9.16
Adult Foster Home (AFH)	Beds	44	498
	Beds per 100K	7.62	11.76
Residential SUD Facility	Beds	202	1418
	Beds per 100K	34.99	33.48
Clinically Managed Withdrawal Management Facility	Beds	0	8
	Beds per 100K	0	0.19

Source: Oregon HeathAuthority Behavioral Health Residential+FacilityStudy, June 2024 Final Report, p. 7

The OHA report also includes a capacity analysis showing increases in bed capacity, additional beds needed, and the percentage of growth in OHA's projected capacity. **Table 16** restates the capacity analysis.

Table 16: Capacity Analysis, TSA 3

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr., 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Does not include state hospital beds)*	60	0	60	66	126	110.00%
Mental Health Residential Facility *(RTF & RTH only)*	84	69	153	14	167	9.15%
Secure Residential Treatment Facility *(Current capacity includes 165 SRTF beds that are part of Oregon State Hospital)*	115	16	131	27	158	20.61%
SUD Residential Facility	202	0	202	321	523	158.91%
Withdrawal Management Facility *(Clinical & Medical)*	55	0	55	78	133	141.82%
Totals	516	85	601	506	1,107	84.19%

Source: Oregon HeathAuthority Behavioral Health Residential+FacilityStudy, June 2024 Final Report

The LLC is pleased with the increase in beds in most categories, including RTF and SRTF; however, while these options are a significant step in creating a continuum of care, they have not mitigated ED boarding or diversions. This is likely due to the community hospital restrictions contained in priority rule OAR 309-035-0163.

PeaceHealth has invested in a robust and knowledgeable team of discharge planners who actively engage and collaborate with its many community partners to ensure appropriate alternative discharge plans. The new inpatient psychiatric bed capacity is both right-sized and beneficial to the continuum, the community, and patients and families in need.

(2) The methods of meeting acute inpatient psychiatric bed need, in order of preference, shall be (preceded by a demonstration that alternatives have been evaluated and found infeasible based on cost, capacity, or access barriers):

(a) Conversion of existing licensed hospital space to purposes of psychiatric treatment where such conversion is feasible to provide an adequate inpatient program at less cost than building new licensed space.

(b) A project resulting in the smallest feasible net increase in acute licensed capacity within an existing hospital or special inpatient care facility.

Tables 15 and 16 demonstrate that the growing alternatives, while pivotal to the continuum, remain under supplied and unable to mitigate the need for more hospital beds. Earlier sections of this application have demonstrated that there is no alternative to hospitalization for the specific adolescent cohort, and that the current PeaceHealth beds are inadequately sized and cannot be efficiently expanded.

PeaceHealth first evaluated the feasibility of expanding inpatient psychiatric bed capacity on the University District campus. PeaceHealth concluded that renovation was unfeasible due to infrastructure limitations, cost, and the inability to safely construct while actively serving patients. Expansion on the RiverBend campus was similarly ruled out due to the higher cost of renovation/expansion vs. the cost of a new freestanding hospital. The disruption to existing operations also makes this an undesirable option. Additionally, PeaceHealth is preserving the remaining acres attached to the RiverBend property for future services that are required to be located next to an emergency room or operating rooms.

Finally, per CMS requirements, neither of PeaceHealth's two CAHs can operate more than ten psychiatric beds, and operating multiple units is inefficient and costly due to duplication of spaces, staff, and equipment. The two CAHs were ruled out for these reasons.

We have determined that the 61 net-bed addition, with the dedicated adolescent unit, is the smallest, most efficient approach that can be constructed to meet the need and help close the accessibility gap.

(c) A separately licensed new psychiatric hospital, not part of a hospital, which will provide psychiatric inpatient care at the most reasonable charges per day and per inpatient stay event, for care that must be rendered on an inpatient basis. Evaluation of reasonableness of charges are qualities that tend to show charges are fair, competitive, and consistent with quality care. These factors include, but are not limited to, taking into consideration of the factors in OAR 333-615-0000(2).:

(A) Market rates for similar services by similarly situated entities;
(B) Patient outcomes and satisfaction;
(C) Regulatory compliance;
(D) Accreditation and certification; and
(E) Qualification of staff.

Timber Springs will be a separately licensed, purpose-built psychiatric hospital that provides inpatient psychiatric care at reasonable, competitive, and sustainable charges per day and per inpatient stay. The structure, operational model, and financial planning for the hospital demonstrate that charges will remain fair and aligned with comparable psychiatric services in Oregon and nationally. This conclusion is supported by the following factors:

- **Market rates for similar services by similarly situated entities**
  The project's financial modeling uses reimbursement, contractual allowance, charity care, and payer-mix assumptions drawn from actual performance at PeaceHealth's existing inpatient behavioral health unit and Lifepoint's experience operating psychiatric hospitals in comparable markets. Operating and capital costs for Timber Springs have been intentionally structured to remain within industry norms for psychiatric inpatient care, including use of a lease model rather than elevated levels of long-term debt, allowing the hospital to maintain predictable and competitive rates.

  Because Timber Springs replaces PeaceHealth's existing 35-bed unit and adds capacity to meet documented unmet need, it does not introduce unnecessary cost inflation or surplus capacity into the region's behavioral health system.

- **Patient outcomes and satisfaction**
  The new hospital is designed to improve patient outcomes through modern, therapeutic environments, a mix of semi-private and private rooms, secure outdoor spaces, evidence-based programming, and integration with the co-located Lane County Crisis Stabilization Center. These features support safe and pleasant care environments, strong discharge planning, and seamless transitions to outpatient, IOP, PHP, and community-based services.

  PeaceHealth's longstanding experience operating the current 35-bed psychiatric unit ensures continuity of clinical quality and patient experience, and Lifepoint brings operational expertise in behavioral health hospitals nationwide. Together, these partners will implement standardized, outcomes-driven protocols that support both improved clinical results and stable, reasonable charges.

- **Regulatory compliance**
  PeaceHealth and Lifepoint have established histories of operating in full compliance with federal and state requirements for psychiatric services, including CMS Conditions of Participation, accreditation requirements, Oregon licensing requirements, and applicable behavioral health regulations. The existing PeaceHealth unit has consistently met regulatory expectations, and Timber Springs will be built to meet or exceed all current standards.

  Compliance reduces operational risk and contributes to maintaining stable, fair charges by avoiding the financial volatility associated with regulatory deficiencies.

- **Accreditation and certification**
  The project will operate in alignment with nationally recognized behavioral health standards, including those established by The Joint Commission, CMS expectations, and the Oregon Health Authority. Program design, staffing, safety features, and clinical protocols meet accepted benchmarks for high-quality inpatient psychiatric facilities. Accreditation and certification support transparency, accountability, and cost-effective care delivery.

- **Qualification of staff**
  The combined workforce strategy of PeaceHealth and Lifepoint ensures that the hospital will be staffed with qualified behavioral health professionals. All existing staff from PeaceHealth's current 35-bed unit will have the opportunity to transition to the new facility, preserving experienced personnel.

  The Eugene–Springfield area offers the strongest workforce pipeline within TSA 3, supported by formal education partnerships with Lane Community College, Bushnell University, and other regional training programs.

  Access to a well-prepared, highly trained workforce supports efficient care delivery and stabilizes operating costs, helping ensure reasonable charges to patients and payers.

Taken together, the project's cost structure, staffing model, operational design, and adherence to established quality standards demonstrate that Timber Springs will provide inpatient psychiatric care at charges that are fair, competitive, and consistent with quality care, meeting the requirements of OAR 333-615-0025(3)(c).

(3) A proposed psychiatric hospital shall be evaluated by comparison to alternatives with preference given in the following order:

(a) Projects which include development of alternative care resources as part of the project if an unmet need for such resources in the Health Service Area is demonstrated.

While the alternatives have grown, and while crisis stabilization beds are proposed to be co-located on the new campus, there is still need for a right-sized inpatient hospital. For all the reasons noted in this application, Timber Springs' net addition of 61 beds is that right-size alternative.

(b) Projects for which formal arrangements, together with triage criteria and mechanisms, are documented in the application with respect to all levels of cost alternative care provided by the applicant; and

(c) Documentation of triage criteria and mechanisms consistent with the level of care evaluation provided at ORS 743A.168(2).

Timber Springs will maintain standardized policies and procedures that ensure all patients are assessed using evidence-based triage criteria and level-of-care determinations consistent with state and regulatory requirements, including ORS 743A.168(2). Upon presentation for services, patients will undergo a comprehensive clinical assessment conducted by licensed behavioral health professionals utilizing established screening tools, risk-stratification protocols, and physician oversight when indicated. These processes guide placement into the least restrictive, most clinically appropriate level of care, including inpatient, partial hospitalization, intensive outpatient, or outpatient services. Formal mechanisms are in place for reassessment, escalation, and transfer when patient acuity changes, and all determinations are documented in the medical record to ensure continuity, quality, and compliance with Timber Springs standards and applicable Oregon regulations.

Further, with the addition of new inpatient beds, PeaceHealth's current continuum of behavioral health services will continue (except for the inpatient beds, IOP and PHP) to deliver a comprehensive continuum of care that ensures timely access, coordinated services, and a full spectrum of behavioral health interventions for individuals and families. The continuum is designed to provide rapid response, integrated treatment, and community-based alternatives that reduce avoidable hospital and crisis utilization. A graphic depicting the continuum is included as **Appendix 3**. A summary of the continuum is detailed below.

Connections Clinic – Rapid Access & Brief Intervention
As part of the Certified Community Behavioral Health Clinic (CCBHC) access model, PeaceHealth operates the Connections Clinic, which provides same-day and rapid-access behavioral health assessments, brief intervention services, therapy, and case management. This clinic serves as an essential front door to care, ensuring individuals can be quickly evaluated and connected to the appropriate level of services without delays or unnecessary use of emergency departments.

Mental Health Intensive Outpatient Program (IOP) & Partial Hospitalization Program (PHP)
PeaceHealth offers both IOP and PHP programs to support individuals requiring structured, intensive treatment as an alternative to inpatient care. These programs provide group therapy, individual therapy, psychiatric services, and skill-building interventions, allowing patients to stabilize in the community while maintaining daily functioning. These levels of care play a critical role in diverting patients from emergency or inpatient settings and promoting safe recovery in a least-restrictive environment. As noted above, these two Programs will be integrated into Timber Springs.

Transition Team – ED & BHU Follow-Up Support
To promote continuity of care and reduce readmissions, PeaceHealth's Transition Team supports individuals discharging from the ED or BHU. Services include socialization and community integration support, psychiatry, case management, group and individual therapy, peer support, and skill-building interventions. This team ensures that patients safely transition to community-based services and receive the support they need to remain stable.

UCare Clinic – Integrated Dual-Diagnosis Care
The UCare Clinic offers comprehensive dual-diagnosis services, including a substance use intensive outpatient program (IOP), individual therapy, addictionology, psychiatry, primary care, community health worker support, peer support, case management, and skill building. This multidisciplinary clinic is designed to address co-occurring mental health and substance use needs in a cohesive, integrated setting.

Young Adult Program – EASA First Episode & CHRp Services
PeaceHealth is the Lane County home for the Early Assessment and Support Alliance (EASA) program, providing both First Episode Psychosis and CHRp (Clinical High-Risk) services. This program includes psychiatry, individual and group therapy, case management, skill building, peer support, and vocational/educational counseling, ensuring early, specialized intervention for youth and young adults experiencing or at risk of psychosis.

Youth HUB Program
Our CCBHC model includes a comprehensive Youth HUB, which provides psychiatry, individual and group therapy, case management, skill building, peer support, and vocational/educational counseling. This multi-disciplinary team supports youth and families with flexible, developmentally responsive care.

Adult and Pediatric Outpatient Clinics
PeaceHealth also provides outpatient behavioral health services for all ages in both pediatric/family clinics and adult behavioral health clinics. These services include psychiatry and a wide range of individual and group therapy options.

Rural Access – Florence, Cottage Grove, and School District Partnerships
Lane County currently represents about two-thirds of the population of TSA 3, and the urban areas of Eugene and Springfield represent a significant percentage of that population. However, PeaceHealth acknowledges that there are rural areas in Lane County and striven to provide easier access to behavioral health services to them.

As an example of our efforts in rural areas, PeaceHealth places therapists onsite in Florence, Cottage Grove, and McKenzie School Districts. We also maintain agreements for therapist placement in Mapleton and Siuslaw School Districts, with active recruitment underway for those locations. These partnerships ensure behavioral health support is available closer to home for rural residents and students.

Telehealth Across All Programs
All programs across the continuum offer telehealth options, ensuring flexible access regardless of geography, mobility, or scheduling barriers.

Community Partnerships & Stabilization Center Development
PeaceHealth's continuum is strengthened through deep collaboration with Lane County Behavioral Health, crisis response partners, housing and social service agencies, schools, primary care providers, and our community partners throughout the continuum of care. PeaceHealth is also actively partnering in the development of the Lane County Stabilization Center, which will provide short-term crisis stabilization, assessment, and diversion from emergency departments and inpatient hospitalization.

PeaceHealth believes in the strength of working together. This is why community-based partnerships are crucial to addressing social drivers of health and improving care and regardless of where individuals are in their health journey. In service of the most vulnerable members of our communities, PeaceHealth has partnered with multiple organizations (reflected in Graphic 1 in the Introduction section) to support essential community services and promote a seamless continuum of care for all ages. This legacy will be continued post the opening of Timber Springs.

> ***(4) In evaluating the relationship of the proposed project to the existing health care system of the Health Service Area, the applicant shall address possible compromising of quality of care. The Oregon Health Authority shall consider the conformity to state safety and program standards of both the proposed project and existing providers, related health services now provided to the population of the Health Service Area; the impact of the project, once completed and operational, upon the financial ability of providers of related services to maintain present quality; and the feasibility that the proposed project will be sufficiently efficient to maintain quality standards at reasonable cost.***

Neither member of the LLC has any history suggesting that its quality of care is sub-par. Likewise, each member of the LLC is committed to partnering to maintain and enhance access, quality, and cost efficiency throughout the TSA.

In terms of financial ability, the pro formas included in this CN request, along with the letters of continued financial commitment that will be provided in the screening response, demonstrate that the funding will be available to continue high quality standards. The bed need methodology in **Appendix 2** also confirms the demand for the number of beds proposed.

Criteria for Approval of a New Psychiatric Hospital (OAR-333-615-0025)

A Certificate of Need for a psychiatric hospital may be granted if the Oregon Health Authority determines that an applicant has shown by a preponderance of the evidence that each of the below criteria are met:

(1) Within the proposal's Health Service Area, access to care is tailored to the specific demographical needs, including appropriate:

(a) Access to public transportation;

Eugene and Springfield are the population centers of TSA 3. Like many urban communities, they enjoy efficient, reliable public transportation, accessibility, and more availability of staff and other providers.

The proposed Timber Springs facility is located approximately six miles and ten minutes from the current UD BHU location. It is less than three-quarters of a mile from Sacred Heart Medical Center RiverBend, and adjacent to the new inpatient rehabilitation facility (IRF) currently under construction. The proximity of these facilities aids in the flow of patients, medical staff, facility personnel, supplies delivery, visitors, public transportation, and emergency vehicles. This ease of access, including ample parking, results in positive impacts for psychiatric patients, their families/visitors, and the staff.

The new location is easily reached via multiple transportation modes, making it accessible for patients, visitors, and staff with a wide range of mobility needs. The Lane Transit District directly serves the location via its EmX bus rapid transit line, which runs on RiverBend Drive and connects the campus area to major transfer hubs in Eugene and Springfield.

