DIRECT CARE AND TREATMENT

Psychiatric Residential Treatment Facility Analysis

A report to the Minnesota Legislature on location risks and benefits, estimated build-out and operating costs, and the potential for cost recovery.

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Important Acknowledgement

To ensure an objective approach to researching, analyzing the data, and presenting the key findings, DCT contracted with Health Management Associates (HMA), a leading national health care and human services consulting firm, to research and write the report. HMA held multiple stakeholder meetings with advocates, counties, service providers, state agencies, the judicial system, as well as DCT staff and leaders.

Executive Summary

The Direct Care and Treatment (DCT) Executive Board submits this report in response to the 2025 directive from the Minnesota Legislature, which instructed the board to plan for the build-out of a locked psychiatric residential treatment facility (PRTF). The directive requires the report to include: 1) an analysis of the risks and benefits of locating the locked PRTF in a metropolitan or rural location; 2) the estimated cost for the build-out of the locked PRTF; 3) the estimated ongoing cost of operating and maintaining the facility; and 4) the estimated costs that can be recouped through fees for service from medical assistance, MinnesotaCare, and private insurance payments.

Minnesota's PRTFs are a vital component of the state's youth mental health system, serving children and adolescents with complex behavioral, developmental, and medical needs who require intensive, inpatient-level care. Recent closures and reductions in provider capacity have strained the system, resulting in long wait times for admission, extended stays, and frequent boarding in hospital emergency departments while youth wait for a more appropriate placement in a PRTF. The current supply of PRTF beds falls short of both statutory authorization and actual demand, leaving many youth without appropriate treatment options.

Regardless of facility location, DCT will admit youth from all regions of Minnesota through a centralized pre-admissions process, ensuring equitable access to care for children and adolescents statewide.

Workforce shortages, especially among specialized clinical staff, continue to challenge providers statewide, with recruitment and retention difficulties exacerbated by low reimbursement rates and budget constraints. These shortages are particularly acute in rural areas, but affect all regions and facility types.

This report provides a comprehensive analysis of the risks and benefits of DCT locating a new locked PRTF in metropolitan, micropolitan, or rural areas of Minnesota. It includes estimated build-out costs, projected ongoing operational expenses, and cost recovery potential. The analysis draws on quantitative data, stakeholder interviews, and workforce and service availability reports.

Cost to Build

Estimated build-out costs for a new PRTF are similar across metropolitan, micropolitan, and rural locations due to state procurement requirements and offsetting factors such as land and labor costs.

- **Metropolitan: $31.8 million to $51.6 million (excluding land), $33.7 million to $54.5 million (including land)**

- **Micropolitan/Rural: $31.7 million to $51.6 million (excluding land), $33.0 million to $53.5 million (including land)**

While metro-area land and permitting costs tend to be higher, state projects have standard procurement requirements, including prevailing wages (Davis-Bacon Act) and sustainability standards (SB2030) that carry across metro and rural settings.

Cost to Operate

First-year operating costs range from $25.4 million to $35.5 million, driven by robust staffing requirements, accreditation standards, and the severity of illness or degree of behavioral challenges presented by the youth served.

- Facilities must maintain 24/7 staffing and provide specialized clinical, nursing, and therapeutic services.
- Workforce shortages, especially in rural areas, result in open bed days and underutilization, impacting allowable billable days.
- The analysis finds that the cost of operating is not significantly influenced by facility location.

Location Risk-Benefit Analysis

- **Metropolitan locations** offer the greatest operational feasibility, with strong workforce availability, access to specialty care, and family involvement, but may be associated with higher land and permitting costs and potential local opposition.
- **Micropolitan** sites provide balanced access to resources and central family accessibility, with moderate risks related to specialty care, workforce diversity, and potential local opposition.
- **Rural** locations offer opportunities for community integration and local investment, with some risk for potential opposition, and face significant challenges in staffing, specialty care access, and family participation, requiring steps to address the concerns.

Cost Recovery

- Per diem payments are **projected to cover approximately 62% of operational expenditures.**
- A legislative appropriation will be needed to ensure long-term financial viability.
- Cost recovery is not influenced by facility location, as reimbursement rates and payer mix remain consistent across metropolitan, micropolitan, and rural sites.

For DCT to establish and operate a PRTF in Minnesota, it will require a carefully chosen location with sufficient workforce availability and a sustainable funding model. While the financial analysis shows that build-out and operating costs remain largely consistent across all settings, selecting a metropolitan site with more favorable access to staff and specialized services, along with a legislative appropriation will be needed to ensure sustainable operations

Report Purpose and Methodology

This report evaluates the risks and benefits of locating a new PRTF in either a metropolitan, micropolitan, or rural area of Minnesota. We analyzed quantitative data, conducted stakeholder interviews with state officials, counties, behavioral health care providers, and family advocates, reviewed workforce and service availability. The purpose of the analysis is to inform policymakers about the most viable location for a new facility, considering workforce sustainability, access to services, community impact, cost, alignment with youth needs, and regulatory factors.

Data Collection. Data sources included: (a) public data on PRTF utilization (referrals, wait times, county of origin), (b) input from about 10 Minnesota-based stakeholder interviews, and (c) cost and workforce reports from DCT and providers, ensuring a well-rounded, factual comparison. For the analysis of PRTF locations, we engaged stakeholders through interviews and focus groups to gather insights regarding location decisions, assess location strengths and weaknesses, and consider additional relevant factors. We conducted 12 interviews with representatives from tribal nations, state agencies (including staff from DCT), behavioral health care providers, hospitals, counties, advocacy organizations, and judicial committees. Each interview followed a standardized protocol to ensure consistency in capturing responses and perspectives. The input gathered from these diverse stakeholders is reflected throughout the report, helping to shape findings and recommendations based on real-world experience and expertise from across Minnesota's mental health system.

Definition of "Metropolitan", "Rural", and "Micropolitan". For this report, "metro" refers specifically to Minnesota's seven-county metropolitan area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. The remainder of the state is considered "rural," except for several larger communities in Greater Minnesota (e.g., Duluth, St. Cloud, Moorhead, Rochester, and Mankato), which are classified as "micropolitan" due to their regional population centers and service hubs. This distinction helps clarify differences in access to services, resources, and infrastructure across Minnesota's diverse geographic regions.

Environmental Overview

Minnesota's PRTFs play a critical role in the continuum of youth mental health care, addressing the needs of individuals who require intensive, inpatient-level services, but not a hospital-level of care. Recent data and stakeholder input reveal persistent challenges in access, service capacity, workforce distribution, and geographic disparities in service delivery.

Key Points:

- PRTFs provide intensive inpatient mental health care for youth under age 21 whose needs cannot be met in less restrictive settings, yet who do not require hospital-level care.
- Admission rates are low due to limited capacity; only 42% of referred youth were admitted in 2024.
- Youth face long wait times for placement and extended stays once admitted.
- Workforce shortages and geographic disparities impact access to care, especially in rural areas.

Hospital resources, emergency response times, and public transportation vary widely across regions.

