

Simpson University

College of Osteopathic Medicine Proposal

1. Executive Summary

The North State stands at a critical intersection. Physician supply in several counties remains as low as approximately 44 physicians per 100,000 residents—well below recommended levels of 60–80. The vast majority of Northern California’s rural counties contain federally designated Primary Care Geographic High-Needs Health Professional Shortage Areas.

This proposal outlines the development of a College of Osteopathic Medicine at Simpson University. The program is designed to recruit, train, and retain physicians within the region through a mission-aligned, distributed clinical model. With strong institutional leadership, existing infrastructure, and urgent regional need, this initiative represents a generational opportunity.

2. Defining the Problem

The North State faces structural healthcare challenges. Over 40% of residents who attempted to access primary care within the last year were unable to find a local provider, and 58% experienced wait times longer than four weeks. Patients routinely travel 60–120 miles for specialty care. Hospitals struggle to recruit physicians and rely on temporary solutions that fail to produce long-term stability. Affirming the impact of the severe shortage of primary care physicians in Shasta County, on June 11, 2025, Public Health Officer Dr. Mu [declared a public health crisis](#).

The 17 northernmost counties contain only 2.5% of the state’s population but cover roughly 25% of California’s total land area and experience a disproportionate share of workforce shortages. Shasta County, the second most populous among the northern counties, still operates below statewide averages and reports higher patient loads ($\approx$ 1,283 patients per Primary Care Physician annually). In short, all 17 northernmost counties of California fall below the statewide average for primary-care physician access (1,199 patients per Primary Care Physician), with several rural counties experiencing physician-to-population ratios many times worse than the California average. This represents a measurable and urgent workforce gap across the North State. Without a local training and residency pipeline, physician retention remains limited. Addressing this challenge requires building a system that develops physicians within the region and connects them to long-term practice opportunities.

3. Proposed Solution

Simpson University proposes the development of a College of Osteopathic Medicine designed to address the region’s critical physician shortage through a scalable, community-based training model. The program will enroll at the start 100 and grow to a 200 students per cohort and operate through a distributed hub-and-spoke structure, with anchors in Redding, the East Bay, and the Central Valley producing an extended network of regional clinical partners.

The 100-200 students per cohort model is intentionally aligned with both financial sustainability and accreditation expectations established by the Commission on Osteopathic College Accreditation (COCA). While osteopathic schools used to be able to start with smaller cohort sizes, the expectations from COCA regarding the number of full-time faculty as well as demands for technological support have made smaller initial cohort sizes unsustainable financially. Cohort size at this level ensures sufficient resources to provide the required administrative and operational infrastructure, faculty, clinical training sites and administration, and technological support systems, while also enabling the program to

achieve long-term operational viability. With the hub-and-spoke structure, the large cohort size is manageable because of its distributed nature.

Similar to the Simpson University nursing curriculum, the DO program will emphasize primary care, rural medicine, and community-based clinical training—preparing physicians to meet the specific needs of the North State. The university will prioritize students having opportunities to train within the region throughout their education, building lasting relationships with local healthcare systems and communities. This approach has been shown to significantly improve long-term physician retention in rural and underserved areas.

Growth over time: The inaugural class of 100 students is targeted for August 2030. This timeline provides a disciplined runway for fundraising, faculty recruitment, and program development, as well as the completion of required accreditation and approvals through WASC Senior College and University Commission, Commission on Osteopathic College Accreditation, and the State of California, with a formal institutional commitment anticipated by August 2027. As the university absorbs the initial class and refines capacity across all required functions, it will endeavor to grow to a maximum cap of 200 students in the future years.

Organizational Chart: Attached as Appendix A, the reader will find a draft of the expected organization of the Simpson University School of Osteopathic Medicine which anticipates, at full operation, addition of 27 specialized faculty and up to 40 support staff. It is important to note that while Simpson grows the program many operational functions (such as business office and enrollment) will be shared with the University. Thus, the draft organizational chart should not be seen as exhaustive of all functions.

The reader will see special emphasis later in this report about two options: 1. Renting a building with remodeling to accommodate or 2. Building near campus.

4. Mission Alignment and Institutional Fit: Simpson University is uniquely positioned to lead this initiative. From its founding, the University has been committed to preparing men and women for lives of service, equipped not only with knowledge, but with the character and conviction to meet our nation's most pressing needs. Nowhere is that need more evident than in the rural and underserved communities of the North State. This is not abstract for us—faculty and staff at Simpson University live here, know this region, and are committed to developing solutions that serve our own communities. In this way, Simpson's historic role as a gateway to world service begins here at home, as evidenced by our #3 state-ranked nursing program.

The proposed medical school represents a direct and compelling extension of this mission. It is not a departure, but a natural next step—forming physicians who embody both clinical excellence and a deep, enduring commitment to serve. Rooted in a Christ-centered worldview, Simpson prepares graduates to think critically, lead courageously, and care for patients with compassion and integrity. In this model, medical education is not merely technical training, but formation—equipping physicians to become thoughtful leaders in both clinical practice and the broader ethical conversations shaping modern healthcare. To that end, Simpson will explore integrated pathways, including the opportunity for medical students to simultaneously earn a Master's in Bioethics, positioning graduates as uniquely prepared voices in the medical leadership space.