For individuals who cannot use fixed-route transit, LTD's RideSource ADA paratransit program offers door-to-door service, ensuring accessible transportation for people with disabilities. Together, these transit options provide reliable, equitable access for individuals without personal vehicles. Overall, the area benefits from strong transportation connectivity and infrastructure that prioritizes accessibility and ease of arrival for diverse patient populations.

Additionally, PeaceHealth has a longstanding history of arranging safe transportation for patients presenting to and admitting into the current UD BHU, including contracting with Secure Transport, and arranging for transportation for patients discharging from the unit via taxi, bus, or their support person to ensure safe transfer home or to their discharge placement. Timber Springs will continue this arrangement.

(b) Access for individuals with disabilities;

The current UD BHU presents physical infrastructure and accessibility limitations, including aging generators and HVAC systems and structural room configurations that can make safely accommodating patients with disabilities more challenging. The proposed Timber Springs facility will replace this dated infrastructure with a spacious, purpose-built, modern behavioral health facility designed to meet all ADA and applicable state accessibility requirements.

The new hospital will provide a mix of semi-private and private patient rooms, secure outdoor spaces, and therapeutic environments designed to safely accommodate adolescents and adults with co-occurring medical and psychiatric needs. The project materially improves accessibility, safety, and functional accommodation for individuals with disabilities across the TSA.

(c) Availability of adequate staffing;

PeaceHealth and Lifepoint acknowledge the statewide behavioral health workforce challenges outlined in the 2026 *State of Oregon Behavioral Health Talent Council Final Report* (the Report) and the *Oregon Behavioral Health Talent Assessment* (the Assessment) and have incorporated a comprehensive and sustainable staffing strategy consistent with these reports' findings into the project's design and planning.[19]

The Assessment, in which PeaceHealth leadership was an active participant, is a comprehensive report that addresses the state's critical shortage of behavioral health providers, particularly in rural and medically underserved areas. It identifies key barriers to care and outlines actionable strategies to strengthen and sustain the workforce. The Assessment is part of a broader effort outlined by the Governor's Behavioral Talent Council Report, providing a roadmap for action.

The Report outlines the scope and causes of Oregon's behavioral health workforce shortage and provides a coordinated strategy to stabilize and grow the system. It finds that Oregon faces significant shortages across nearly all behavioral health professions—particularly psychiatrists, licensed clinicians, and substance use disorder counselors—driven by limited training capacity, complex licensure processes, low reimbursement rates, burnout, and geographic maldistribution. Rural communities are disproportionately impacted by these shortages. The report recommends expanding education and supervision capacity, increasing loan repayment and tuition support, improving Medicaid reimbursement and wages, streamlining credentialing, strengthening rural recruitment, and building a more diverse and culturally responsive workforce to meet long-term demand.

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[19] Higher Education Coordinating Commission. (2025). *Oregon Behavioral Health Talent Assessment*. Oregon Higher Education Coordinating Commission. https://www.oregon.gov/workforceboard/data-and-reports/Documents/2025-Oregon-Behavioral-Health-Talent-Assessment-Report-final.pdf

The Report also specifically identifies Lane County as having notable behavioral health workforce shortages, with provider-to-population ratios well below recommended levels and more severe access gaps in its rural areas.

The Lane County Behavioral Health Workforce Planning Task Force, co-led by PeaceHealth and Lane County Health and Human Services, is actively building a comprehensive regional workforce pipeline. These efforts are supported by the Report and the Assessment. This initiative ensures long-term workforce availability across the behavioral health continuum.

Behavioral health workforce staffing shortages cut across TSA 3 as well. The federal Human Resources & Service Administration designates Health Professional Shortage Areas (HPSA) by geography, population, or facilities. In addition to the entirety of Lane County, Coos and Curry counties are also designated High Needs Geographic HPSAs. Across TSA 3, including Douglas County, eleven Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), or Indian Health Services Organization facility services areas are designated HPSAs.

Current inpatient psychiatric staff employed at PeaceHealth's existing 35-bed unit will be offered the opportunity to transfer to the new facility, ensuring continuity of trained and experienced clinical personnel and minimizing disruption to the regional behavioral health workforce. In addition, we believe that the promise of Timber Springs is also attractive to potential staff. The LLC's focus on clinical excellence and maximizing outcomes for each patient, soliciting stakeholder involvement at every level of the performance measurement process, and creating and supporting a culture that uses measured results to facilitate learning/continuous improvement, will help attract and retain qualified, exceptional staff.

The proposed hospital is located in Eugene–Springfield, the population and healthcare workforce center of TSA 3, where recruitment capacity and training infrastructure are strongest. PeaceHealth is one of the largest employers in the region, with an established talent acquisition infrastructure that hires more than 2,500 positions annually and maintains a dedicated recruitment team supporting clinical and behavioral health roles. For example, historic nursing turnover at Sacred Heart Medical Center remains below national averages, reflecting successful retention strategies and workforce stability.

PeaceHealth maintains formal partnerships with Lane Community College, Bushnell University, and other regional institutions that serve as primary pipelines for newly licensed nurses and allied health professionals. **Table 17** details these arrangements. Sacred Heart functions as the principal acute care clinical training site for these programs, and newly licensed nurses transition into practice through a structured 12-month Nurse Residency Program with demonstrated high retention rates. These existing workforce pipelines provide a stable and renewable source of qualified clinical staff.

Collectively, these partnerships supporting recruitment, retention, education, and regional planning efforts demonstrate, by a preponderance of the evidence, that there is a concerted effort to ensure adequate staffing to operate the proposed hospital safely and effectively upon opening and on a sustained basis thereafter.

Table 17: Workforce Development	
School	**State**
Oregon State University – Cascades	OR
Pacific Northwest Univ. of Health Sciences	OR
Western University – Oregon	OR
Bates Technical College	WA
Bushnell University	OR
California State University – Chico	CA
Emory University	Nationwide
Gurnick Academy of Medical Arts	CA
Idaho State University	ID
Institute of Technology	CA
Lane Community College	OR
Loma Linda University	CA
Ohlone College	CA
Pacific Lutheran University	WA
Pacific Northwest University of Health Sciences	WA
Pierce College	WA
Pima Medical Institute	Nationwide
San Diego State University	CA
San Jose State University	CA
Stanbridge University	CA
Tacoma Community College	WA
University of California, San Francisco	CA
University of Puget Sound	WA
University of Southern California	CA
University of St. Augustine for Health Sciences	CA
University of the Pacific	CA
University of Washington	WA
Western Governors University	Nationwide

In addition, the new Timber Springs hospital will participate in registered apprenticeship programs. These programs are recognized by the Department of Labor and have been developed to support advancing employees with education and mentorship in several occupations, including Cook/Culinary Aide; Rehabilitation RN Residency; Environmental Services Technician; and LPN/LVN.

(d) Accessibility to other care providers.

Timber Springs is intentionally proposed to be co-located with the Lane County Crisis Stabilization Center, creating an integrated Behavioral Health Campus designed to provide

immediate access to appropriate levels of care, 24/7. This public-private partnership strengthens system coordination and reduces fragmentation across crisis stabilization, inpatient psychiatric care, and step-down services.

The campus location near Sacred Heart Medical Center RiverBend ensures ready access to specialty physicians, diagnostic services, and medical consultation as, or if, needed. Discharge planning will coordinate with Lane County Behavioral Health, PeaceHealth outpatient services and community-based partners.

By integrating inpatient care with crisis services and established outpatient networks, the project enhances continuity of care and strengthens the overall behavioral health delivery system within TSA 3.

(2) The number of beds needed to provide an anticipated range of patient days in a given psychiatric hospital Health Service Area will not exceed 36 beds per 100,000 individuals in the Health Service Area.

At project completion, TSA 3 will be at 55% of the 36-bed ratio.

(3) Applicants must describe how the proposed project will improve access to care for all individuals in the Health Service Area, with particular attention to vulnerable populations, including those who are uninsured, underinsured, high-deductible plans, or enrolled in Medicaid.

Nearly half of all households in TSA 3 are experiencing financial hardship or living below the ALICE (Asset-Limited, Income-Constrained, Employed) threshold, limiting their ability to afford basic life essentials. Households below the ALICE threshold have income above the Federal Poverty Level (FPL), but not enough to afford basic expenses in the county where they live.[20] All four TSA 3 counties have higher rates of ALICE-constrained households than the state average:

- Oregon: 42%
- Lane County: 43%
- Curry County: 45%
- Coos County: 45%
- Douglas County: 49%

Affordable housing shortages further worsen economic strain, with high rental costs and limited housing options contributing to instability and, in some cases, homelessness.

Statistics show that these challenges disproportionately affect historically excluded communities, including Black, Indigenous, Latino, and other populations, highlighting persistent inequities. Residents frequently report that unmet basic needs interfere with their ability to maintain good health.

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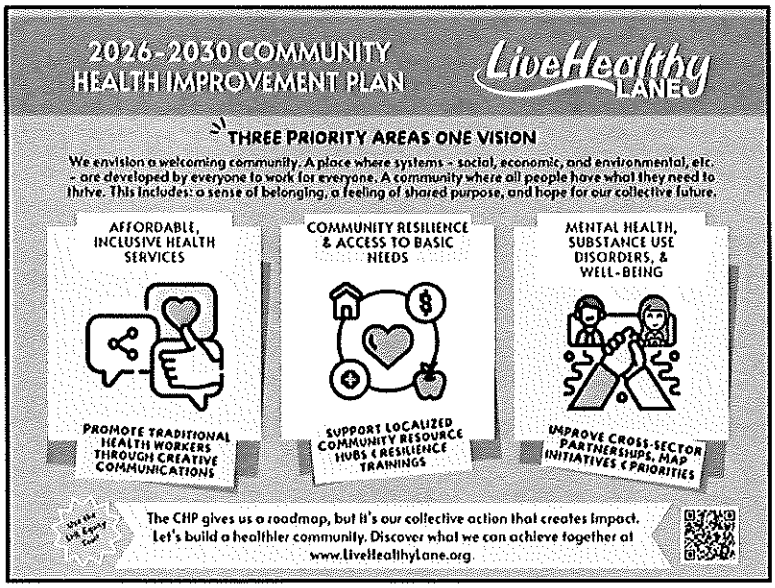
[20] United For ALICE, *Introducing ALICE: Oregon*, https://www.unitedforalice.org/introducing-ALICE/Oregon

As detailed in an earlier section of this Application, rates of homelessness and housing insecurity are particularly high in Lane County. According to the Journal of American Medicine (JAMA), a 2024 systemic review and meta-analysis found that about 67% of people experiencing homelessness have a current mental health disorder, and 77% have a lifetime prevalence of a mental health condition.[21] Data provided in earlier also demonstrate that these individuals have complex behavioral health needs and are more difficult to discharge.

Graphic 4



As an example, Live Healthy Lane, a community-based effort which includes membership from PeaceHealth, Lane County Community Advisory Council, Kaiser Permanente, Lane Community Health Council, Lane County Health & Human Services, Pacific Source Health Plans, and Trillium Community Health Plan, works to improve the health and well-being of those who live, learn, work, and play in Lane County. It recently released its 2026–2030 Community Health Improvement Plan, a roadmap for advancing health and well-being across the region, which identified behavioral health as a top community priority (see **Graphic 4**).

(3) All other criteria in OAR chapter 333, division 615 are met, including analyses of:
(a) Need;
(b) Quality;
(c) Cost; and
(d) Availability of Alternatives in the Health Service Area.

Other sections of the Application detail that each of these OAR chapter requirements are met.

[21] Barry R, Anderson J, Tran L, et al. Prevalence of Mental Health Disorders Among Individuals Experiencing Homelessness: A Systematic Review and Meta-Analysis. JAMA Psychiatry. 2024;81(7):691–699. doi:10.1001/jamapsychiatry.2024.0426

Quality (OAR 333-615-0050)

An application for a new psychiatric hospital shall include evidence showing:
(1) Triage criteria and mechanisms, including documentation that such criteria and mechanisms will be consistent with the level of placement criteria developed by the Office of Health Policy and insurers under ORS 743A.168 (2);

As they are today at the PeaceHealth inpatient unit, the Timber Springs' triage processes will be aligned with Oregon statutory requirements and national evidence-based guidelines. Triage criteria will follow OAR 333-615-0040, which requires documentation of triage mechanisms and their consistency with placement criteria established by the Office of Health Policy and insurers under ORS 743A.168. Further, and again as is currently done, there will be a 24/7 triage team (RN/LCSW) that adheres to CMS' psychiatric hospital Conditions of Participation (42 CFR 482.60-482.62), ensuring rapid admission decisions, clear documentation of medical necessity, and appropriate level-of-care placement consistent with national inpatient psychiatric standards. Finally, as is done today, admission and placement decisions will be guided by structured level-of-care assessment tools, including LOCUS (Level of Care Utilization System) and ASAM criteria for substance use disorders where applicable.

Structured violence risk assessment instruments consistent with industry best practice will be utilized to inform safety determinations. All assessments and placement decisions will be documented within the electronic health record through standardized workflows. In cases of level-of-care disagreement, a secondary clinical review process will be initiated to ensure appropriate placement and alignment with Oregon Health Authority placement standards and medical necessity criteria.

The new hospital will continue with comprehensive, evidence-based triage criteria and admission mechanisms to ensure all behavioral health patients are placed at the appropriate level of care in accordance with the OHA's placement criteria, payer requirements, and nationally recognized clinical standards.

Timber Springs will also adhere to clearly defined criteria consistent with American Psychiatric Association, Joint Commission standards, and insurer medical necessity. Triage will include intake coordination with emergency departments, community providers, and crisis response teams. Bed management protocols will be in place to ensure timely access to care, appropriate placement, and continuity across the behavioral health continuum.

All patient referrals will have a structured clinical screening by licensed clinicians (RN and LCSW) using validated tools consistent with APA guidelines for evidence-based psychological practice, including standardized suicide (C-SSRS), violence-risk, SUD, and Social Determinants of Health (SDOH) assessments, consistent with generally accepted standards of care defined in ORS 743A.168(1)(e) (evidence-based, recognized clinical practice guidelines).

Admission determination will be based on severity of risk, functional impairment, safety risk, and the need for 24-hour structured psychiatric care. The medical director will provide direct oversight of all admissions and triage criteria to ensure alignment with all standards and criteria. The medical director will also review admission patterns, denials, and level of care determinations on a monthly basis and provide clinical guidance to ensure appropriate utilization and patient safety. The medical director will maintain ultimate clinical authority over admission appropriateness, clinical decisions, and patient safety protocols.

Individualized treatment plans will include clearly defined functional benchmarks—such as improved activities of daily living, enhanced insight and judgment, and readiness for step-down to a less restrictive level of care—monitored through ongoing reassessment and documented outcome measures. Care planning will incorporate trauma-informed, culturally responsive practices consistent with Oregon's standards for patient-centered behavioral health services.

Timber Springs will admit individuals requiring acute psychiatric stabilization who meet medical necessity criteria for 24-hour structured psychiatric care within the hospital's licensed capabilities. The hospital will triage primary forensic patients requiring secure state hospital placement and individuals whose medical complexity meets the criteria for expedited admissions to the Oregon State Hospital. Clear transfer protocols and coordination agreements will ensure timely referral to appropriate higher-acuity medical or forensic settings when indicated.

Timber Springs will maintain fully integrated EHR and data management systems to support clinical care, regulatory compliance, quality management, and key performance indicators (KPI). Such KPIs will include, but are not limited to:

- Admission and referral response times
- ALOS
- Emergent medications
- Seclusion/Restraint utilization
- Patient safety events
- Patient satisfaction
- Staff responsiveness and engagement
- Readmission rates
- Discharge outcomes
- Workplace violence incidents

The hospital will maintain a clearly defined clinical quality governance structure. The medical director will serve as the clinical quality lead, with responsibility for oversight of performance metrics, patient safety indicators, and adherence to evidence-based standards of care. Quality data and performance trends will be reviewed monthly through the QAPI program and formally reported to the Governing Board on a quarterly basis. When established performance thresholds are not met, documented corrective action plans will be developed, implemented, and monitored to ensure timely performance improvement and regulatory compliance.