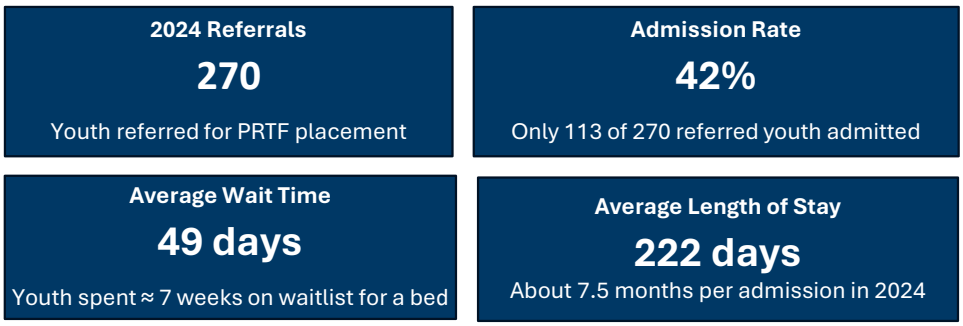
PRTFs in Minnesota's Youth Mental Health System

Minnesota's PRTFs provide intensive inpatient-level mental health care for youth under age 21 in a non-hospital setting. These facilities are designed for individuals whose needs cannot be safely or effectively met in less restrictive environments. PRTFs provide 24/7 therapeutic care, education, and comprehensive discharge planning, with a strong emphasis on family involvement throughout treatment. After approval for care in a PRTF, the placing agency (Minnesota Department of Human Services or county) works with service providers to locate an available bed, as capacity is limited. Children are admitted to a PRTF based on bed availability and service appropriateness, not according to proximity to the child's home. Thus, children may be separated from their communities and support networks.

Access and Capacity

Data from the Minnesota Department of Human Services points to high demand, restricted admission capacity, and prolonged episodes of care among Minnesota's PRTFs. **Figure 1** illustrates that, in 2024, Minnesota's current PRTFs received 270 referrals; only 42% (113) of which were admitted, indicating significant capacity constraints. Those admitted waited an average of 49 days (about seven weeks) for a bed, reflecting access delays. Once placed, the average length of stay was 222 days (about 7.5 months), suggesting intensive treatment needs and slow bed turnover. The available capacity (166 beds) is below the 300 beds authorized by statute. Limited capacity contributes to wait times, placements outside Minnesota, and temporary boarding in hospitals or other settings.

Figure 1. Select MN PRTF Data



Reimbursement

PRTFs are primarily reimbursed through Medicaid, which covers room, board, and therapeutic services. Reimbursement rates are set by the Minnesota Department of Human Services and are based on a daily per diem that includes clinical care, psychiatric oversight, and support services. Private insurance may also cover PRTF services, but coverage and rates vary by policy and facility characteristics.

Need for Services

Minnesota's youth population is nearly evenly split between the Twin Cities metro area (56%) and Greater Minnesota (44%), with future declines projected mainly in rural regions due to aging demographics and

lower birth rates.[1] While urban areas continue to grow modestly, many rural counties face long-term population decreases, which will exacerbate disparities in access to specialized mental health services.[2]

The state's mental health system for children is facing severe strain, as almost all providers either closed or scaled back programs in 2024, and over 80% expect further reductions in 2025.[3]

The shortage of high-acuity treatment settings leaves many youth with complex needs such as severe behavioral challenges, trauma histories, developmental disabilities, or medical complexities without appropriate care. Emergency department boarding and delayed discharges have become routine, with hospitals reporting tens of thousands of avoidable inpatient days due to a lack of community-based options. These systemic gaps highlight the urgent need for expanded and specialized PRTF capacity in Minnesota, alongside policy reforms to stabilize provider reimbursement and workforce sustainability.

Workforce Access and Availability

Minnesota's mental health workforce is concentrated in urban areas, with higher provider-to-population ratios than in rural regions. Metropolitan areas have one licensed mental health care provider for every 197 residents, compared to one for every 741 residents in most rural areas. Eighty percent of Minnesota counties are designated as mental health care provider shortage areas, and 82% of licensed providers are in urban centers. Providers report challenges in recruiting and retaining specialized staff due to reimbursement rates, budget constraints, and workforce availability. Workforce shortages have led to program closures and reductions statewide, with further strain anticipated. Stakeholders identify workforce shortages, especially for secure units and culturally competent, bilingual staff, as a significant barrier to youth residential treatment. Expansion of services and improved outcomes depend on workforce strategies such as partnerships with educational institutions, competitive wages, and targeted incentives.

Table 1 illustrates the disparity in the availability of behavioral health clinicians in rural and urban areas in Minnesota. It shows the number of providers per 100,000 residents for five key behavioral health professions[4]. The data highlights the significant workforce gap facing rural communities, which impacts access to care and the ability to sustain youth

Table 1: Behavioral Health Clinician Supply in Minnesota

Provider Type	Rural (per 100,000)	Urban (per 100,000)
Psychiatrists	6.0	21.2
Psychologists	31.0	74.0
Psychiatric NPs	11.3	13.5
Social Workers	61.6	129.8
Counselors	78.4	162.5

[1] U.S. Census Bureau. (2023). American Community Survey (ACS)
[2] The State of Rural 2025 | Center for Rural Policy and Development

[3] AspireMN. (2025, January). Minnesota's children's mental health services are reporting closures and shrinkage statewide. Retrieved December 2, 2025, from https://assets.senate.mn/committees/2025-2026/3123_Committee_on_Health_and_Human_Services/Closure-and-Diminished-Capacity-in-Childrens-Mental-Health-Jan-2025.pdf
[4] Woolcock SC et al., "The Supply and Rural-Urban Distribution of the Behavioral Health Workforce in Minnesota," WWAMI Rural Health Research Center, University of Washington, October 2025.

mental health programs and facilities statewide.

Access to a qualified workforce is a major challenge for youth mental health programs in Minnesota, especially for new PRTFs that require specialized, resilient staff for secure, high-acuity care. Workforce shortages have already forced closures and reductions in programs statewide, and upcoming rate cuts threaten further strain. Stakeholders consistently cite workforce shortages – particularly for secure units and culturally competent, bilingual staff – as the greatest barrier to effective youth residential treatment. Expanding services and improving outcomes hinges on creative workforce strategies, such as partnerships with colleges, competitive wages, and targeted incentives. Workforce availability is the main obstacle and a key determinant of a new PRTF's success, with location -- metro, rural, or micropolitan— playing a crucial role in recruitment and sustainability.

Proximity to Medical Supports and Services

Minnesota's hospital landscape is diverse, with facilities distributed across metropolitan, micropolitan, and rural regions. The location of a hospital significantly influences the availability and type of medical services, emergency response times, and access to specialized care such as pediatrics, neurology, and autism services. See **Appendix A** for a map of hospitals and PRTFs in Minnesota.

Emergency response times differ widely depending on location. In the Twin Cities metro area, a strong transportation infrastructure and dense hospital networks result in ambulance arrivals within 7 to 10 minutes, on average. Response times in rural regions vary, with some areas facing much greater delays. Rural counties report response time averages of 7 to 26 minutes[5]. These differences reflect the varying availability of hospital resources and transportation options across the state.

Public transportation availability in Minnesota varies by region. The seven-county metro area has extensive public transit systems, including buses and light rail, providing frequent and widespread service. Micropolitan cities offer moderate public transportation options, typically within limited bus routes and schedules focused on central areas. In contrast, rural regions have minimal or no public transit, making residents largely dependent on private vehicles for travel.

[5] MN EMSRB 2024 EMS System Report (https://mn.gov/oems/assets/2024%20EMS%20System%20Report_tcm1221-678986.pdf)

Table 2 summarizes key differences in hospital resources and services across Minnesota's metropolitan, micropolitan, and rural regions. It highlights variations in emergency response times, access to pediatric and specialty care, and the availability of public transportation, providing a comparison of how location impacts health care access for youth and families.

Table 2: Medical Services and Supports in Minnesota

Area	Hospital Type & Services	Emergency Response	Pediatric/Neuro/Autism Specialists
Metro	Level I Trauma, Major Hospital Systems, Children's Hospitals, Robust specialty	7-10 minutes	Extensive
Micropolitan	Regional hospitals, some specialty clinics	5-10 minutes	Moderate, some specialties local
Rural	Critical Access Hospitals, some small regional hospitals, limited specialty care	7-26 minutes	Sparse. Often require travel or transfer

Ensuring Access to School

Youth who are admitted to a PRTF still have the right to attend school. The public school district where the PRTF is located (the *serving district*) is responsible for providing that education. Even though the serving district delivers the instruction, the young person's home district remains financially responsible and reimburses the serving district for general education and, when needed, special education services.

PRTFs play a key role in making sure education can happen. They are responsible for arranging educational services and coordinating with parents and school districts to ensure that clients have access to education.

If a PRTF offers an on-site school program, it must be approved by the Minnesota Department of Education before the facility can be licensed. The application for this approval must be written and submitted jointly by the serving school district and the PRTF, ensuring that both partners are involved in planning and meeting state education requirements.

Estimated Build-Out and Ongoing Operational Costs

Developing a PRTF requires a comprehensive financial strategy that accounts for enhanced services and features required for a locked facility serving a population with complex needs while also balancing the need for long-term financial sustainability. Stakeholders noted the need for higher staffing ratios with specialized clinical staff, a secure-but-therapeutic facility design, substantial on-site enrichment spaces, specialty programming for complex needs, and multiple dedicated units ("pods") for different patient populations. This section outlines estimated build-out costs, ongoing operational expenses, and cost

recovery considerations, enabling informed decisions that align fiscal responsibility with treatment objectives.

Understanding the relationship between development costs, recurring expenditures, and cost recovery opportunities is essential for creating a financially viable and sustainable model that supports regulatory compliance and program excellence. To illustrate the impact of location and facility size, scenarios are provided for 18-, 24-, and 30-bed facilities in both metropolitan and micropolitan/rural areas. In most cases, micropolitan and rural estimates are grouped due to similar cost structures.

Selecting a location for a new facility involves weighing a range of cost factors and infrastructure advantages across metropolitan, micropolitan, and rural settings. Each option presents distinct benefits and risks related to land acquisition, construction expenses, and operational efficiency. The following overview summarizes key considerations for each setting, along with strategies to address challenges.

Estimated Build-Out Costs

Constructing a new PRTF involves several key phases, including site selection, preparation, building construction, and furnishing. Cost estimates are based on publicly available data and account for major inputs such as land acquisition, site development, facility construction, and amenities for patients and staff. For example, state projects come with some standard procurement requirements including prevailing wages (Davis-Bacon Act) and sustainability standards (SB2030) that carry across metro and rural settings. All figures are adjusted for projected inflation through 2028 to reflect current trends in the construction industry. This section provides a clear overview of the assumptions, cost components, and estimated ranges for both metropolitan and micropolitan/rural locations.

Assumptions and Details

Lot size

- Required lot size ranges from 3.0 to 4.4 acres, depending on bed count.

Space Requirements

- Each bed requires 1,300 square feet (including patient and staff areas).
- Parking space allocation is about 430 square feet per space, including alleys and access roads.
- Green space is included, doubling the combined area of the building and parking lot.

Land Costs

- Metro: $14 per square foot (2025 rate), adjusted for inflation.
- Micropolitan/Rural: $9 per square foot (2025 rate), adjusted for inflation.
- Inflation rate for land: about6% per year, projected to 2027 bid approval.

Preparation Costs

- Includes access, drainage, utility connections, green space, and parking.
- Metro areas have higher costs due to infrastructure complexity.

Construction Costs

- Includes all building components: patient rooms, common areas, staff offices, security stations, and utility rooms.
- All construction estimates include funding for contingency spending and commissioning fees.

Furnishings and Equipment

- Medical equipment per bed: $14,000 (all settings) at 2025 rates; inflation-adjusted to $16,721 by 2028.
- Patient room furnishings per bed: $7,980 (2028 estimate).
- Common area furnishings: $18,000 per space.
- The number of common areas increases with facility size (2 for 18 beds, 3 for 24 beds, 4 for 30 beds).

Staff and Technology

- Staff workstation: $5,375 per FTE (inflation-adjusted).
- Security station build-out: $89,000 to$90,000 for a space large enough for three staff.
- Surveillance equipment: $475,000 to $672,000, depending on facility size.

Project Management

- On-site Project Director: $208,000 (2025 rate) + 35% for benefits/payroll.
- Project Manager: $112,000 (2025 rate) + 35% for benefits/payroll.
- Temporary site office and portable restrooms included.

Inflation Adjustments

- All costs are adjusted for inflation to a 2027 bid approval date (unless otherwise noted).

Cost Ranges

- Total costs are similar for metro and micropolitan/rural locations due to offsetting factors (land vs. labor/logistics).

Overall, excluding land, project costs range from $31.8 million to $51.6 million (metro) and $31.7 million to $51.6 million (micropolitan/rural). Including land, costs range from $33.7 million to $54.5 million (metro) and $33.0 million to $53.5 million (micropolitan/rural). Cost differences are offset by labor and logistics efficiencies in metro areas, while metro sites incur higher land and permitting costs. Table 3 illustrates these costs.

Table 3: Key Estimated Build-Out Costs

	Metro			Micropolitan/Rural		
	18 beds	**24 beds**	**30 beds**	**18 beds**	**24 beds**	**30 beds**
Plans and Permits	$3.5M	$4.6M	$5.6M	$3.5M	$4.5M	$5.6M
Property preparation	$0.8M	$1.1M	$1.2M	$0.8M	$1M	$1.1M
Facility construction	$25.4M	$33.7M	$42.1M	$25.4M	$33.8M	$42.2M
Furnishings	$0.4M	$0.6M	$0.7M	$0.4M	$0.6M	$0.7M
Staff & technology	$1.1M	$1.3M	$1.4M	$1.1M	$1.3M	$1.5M
Project management	$0.5M	$0.5M	$0.5M	$0.5M	$0.5M	$0.5M
Total (excluding land)	**$31.8M**	**$41.8M**	**$51.6M**	**$31.7M**	**$41.8M**	**$51.6M**
Land acquisition	$2.0M	$2.5M	$2.9M	$1.2M	$1.6M	$1.9M

See **Appendix B** for a more detailed breakdown of these cost estimates.

Projected Ongoing Operational Expenses

If a facility location is identified around the time the Legislature approves funding, the new facility is scheduled to begin operations approximately 2.5 to 3 years after legislative approval. The new facility will gradually ramp up as staff are trained and the milieu is established in the new program. PRTFs receive a fixed daily rate based on patient characteristics such as diagnosis, age, and severity. It is crucial to define the full costs in the initial budget to create the proper rate related to the acuity and needs of the patients and the proper staffing model.

Staffing Model

Operating a Psychiatric Residential Treatment Facility (PRTF), whether an 18-bed, 24-bed, or 30-bed program, requires a comprehensive, multi-disciplinary team to deliver treatment, ensure safety and maintain efficient 24/7 operations. Each facility must employ a mix of clinical, support and administrative staff covering all aspects of care and facility management. Key positions include:

- Administrative Leadership and Oversight: Each facility should have an on-site Director/Administrator (often with an Assistant Director), QA and Compliance staff to meet regulatory requirements, including accreditation with the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission (accreditation is a PRTF requirement), a dedicated QA manager, compliance officers, a data reporting role, a Data Analyst for tracking patient outcomes and quality metrics, and a Human Resources Manager with support staff for workforce management.
- Clinical and Specialized Treatment Staff: A multidisciplinary team of licensed clinicians, nurses, mental health professionals, substance use counselors, recreation staff, BCBAs, behavioral aides, occupational therapists, and on-call psychiatric and medical providers deliver therapeutic care and supervision for youth in the PRFT. These roles are vital to support youth with diverse mental health conditions, behavioral challenges, and developmental needs.
- Operational Support Staff: Each PRTF relies on support staff for daily operations, including admissions coordinators, food service workers, clerical/administrative staff, safety and security officers, maintenance workers, and janitorial staff to ensure the facility runs smoothly and safely.