(2) A sufficient supply of qualified personnel, including clinical, administrative, operational, and technical staff, are available or can be timely recruited to ensure the hospital operates safely, efficiently, and in compliance with applicable standards.

Timber Springs will recruit and maintain a comprehensive complement of clinical, administrative, and support personnel needed to safely operate a 96-bed hospital. Staffing plans are based on national benchmarks and will always reflect the highest standard of care to mirror patient acuity and ensure meeting of regulatory requirements.

Staffing ratios will meet or exceed applicable regulatory and industry standards, and will be adjusted based on census and patient acuity. The hospital will maintain staff-to-patient ratios by shift to ensure safe clinical oversight as defined by Oregon Law, along with designated therapist coverage sufficient to support structured daily programming and individualized treatment planning. Psychiatry services will include daily rounding by a board-certified psychiatrist or psychiatric provider, with on-site or telepsychiatry coverage as appropriate, and 24/7 on-call availability to address emergent clinical needs. Clear response expectations will be established to ensure timely evaluation and intervention.

Please refer to the responses to the ***Criteria for Approval of a New Psychiatric Hospital (OAR-333-615-0025)*** for additional information.

(3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.

The current UD BHU is managed by Lifepoint and has been since 2024. It operates in full compliance with clinical standards of practice, and all applicable state and federal licensing, certification, and accreditation requirements.

Timber Springs will obtain and maintain all required OHA licensure prior to opening and will seek certification for participation in both Medicare and Medicaid programs, as well as accreditation from the Joint Commission.

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the Health Service Area's existing health care system.

While the PeaceHealth Behavioral Continuum is significant, Timber Springs is necessary and critical to close the gap regarding timely admission and access to the level of service needed. Its programming will include adolescent, adult, and geriatric acute inpatient psychiatric services, PHP, and IOP for both mental illness and SUD. It will enhance continuity by coordinating closely with other TSA 3 and regional hospitals, establishing referral pathways and partnering with external community mental health programs. Discharge planning begins at admission and includes documented communication with

receiving providers. It will also include a multi-disciplinary approach to each patient's community step-down resources. Discharge planning goals will include relapse prevention strategies, medication adherence planning, confirmed follow-up appointments, and identification of community supports to promote sustained improvement beyond hospitalization. It will also include confirmation of follow-up appointments prior to discharge (target within 7 days), and transmission of relevant clinical records to ensure continuity of care.

The proposed project directly responds to documented psychiatric bed shortages within the TSA. By increasing local acute psychiatric capacity, Timber Springs will reduce reliance on out-of-area placements, shorten emergency department wait times for psychiatric admissions, and improve timely access to appropriate levels of care within the community.

By increasing the psychiatric capacity within the TSA, the project reduces delayed care, and reliance on out-of-area psychiatric placements. As a result of the public-private partnership, Timber Springs will be located on the same campus as the crisis stabilization center, and the two will work closely to quickly and appropriately process those in need of admission.

(5) The ability to provide appropriate access to quality general and multispecialty medical inpatient care.

As noted earlier, PeaceHealth's current inpatient unit, with Lifepoint as manager, has maintained a full complement of board-certified physicians, APRNs, and special services capable of addressing complex medical and psychiatric needs. Timber Springs will implement clear medical screenings, consultations, and transfer processes to ensure patient safety and compliance with all Emergency Medical Treatment & Labor Act (EMTALA) and regulatory requirements. It will ensure that all patients have equitable access to medical evaluations prior to admission and continued medical oversight, if necessary.

Timber Springs will maintain formal transfer agreements with identified regional medical facilities, including PeaceHealth and other appropriate providers, to ensure timely access to higher levels of medical care when clinically indicated. Clear medical consultation response timelines will be established, including defined expectations for on-call physician availability and telemedicine consultation when appropriate. All transfers and medical screenings will be conducted in full compliance with EMTALA requirements to ensure patient safety and regulatory adherence.

(6) The applicant will accept and provide access to individuals enrolled in Medicaid, Medicare, or uninsured.

Timber Springs will ensure that all individuals, regardless of payer source, have access to equitable care.

Timber Springs will provide care without discrimination based on payer source, race, ethnicity, gender identity, sexual orientation, disability status, or other protected characteristics. Interpreter services and language access resources will be available to ensure meaningful communication for individuals with limited English proficiency or hearing impairment. The hospital is committed to delivering culturally responsive and equitable care, with staff training and policies designed to promote inclusion, respect, and improved health outcomes across diverse populations.

As stated elsewhere in the application, the current PeaceHealth admission and charity care policies and practices will be continued at Timber Springs.

(7) The applicant will facilitate coordination with alternatives and other appropriate community resources.

Timber Springs will continue all existing collaborative relationships and will put in place formalized coordination agreements with local hospitals, community mental health programs (CMHPs), primary care providers, substance use treatment providers, and social service agencies to ensure continuity across the behavioral health continuum.
Each patient will receive a comprehensive assessment upon admission, with treatment goals established within the first 24 hours and reviewed daily. Goals will address symptom stabilization, medication management, coping skills, safety planning, and readiness for lower levels of care. In the event an assessment reveals that a lower level of care is clinically appropriate, patients will be transitioned through structured warm handoffs to IOP, PHP, or community-based services, with confirmation of placement and documented follow-up.

The hospital will track step-down placement rates and post-discharge engagement as part of its quality improvement program to ensure coordination efforts are effective and measurable.

(8) The applicant has treatment goal-setting protocols that focus on achieving sustained improvements in patient health and functioning.

Upon admission, each patient will receive a comprehensive psychiatric, nursing, and biopsychosocial assessment. Individualized treatment goals will be established within 24 hours by the interdisciplinary treatment team and will be measurable, time-limited, and directly tied to documented medical necessity.
Goals will address symptom reduction, medication optimization, coping skill acquisition, safety stabilization, functional improvement, and readiness for transition to a lower level of care.

Treatment goals will be reviewed and updated daily by the interdisciplinary team and will incorporate objective symptom measures, when clinically appropriate, to assess progress. Timber Springs will provide active, recovery-oriented treatment focused on stabilization beyond minimal symptom control. Treatment goals will emphasize restoration of safety and community integration. The clinical model will focus on measurable improvement in

symptom stabilization and reduction of acute symptomatology, development of coping skills, and relapse prevention strategies. Additional focus will be placed on medication adherence, family engagement (where appropriate), and connections to community-based aftercare.

Treatment goals will also emphasize measurable symptom reduction, functional restoration, relapse prevention, and supportive discharge planning. This aligns with APA Practice Guidelines for psychiatric evaluation and treatment, which emphasize comprehensive assessment, individualized treatment modalities, and evidence-based psychotherapies (e.g., CBT, DBT, medication optimization). Treatment will be delivered by a multidisciplinary team including psychiatrists, APRNs, RNs, therapists, case managers, and peer support resources. The goal of Timber Springs is not only stabilization sufficient for discharge, but clinical improvement that supports sustained recovery.

CMS requirements in **42 CFR 482.61(a–c)** mandate detailed psychiatric evaluation, psychosocial assessment (including family systems), and individualized treatment planning—all of which support higher-level recovery goals beyond basic stabilization.

Additionally, Oregon's policy preference under **ORS 430.610(3)** stresses treatment that promotes community integration and minimizes disruption to patients' lives, further supporting the focus on functional improvement and continuity of care.

Timber Springs will operate within a trauma-informed and recovery-oriented framework consistent with Joint Commission behavioral health standards. The clinical model will emphasize patient safety, dignity, skill development, and collaborative treatment planning to promote sustained recovery and functional improvement beyond hospitalization.

(9) The applicant will maintain a readmission rate lower than or comparable to available regional or national benchmarks.

The hospital will implement a measurement-driven clinical model designed to reduce readmissions. Tracking and reporting of KPIs will include 30-day readmission rates, step-down continuity, and engagement in aftercare. Through the use of evidence-based treatment, interdisciplinary team planning, and structured discharge planning, we anticipate readmission performance that meets or exceeds national benchmarks.

To further reduce recidivism, Timber Springs will implement a standardized 72-hour post-discharge follow-up contact, consistent with Joint Commission continuity-of-care expectations. The Joint Commission's performance measure, ACHF-06: Post-Discharge Evaluation Within 72 Hours, supports early transition follow-up as a validated quality practice, permitting telephone or electronic contact and recognizing scheduled follow-up appointments or documented attempts as compliance. This early contact improves safety, reinforces discharge instructions, and helps prevent avoidable readmissions.

We will monitor 30-day all-cause readmission rates as a key quality indicator, with a target of the expected CMS benchmark of less than 10%, even while accepting and caring for highly complex and dual-diagnosis patients. Readmission performance will be reviewed monthly through the hospital's QAPI program and reported quarterly to the Governing Board. When readmission rates exceed established thresholds, structured root-cause analysis and corrective action plans will be implemented.

Timber Springs' recidivism reduction strategy aligns with national benchmarks and adheres to CMS' expectation for monitoring readmissions under the IPFQR program.

Tracking 30-day readmissions, aftercare engagement, and step-down coordination complies with Oregon's OAR 333-615-0040(2) requirement to maintain documented triage pathways and structured relationships with lower levels of care (IOP, PHP, CMHPs).

To support sustained outcomes, discharge planning will include confirmed follow-up appointments within seven days, medication reconciliation, and relapse prevention planning.

(1) The applicant will offer charity care, as defined in ORS 442.601(1), commensurate with other facilities with a comparable payor mix. Applicant must provide their policy for charity care and demonstrate compliance with federal and state law. The Oregon Health Authority may consider the applicant's history of offering charity care in evaluating these criteria.

Timber Springs will provide charity care using the current PeaceHealth policies and processes, which are fully consistent with federal and state law, including ORS 442.601(1).

The hospital will maintain a written charity care policy outlining eligibility standards, application procedures, and appeal processes, and will ensure that information regarding financial assistance is made readily available to patients and families.

Charity care will be offered to eligible patients based on the established financial need criteria in the policy, and in accordance with all applicable federal and state laws.

Charity care determinations and reporting will be documented and monitored through the hospital's compliance and financial oversight processes to ensure transparency, consistency, and alignment with community benefit expectations.

(11) The project's proposed services will be delivered safely and adequately, in compliance with all relevant federal and state laws, rules, and regulations. The evaluation of this criterion will consider whether the applicant has, in this state or elsewhere:

(a) Been criminally convicted related to operating a healthcare facility where the applicant held a direct or indirect ownership interest of five percent or more;

(b) History of the denial or revocation of a license to operate a healthcare facility where the applicant had a direct or indirect ownership interest of five percent or more;

© Had a license to practice a health profession revoked; or

(d) Been decertified as a provider in the Medicare or Medicaid program due to non-compliance with federal participation conditions where the applicant held a direct or indirect ownership interest of five percent or more.

No member of the LLC, nor any current clinical staff or employees, have any history related to the above.

Cost (OAR 333-615-0030)

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or feasible.

A determination that the proposed project will foster cost-efficient services without compromising quality is supported by the evidence presented throughout this application. Timber Springs represents the most cost-effective, right-sized, clinically appropriate, and operationally feasible solution to the significant unmet behavioral health need in TSA 3. Specifically, PeaceHealth individually, and the LLC collectively, evaluated all reasonable alternatives to new construction, including renovation or expansion of existing PeaceHealth facilities. As detailed earlier in this application, PeaceHealth explored expanding the current 35-bed UD BHU, but renovation was deemed unfeasible due to infrastructure limitations, cost, and the inability to safely construct while actively serving patients.

Similarly, expansion on the RiverBend campus was ruled out because it would require displacing existing services, entail significantly higher construction costs, and create prolonged operational disruption. Both Critical Access Hospitals in the TSA were also eliminated as options because CMS limits CAHs to ten psychiatric beds and operating multiple small units would be inefficient and costly due to duplication of spaces, staff, and equipment.

Given these constraints, no superior alternative to the demonstrated and documented need for more beds exists. In comparison, constructing a new hospital will deliver the required number of beds, modern therapeutic environment, and operational efficiencies at a lower cost.

(2) Construction costs, scope, and methods are consistent with current standards; and the project's impact aligns with ORS 442.310:
(a) Construction standards and energy efficiency

The project's construction budget, design approach, and energy-efficient systems are consistent with healthcare facility construction standards (e.g., Facilities Guidelines Institute, which publishes guidelines and standards covering space, risk, infection prevention, architecture, and building systems) and the State of Oregon and CMS regulations.

The building will also be guided by LEED (Leadership in Energy and Environmental Design) standards, providing a framework for healthy, efficient, and cost-saving sustainable buildings, focusing on energy savings, water efficiency, and improved health for occupants.

The proposed costs for this project are consistent with current market conditions in the Pacific Northwest, in the range of $800–$900+ per square foot.

The project includes appropriate contingencies to address any ongoing market volatility in labor and materials, and the building systems are selected using life-cycle cost analysis to ensure long-term operational efficiency.

(b) Consistency with ORS 442.310

ORS 442.310 emphasizes equitable access to quality care at a reasonable cost and discourages unnecessary duplication, inappropriate use of existing capacity, and reliance on emergency departments for behavioral healthcare. Timber Springs directly advances these goals.

The current TSA 3 delivery system regularly experiences high deflection rates, prolonged ED boarding, insufficient inpatient capacity, and unnecessary, stressful, and costly out-of-area travel. As noted earlier in the application, on an average day, the PeaceHealth Oregon System has more than ten patients in an ED awaiting a bed. Boarding means the patient is not being actively treated in an appropriate therapeutic environment for their psychiatric needs.

By reducing ED boarding, shortening the length of stay at referring hospitals, and providing right-sized inpatient capacity, the project lowers system-wide costs and improves access.

(3) The project incorporates improvements and innovations that foster cost-containment, quality assurance, and cost-effectiveness.

Timber Springs will include various structural and operational innovations that reduce long-term costs while improving quality patient care:

- Purpose-built design improves patient flow and minimizes safety-related room conversions that currently reduce capacity.
- Co-location with the Lane County Crisis Stabilization Center creates a fully integrated Behavioral Health Campus, reducing unnecessary ED utilization and enabling rapid triage and access to the appropriate level of care.
- Continuation of PeaceHealth's IOP and PHP programs provide step-down and diversion alternatives that reduce inpatient length of stay and prevent avoidable admissions.
- Modern infrastructure that replaces the current and aging UD BHU facility, which suffers from aging generators and HVAC systems and requires seismic upgrade requirements, all of which would require substantial capital investment without improving capacity.

Collectively, Timber Springs' innovations create a more efficient continuum of care and reduce the financial burden on hospitals, payers, and the public.

(4) Rates reflect low capital and operating costs and a justifiable rate of return.

The construction costs have already been value-based engineered to analyze material and functions to eliminate unnecessary expenses without compromising quality, performance, or patient or staff safety.

The financial pro formas demonstrate that this new hospital is feasible, cost-efficient, and appropriately priced.

Key factors supporting cost-efficient operating costs include:

- Lower operating costs compared to the current 35-bed PeaceHealth unit due to economies of scale and reduced hospital overhead.
- A lease-based financing structure that avoids long-term debt and keeps capital costs low.
- Conservative inflation assumptions (generally 2.5%) and realistic payer mix projections.
- A management fee and operating model consistent with industry norms.