PRTFs operate 24/7, requiring multiple staff for each full-time role to cover all shifts, weekends, and absences. Facilities use swing-shift schedules and budget an additional 16 hours per FTE (1.4 FTE) to ensure continuous coverage and maintain safety and care standards at all times.

Most of these roles are fixed, although food service and safety/security staffing vary by facility size and occupancy rates to various degrees. Since PRTFs are funded based on operating expenses the support staff is included within the rate development; therefore, those costs will be included within anticipated cost collections to support the new facility. The ratio for support staff FTEs per patient range from 2.3 to 3.2, with 30-bed facilities being the most efficient. Table 4 displays the estimated FTE counts by facility size.

Table 4: FTE Counts			
	18 beds	**24 beds**	**30 beds**
Clinical & Care Support	76.2	107.8	116.8
Facility Directors	2.8	2.8	2.8
Admissions	8.2	8.2	8.2
Food Service	7.2	7.2	7.2
Clerical	13.4	13.4	17.0
Safety & Security	16.2	21.6	21.6
Maintenance	4.2	4.2	4.2
Janitorial	10.4	10.4	10.4
Total FTE	**138.6**	**175.6**	**188.2**

Salary and Benefits

Salary rates are based on the State of Minnesota Salary Plan Classifications and Salary Ranges as of June 30, 2025. The midpoint of each salary range was used, with adjustments for inflation through 2029. Compensation projections include payroll taxes, medical insurance, pension costs, and accruals for additional pay. Annual cost of living adjustment increases of 2.5% are included to align with inflation, while insurance costs are projected to rise at a higher rate, reflecting historical trends. Table 5 displays these rates for projected staffing levels by job function, based on the Minnesota Management and Budget February 2025 forecast.[6]

Table 5: FTE Salary and Benefits – Year 1			
	18 beds	**24 beds**	**30 beds**
Clinical & Care Support	$10.7M	$14.8M	$15.8M
Facility Directors	$0.5M	$0.5M	$0.5M
Admissions	$1.0M	$1.0M	$1.0M
Food Service	$0.6M	$0.6M	$0.6M
Reception/ Clerical	$1.4M	$1.4M	$1.6M
Safety & Security	$1.1M	$1.4M	$1.4M
Maintenance	$0.5M	$0.5M	$0.5M
Janitorial	$0.9M	$0.9M	$0.9M
Total	$16.6M	$21.1M	$22.3M

[6] Medical Office Space. (2025): https://medicalofficespace.us/calculator/

Operating Costs

In addition to the treatment providers and staff that operate the facility, there will be costs incurred that aid in the care of the patients, maintain comfort, allow for communication, and continued development of the individuals at the campus. A summary of those costs can be seen in **Table 6** by expense type and across sizes of facilities.

Table 6: Operating Costs (non-FTE related) – Year 1			
	18 beds	**24 beds**	**30 beds**
Facility Utilities	$1.0M	$1.4M	$1.7M
Med Supply/Equipment	$0.2M	$0.3M	$0.3M
Food Service	$0.1M	$0.1M	$0.1M
Insurance	$0.1M	$0.2M	$0.2M
Adm Expenses	$0.1M	$0.1M	$0.1M
Maintenance/Replacement	$0.5M	$0.6M	$0.8M
Staff Training/Development	$0.0M	$0.0M	$0.0M
DCT Overhead	$4.4M	$5.7M	$6.2M
Depreciation	$0.6M	$0.8M	$1.0M
Interest Expense	$1.7M	$2.2M	$2.7M
Total	**$8.7M**	**$11.4M**	**$13.2M**

Note: There are no separate or additional projected costs to the PRTF specifically for providing education. Any expenses involved in arranging for school (e.g., providing classroom space, coordinating schedules) are already captured within the broader facility and operating cost estimates.

Financial Projections

The following financial projections provide a comprehensive overview of anticipated operational costs and revenue for the new facility over its initial years of operation. These estimates are designed to provide information about the fiscal realities associated with DCT launching and sustaining a PRTF at various capacity levels. The projections account for staffing, salary and benefits, facility overhead, utilities, supplies, and other essential expenses. They also reflect the expected ramp-up period, ongoing operational needs, and the impact of inflation and insurance costs. They are based on allowable costs anticipated through the PRTF rate setting process defined in Statute 256B.0941, subdivision 3.

The first-year projection for operations is completed by calculating the revenue needed to support the patients and facility. These per diem rates inform the level of funding required for each scenario, excluding start-up costs associated with preparing to begin operations. Those identified operational expenses establish the level of funding necessary to support the population in focus for a PRTF of this nature.

A significant challenge for all DCT programs is the behavioral health workforce shortage. Rural health care and behavioral health staffing gaps are particularly impactful for PRTF operations as noted in our environmental scan. Fully staffing the facility to 100% capacity will be difficult given the current shortage of qualified professionals in Minnesota's behavioral health workforce. Consequently, there will be open bed days (unbillable days) when the PRTF cannot operate at full capacity. [i]

Operating projections assume 20% underutilization for both metro and rural locations to reflect real-world conditions. While staffing shortages may be more likely in rural areas, the impact cannot be quantified with available data. This assumption affects bed utilization and revenue estimates. Because per diem rates are based on projected reimbursable days, any non-reimbursable days create an operational loss. **Table 7** provides a summary of the financial projections for the first year of operations based on above inputs and anticipated appropriations based on bed days (negligible cost differences between facility locations).

Table 7: Summary of Operations – Year 1			
Beds	**18 beds**	**24 beds**	**30 beds**
Salary and Benefits	$16.6M	$21.1M	$22.3M
Non-Compensation Admin	$7.0M	$9.1M	$10.5M
Interest Expense	$1.6M	$2.2M	$2.7M
Operating Costs	**$25.3M**	**$32.5M**	**$35.5M**
Revenue Collections	$15.7M	$20.2M	$22.1M
Surplus / (Loss)	**($9.6M)**	**($12.3M)**	**($13.4M)**

These projections are designed to support informed decision-making regarding funding, rate-setting, and long-term sustainability of the facility (recall; 80% occupancy rate per scenario with a 15% bad debt assumption for protected per diem collections). Overall, **per diem payments are projected to cover 62% of expenditures required for operations and facility-related costs.** Since per diem reimbursements are expected to cover only about 62% of the PRTF's operating and facility costs, DCT will require significant additional funding to keep the facility financially sustainable. DCT cannot fill this remaining gap through other sources like grants, material donations, or private benefactors, so it will need to rely solely on a legislative appropriation to ensure the PRTF's long-term viability.

Location Risk-Benefit Analysis

This analysis evaluates how metropolitan, micropolitan, and rural settings affect the feasibility and sustainability of PRTFs in Minnesota. It draws on research and extensive stakeholder feedback, including input from DCT leadership and community partners. Key factors considered include workforce availability, proximity to medical and support services, family accessibility, community impact, alignment with youth needs, regulatory requirements, and cost considerations. Regardless of whether the facility is located in the metropolitan, micropolitan, or rural area, DCT will admit youth from all regions of Minnesota through a centralized pre-admissions process. This ensures that access to care is equitable and statewide, and that the facility's location does not limit service to any particular geographic area.

Summary of Findings

- Metropolitan locations are generally the most favorable for operational feasibility and service reach, offering strong advantages in workforce, access to specialty care services, and family involvement
- Micropolitan sites (e.g., St. Cloud) present a balanced option, with moderate access to resources and central accessibility for families, but some gaps in specialty care and workforce diversity.

- Rural locations offer unique opportunities for local investment and community integration, but face significant challenges in staffing, specialty care access, and family participation.

Workforce

Workforce availability is the most significant factor influencing PRTF sustainability:

- **Metropolitan** areas typically offer a larger and more diverse pool of qualified staff, supported by university partnerships, established training pipelines, and an increased ability to hire clinical providers. These advantages are balanced by higher wage competition and the potential for increased turnover. However, DCT's experience in metropolitan settings differs from broader stakeholder concerns: DCT reports a turnover rate of only 12-15%%, which is substantially lower than what stakeholders anticipate for metro locations.
- **Micropolitan** regions present a moderate scenario, with access to regional medical centers and local colleges. Although the workforce in these areas may be less diverse and smaller than in metropolitan settings, they can benefit from lower wage pressure and regional recruitment partnerships. Nonetheless, gaps in specialty care coverage and the possibility of staff moving to metropolitan areas are factors to consider.
- **Rural** locations face significant challenges related to workforce availability. These areas often experience chronic staffing shortages, limited diversity, and restricted access to training and professional development. While rural communities may offer lower wage baselines and foster strong local loyalty, attracting and retaining clinical providers and accessing specialty care for this complex group of youth remains difficult.

Stakeholder feedback consistently highlights workforce availability as the primary factor affecting PRTF sustainability across all settings. Each location presents distinct risks and benefits regarding recruitment, retention, and overall workforce stability. Metropolitan areas generally offer the greatest feasibility for staffing, micropolitan areas provide intermediate options, and rural sites may require substantial mitigation strategies to address workforce gaps. Regardless of location, a DCT-operated facility may face greater difficulty attracting staff compared to other PRTFs. It would be admitting the most challenging patients, and many staff are reluctant to work with this population.

Workforce		
	Risk	**Benefit**
Metro	High competition drives wage pressure and turnover; however, DCT does not currently experience high turnover; risk of burnout if positions lag in hiring	Largest, most diverse talent pool; easier local recruitment; strong university partnerships and training pipelines.
Micropolitan	Smaller, less diverse workforce; gaps in clinical providers and other specialty care providers	Moderate talent availability; regional medical centers and colleges; lower competition than metro.
Rural	Severe staffing shortages, especially recruiting/retaining clinical providers; chronic vacancies; limited diversity and training access; costly incentives needed.	Lower wage baseline; potential for strong local loyalty; community pride; ability to grow workforce locally.

Proximity to Medical, Specialty Care & Support Services

Proximity to medical and supportive services directly impacts a PRTF by shaping its ability to provide timely emergency care, access specialized clinical expertise, and connect youth with essential aftercare and educational resources. Facilities located near hospitals, specialty clinics, and support programs can respond quickly to crises, offer a broader range of therapeutic and developmental services, and ensure smoother transitions for youth. In contrast, sites farther from these resources face greater challenges in managing medical emergencies, coordinating ongoing care, and maintaining continuity of services, making strategic partnerships, telehealth, and infrastructure investments critical for bridging gaps and supporting positive outcomes.

- **Metropolitan** facilities benefit from immediate access to emergency care, specialty clinics, and a dense network of support services and educational institutions. However, the abundance of providers and resources can lead to coordination challenges. Metro sites can address these issues by establishing formal liaison roles, use integrated health IT systems, create interagency task forces, and select locations near major hospitals and transit lines. Leveraging telemedicine and written agreements with key partners further streamlines care and ensures rapid response. Notably, DCT's experience differs from other stakeholders: while DCT has formal links with metro hospitals, patients often still require physical transport for most tests and procedures due to limited telehealth options. Some follow-ups can be managed via telehealth, but this in-person care remains necessary.

- **Micropolitan** communities offer nearby regional hospitals, some specialty providers, and moderate access to support programs and educational partnerships. Although these centers may lack the highest-end specialty care, and some youth may be distant from home supports depending on the specific location of the facility, gaps can be mitigated by forming formal links with metro hospitals, utilizing telehealth for specialty consultations, and leveraging local infrastructure for family and provider engagement. Additional strategies such as flexible transportation assistance and partnerships with organizations for family lodging can help maintain continuity and access. As with metropolitan area analysis, DCT's experience indicates transportation is still required for most procedures, and telehealth is not a comprehensive solution.

- **Rural** sites face significant barriers due to distant emergency and specialty care, sparse support services, and limited training resources. Rural facilities can develop robust emergency protocols, contract traveling specialists, maintain on-site urgent care, and invest in telemedicine for ongoing therapy and consultation. Building partnerships with regional centers, creating mobile or distance education services, and operating with scalable staffing models further support care quality and continuity in remote settings.

Proximity to Medical & Support Services		
	Risk	**Benefit**
Metro	Coordination complexity with many providers, however DCT reports already having formalized partnerships in the metro area; possible traffic delays.	Immediate access to emergency and specialty care focused on youth; dense network of clinics, hospitals, and training institutions.
Micropolitan	Limited access to the highest-end specialty care; some youth are far from home supports.	Nearby regional hospitals and some specialists; moderate emergency response times; access to local support programs and educational partnerships.
Rural	Distant emergency and specialty care; sparse support services; limited training resources; slower response times.	Potential for community partnerships

Family Accessibility & Community Impact

Access for families and the broader impact on local communities are important factors in selecting a location for a PRTF. Each setting (metropolitan, micropolitan, and rural) offers different levels of convenience for family involvement and unique opportunities for community integration.

- **Metropolitan**. With approximately 56% of youth and referrals originating from this region, a metro location supports frequent family involvement, offers public transit and ancillary services may be more readily available. The area has experience with similar facilities, which may facilitate integration. Some stakeholders indicated that local opposition to facility location is higher in the metro area; however, some disagreed with this sentiment, believing that opposition can occur anywhere. In addition, stakeholders indicated concerns about concentrating resources in the metro may be a risk. These can be addressed through community engagement, careful site selection, and communication that the facility serves youth from across the state, with travel support for families outside the metro.

- **Micropolitan.** A centrally located micropolitan city, such as St. Cloud, offers a middle-ground solution for accessibility, with most families within a reasonable travel distance. These communities may be receptive to hosting a facility and can benefit from associated economic and service opportunities. Some families, particularly those in remote areas, may still face significant travel requirements, and there may be moderate local concerns. Mitigation strategies include providing travel assistance, tele-engagement options, and emphasizing the facility's statewide service role.

- **Rural.** A rural location benefits families in the immediate area and demonstrates investment in Greater Minnesota. Local support may be strong, and the facility may be integrated into the community. However, most families would experience longer travel times, which could limit participation. There is also a risk of operational isolation. Mitigation strategies include offering travel support, providing tele-family therapy, fostering local partnerships, maintaining connections to statewide resources, and considering future expansion to other regions.

Family Accessibility & Community Impact		
	Risk	**Benefit**
Metro	Potential for NIMBY opposition and zoning hurdles; perception of metro-centricity	Highest family accessibility; public transit options; established service community; ancillary supports
Micropolitan	Still far for some families depending on the specific location utilized; moderate NIMBY/political mixed reactions, with some stakeholders indicating that NIMBY can be high anywhere	Balanced accessibility if centrally located community likely to embrace facility; central location on major highways
Rural	Long distance for the majority of families; possible operational isolation; some NIMBY opposition is present	Close to a small number of rural families; symbolic investment in Greater MN; great local pride and support

Alignment with Youth Needs

The suitability of a facility's location is closely tied to its ability to meet the diverse needs of youth requiring PRTF services. Metropolitan, micropolitan, and rural settings each offer unique advantages and challenges in serving different populations, accessing specialized care, and supporting cultural and demographic diversity.