The resulting rates are competitive, justified by the project's cost structure, and aligned with the goal of expanding access without imposing undue financial burden on patients or payers.

Economic Evaluation (OAR 333-580-0060)

(1) 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?

As will be demonstrated in the financing commitment letters that will be provided by the LLC members and the Developer in the screening response. Each LLC member is committed to, and financially capable of, undertaking the project individually (including initial capital costs and the start-up and ongoing operating costs). Collectively, as the pro formas included in **CN Form 5** demonstrate, Timber Springs produces a positive bottom line by Year 2 and is sustainable in its operations from that point forward.

(a) 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;

The hospital will be new; there is no historical period to present.

(b) 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.

The LLC members fully expect the project to meet the revenue and expense projections provided in this application. In the unlikely event of revenue shortfalls or increased operating expenses, both members have committed to providing additional funding.

(c) Applicants must discuss the results of ratio analysis required by Form CN-cd9 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;

(A) ***Applicants must describe their debt capability in terms of the required ratio analysis;***

(B) ***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;***

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

Per OAR 333-580-0100(4), financial performance will be evaluated by common healthcare industry ratios. The ratios are included in **Form 9**, and our responses are below. We do note that the requested ratios do not contemplate a structure such as that proposed in this application. Specifically, and as discussed below, the LLC structure, coupled with the lease-

based funding (versus debt service), impacts several of the ratios. The lease remains the preferred method of funding this project, as it does not burden Timber Springs nor either member with increased debt. That said, these ratios unequivocally demonstrate financial soundness, the creditability of the project's economic assumptions used, the overall effect on patient charges, and the efficiency of the larger healthcare delivery system.

Specific discussion regarding each ratio detailed in Table 1 of OAR 333-580-0100(4) is included below:

Ratio Category: Profitability

- **Operating Margin:**
  The operating margin is negative for the first year of operation but turns positive in Year 2.
- **Operating Ratio:**
  The ratio meets industry expectations for Years 2–5, including rent.
- **Deductibles Ratio:**
  The deductible ratio is 48%, or the estimated contractual allowance. This amount was based upon experience in other markets.
- **Bottom Line Ratio:**
  This ratio is the same as the operating margin ratio, so it follows the same pattern.
- **Return on Assets A:**
  This ratio measures net operating income to total assets, and, while negative in Year 1, is positive beginning in Year 2. It continues to improve annually thereafter.
- **Return on Assets B:**
  This ratio measures net income to total assets. It turns positive in Year 1 and stays positive thereafter.
- **Return on Equity A:**
  This ratio measures net operating income as a percentage of the funds balance. It is positive beginning in Year 2.
- **Return on Equity B:**
  This ratio is the same as Return on Equity A, as net income and net operating income are the same.

Ratio Category: Debt

- **Equity Financing – A and B:**
  These ratios are the same, as they show the portion of long-term debt and total debt to the funds balance. This ratio is positive for the 5-year projection period and is 73–90% in Years 4 and 5.
- **Debt Service as a Percentage of Gross Patient Revenue:**
  This ratio is low due to the structure of the transaction. It is 2% in Year 2, and increases to 5% by Year 4.
- **Cash Flow to Total Debt:**
  The ratio is negative during Year 1 but turns positive in Year 2 when the facility becomes profitable from operations.

- **Total Debt to Total Assets:**
  The ratio is increasing to 19% by Year 5 because the joint venture is paying off increasing amounts of a working capital line of credit through the end of Year 5. We expect this line of credit to be fully paid off by the end of Year 5, at which point this ratio would fall to 0% in Year 6 and beyond.
- **Peak Debt Service Coverage by Historical Net Revenue:**
  This is negative in Year 1 but positive in Years 2–5 as the facility pays down the debt from the Year 1 loss.
- **Debt Service Safety Margin:**
  This ratio turns positive in Year 2 and increases from 1.0% in Year 2 to 2.4% in Year 3.
- **Debt to Plant:**
  This ratio remains at zero throughout the forecast period because there is no long-term debt.

Ratio Category: Liquidity

- **Current Ratio:**
  This ratio measures current assets as a percentage of current liabilities. The ratio is positive in Year 1 and improves each year thereafter.
- **Days Revenue in Accounts Receivable:**
  Days in AR for psychiatric hospitals typically range between 30–75 days. Estimated days in AR will be within this range beginning in Year 2.
- **Average Payment Period:**
  The average payment period is better than industry guidelines for the entire forecast period.
- **Days Cash on Hand:**
  Days cash on hand is assumed to be about 93 days once the facility reaches 80% occupancy.
- **Quick Ratio:**
  This ratio measures about the same metrics as the current ratio and is strong.

Other Ratios:

- **Adjusted Patient Days and Adjusted Admissions:**
  This ratio is not applicable, as Timber Springs tracks outpatient volume based on visits. Based on Lifepoint's experience, Year 1 outpatient visits are 3,233 and ramp up to 9,433 by Year 3.

(d) Board-Designated Assets:

There are no board-designated assets. Board-designated assets are typically assets without donor restrictions that are set aside by a long-standing board for future projects. These assets are generally subject to self-imposed limits by the action of the governing board. Board-designated net assets may be earmarked for future programs, investments, contingencies, purchase or construction of fixed assets, or other uses.

(e) ***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;***

This project proposes a lease. The LLC members have the funding in place.

(f) Money Market conditions must be discussed in terms of their impact on project funding, including interim interest.

(A) 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.

(B) 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.

(C) The financing term selected must be supported with evidence showing the benefits of its selection;

This project is being funded through member contributions and the lease; this method preserves cash for the LLC members. There is no long-term debt associated with this project. There is a short-term line of credit that results in the small amount of interest included in the income statement.

There is no debt assumed for this project.

(g) 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;

The LLC members generally, and Lifepoint specifically, have considerable experience and expertise in developing projects of this type, and they have high confidence in the project meeting its projections. Further, the ADC of the current PeaceHealth 35-bed UD BHU, along the quantification of new volume and the high interest expressed by other hospitals to refer patients to the new hospital, lends further confidence to the estimates of patient days.

A key component of the planning is developing detailed capital, revenue, and expense models that consider local conditions. PeaceHealth has operated in the service area for decades, and Lifepoint has managed the UD BHU for more than one year. As such, this actual experience was used to project utilization, patient mix, length of stay, etc.

(h) 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:

(A) 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;

(B) Projected deductions from revenues should be explained and justified;

(C) 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;

(D) Projected gross revenue must reflect:

(i) Patient day increases/decreases;

(ii) Outpatient activity increase/decrease;

(iii) All debt service coverage requirements; and

(iv) Other significant impacts the proposal will make on revenue projections.

The financial models assumed a 2.5% annual inflation rate for gross revenue per discharge, and 2.5% generally for other operating expenses. The underlying assumptions included in **Table 18** below provide the requested detail.

Table 18: Revenue and Expense Assumptions	
Budget Line Item	**Assumption**
REVENUE	
Inpatient Revenue (Gross)	Based on PeaceHealth's Average Gross Revenue PPD for FY 2025, escalated to Year 1 of the project. Average gross revenue is $2,496 in Year 1; $2,614 in Year 2; and then increases 2.5% each year thereafter. Year 1 includes a 45-day period waiting for the billing number.
DEDUCTIONS	
Contractual Adjustments	Based on PeaceHealth's UD BHU average contractual adjustments for FY 2025 to determine net revenue. This is 37.9% in Year 1 and 38.8% in Years 2–5. Year 1 payer mix is slightly different due to the waiting period for the billing number.
Free Care/Charity Care	Based on PeaceHealth's UD BHU historical rate of providing charity care on the unit during the period of FY 2025 (2.0% of gross inpatient revenue).
Other Deductions (Doubtful Accounts)	Based on Lifepoint's experience and projected at 1.9% of total gross revenue.

OTHER OPERATING REVENUE	
Other Operating Revenue	Not expecting any significant other operating revenue.
EXPENSES	
Salaries, Wages, and Benefits	Nursing and Tech salaries based on average hourly wages for these positions on the existing PeaceHealth UD BHU, escalated to Year 1 of the joint venture. Increases in Years 2–5 include patient days increases (Years 2 and 3), as well as a 2.5% annual escalator (Years 2–5). Benefits are 30% of salaries and wages (excluding contract staff). Contract staff costs are assumed to be $40/PPD.
Outside Services and Professional Fees	Includes medical direction, legal fees, audit and accounting fees, and landscaping. Based on Lifepoint's experience.
Supplies	Includes pharmaceuticals ($25/PPD), medical supplies ($4.0/PPD), non-medical supplies ($9.0/PPD), and dietary supplies ($15.5/PPD). Includes annual escalator of 2.5%.
Purchased Services	Includes radiology, lab, procedural services, EKG, after-hours pharmacy, laundry and linen, employee health, and security. Assumed to be $11.5/PPD in Year 1; escalated annually by 2.5% each year thereafter.
Insurance	Includes malpractice and liability insurance. Based on Lifepoint's experience.
Facility Lease Rent	Facility rent based on projected cost, 8.5% cap rate, 2.5% annual escalator.
Land Lease Rent	Land rent based on fair market value of land, a 6.0% cap rate and 2.0% annual escalator.
Taxes, Except Insurance	Includes property taxes, provider taxes, and sales taxes.
Depreciation and Amortization	Depreciation of equipment based on a 7-year life span.
Interest	The joint venture expects to utilize a line of credit in Years 1 and 2, estimated at $9.3M, to fund start-up losses. This line of credit will be paid off in full by the end of Year 5. Interest associated with the projected use of a working capital line of credit is assumed to be 7.5%.
Management Fee	5% of net revenue that the joint venture pays to the manager.
Other Operating Expenses	Includes EMR, continuing education, recruiting, repairs and maintenance, patient transport, collection agency, printing, bank fees, miscellaneous service charges, utilities, and other minor miscellaneous expenses.

Source: Applicant

2. ***Criterion: Will the impact of the proposal on the cost of health care be acceptable?***
   - ***(a) The applicant must discuss the impact of the proposal on overall patient charges at the institution and on charges for services affected by the project.***
     - ***(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;***
     - ***(B) When a health service is affected by the proposal, an applicant must demonstrate what impact the proposal will have on related patient charges and operating expenses. Expenses and patient charges for individual health services will be compared to historical and forecasted rates of increase for the facility as a whole.***
   - ***(b) The applicant must discuss both the propose or actual charges for the prosed service sand the profitability of the proposed service, compared to other similar services in the state (if any);***
   - ***(c) The applicant must discuss the projected expenses for the proposed service, and demonstrate the reasonableness of these expense forecasts.***

The impact of the proposed project on the cost of healthcare is both acceptable and beneficial.

As discussed earlier in this application, the projected operating expenses for Timber Springs are expected to be lower on a per-patient basis than those associated with the current 35-bed UD BHU, excluding depreciation. This improvement reflects the operational efficiencies associated with a purpose-built facility and a larger program size. With 96 beds, Timber Springs will benefit from economies of scale in staffing, clinical operations, and support services, allowing fixed overhead costs to be distributed across a larger patient base. As a result, projected gross revenues and expenses per inpatient day and per adjusted patient day are expected to remain consistent with, or lower than, those of the existing program.

The proposed hospital will not result in disproportionate increases in patient charges. Charges for services provided at Timber Springs are expected to be consistent with prevailing rates for inpatient psychiatric services in Oregon and will follow the same general rate structure used for similar behavioral health services in the state. As with the existing PeaceHealth UD BHU, the proposed facility will serve patients covered by a mix of payers, including commercial insurance, Medicare, Medicaid managed care organizations, and patients eligible for charity care. Charges and operating expenses associated with the proposed services are projected to increase in line with historical and forecast trends for the facility as a whole.

Importantly, the addition of new inpatient psychiatric capacity will also reduce system-wide costs associated with prolonged emergency department boarding. As discussed in the **Need** section of this application, patients experiencing behavioral health crises are frequently held in hospital emergency departments for extended periods—usually longer than 24 hours while awaiting placement in an appropriate inpatient psychiatric facility. These extended stays increase overall healthcare costs and reduce the availability of

emergency department resources for other patients. By expanding access to dedicated inpatient psychiatric beds, Timber Springs will facilitate earlier admission for patients requiring inpatient care, reduce emergency department boarding times, and improve care coordination across the regional healthcare system.

Finally, the projected expenses for the proposed service are reasonable and reflect the operational characteristics of modern inpatient psychiatric facilities. Expense forecasts were developed using Lifepoint Health's experience operating similar behavioral health hospitals nationwide, and reflect standard staffing models, supply costs, and facility operating expenses typical for inpatient psychiatric programs. These projections are consistent with the expected costs associated with delivering safe, high-quality inpatient behavioral healthcare.

(d) If the proposed service is currently not being provided in the area, the applicant should identify potential travel cost savings by:

(A) Establishing what the existing travel costs are to patients;

(B) Establishing what the travel costs will be to patients after implementation of the proposal; and

(C) Showing what the difference is between the figures in paragraphs (A) and (B) of this subjection.

The proposed facility is located approximately six miles and ten minutes from the current 35-bed UD BHU. The issue is not travel; the issue is a shortage of beds and no current capacity for adolescents. There will be no real change in travel costs for patients, but the new location will have increased access and better parking. It is also on a regular bus line.

(e) ***The applicant must discuss the architectural costs of the proposal by:***

(A) An applicant must demonstrate that the existing structure will last long enough to derive full benefits from any new construction or remodeling;

(B) 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).

The proposed costs for this project are consistent with current market conditions in the Pacific Northwest. Excluding contingency and escalation, the total cost of construction is estimated to be approximately $53 million, or measured differently, in the range of $800–$900 per square foot. This cost is in line with trends reported by the Dodge Report and reports published by nationally recognized General Contractors (GCs) and Construction Managers. When further adjusted for Oregon, it can be confirmed that that the cost reflects current market conditions.

The cost of construction everywhere has escalated significantly in the last several years, leading to unprecedented cost increases for material and labor. In an effort to bridge this potential gap, the LLC is carrying a contingency to account for potential future risk of

further cost increases. Given the expected schedule, we believe that the proposed contingency of $7.1 million is appropriate, based on our knowledge today. We further understand that increases above the CN-approved amount must be shared with the CN Program.

The systems and spaces designed for Timber Springs are intended to serve the proposed use for many years to come. Life-cycle costs are used to determine the best value, and systems are being proposed to provide for better-than-average long-term operating costs to allow for the most sustainable operations possible within a reasonable budget.

Availability of Resources and Alternative Uses of Those Resources (OAR 333-580-0050)

Applicants must provide a narrative discussion of each of the following:

(1) Criterion:

Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?

(a) The applicant must demonstrate that the best price for the proposal has been sought and selected;

The LLC members jointly conducted a comprehensive review of alternatives and cost structures to ensure that the final Timber Springs proposal represented the most cost-efficient and clinically appropriate solution. Through iterative feasibility analyses, multiple delivery models and construction methods were reviewed—including expansion at existing campuses, renovation of the current UD BHU facility, co-location within RiverBend, and construction of an entirely new facility.

Each option was evaluated against measurable criteria: capital cost, constructability, patient safety, schedule efficiency, clinical quality, and long-term operational sustainability. New greenfield construction was selected because it was the only option that balanced immediate need, scalability, and cost containment. The design-build development model being utilized reflects best value procurement practices, incorporating competitive bidding and value engineering to ensure the best price is achieved for the proposed scope.

The selected developer, PMB, was chosen for its demonstrated track record of efficient healthcare project delivery nationwide and, specifically, with Lifepoint projects of comparable size and scale. PeaceHealth and Lifepoint leveraged national pricing benchmarks, healthcare cost indices, and regional construction data (Dodge Research Reports, 2024–2025) to confirm that the project's anticipated range per square foot aligns with, or is under, current market averages for behavioral health hospitals in the Pacific Northwest. This thorough vetting was undertaken to ensure the best value and cost efficiency for this project without compromising on quality or clinical functionality.

(b) The applicant must demonstrate that the proposed solutions to identified needs represent the best solution from among reasonable alternatives.

PeaceHealth has continuously operated behavioral health services in Eugene since 1969, with increasing demand far exceeding available capacity, despite modernization and service and program expansion efforts. When evaluating how best to address persistent behavioral health shortages in the region, several alternatives were reviewed:

(1) Renovation/Expansion of the Current UD BHU Site
Renovation was evaluated in 2022–2023, and determined to be cost-prohibitive given significant infrastructure deficiencies, seismic upgrade requirements, aging HVAC and generator systems, and the inability to safely construct while patients remained onsite. Further expansion would not have achieved the desired bed capacity or modern design and safety standards required.

(2) Expansion at Sacred Heart Medical Center RiverBend
RiverBend's physical plant and clinical footprint are heavily utilized for tertiary and critical services. Adding behavioral health beds would displace existing programs and significantly disrupt local acute-care operations. In addition, renovation within a functioning hospital during active patient care is slower and more expensive than new construction, yielding higher cost-per-bed than the standalone Timber Springs project.

(3) Distributed Expansion at Critical Access Hospitals (CAHs)
Both PeaceHealth CAHs in TSA 3 are limited by CMS regulations to ten psychiatric beds. Operating multiple small units was determined to be clinically inefficient and fiscally unsustainable due to duplicated staffing and regulatory and equipment requirements.

After detailed assessment, new construction of a freestanding psychiatric hospital emerged as the only model that met both clinical need and fiscal efficiency. It allows creation of modern therapeutic environments, including trauma-informed design features while leveraging economies of scale that lower cost-per-bed and enhance staff efficiency. Through shared infrastructure with the co-located Lane County Behavioral Health Crisis Stabilization Center, Timber Springs maximizes cost avoidance by sharing certain campus support services.

Finally, the greenfield model offers the advantage of speed to market—permitting the facility to open by 2029, in alignment with Oregon Health Authority's identified 2029 target for addressing the 66-bed shortfall in TSA 3. It is, therefore, both the most cost-effective and timely solution for meeting regional needs.

(A) Internal Alternatives

(i) The applicant must list the major internal operational adjustments considered which could lower the cost and improve the efficiencies of offering the beds, equipment, or service.

PeaceHealth (the owner) and Lifepoint (as manager) at the current 35-bed UD BHU, evaluated optimizing existing inpatient psychiatric operations through workflow redesign, increased telepsychiatry, and reduction of beds to assure safety. However, these operational adjustments could not offset the underlying physical constraints and bed scarcity inherent in current facilities.

(ii) The applicant must demonstrate that the alternative considered represents the best solution for the patients, and discuss why other alternatives were rejected.

Each alternative—renovations, partial expansions, and distributed beds across multiple hospitals—was assessed but ultimately rejected due to clinical inefficiency, excessive cost, and prolonged implementation timelines. Timber Springs' purpose-built environment represents the only solution that adequately supports patient safety, privacy, and the therapeutic milieu while expanding access within a sustainable cost framework, and is less costly than the current 35-bed UD BHU due to economies of scale and efficiencies in operation resulting from the design and number of beds.

(iii) If the proposal is for an inpatient service, whether new or expanded, applicant must demonstrate this method of delivery is less costly than if done on an outpatient basis.

The proposed Timber Springs hospital directly addresses the need for acute inpatient psychiatric beds, as evidenced by both internal data on boarding and deflections and OHA's *2024 Behavioral Health Residential + Report*. The population requiring 24-hour supervision, intensive stabilization, and safety monitoring of complex care patients cannot be appropriately or safely treated in outpatient settings. The existence of IOP and PHP services as part of the continuum will, however, reduce unnecessary inpatient utilization, improving overall cost efficiency in the TSA.

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

The architectural design integrates energy-efficient systems and modular space planning to support future adaptation without major cost escalation. Compared to upgrading a 1950s-era facility, the new construction eliminates redundant operational expenses, reduces deferred maintenance liabilities, and optimizes staff flow, producing long-term cost avoidance over renovation scenarios. There are also significant savings associated with the co-location with the Crisis Stabilization center around parking, maintenance, etc.

(B) External Alternatives

(i) If the proposed beds, equipment or services are currently being offered in the service area, applicant must demonstrate:

(I) Why approval of the application will not constitute unnecessary duplication of services.

Based on the 2024 OHA Behavioral Health Facility Study, but more importantly, the data included in this application, this project is not duplication. In summary, TSA 3 currently has 60 inpatient psychiatric beds—all adult—across three hospitals, and high rates of diversion and ED Boarding among other factors. Timber Springs fills this gap while adding the only dedicated adolescent unit outside the Portland metro area, preventing duplication and directly targeting unmet need.

(II) Why the proposal is an efficient solution to identified needs.

Co-location with the Lane County Behavioral Health Crisis Stabilization Center creates operational efficiencies through resource sharing and coordinated patient flow, allowing faster triage and cost containment across the behavioral health continuum.

(III) Why the proposal represents the most effective method of providing the proposal.

Timber Springs consolidates inpatient, crisis stabilization, and step-down programs within one regional campus—aligning with OHA's strategic objective of integrated, community-based behavioral health services.

(IV) That the applicant can provide this proposal at the same or lower cost to the patient than is currently available

The LLC expects that Timber Springs' negotiated payer contracts will mirror PeaceHealth's, ensuring that patient costs remain consistent or lower than current inpatient behavioral health charges in the TSA based on economies of scale and the efficiency of the new design.

(ii) If paragraphs (A)(i) to (A)(iv) of this subsection cannot be demonstrated, the applicant must show that without the proposal, the health of the service area population will be seriously compromised.

Failure to approve this project would leave TSA 3 with only 10.7 beds per 100,000 residents— about 170% below the current national average of 28.5 beds per 100,000, and well below the OAR maximum of 36 beds per 100,000, resulting in continued emergency

department boarding, delayed access to care, and unnecessary and costly out-migration.

(C) Less Costly Alternatives of Adequate Quality

While the increase in alternatives has been beneficial, there are no adequately effective, lower-cost alternatives available in the TSA capable of meeting the inpatient psychiatric need identified in this application. Operating multiple small (10-bed) programs would result in cost duplication and inefficiency and would not address the totality of unmet need. It would also not allow for a dedicated adolescent program.

The proposed hospital is a more efficient, consolidated solution, providing both adult and adolescent capacity under one roof, thereby expanding access while leveraging shared administrative and clinical resources.

(D) Competing Applications

To the LLC's knowledge, no competing Letters of Intent nor Certificate of Need applications have been submitted for comparable psychiatric hospital capacity in TSA 3.

(2) Criterion: Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project?

The proposed Timber Springs Behavioral Health Hospital is backed by substantial capital, site readiness, and robust workforce planning.

- **Qualified Personnel:** PeaceHealth's existing inpatient psychiatric staff will ideally transition to the new hospital, ensuring continuity and experience. Lifepoint's specialized behavioral health recruitment models related to psychiatrists, psychiatric nurses, therapists, and support staff, and PeaceHealth's efforts related to workforce planning, described below, combine to help support adequate supply of staff.

  The Lane County Behavioral Health Workforce Planning Task Force, co-led by PeaceHealth and Lane County Health and Human Services, is actively building a comprehensive regional workforce pipeline. Supported by the Governor's Behavioral Health Talent Council and the 2025 Oregon Behavioral Health Talent Assessment, this initiative ensures long-term workforce availability across the behavioral health continuum.

  Ongoing partnerships with Lane Community College, Bushnell University, and Pacific University, among others, provide a stable and renewable talent pipeline.

  Metrics confirm sustainable workforce development: there is a 98.5% retention rate among new nurse residents, 8.9% total nursing turnover (vs. 12.6% nationally), and

more than 200 planned new nurse hires in FY 2026 through residency and apprenticeship programs.

The new hospital 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 4) a fine-tuned onboarding process that improves employee retention. To enhance retention, Timber Springs will offer comprehensive benefits and flexible hours and scheduling.

- **Land and Site:** The selected site—adjacent to Sacred Heart RiverBend and co-located in a private-public partnership with the future Lane County Crisis Stabilization Center—has been secured and fully assessed for adequacy, accessibility, and regulatory compliance. Both the zoning and infrastructure capacity support future expansion, if needed.

- **Financing:** Financing for the project has been committed by both LLC members. No long-term debt will be incurred; the project is structured as a lease-based equity partnership, minimizing financial risk. Financial pro formas show a positive operating margin by Year 2 and sustainable profitability thereafter.

Collectively, these measures demonstrate the applicant's readiness to staff, finance, and operate Timber Springs safely and effectively while achieving the most cost-efficient, clinically appropriate, and sustainable behavioral health solution for TSA 3.

(3) Criterion: Will the proposed project have an appropriate relationship to its service area, including limiting unnecessary duplication of services and any negative financial impact on other providers?

(a) The applicant must identify the extent to which the proposal and its alternatives are currently being offered to the identified service area population, or, in the case of acute inpatient beds, could be offered on the basis of an analysis under division 590 of this chapter.

(b) The applicant will discuss to the best of his or her knowledge, any negative impact the proposal will have on those presently offering or reimbursing for similar or alternative services. Areas to be discussed are utilization, quality of care, and cost of care.

(c) The applicant must demonstrate that jointly operated or shared services between the applicant and other providers have been considered and the extent to which they are feasible or not.

(d) The applicant must demonstrate that all necessary support services and ancillary services for the proposal are available at acceptable levels to insure that patients will have the necessary continuity in their health care.

OHA's June 2024 report demonstrates the need for the proposed beds, as do all the other data and statistics reported in the **Need** section. As noted earlier, the current 35-bed UD BHU will close upon the opening of the new hospital.

(4) Criterion: Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standards, 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.

The new Timber Springs hospital will conform to all relevant state construction standards and provides a superior environment over the current 35-bed program at PeaceHealth UD, which will close at the time of opening of the new psychiatric hospital.

Lifepoint has prior experience with the proposed developer. In selecting a final developer, best value for the proposal will be assured through a rigorous evaluation process that includes a review of capabilities, experience, and success with all aspects of development, including assembling the design and construction team, managing the construction, supplying the equity capital, arranging debt financing, and applying a collaborative development experience to meet the project's specific needs. Furthermore, the LLC and the selected developer will qualify every contractor, review individual bids, and help negotiate the best pricing to keep our project on budget and on time.

Section C and D: Forms and Appendices

Form 2: Architectural Section

ARCHITECTURAL SECTION

PROJECT SUMMARY

(1.) PROJECT DESCRIPTION

(a) Project Type(s): New Structure: ☒ Addition: ☐ Remodel: ☐

(b) Number of Floors: Basement: N/A No. of floors above grade: 1

(c) Shelled-in areas (identify location of any unfinished spaces with description of future intended use):
N/A

(d) Renovation Considerations (for projects involving remodel): N/A

Will the renovations involved be done to conform to the new construction/major alteration standards of the Senior and Disables Services or Health Division (as applicable) and NFPA 101 codes?
YES ☐ NO ☐

If no, explain in detail which of these standards will not be complied with and explain why:

(e) Building Structural System (in accord with Uniform Building Code):

☒ Type I - Noncombustible ☐ Type II - Noncombustible

☐ Type III - HR or N ☐ Type IV - 1 hr. ☐ Type V - 1 hr.

(2.) MAJOR DIAGNOSTIC AND TREATMENT EQUIPMENT N/A

(List all diagnostic and treatment equipment items in excess of $1,000,000 purchase cost.)

Identify Item	Department	Cost of Each Item	Number of Purchased Items

(3.) PROJECT DEPARTMENT BREAKDOWN

(Complete department breakdown required for hospital applications only; nursing home applications require completion of totals column only)

DEPARTMENT AREA SCHEDULE					DEPARTMENT COST SCHEDULE			
Ancillary Dept. or Patient Care Unit	Departmental Areas in Gross Square Feet[1]				Departmental Remodel Cost	Departmental New Constr. Cost	Remodel Cost Per Sq. Ft.	New Constr. Cost Per Sq. Ft.
	Existing	Remodel Area	New	Total at Completion				
Inpatient Units	0	0	37,905	37,905	N/A		N/A	$940.00/SF
Activity Therapy	0	0	795	795				
Administration	0	0	4,470	4,470				
Assessment	0	0	2,465	2,465				
General Support	0	0	2,310	2,310				
Patient Support	0	0	3,925	3,925				
Outpatient PHP/IOP	0	0	5,475	5,475				
Remaining unassignable spaces: (Shared Corridors)	0	0	4,245	4,245	N/A		N/A	$940.00/SF
TOTALS	**0**	**0**	**61,590**	**61,590**	**N/A**		**N/A**	**$940.00/SF**

REMARKS:

→ General Support spaces include Mechanical/Electrical, Maintenance, and General Stores Areas.

→ Patient Support spaces include Dining/Kitchen, Lab, and Pharmacy Areas.

[1] Gross square feet is calculated including interior partitions and related outside walls. Do not include stairwells, corridors or mechanical areas serving more than a single department.

Form 3: Capital Expenditure Estimate with Attachments

CAPITAL EXPENDITURE ESTIMATE

a. Planning:				
(A)	Consultant Fees	$ 150,000		
(B)	Surveys and Studies ...	$ 0		
(C)	Other	$ 0		
(D)	TOTAL PLANNING		**$**	**150,000**
b. Administrative:				
(A)	Legal.....	$ 125,000		
(B)	Other.....	$ 5,682,061		
(C)	TOTAL ADMINISTRATIVE.....		**$**	**5,807,061**
c. Site:				
(A)	Purchase Price of Property (if within previous year or yet to be purchased)	NA		
(B)	Appraisals.....	$ 15,000		
(C)	Site Surveys.....	$ 30,000		
(D)	Soil Investigations.....	$ 7,500		
(E)	Site Preparation (not paid for under construction contract).....	$ 1,989,643		
(F)	Other.....	$ 0		
(G)	TOTAL SITE.....		**$**	**2,042,143**
d. Equipment:				
(A)	Diagnostic or Therapeutic Purchase.....	$ 0		
(B)	Diagnostic or Therapeutic Equipment Lease Value[1].....	$ 0		
(C)	Other Equipment Purchase.....	$ 4,000,000		
(D)	Other Equipment Value or Lease[1].....	$ 0		
(E)	Contingency Fund for Equipment.....	$ 200,000		
(F)	TOTAL EQUIPMENT.....		**$**	**4,200,000**
e. Architectural/Engineering Services and Related Costs:				
(A)	Architectural Master Planning Prior to Project.....	$ 85,000		
(B)	Project Architectural/Engineering Fees	$ 3,236,822		
(C)	Plan Check Fees (not paid for under construction).....	$ 200,000		
(D)	Project Inspection Fees (owner's Clerk of the Works and inspections not included in (B)).....	$ 1,500,000		
(E)	Other Costs.....	$ 337,126		
(F)	TOTAL ARCHITECTURAL/ENGINEERING SERVICES.....		**$**	**5,358,948**

[1] Use this space to describe the basis for estimate of value of leased equipment and space. Explain other items as may be necessary. Use additional sheets if more space is needed.

f. Construction:

(A)	General Construction - New.....	$ 57,947,328	
(B)	General Construction - Remodel	$ 0	
(C)	Demolition (not included under f(A) and f(B) or c(E).....	$ 0	
(D)	Contingency (5%)	$ 2,523,213	
(E)	TOTAL CONSTRUCTION.....		**$ 60,470,541**

g. Landscaping:

(A)	Owner's Costs (not paid for under construction contract)	$ 0	
(B)	TOTAL LANDSCAPING.....		**$ 0**

h. Miscellaneous:

(A)	Owner's Fire and Liability Insurance During Construction.....	$ 427,500	
(B)	Performance Bonds or Other Bonds (not paid for under construction contract).....	$ 0	
(C)	Other (list).....	$3,210,065	
(D)	TOTAL MISCELLANEOUS.....		**$3,637,565**

i. TOTAL PROJECT COST (items a through h)

$81,666,228

j. CONSTRUCTION COST PER BED (if applicable)

f(E) / # beds added: $629,901

k. PROJECT COST PER BED (if applicable)

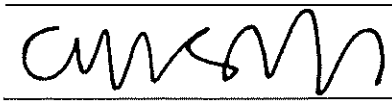
total project cost / # beds added: $850,690

l. CONSTRUCTION INFLATION ASSUMPTION

5 % per year

VERIFICATION BY LICENSED ARCHITECT OR ENGINEER OF PROBABLE CONSTRUCTION COSTS

I hereby submit and declare that the amounts listed Sections e., f., g., and h., above, are true and correct to the best of my knowledge and belief.