- **Metropolitan.** Metro locations align with the highest concentration of youth needing PRTF services, particularly those from diverse backgrounds and specialized subgroups such as girls, older teens, and youth with medical or developmental needs. The metro setting offers access to culturally competent staff and specialty care resources, supporting continuity with local support. Risks include potential gaps in addressing rural-specific needs and perceptions of metro-centricity, which can be mitigated through individualized treatment planning and incorporating rural perspectives into staffing and programming.

- **Micropolitan.** A centrally located micropolitan site provides more equitable travel distances for families, serving both urban and rural youth with reasonable travel requirements. It can leverage local and metro resources to address specialized needs and offer a demographically balanced resident mix. Risks include the potential lack of immediate alignment with specific subgroups. Mitigation involves hiring diverse staff, providing targeted programming, and ensuring adaptability in service delivery.

- **Rural.** A rural location may better support those who prefer non-urban settings. It can integrate local cultural practices but may struggle to meet the needs of most of the high-acuity youth needing specialized or culturally diverse services. Risks include limited access to specialized staff and specialty care, and possible cultural isolation for nearly half of the patients served, who would be urban youth placed in rural settings. Mitigation strategies include recruiting specialized staff, fostering cultural competency, and maintaining connections to urban support through partnerships and telehealth.

Alignment with Youth Needs		
	Risk	**Benefit**
Metro	May not address rural-specific perceptions and viewpoints; perception of metro-centricity; cultural mismatch for rural youth	Serves majority of youth near home; access to diverse staff and specialty care resources; supports continuity with cultural communities
Micropolitan	May lack immediate alignment with specific subgroups	A centrally located micropolitan site provides more equitable travel distances for families and access to both local and metro resources for specialized programming
Rural	Limited access to specialized staff/resources; may not serve majority of high-need youth; cultural isolation for urban youth	Supports youth preferring non-urban settings; can integrate local cultural practices

Regulatory and Other Factors

Navigating the regulatory landscape is a critical step in planning a new facility. Each potential location faces specific requirements for licensing, zoning, and permitting, as well as varying degrees of political and community involvement. These factors can influence project timelines, approval processes, and operational parameters, making early assessment and strategic planning essential for successful development.

- **Metropolitan.** A metropolitan location offers proximity to licensing agencies (Minnesota Department of Human Services and Minnesota Department of Health), which can streamline oversight and approvals. Risks include potential delays due to municipal zoning and permitting processes, as well as regional tension among non-metro legislators. Mitigation strategies include selecting sites with existing institutional zoning, initiating permitting early, leveraging political support, and framing the project as a statewide solution with complementary investments in rural areas.

- **Micropolitan.** A centrally located micropolitan site provides balanced family travel accessibility and often gains broader political consensus. Regulatory requirements are typically manageable, and zoning processes are generally less complex than in metro areas. Risks include less urgency or strong advocacy in the Legislature and the need for community acceptance. Mitigation strategies include positioning the site as a practical compromise, engaging local and regional stakeholders, and planning for future reassessment to address unmet needs.

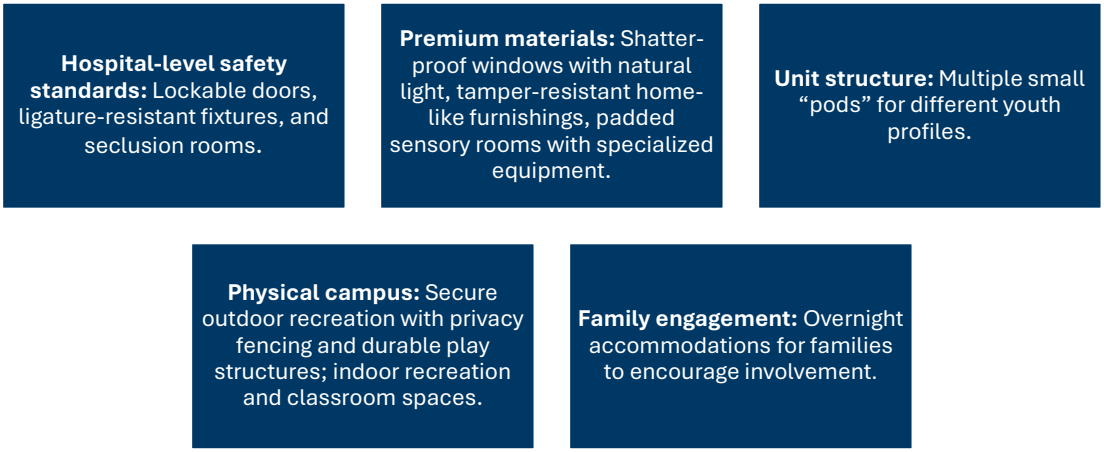
- **Rural.** A rural location may benefit from strong local political support and streamlined zoning processes, with possibly fewer neighbors and flexible land use regulations. Risks include licensing caution due to distance from hospitals, potential program limitations, and resistance from metro legislators. Mitigation strategies include providing travel support for families, working closely with state agencies for provisional licensing, and planning for future metro facilities to address equity concerns.

Regulatory and Other Factors		
	Risk	**Benefit**
Metro	Municipal zoning and permitting delays; regional tension among non-metro legislators	Proximity to licensing agencies; strong political support; expedited oversight and approvals
Micropolitan	Less urgency or strong advocacy in the legislature; need for community acceptance	Broad political consensus; manageable regulatory requirements; flexible zoning
Rural	Licensing caution due to distance from hospitals; potential program limitations; resistance from metro legislators	Enthusiastic local support; streamlined zoning; potential for bipartisan legislative backing

Services Design Enhancements

Stakeholder recommendations for a locked PRTF include enhanced services design elements and are based on promising practices. The location of the PRTF does not impact the recommendation. Therefore, no risk-benefit analysis was conducted. Key recommendations are included in Figure 2.

Figure 2. Service Design Recommendations



Cost Recovery Considerations

The primary sources of payment for the state-run PRTF will be Medical Assistance, Minnesota Care, and some county payments based on their obligations for certain youth along with a small amount of private insurance. All payments received by DCT will be deposited in the state's general fund, not retained by the program. There will be open bed days because of anticipated workforce shortages, and there will be times when there is not a billing source, and the PRTF will provide uncompensated care. The DCT PRTF will support youth who cannot be served by other providers, regardless of their insurance coverage.

Minnesota funds PRTFs through a mix of reimbursement programs, county obligations, and supplemental funding sources:

- **Medical Assistance (MA) and MinnesotaCare** provide coverage for eligible youth under 21 as an inpatient psychiatric benefit. Providers receive a daily rate based on annual cost reports, which include treatment and room-and-board. These programs are the primary source of PRTF funding in Minnesota.
- **Counties** act as the payer of last resort[7], assuming financial responsibility for children's mental health care when no other payer is available. Counties pay for treatment not covered by insurance or MA and cover "non-acute" days—when youth remain in a facility after medical necessity ends—often at the full per diem rate.
- **Private insurers** are not required by Minnesota law to cover PRTF care. Many commercial plans exclude or limit coverage, so families with private insurance often cannot rely on it for PRTF costs. This gap shifts costs to MA, counties, or requires out-of-pocket payment, resulting in non-reimbursable days since the program will take an eligible youth regardless of funding source.

Revenue and Rates

The PRTF is expected to operate at 80% of total billable days across all beds. Current projections assume:

- 80% of the total billable patient days funded by MA and MinnesotaCare
- 5% of the total billable patient days funded by counties with fiscal responsibility
- 15% of the total billable patient days funded by private insurance

These estimates are based on recent financial filings from Minnesota PRTFs, including Grafton Integrated Health Network, Leo A. Hoffmann Center, Nexus Family Healing, and Northwood Children's Services.

Rates for 2029 are based on a cost-based per diem methodology. This process starts with projected allowable costs from a standard PRTF cost report. That total is divided by the number of eligible bed days, which includes assumptions for patients who are staying within the facility and for those that are temporarily out of the facility (short-term hospital admits or temporary family leave) for approved patient leave. All rates are adjusted for inflation over the projection period.

Gross revenue is calculated using payer-specific rates and the distribution of patient days. A 15% reduction is applied to account for disputed fiscal responsibility and payment defaults. This adjustment also identifies opportunities to improve collections over time.

Under a cost-based methodology, projected revenues will cover about 62% of operating costs for a facility with a high staffing model and robust design.

[7] Minn Stat. 252.27.

Policy and Regulatory Frameworks

Compliance with staffing ratios, treatment protocols, and reporting requirements is essential for timely reimbursement and risk mitigation. Strong adherence to regulatory standards reduces administrative overhead and ensures eligibility for payer contracts.

Eligibility and Admission Criteria

Financial sustainability requires a comprehensive revenue model that accounts for occupancy variability and reimbursement structures. Strategies include setting rates, analyzing per diem costs, and maintaining strong data to document the legislative appropriation needed to maintain the program. The state PRTF will have a waitlist based on clinical need, regardless of payer, due to its statutory responsibility to serve all youth. This will result in unfunded bed days and will require legislative appropriation to fund the budget gap. Based on the DCT's experience with its Child and Adolescent Behavioral Health Hospital in Willmar, disputed claims and unpaid claims are considered when building the revenue model.

Understanding the revenue and the unique requirement to serve all youth who meet the criteria is critical for defining the ongoing legislative appropriation needed to sustain this program. Revenue modeling provides DCT with the ability to communicate financial needs and challenges. Table 10 presents a sample revenue model:

Table 10: Sample Revenue Model

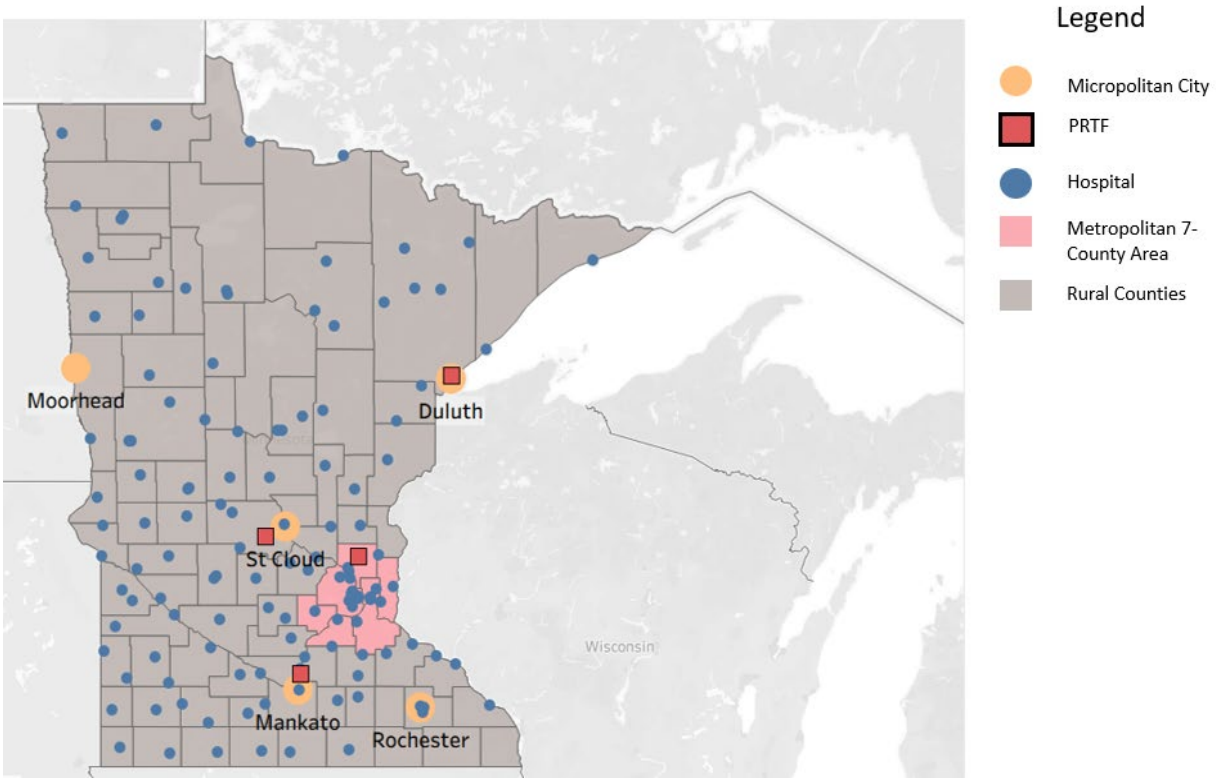
Revenue Source	Description	Estimated Share of Revenue	Notes
Medical Assistance (MA/ Medicaid)	Federal/ state Medicaid reimbursement for eligible youth under 21.	80%	Covers PRTF services when medically necessary; requires prior authorization.
County Payments	The County of financial responsibility pays for non-MA covered services.	5%	Counties pay when youth are placed out of the home and not fully covered by MA. Counties also pay for youth who stay after they are ready for discharge.
Private Insurance	Limited coverage for residential psychiatric care; varies by plan	15%	Often excludes PRTF; may cover partial hospitalization or RTC instead.

Closing

Minnesota's youth mental health system faces significant challenges due to limited PRTF capacity, workforce shortages, and geographic disparities in access to care. While the financial analysis shows that build-out and operating costs remain largely consistent across all settings, selecting a metropolitan site with more favorable access to staff and specialized services, along with a legislative appropriation, will be needed to ensure sustainable operations.

Appendix

A. Hospital and PRTF Locations



B. Estimated Build-Out Costs: Detailed Breakdown Tables

Establishing a PRTF in Minnesota involves several major cost components, each influenced by the facility's location (metro vs. micropolitan/rural) and size (number of beds). Below is a step-by-step overview of the process and associated costs, with tables summarizing key figures.

Land Acquisition. In all scenarios, campus planning began with DCT guidance specifying 1,300 square feet per bed to accommodate both patients and staff. Additional space was allocated for parking, with each spot requiring approximately 430 square feet. This includes a standard 9-by-22-foot space plus necessary alleys and access roads.

To ensure adequate therapeutic green space, the combined area of the building and parking lot (assuming single-story construction) was doubled. This total area serves as the benchmark for evaluating whether existing DCT properties or new land parcels meet the facility's requirements.

Once the number of beds and lot size were determined, locations were compared using land cost assumptions: $9 per square foot for micropolitan/rural areas and $14 per square foot for metro areas (2025 rates). These rates were adjusted for anticipated inflation, estimated at 6% or more per year, up to the projected bid approval date. Factoring in access to utilities, internet, and roads, the estimated cost to acquire suitable land for the facility ranges from $1.2 million to $3.0 million, depending on size and location.

Table 1: Land Acquisition

	18 beds	24 beds	30 beds
Lot Size (acres)	2.8 - 3.0	3.5 - 3.7	4.2 - 4.4
Cost of Land - Metro	$2.0 - $2.2M	$2.4 - $2.6M	$2.9 - $3.0M
Cost of Land - Micropolitan/ Rural	$1.2 - $1.4M	$1.5 - $1.7M	$1.8 - $2.0M

Property Preparation. Once the facility's location and size are finalized, the next step is property development. This includes creating access roads, managing drainage, connecting essential infrastructure (such as water, electricity, sewer, and Internet), establishing green spaces, building the parking lot, and constructing the PRTF facility itself.