Name:	Charles A. Hill	Phone:	502-893-1875
Title:	Senior Principal	License:	ARI-6522
Firm Name:	Stengel Hill Architects, LLC (ARF-14666)		
Address:	613 West Main Street / Louisville, KY / 40202		
Signature:		Date:	12/15/2025

PROJECT DEVELOPMENT SCHEDULE

a. Estimated completion date of final drawing and specifications: 2/01/2027

b. Estimated construction start date: 8/01/2027

c. Estimated project completion date: 12/01/2028

SUPPORTING INFORMATION

Provide the following as attachments, referenced by subsection and number.

a. Architectural master plan indicating long-range concept and expansion potential. **Not Applicable**

b. A short statement regarding accessibility of the proposed facility to each of the following:

(A) Patients;
(B) Medical staff;
(C) Facility personnel;
(D) Supplies delivery;
(E) Visitors;
(F) Public transportation;
(G) Highway systems; and
(H) Emergency vehicles (including air)

Attachment 1

c. Schematic architectural plans, prepared by a licensed architect or engineer as follows:[1]

(A) Scale site plan, indicating property dimensions, location of existing and new structures, parking, access roads, and location of planned additions. **Attachment 2**

(B) Floor plans for all proposed construction and remodel areas, indicating the intended use of each room, location and number of beds, plumbing fixtures and major built-in equipment. Plans must be drawn at 1/16" = 1'0" minimum scale. A single line drawing is acceptable. **Attachment 2**

(C) Small scale floor plan of existing building if the project involves remodel, addition to an existing building, or replacement of existing departmental areas. **Not Applicable**

A listing of equipment is included in Attachment 3.

[1] Only one copy of larger scale plans is required with submission to the Health Division. All other application copies may include small reductions only.

Attachment 1
Accessibility Statement

Accessibility Statement

Inpatient behavioral health services are currently provided at PeaceHealth's University District Campus (UDC). The proposed facility, PeaceHealth Timber Springs Behavioral Health Hospital, will be a modern, high-technology, full-service behavioral health hospital providing inpatient and outpatient care with a patient-centered focus to ensure the safest and most therapeutic environment for care.

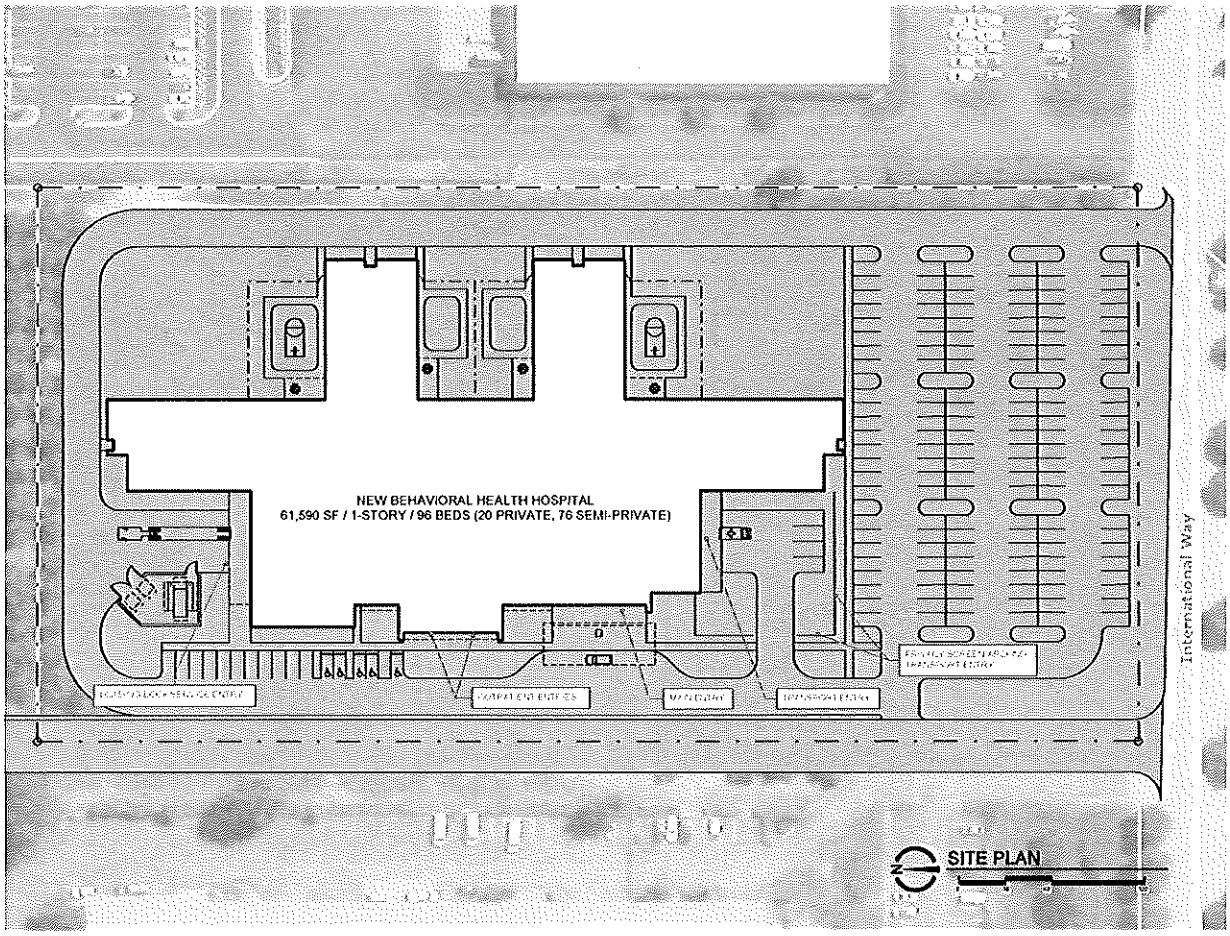
The proposed facility is located approximately 5.5 miles / 12 minutes from the current University District Campus, and approximately 1.3 miles / 5 minutes from the PeaceHealth Sacred Heart Medical Center RiverBend Campus (RBC). The new location will have dedicated parking and will be on a bus line. The same bus line also serves the RiverBend Campus.

Due to the close proximity to the existing UDC, there will be minimal impact to the physical accessibility of the proposed facility to patients, medical staff, facility personnel, supplies delivery, visitors, public transportation, highway systems, and emergency vehicles. And any impact will be positive including better parking and closer proximity to the RiverBend Campus where the majority of specialists that will support the new facility and its patients and personnel are located.

In terms of accessibility to state-of-the-art, modern, full-service inpatient and outpatient behavioral health services, the new facility will enhance access, as it will be designed with a patient-centered focus to ensure the safest, most therapeutic environment for care. The new facility will include:

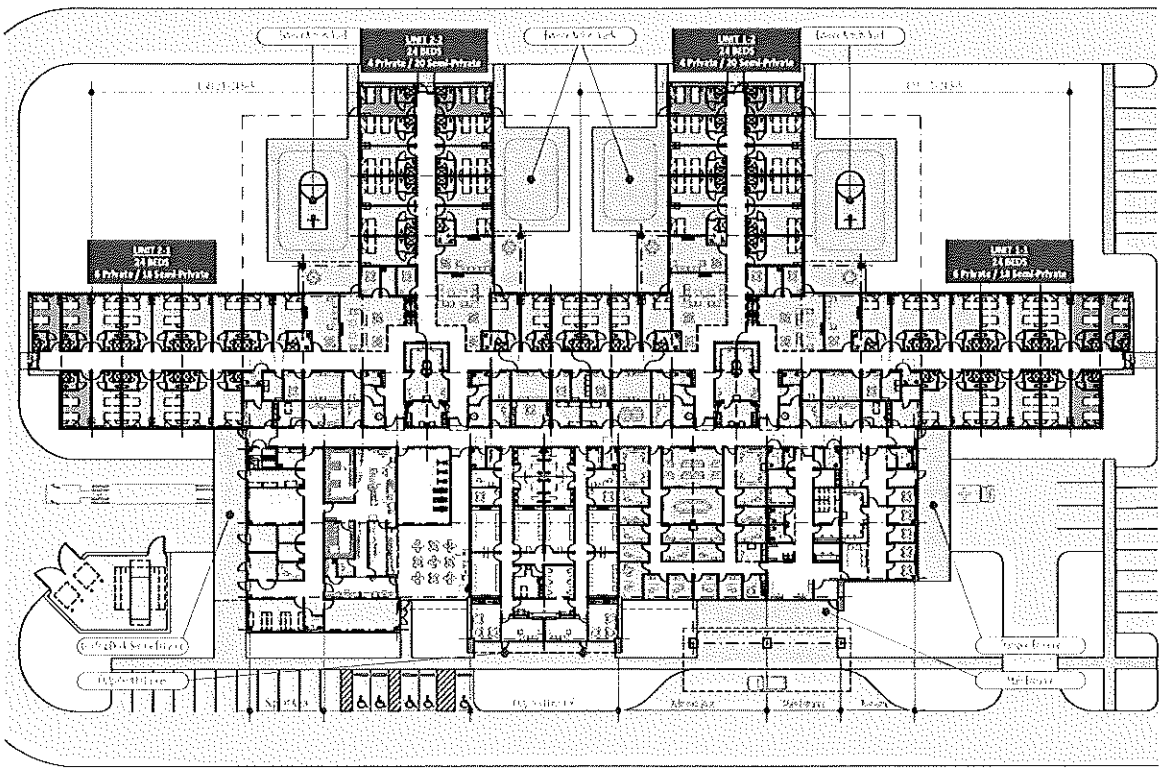
a. A total of 96 inpatient behavioral health beds in a combination of 20 private and 76 semi-private patient rooms, including the required complement of handicap accessible patient rooms. The 96-bed complement is separated into 4 distinct 24-bed patient units to allow for the complete segregation of incompatible patient populations. Each patient unit includes noisy and quiet activity rooms, a group therapy room, 2 consult/visitation rooms, a seclusion suite, other required support spaces, and access to a dedicated exterior activity courtyard which is not shared with other patient units.
b. Support spaces for patient units including an activity therapy room with exercise equipment, a dietary department and dining room, an assessment department for evaluation of incoming patients, an administration department, a pharmacy, and service/support areas.
c. An outpatient partial hospitalization program / intensive outpatient program (PHP/IOP) department containing two separate suites to allow for the complete segregation of incompatible patient populations. Each PHP/IOP suite includes three group therapy rooms, a multipurpose room, a consult room, and male/female restroom facilities supported by shared staff work areas. The PHP/IOP suites are designed to be accessed by outpatients direct from the building exterior – i.e. – outpatients will not traverse inpatient portions of the hospital to access the PHP/IOP suites.

Attachment 2
Floor Plans



LIFEPOINT BEHAVIORAL HEALTH HOSPITAL - SPRINGFIELD, OREGON

NOVEMBER 14TH, 2025



NEW 96-BED BEHAVIORAL HEALTH HOSPITAL

LEGEND

- Inpatient Nursing Unit
- Activity Therapy
- Administration
- Assessment
- General Support Facilities
- Patient Support Facilities
- Outpatient PHP/IOP
- Horizontal Circulation

TOTAL 96-BED FACILITY AREA — 83,905 SF

+4,500 SF VERSUS ALL SEMI-PRIVATES

OPTION 1
96 BEDS
20 Private / 76 Semi-Private

COMPOSITE FLOOR PLAN

GRAPHIC SCALE

0	20	40	80

NORTH

SCHEMATIC COMPOSITE FLOOR PLAN

NEW BEHAVIORAL HEALTH HOSPITAL
LEPSON HEALTH
SYLVERTON, OREGON
LPS-2405

SD01-01

10 FEBRUARY 2025

STENOBEL-HILL

Attachment 3
Equipment List

Peace Health Equipment Categories

Major Categories of Fixed and Moveable Equipment	
Moveable Equipment	
Patient Room Equipment	50,000
Nursing Unit/Nursing Support Areas Equipment	470,000
Behavioral Health Support Areas Equipment	520,000
Other Clinical Support Areas Equipment	88,000
IT Equipment, Including EMR	960,000
Furniture - All Areas (Patient, Support & Public)	509,000
Other minor equipment includes the equipment planning company	305,000
Artwork	80,000
Subtotal Mo Subtotal Moveable Equipment	2,982,000
Fixed Equipment	
Fixed Equipment (Patient, Activity and Support)	1,218,000
Total Equipment	**4,200,000**

(All includes; equipment planning, taxes, freight & installation)

Form 4: Project Cost Estimate and Financing

FINANCIAL SECTION
PROJECT COST ESTIMATE

1.	TOTAL PROJECT COST (from Form CN-3, item i.): **81,666,228**		
2.	AMOUNTS TO BE FINANCED:		
	a. Tax-Exempt Bonds:		
	(A) Principle Amount		
	(B) Interest Amount		
	(C) Rate _____% Term _____Years		
	(D) Will a hospital authority be sponsoring project related bonds? ☐YES ☐NO		
	b. Conventional Loan:		
	(A) Principle Amount		
	(B) Interest Amount		
	(C) Rate _____% Term _____Years		
	c. Federal Loan:		
	(A) Principle Amount		
	(B) Interest Amount		
	(C) Rate _____% Term _____Years		
	d. Interim Financing:		
	(A) Principle Amount		
	(B) Interest Amount		
	(C) Rate _____% Term _____Years		
	e. Other: Developer Lease		
	(A) Principle Amount	$77,466,228	
	(B) Interest Amount		
	(C) Rate 8.5% Term 15 Years		
	f. TOTAL PRINCIPLE	$77,466,228	
	g. TOTAL INTEREST		
	h. TOTAL PRINCIPLE & INTEREST		$77,466,228
	i. ANNUAL DEBT SERVICE REQUIREMENT	$6,584,629	
3.	INTERIM FINANCING:		
	a. Principle Amount		
	b. Interest Amount		
	c. Rate _____% Term _____Years		
	d. TOTAL INTERIM FINANCING		
	e. Interest earned during the period principal is invested		
	f. NET GAIN OR LOSS DURING INTERIM FINANCING		
4.	AMOUNT OF PROJECT COSTS TO BE PAID FROM NON-INTEREST BEARING SOURCES		
	a. Cash on Hand	4,200,000	
	b. Community Contributions		
	c. District or County Tax Levy:		
	(A) Amount		
	(B) Rate per $1,000 Assessed Value		
	(C) Pay-Back Period _____Years		
	d. Federal Grant (identify source)		
	e. Other		
	f. TOTAL NON-INTEREST BEARING SOURCES	4,200,000	
5.	TOTAL PROJECT COST INCLUDING INTEREST: **81,666,228**		

Form 5: Income Statement

YEAR	PROJECTED				
	Year 1[1]	Year 2	Year 3	Year 4	Year 5
OPERATING REVENUE: Inpatient Revenue	35,080,350	64,110,060	75,100,356	77,188,763	78,902,312
Outpatient Revenue	3,435,000	8,988,840	10,529,784	10,834,381	11,020,468
Patient Service Revenue	-	-	-	-	-
DEDUCTIONS FROM OPERATING REVENUE: Provision for Medicare, Welfare & Other Contractual Adjustments	(14,612,221)	(28,394,713)	(33,262,378)	(34,194,692)	(34,919,857)
Free / Charity Care	(701,607)	(1,282,201)	(1,502,007)	(1,543,775)	(1,578,046)
Other Deductions (Doubtful Accounts)	(738,068)	(1,384,560)	(1,621,913)	(1,667,171)	(1,703,464)
Total Deductions	(16,051,896)	(31,061,474)	(36,386,298)	(37,405,639)	(38,201,367)
Net Operating Revenue	22,463,454	42,037,426	49,243,842	50,617,506	51,721,412
Other Operating Revenue	-	-	-	-	-
TOTAL OPERATING REVENUE	**22,463,454**	**42,037,426**	**49,243,842**	**50,617,506**	**51,721,412**
OPERATING EXPENSES: Salaries, Wages & Benefits	16,074,119	23,691,217	27,041,031	27,837,331	28,456,739
Outside Services and Professional Fees	1,951,110	3,159,091	3,670,632	3,772,115	3,856,457
Supplies	951,782	1,345,054	1,575,635	1,619,451	1,655,401
Purchased Services	161,598	289,124	338,688	348,106	355,834
Insurance	148,364	227,238	258,689	265,735	271,785
Facility Lease Rent	6,584,629	6,749,245	6,917,976	7,090,926	7,268,199
Land Lease Rent	169,141	172,524	175,975	179,494	183,084
Taxes, Except Income	1,075,600	1,100,600	1,126,225	1,152,491	1,179,413
Depreciation & Amortization	600,000	603,714	618,000	638,571	659,143
Interest	268,715	674,836	630,380	407,381	143,694
Management Fees	1,123,173	2,101,871	2,462,192	2,530,875	2,586,071
Other Operating Expenses[2]	1,470,540	1,522,449	1,633,883	1,676,124	1,716,066
TOTAL OPERATING EXPENSE	**30,578,772**	**41,636,965**	**46,449,305**	**47,518,600**	**48,331,887**
OPERATING INCOME	**(8,115,317)**	**400,461**	**2,794,536**	**3,098,905**	**3,389,526**
NET NON-OPERATING REVENUE: Interest Income, Rental Income, etc.	-	-	-	-	-
EXCESS REVENUE OVER EXPENSES	**(8,115,317)**	**400,461**	**2,794,536**	**3,098,905**	**3,389,526**

[1]Year 1 figures include all pre-open operating expenses

[2] Other Operating Expenses include the following items: EMR, Continuing Education, Recruiting, Repairs and Maintenance, Patient Transport, Collection Agency, Printing, Bank Fees, Misc. Service Charges, Utilities and Other Minor Miscellaneous Expenses

Form 6: Balance Sheet

YEAR	PROJECTED				
	Year 1	Year 2	Year 3	Year 4	Year 5
CURRENT ASSETS: Cash	$ 1,503,157	$ 1,664,211	$ 1,885,664	$ 1,932,648	$ 1,863,158
Gross Accounts Receivable: - Direct Patient Care	6,986,210	8,325,653	9,752,907	10,012,298	10,246,648
- Other	-	-	-	-	-
Net Accounts Receivable: - Direct Patient Care	6,986,210	8,325,653	9,752,907	10,012,298	10,246,648
- Other	-	-	-	-	-
Inventories	49,755	57,119	66,911	68,583	70,298
Other Current Assets	-	-	-	-	-
TOTAL CURRENT ASSETS	**8,539,122**	**10,046,983**	**11,705,482**	**12,013,529**	**12,180,105**
INVESTMENTS	-	-	-	-	-
DONOR RESTRICTED ASSETS - Identify	-	-	-	-	-
ASSETS HELD BY TRUSTEES Identify	-	-	-	-	-
FIXED ASSETS: Property, Plant & Equipment	4,200,000	4,248,000	4,392,000	4,536,000	4,680,000
Construction in Progress	-	-	-	-	-
TOTAL FIXED ASSETS	**4,200,000**	**4,248,000**	**4,392,000**	**4,536,000**	**4,680,000**
Less: Accumulated Depreciation	(600,000)	(1,203,714)	(1,821,714)	(2,460,286)	(3,119,429)
NET FIXED ASSETS	**3,600,000**	**3,044,286**	**2,570,286**	**2,075,714**	**1,560,571**
OTHER ASSETS	6,225,000	6,225,000	6,225,000	6,225,000	6,225,000
TOTAL ASSETS[1]	**18,364,122**	**19,316,268**	**20,500,767**	**20,314,244**	**19,965,676**
CURRENT LIABILITIES: Trade Accounts Payable	$ 1,448,973	$ 1,604,491	$ 1,824,450	$ 1,869,904	$ 1,916,494
Accrued Compensation & Professional Fees	-	-	-	-	-
Liabilities to be Paid from Donor Restricted Assets	-	-	-	-	-
Liabilities to be Paid from Assets Held by Trustees	-	-	-	-	-
Current Portion of Long-Term Debt	8,330,467	8,726,634	6,896,638	3,565,755	-
Other Current Liabilities	-	-	-	-	-
TOTAL CURRENT LIABILITIES	**$ 9,779,440**	**$ 10,331,125**	**$ 8,721,088**	**$ 5,435,658**	**$ 1,916,494**
DEFERRED REVENUE	-	-	-	-	-
LONG-TERM DEBT (less current portion): Secured	-	-	-	-	-
Unsecured	-	-	-	-	-
TOTAL LONG-TERM DEBT	-	-	-	-	-
FUND BALANCE	**8,584,683**	**8,985,144**	**11,779,680**	**14,878,585**	**18,049,182**
LIABILITIES PLUS FUND BALANCE	**18,364,122**	**19,316,268**	**20,500,767**	**20,314,244**	**19,965,676**
[1] Identify line item and amount of any pledged assets.	$ (1,240,317.30)	$ (284,142.07)	$ 2,984,394.09	$ 6,577,871.00	$ 10,263,610.70

Form 7: Financial Position and Working Capital

YEAR	PROJECTED				
	Year 1	Year 2	Year 3	Year 4	Year 5
SOURCES OF WORKING CAPITAL: Net Income	($8,115,317)	$400,461	$2,794,536	$3,098,905	$3,389,526
Depreciation and Amortization	$600,000	$603,714	$618,000	$638,571	$659,143
Working Capital Provided by Operations	(7,090,150)	(1,352,342)	(1,438,540)	(262,594)	(119,985)
Proceeds from Long-Term Borrowings	$ 8,330,467	$ 396,167	$ (1,829,997)	$ (3,330,883)	$ (3,565,755)
Other Sources of Working Capital					
TOTAL SOURCES OF WORKING CAPITAL	**($6,275,000)**	**$48,000**	**$144,000**	**$ 144,000**	**$ 362,929**
USES OF WORKING CAPITAL: Dividends	$ (16,700,000)	$ 0	$ 0	$ 0	$ 218,929
Repayment of Long-Term Debt					
Additions to Plant & Equipment	$ 4,200,000	$ 48,000	$ 144,000	$ 144,000	$ 144,000
Increases in Other Non-Current Assets	$ 6,225,000	$ -	$ -	$ -	$ -
Increase (Decrease) in Working Capital					
TOTAL USES OF WORKING CAPITAL	**$ (6,275,000)**	**$ 48,000**	**$ 144,000**	**$ 144,000**	**$ 362,929**

Form 8: Debt Service Coverage

YEAR	PROJECTED				
	1	2	3	4	5
INCOME FOR DEBT SERVICE COVERAGE:[4] Excess of Revenue Over Expense, or Net Income	$ (8,115,317)	$ 400,461	$2,794,536	$3,098,905	$3,389,526
Depreciation and Amortization	$ 600,000	$ 603,714	$ 618,000	$ 638,571	$ 659,143
Interest Expense	$ 268,715	$ 674,836	$ 630,380	$ 407,381	$ 143,694
TOTAL DEBT SERVICE COVERAGE	**$ (8,984,032)**	**$ (878,090)**	**$1,546,156**	**$2,052,953**	**$2,586,689**
DEBT SERVICE REQUIRMENTS: Interest Expense	$ 268,715	$ 674,836	$ 630,380	$ 407,381	$ 143,694
Principle Payments	$ -	$ 595,085	$2,246,171	$3,330,883	$3,565,755
TOTAL DEBT SERVICE REQUIREMENTS	**$ 268,715**	**$ 1,269,922**	**$2,876,552**	**$3,738,264**	**$3,709,448**
RATIO:[5] Income for Debt Service Coverage to Debt Service Requirements	(26.97)	1.32	1.41	1.11	1.13

[4] Forecast debt service coverage on accrual basis.

[5] Ratio calculation = (net income + depreciation + interest) ÷ (principle + interest).

Form 9: Ratio Analysis

YEAR	PROJECTED				
PROFITABILITY RATIOS: Operating Margin	-36%	1%	6%	6%	7%
Operating Ratio	133%	98%	93%	93%	92%
Deductibles Ratio	46%	48%	48%	48%	48%
Bottom Line Ratio	-36%	1%	6%	6%	7%
Return on Total Assets - A	-44%	2%	14%	15%	17%
- B	-44%	2%	14%	15%	17%
Return on Equity - A	-95%	4%	24%	21%	19%
- B	-95%	4%	24%	21%	19%
DEBTS RATIOS: Equity Financing - A	47%	47%	57%	73%	90%
- B	47%	47%	57%	73%	90%
Debt Service as a Percentage of Gross Patient Revenue	1%	2%	4%	5%	5%
Cash Flow to Total Debt	-77%	10%	39%	69%	211%
Total Debt to Total Assets	1%	7%	14%	18%	19%
Peak Debt Service Coverage by Historical Net Revenue	-2697%	132%	141%	111%	113%

YEAR	PROJECTED				
Debt Service Safety Margin	-33.5%	1.0%	2.4%	0.8%	0.9%
Debt to Plant	0.0%	0.0%	0.0%	0.0%	0.0%
LIQUIDITY RATIOS: Current Ratio	87%	97%	134%	221%	636%
Days Revenue in Accounts Receivable	113.5	72.3	72.3	72.2	72.3
Average Payment Period	31.7	30.9	31.0	30.9	31.0
Days Cash on Hand	103.97	89.37	93.22	93.54	93.26
Quick Ratio	87%	97%	133%	220%	632%
OTHER RATIOS: Adjusted Patient Days	14,052	24,528	28,032	28,109	28,032
Adjusted Admissions	1,902	3,320	3,794	3,805	3,794

YEAR	PROJECTED				
	Year 1	Year 2	Year 3	Year 4	Year 5
Number of Patient Days	14,052	24,528	28,032	28,109	28,032
Gross Expense per Patient Day	$2,176	$1,698	$1,657	$1,691	$1,724
Amount Attributable to Proposal					
Gross Revenue per Patient Day	$2,496	$2,614	$2,679	$2,746	$2,815
Amount Attributable to Proposal					
Number of Adjusted Patient Days					
Gross Expense per Adjusted Patient Day					
Amount Attributable to Proposal					
Gross Revenue per Adjusted Patient Day					
Amount Attributable to Proposal					
Number of Admissions	1,902	3,320	3,794	3,805	3,794
Gross Expense per Admission	$16,077	$12,541	$12,242	$12,489	$12,738
Amount Attributable to Proposal					
Gross Revenue per Admission	$18,444	$19,310	$19,793	$20,288	$20,795
Amount Attributable to Proposal					
Number of Adjusted Admissions					
Gross Expense per Adjusted Admission					
Amount Attributable to Proposal					
Gross Revenue per Adjusted Admission					
Amount Attributable to Proposal					

Form 12: Sources and Uses of Funds

SOURCES AND USES OF FUNDS FOR THE PROPOSED PROJECT

Sources of Funds:		
Bond Issue		
Applicant Contribution		$4,200,000
Interest Earned on Assets Held by Trustee During Construction		
Other Sources (Lease)	$77,466,228	
Total Sources of Funds		$81,666,228
Uses of Funds:		
Construction Costs	$60,470,541	
Interest During Construction		
Debt Service Reserve Fund		
Bond Discount to Underwriters		
Legal, Accounting and Printing Costs	$5,807,061	
Other Sources	$15,388,626	
Total Uses of Funds		$81,666,228

Appendix 1 – Deflection Data

Nov-24			Dec-24			Jan-25			Feb-25		
Referred	Accepted	Deflected	Referred	Accepted	Deflected	Referred	Accepted	Deflected	Referred	Accepted	Deflected
99	86	13	89	83	6	112	95	17	101	91	10
18	16	2	22	16	6	14	12	2	6	6	0
3	1	2	0	0	0	13	1	12	29	0	29
1	0	1	1	0	1	5	0	5	7	0	7
2	0	2	0	0	0	0	0	0	2	0	2
0	0	0	0	0	0	6	2	4	9	0	9

Mar-25			Apr-25			May-25			Jun-25		
Referred	Accepted	Deflected	Referred	Accepted	Deflected	Referred	Accepted	Deflected	Referred	Accepted	Deflected
106	95	11	86	80	6	112	105	7	112	98	14
12	10	2	14	14	0	8	6	2	16	12	4
28	4	24	23	3	20	35	5	30	57	7	50
20	0	20	14	0	14	10	0	10	11	1	10
4	3	1	5	4	1	4	2	2	1	0	1
14	0	14	8	1	7	13	3	10	8	0	8

Jul-25			Aug-25			Sep-25			Oct-25		
Referred	Accepted	Deflected	Referred	Accepted	Deflected	Referred	Accepted	Deflected	Referred	Accepted	Deflected
97	87	10	135	112	23	120	103	17	120	103	17
8	4	4	13	10	3	11	8	3	11	8	3
36	0	36	42	1	41	31	1	30	31	1	30
23	1	22	9	0	9	8	0	8	8	0	8
3	1	2	7	1	6	1	0	1	1	0	1
3	0	3	13	0	13	8	0	8	5	0	5

Appendix 2 – Numeric Need Methodology

Step 1a:

Determine the estimated population for the Health Service Area identified in OAR 333-615-0010(3) for the prior 10 years in five-year increments, and five- and 10-year forecasts as a basis for estimating the population for previous years and forecasting future years.

Applicants shall use Portland State University's Population Research Center (PRC) Intercensal Estimate reports, and when available, United States Census Data. If the applicant uses an alternate data source, the applicant must provide justification for the alternate data source.