Architectural plans must be commissioned, with current DCT estimates range from $2.7 million to $4.5 million at 2025 rates. Adjusted for inflation, these plans are projected to cost between $3.2 million and $5.4 million. After plan approval and successful environmental testing, permits are issued, and site preparation begins. This involves silt control, excavation for accessibility and drainage, and utility connections extended into the build site.

The cost for property preparation, including these activities, is expected to total $0.5 million to $0.8 million, depending on facility size and location. Metro sites generally incur higher costs due to more complex infrastructure, permitting, and environmental testing requirements. All estimates in Table 2:

Property Preparation include a 10% contingency covering unexpected work during construction preparation.

Table 2: Property Preparation

	18 beds	24 beds	30 beds
Lot Size (acres)	2.8 - 3.0	3.5 - 3.7	4.2 - 4.4
Preparation - Metro	$0.6M	$0.7M	$0.8M
Preparation - Micropolitan/ Rural	$0.5M	$0.6M	$0.7M

Facility Construction. After the land is prepared, construction of the facility begins. This phase includes building the structure and all internal spaces: individual bedrooms for patients, an entry area for visitors, common areas for socializing, dedicated rooms for counseling and coaching, staff facilities, a surveillance center for monitoring the grounds, and a utility room for mechanical, electrical, and plumbing systems.

Construction costs historically differ between metro and micropolitan/rural locations. In rural areas, expenses are higher due to limited resource availability, increased transportation costs, and potential shortages of skilled labor. However, current procurement contracts are structured in a manner that allows the state to avoid those cost differentials and have access to necessary materials at a more consistent rate, thus eliminating the differential between metro and micropolitan/rural settings.

All estimates in Table 3: Facility Construction include a 10% contingency for potential cost overruns and a 1.5% allowance for commissioning.

Table 3: Facility Construction

	18 beds	24 beds	30 beds
Facility Size ($ft.^2$)	23,400	31,200	39,000
Construction - Metro	approx. $31.8M	approx. $41.8M	approx. $51.6M
Construction - Micropolitan/ Rural	approx. $31.7M	approx. $41.8M	approx. $51.6M

Furnishings and Equipment. As each area of the facility is completed, installation of medical equipment, furnishings, and technology systems begins. Medical equipment includes vital sign monitors, medication charts, therapy tools, disaster kits, and secure storage. The estimated cost for required medical equipment in a locked PRTF is $14,000 per bed for metro and micropolitan/rural facilities. By 2028, these costs are projected to rise to $16,721 per bed.

Each patient room is outfitted with a bed, medically approved restraints, desk, two chairs, a secured television, dresser, and nightstand, at an estimated cost of $7,980 per room by 2028. There is no cost difference for these furnishings between metro and micropolitan/rural locations, as items are ordered online with delivery included.

Beyond individual rooms, the facility will feature several common areas for patients to gather, relax, watch television, and access a kitchenette. The number of common spaces scales with facility size: two for 18

beds, three for 24 beds, and four for 30 beds. Furnishing each common area is estimated at $18,000. Multiple common spaces allow smaller groups to gather, supporting a more therapeutic environment.

A summary of these furnishing costs is provided in Table 4: Furnishings below.

Table 4: Furnishings			
	18 beds	**24 beds**	**30 beds**
Medical Equipment	$301K	$401K	$502K
Patient Room	$144K	$192K	$240K
Common Area	$43K	$64K	$86K

Staff and Technology. To support staff who provide patient care, as well as security, maintenance, and janitorial teams, the facility construction budget includes necessary equipment and workstations. Based on prior experience and inflation adjustments, each staff workstation is estimated at $5,375, with costs varying by role but sufficient to meet technology needs.

For security, a dedicated and secure monitoring area is required, enabling staff to respond quickly to issues. This space is estimated to cost $400 to$500 per square foot at 2025 rates, with a total build-out cost of $89,000 to $90,000 for an area sized for three staff members. This security center will oversee $448,000 to $669,000 worth of observation equipment and cameras, with costs adjusted for facility size and inflation.

Table 5: Staff and Technology			
	18 beds	**24 beds**	**30 beds**
Staff Equipment	$391K - $392K	$487K - $489K	$515K - $516K
EMR System	$178K - $179K	$178K - $179K	$179K - $180K
Guard Station	$89K - $90K	$89K - $90K	$89K - $90K
Surveillance	$448K - $449K	$577K - $580K	$667K - $669K

Project Management. To manage a project of this scale, the construction budget includes a dedicated project management team. This team consists of an on-site Project Director and a Project Manager, responsible for overseeing progress, coordinating subcontractors, and ensuring all work meets or exceeds code requirements. Given the one-year construction timeline, these roles are well compensated at $207,500 and $111,600 respectively (2025 rates), with an additional 35% allocated for benefits and payroll fees.

The budget also accounts for an on-site office (contractor's trailer) and a sufficient number of portable restrooms for construction workers throughout the project.

Table 6: Project Management			
	18 beds	**24 beds**	**30 beds**
PM Director	$334 - $335K	$334 - $335K	$334 - $335K
PM Manager	$179 - $180K	$179 - $180K	$179 - $180K
Site Office	$9K	$9K	$9K
Portable Restrooms	$10K	$10K	$10K

Total Construction Costs. Based on the inputs and assumptions above, the total cost to establish a facility varies widely depending on its capacity, with location having a relatively limited impact. For Micropolitan/Rural areas, excluding land acquisition, project costs range from $31.8 million to $51.6 million. If land must be purchased, the total rises to $33 million to $53.5 million. Metro area costs are similar: $31.8 million to $51.6 million without land, and $33.7 million to $54.5 million with land included. These similar cost ranges are due to offsetting factors. Metro locations benefit from greater labor availability, reduced travel, and lower freight costs for materials, but have higher land acquisition and environmental testing costs. Rural sites face higher transportation and labor costs but lower land prices.

Table 7: Construction Plan – Micropolitan/Rural			
	18 beds	**24 beds**	**30 beds**
Architectural Plans	$3.5M	$4.5M	$5.6M
Property Preparation	$0.8M	$1.0M	$1.1M
Facility Construction	$25.4M	$33.8M	$42.2M
Furnishings	$0.4M	$0.6M	$0.7M
Staff & Technology	$1.1M	$1.3M	$1.5M
Project Management	$0.5M	$0.5M	$0.5M
Total (excluding land)	**$31.8M**	**$41.8M**	**$51.6M**
Land Acquisition	$1.3M	$1.6M	$1.9M
Total (including land)	**$33.0M**	**$43.4M**	**$53.5M**

Table 8: Construction Plan – Metro			
	18 beds	**24 beds**	**30 beds**
Architectural Plans	$3.5M	$4.6M	$5.6M
Property Preparation	$0.8M	$1.1M	$1.2M
Facility Construction	$25.4M	$33.7M	$42.1M
Furnishings	$0.4M	$0.6M	$0.7M
Staff & Technology	$1.1M	$1.3M	$1.4M
Project Management	$0.5M	$0.5M	$0.5M
Total (excluding land)	**$31.8M**	**$41.8M**	**$51.6M**
Land Acquisition	$2.0M	$2.5M	$2.9M
Total (including land)	**$33.7M**	**$44.3M**	**$54.5M**

[i] Map of Health Professional Shortage Areas: Mental Health, Geographic, by County, October 2025 - Rural Health Information Hub