Health Service Area Trauma System Area in which the proposed hospital will be located. Trauma System Areas are defined by the Oregon Health Authority (OAR 333-200-0040). For this project, Trauma Service Area is: Coos, Curry (only zips 97450, 97465, 97476), Douglas and Lane Counties. (TSA 3)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Population																
Combined Coos, Douglas and Lane Counties																
Population 13-17	33,388	33,303	33,220	33,137	33,055	32,974	32,894	32,814	32,735	32,657	32,579	32,582	32,585	32,587	32,590	32,593
Population 18+	416,463	420,136	423,845	427,590	431,371	435,189	439,044	442,936	446,866	450,835	454,842	455,986	457,135	458,287	459,443	460,604
Curry County, Portion Located in TSA 3																
Population 13-17	125	122	120	117	114	111	109	106	104	101	99	101	103	106	108	111
Population 18+	2,644	2,657	2,670	2,683	2,696	2,709	2,722	2,735	2,748	2,762	2,775	2,766	2,758	2,749	2,741	2,732
13-17	**33,513**	**33,426**	**33,340**	**33,254**	**33,169**	**33,086**	**33,002**	**32,920**	**32,839**	**32,758**	**32,678**	**32,683**	**32,688**	**32,693**	**32,698**	**32,704**
18+	**419,107**	**422,793**	**426,515**	**430,273**	**434,067**	**437,898**	**441,766**	**445,671**	**449,615**	**453,596**	**457,617**	**458,752**	**459,892**	**461,036**	**462,184**	**463,336**

Step 2: Calculate TSA 3 Discharge and Patient Day Use Rates

Determine current year proposed Health Service Area and historical Health Service Area population-based discharge and patient day use-rates utilizing relevant and recent data. Future use-rate deviations must be explained.

(a) Determine current year and historical utilization by the Health Service Area population of existing facilities. For this step, the applicant shall use the Medicare Cost Reports and All Payer All Claims (APAC) data and may elect to use other relevant may elect to use other relevant data. For the current year, and each of the prior 10 years, the applicant shall explain factors which may have affected identified trends. Factors to be addressed include, but are not limited to, changes in: population, public health needs (including any public health emergency), hospital location, service mix, age mix, reimbursement mix, transportation patterns, locations of physicians, specialists, unmet need, and the intensity or types of services delivered;

Definition: Ages 0-12 are excluded from the use rate calculation and use rates are based on MDC 19 only

Discharges	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025A	average (2022-2025A)
13-17	89	102	101	143	101	94	92	113	141	128	117	125
18+	1,353	1,522	1,511	1,647	1,562	1,470	1,455	1,466	1,580	1,543	1,691	1,570
Total	1,442	1,624	1,612	1,790	1,663	1,564	1,547	1,579	1,721	1,671	1,808	1,695
Discharge Use Rate	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025A**	
13-17	2.69	3.09	3.07	4.35	3.08	2.88	2.81	3.46	4.31	3.91	3.58	3.82
18+	3.09	3.45	3.39	3.66	3.44	3.21	3.17	3.19	3.43	3.34	3.65	3.40
Total	3.06	3.42	3.37	3.71	3.42	3.19	3.15	3.21	3.49	3.38	3.64	3.43

(b) Estimate future utilization rates by the Health Service Area population, based on population forecasts for age and sex breakdowns, including consideration of an explained range of age and sex adjusted use-rates specific to:

(A) The Health Service Area;

(B) The nearest facilities with service mixes most comparable to the proposed facility; and

(C) The nearest facilities with comprehensive service mixes.

Estimated Population

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2038
Population												
Combined Coos, Douglas and Lane Counties (PRC)												
Population 13-17	32,593	32,905	33,220	33,538	33,860	34,184	34,135	34,086	34,038	33,993	33,947	33,154
Population 18+	460,604	463,448	466,311	469,192	472,091	475,009	477,606	480,218	482,844	485,486	488,142	494,416
Curry County, Portion Located in TSA 3 (Claritas)												
Population 13-17	111	112	114	115	117	119	119	119	120	120	120	121
Population 18+	2,732	2,743	2,754	2,765	2,776	2,787	2,796	2,804	2,813	2,822	2,831	2,846
13-17	**32,704**	**33,017**	**33,334**	**33,654**	**33,977**	**34,303**	**34,254**	**34,205**	**34,158**	**34,113**	**34,068**	**33,275**
18+	**463,336**	**466,191**	**469,065**	**471,957**	**474,867**	**477,796**	**480,402**	**483,022**	**485,657**	**488,307**	**490,972**	**497,262**

Step 3:

(3) Develop a consistent and reasonable set of well-documented assumptions regarding the appropriate use-rates reviewed in section (2) of this rule including the extent to which utilization at the proposed psychiatric hospital will be new and the extent to which it will replace existing utilization at hospitals.

Assumes Hospital opens in 2029 so projected out to 2098 (10 years)

2022-2025 Average Use Rate Increased by 50%

Use Rate	average (2022-2025A)	Adjusted Use Rate
13-17	3.82	5.72
18+	3.40	5.10
Total	3.43	5.14

Population

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2036	2038
13-17	32,704	33,017	33,334	33,654	33,977	34,303	34,254	34,205	34,158	34,113	34,068	33,800	33,535	33,275
18+	463,336	466,191	469,065	471,957	474,867	477,796	480,402	483,022	485,657	488,307	490,972	493,064	495,161	497,262
Total (13+)	496,039	499,208	502,399	505,610	508,844	512,099	514,656	517,228	519,815	522,421	525,040	526,864	528,696	530,536

Projected Discharges Unadjusted Use Rate

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2036	2038
13-17	125	126	127	128	130	131	131	131	130	130	130	129	128	127
18+	1,576	1,586	1,595	1,605	1,615	1,625	1,634	1,643	1,652	1,661	1,670	1,677	1,684	1,691
Total (13+)	1,701	1,712	1,723	1,734	1,745	1,756	1,765	1,773	1,782	1,791	1,800	1,806	1,812	1,818

Projected Discharges Adjusted Use Rate

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2036	2038
13-17	187	189	191	193	194	196	196	196	195	195	195	193	192	190
18+	2,364	2,378	2,393	2,408	2,423	2,438	2,451	2,464	2,478	2,491	2,505	2,515	2,526	2,537
Total (13+)	2,551	2,567	2,584	2,600	2,617	2,634	2,647	2,660	2,673	2,686	2,700	2,709	2,718	2,727

"New Discharges"

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2036	2038
13-17	62	63	64	64	65	65	65	65	65	65	65	64	64	63
18+	788	793	798	803	808	813	817	821	826	830	835	838	842	846
Total (13+)	850	856	861	867	872	878	882	887	891	895	900	903	906	909

Step 4: *Analyze the advantages and disadvantages of both new and replacement components of utilization, with respect to both the population to be served and to existing facilities. Address the legislative findings cited in ORS 442.310.*

Please refer to Step 4 of the narrative for a discussion of the advantages and disadvantages.

Step 5: Projection of Future Patient Days and ADC

Given all information from the preceding steps, and five and 10-year population forecasts, compute the range of possible future patient days in five years and in 10 years at the proposed psychiatric hospital, allowing appropriate adjustments for out-of-area utilization and other identified and justified special factors or considerations relevant to the proposal.

AND

Step 6: *Convert each computed value of forecasted patient days based on preceding sections of this rule to an average daily census (ADC).*

Age Cohort **13-17**

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Use Rate (Adjusted)	5.72	5.72	5.72	5.72	5.72	5.72	5.72	5.72	5.72	5.72	5.72	5.72	5.72	5.72
Population	32,704	33,017	33,334	33,654	33,977	34,303	34,254	34,205	34,158	34,113	34,068	33,800	33,535	33,275
Discharges	187	189	191	193	194	196	196	196	195	195	195	193	192	190
Patient Days @ 14.8 (ALOS)	2,770	2,797	2,823	2,851	2,878	2,906	2,901	2,897	2,893	2,889	2,886	2,863	2,841	2,818
ADC	7.6	7.7	7.7	7.8	7.9	8.0	7.9	7.9	7.9	7.9	7.9	7.8	7.8	7.7

Age Cohort **18+**

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Use Rate	5.10	5.10	5.10	5.10	5.10	5.10	5.10	5.10	5.10	5.10	5.10	5.10	5.10	5.10
Population	463,336	466,191	469,065	471,957	474,867	477,796	480,402	483,022	485,657	488,307	490,972	493,064	495,161	497,262
Discharges	2,364	2,378	2,393	2,408	2,423	2,438	2,451	2,464	2,478	2,491	2,505	2,515	2,526	2,537
Patient Days @ 10.6	25,056	25,211	25,366	25,522	25,680	25,838	25,979	26,121	26,263	26,407	26,551	26,664	26,777	26,891
ADC	68.6	69.1	69.5	69.9	70.4	70.8	71.2	71.6	72.0	72.3	72.7	73.1	73.4	73.7

Age Cohort **13+**

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Discharges	2,551	2,567	2,584	2,600	2,617	2,634	2,647	2,660	2,673	2,686	2,700	2,709	2,718	2,727
Patient Days	27,826	28,007	28,190	28,373	28,558	28,744	28,881	29,018	29,157	29,296	29,436	29,527	29,618	29,709

Step 7 *Estimate the statistically expected peak daily census, the statistical variability, or standard deviation, of the daily census and and provide the methodology used by the applicant and sufficient information to validate use of the applicant's statistical model.*

Age Cohort **13-17**

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
ADC	7.6	7.7	7.7	7.8	7.9	8.0	7.9	7.9	7.9	7.9	7.9	7.8	7.8	7.7
Bed Need at 99% CI	14.0	14.1	14.2	14.3	14.4	14.5	14.5	14.5	14.5	14.5	14.5	14.4	14.3	14.2

Age Cohort

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
ADC	68.6	69.1	69.5	69.9	70.4	70.8	71.2	71.6	72.0	72.3	72.7	73.1	73.4	73.7
Bed Need at 95% CI	82.3	82.8	83.3	83.7	84.2	84.7	85.1	85.5	86.0	86.4	86.8	87.2	87.5	87.8

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Combined Total	96.3	96.9	97.5	98.0	98.6	99.2	99.6	100.0	100.4	100.9	101.3	101.5	101.8	102.0

Step 8 *Using a 10-year projection from the anticipated opening date of the facility, the applicant shall identify supported mathematical estimates of appropriate utilization levels and patient days generated because of changes identified in prior steps. Applicant shall explain the degree to which the utilization will be "new" days for the health service area population, or will shift present health service area utilization patterns for the services. Applicant shall address whether this analysis supports the need for the proposed hospital.*

	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
	13-17 Population									
TSA 3 ADC	7.9	8.0	7.9	7.9	7.9	7.9	7.9	7.8	7.8	7.7
Estimated Market Share	60.0%	72.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Market Share Adjusted ADC	4.73	5.73	6.36	6.35	6.34	6.33	6.32	6.27	6.23	6.18
Discharges from In-Migration	0	111	173	197	197	197	197	197	197	197
Days from In-Migration	0	1,643	2,555	2,920	2,920	2,920	2,920	2,920	2,920	2,920
ADC from In-Migration	0	4.5	7.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Total ADC (TSA 3+ In-Migration)	**4.7**	**10.2**	**13.4**	**14.4**	**14.3**	**14.3**	**14.3**	**14.3**	**14.2**	**14.2**
	2029	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
	18+ Population									
TSA 3 ADC	70.4	70.8	71.2	71.6	72.0	72.3	72.7	73.1	73.4	73.7
Estimated Market Share	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Market Share Adjusted ADC	49.2	49.6	49.8	50.1	50.4	50.6	50.9	51.1	51.4	51.6
Discharges from In-Migration	0.0	223.8	344.3	344.3	344.3	344.3	396.0	396.0	396.0	396.0
Days from In-Migration	0	2,373	3,650	3,650	3,650	3,650	4,198	4,198	4,198	4,198
ADC from In-Migration	0	6.5	10	10	10	10	11.5	11.5	11.5	11.5
Total ADC (TSA 3+ In-Migration)	**49.2**	**56.1**	**59.8**	**60.1**	**60.4**	**60.6**	**62.4**	**62.6**	**62.9**	**63.1**
	2029	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**2038**
	13+ Population									
ADC	54.0	66.3	73.2	74.4	74.7	75.0	76.7	76.9	77.1	77.2
Patient Days	19,703	24,194	26,712	27,172	27,269	27,366	28,012	28,073	28,134	28,196
Beds Needed @ 80% Occupancy	67	83	91	93	93	94	96	96	96	97

Step 9

If the result of the above analysis indicates that psychiatric inpatient beds is needed in the proposed Health Service Area, an applicant for a new facility shall weigh it against the availability of beds at other facilities within the Health Service Area. Applicants shall use inpatient psychiatric bed capacity for all facilities in the Health Service Area provided by the Oregon Health Authority.

Conversion of existing beds to psychiatric inpatient beds will be presumed infeasible where a general hospital in the proposed Health Service Area has not increased their psychiatric inpatient bed capacity by 20 percent or greater over the prior three-year interval from the date the applicant submitted their letter of intent.

Please see the discussion in the narrative.

Step 10: *Applicants must document how the project will avoid adverse financial impact to existing psychiatric service providers, particularly those serving high-acuity or underserved populations.*

The analysis shall address whether the proposed project with contribute to continuity or conversely, fragmentation of psychiatric care in the Health Service Area.

Please see the discussion in the narrative.

Appendix 3 – Continuum of Care

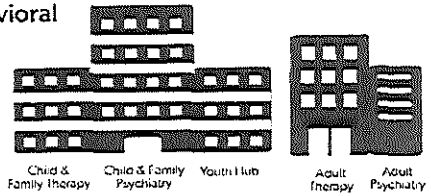
Peace Health

Continuum of Care

Behavioral Health Services in Oregon

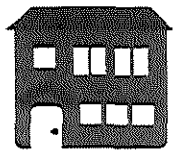
Outpatient Behavioral Health Services

Outpatient psychiatry, counseling therapy, occupational therapy for all ages.



Connections Clinic

Access clinic for all ages seeking behavioral health services. Short term services available in clinic and referral to long term services at Peacel lealth and the community.



Unified Care (UCare) Behavioral Health Medical Home

Full range of behavioral health services and primary care for patients with co-occurring complex mental health and medical needs

Co-Occurring Substance Use Services

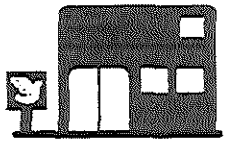
Outpatient substance use treatment for adults with co-occurring mental health and substance use issues.

Virtual Care and Telepsychiatry

Emergency department crisis services and telepsychiatry and many outpatient services are delivered virtually.

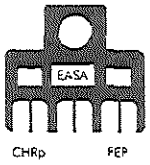
Behavioral Health Integrated in Primary Care

Evidenced-based model of behavioral health clinicians integrated in pediatrics, family medicine, and primary care.



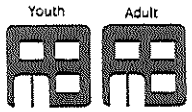
Youth/Young Adult Behavioral Health

Coordinated specialty care for youth and young adults with emerging and chronic mental health conditions. Includes individual, family and occupational therapy, supported education and employment, psychiatric medication management, nursing, and peer support services.



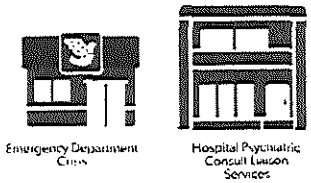
Co-Occurring Intensive Outpatient

Intensive outpatient substance use treatment for youth adults with co-occurring mental health and substance use issues.



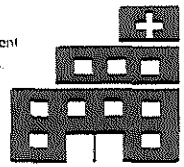
Crisis and Consult Liaison (Emergency Department and Hospital)

Crisis interventions, mental health evaluations, and psychiatric consultations provided in the Emergency Departments and on hospital units.



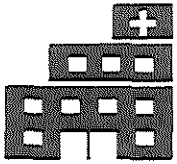
Behavioral Health Inpatient Unit

Acute inpatient psychiatric treatment for up to 35 adults.



Intensive Outpatient Program and Partial Hospitalization

Group-based treatment programs for adults experiencing acute exacerbation of mental health symptoms.



Transition Team

Intensive community-based support to patients discharging from the hospital or at high risk for hospitalization.