Importantly, this effort is grounded in demonstrated institutional capacity. Simpson is actively advancing new healthcare programs, including the launch of a Doctor of Psychology (PsyD) and a Family Nurse Practitioner (FNP) program, while continuing to expand an already high-performing nursing program that now graduates approximately 90 students annually. These outcomes reflect a proven ability to design, scale, and sustain rigorous healthcare education in service of regional need. Building on this foundation, the medical school will serve as a catalytic hub for a broader portfolio of aligned health science programs over time—including a post-baccalaureate Master's in Biomedical Sciences, and, as the model matures, potential future programs in dental health, physical and occupational therapy, pharmacy, and other high-need disciplines. Many of these programs can be delivered through hybrid and distance-enabled models, expanding reach while maintaining academic rigor.

This work is further strengthened by Simpson's demonstrated commitment to access and cultural engagement. As a Hispanic-Serving Institution with a student body that is approximately 53% students of color, the University is uniquely positioned to expand access to medical education for both majority and underrepresented populations across the North State, developing a physician workforce that serves the entire region. This alignment is not incidental—it is central to the mission. By increasing representation within the healthcare workforce, Simpson advances measurable outcomes in patient trust, access to care, and long-term health equity in rural and underserved regions. To further this aim, Simpson will intentionally leverage emerging technologies—including AI-supported learning platforms, virtual and augmented reality clinical simulations, and bilingual instructional pathways—to reduce barriers to entry, enhance learning outcomes, and extend opportunity to students who have historically been underserved by traditional medical education models.

In doing so, the University advances its historic role as a gateway to world service, while, in this moment, answering a clear and urgent call at home.

5. Why the Osteopathic Model - Rural regions consistently benefit from the osteopathic (D.O.) model because it produces physicians whose training patterns align with the realities of underserved communities. National data show that approximately 55–60% of D.O. graduates enter primary care—nearly double the rate of M.D. graduates—and D.O.s are about twice as likely to practice in rural or underserved areas. This is reinforced by admissions patterns that favor students from rural backgrounds, who are 2–3 times more likely to return to similar communities to practice. In addition, osteopathic education emphasizes a distributed, community-based clinical training model, placing students in local hospitals and clinics where they build relationships and are more likely to remain long-term. Combined with residency pipelines focused on high-need specialties such as family medicine and internal medicine, the osteopathic model has proven to be one of the most effective, data-driven approaches to addressing persistent physician shortages in rural America.

Sources:

<https://www.aacom.org/reports-programs-initiatives/aacom-reports>

<https://www.hrsa.gov/rural-health/about-us/what-is-rural-health>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7153666/>

At the same time, current training outcomes demonstrate that osteopathic physicians participate fully across the modern medical landscape. Following the transition to a single accreditation system under the Accreditation Council for Graduate Medical Education (ACGME), D.O. graduates now enter the same residency programs as M.D. graduates and match into a broad range of specialties, including competitive fields. Data from the National Resident Matching Program (NRMP) show continued growth in osteopathic representation across specialties, while the American Association of Colleges of Osteopathic Medicine (AACOM) reports expanding graduate output and increasing specialty diversity. In parallel, osteopathic institutions are actively engaged in clinical, translational, and population health research, particularly in areas tied to rural health access and outcomes, as reflected by the American Osteopathic Association (AOA). Together, these data points reflect a model that not only addresses primary care and rural workforce needs but also supports full participation in specialty medicine and scholarly activity.

Sources:

<https://www.nrmp.org/match-data/>

<https://www.aacom.org/news-and-events/news>

6. Clinical Training Rotation- Residency Network Strategy Toward a Fortified Healthcare Ecosystem

Clinical rotation and residency development are central to success. The North State possesses a strong network of hospitals and clinics capable of supporting a distributed clinical education model. Anchor institutions in Redding will support core rotations, while regional and rural sites extend reach. This model ensures both depth and geographic coverage while strengthening ties between students and communities.

Partnerships with hospitals and clinics will support third- and fourth-year clinical rotations as well as residency programs including, but not limited to Family Medicine, Internal Medicine, Psychiatry, and Emergency Medicine. Within the radius of each anchor region, all third and required fourth-year rotations will be available to students, though students may choose to do fourth year rotations elsewhere. Those same regions will have residencies, though again; students may choose to pursue specialist residencies within other hubs, nationally, or internationally. These programs form the bridge from education to practice and significantly increase regional physician retention. Simpson University has engaged three consultants to guide us in seeking out, applying for, and implementing grants and funding for the development of the medical school, the eco-structure around the medical school, and/or graduate medical education (GME).

- **Joseph C. Green Jr. is a Washington, D.C.–based federal lobbyist** with G.S. Proctor & Associates, where he focuses on helping public entities, nonprofits, and educational institutions secure federal funding and navigate the legislative process. His work centers on congressional appropriations, federal grants, and agency engagement, leveraging relationships across Capitol Hill and federal departments. With a background in both state and federal advocacy, he is typically engaged by organizations seeking practical, execution-oriented support in advancing projects and accessing government resource
- **Jhenileen “Jheni” Libongco-Barbour** is the CEO and founder of Continuum Healthcare Network, a Maryland-based healthcare organization focused on expanding access to care through community-based services, care coordination, on-site specialty care, telehealth-related support, and outreach to

underserved and senior populations. With more than two decades of healthcare leadership experience, she has built Continuum as a platform engaged in serving vulnerable populations, particularly in the Mid-Atlantic region.

Her work emphasizes community-based delivery models, care coordination, chronic disease support, senior services, and culturally responsive outreach. She also brings experience participating in community-health partnerships and grant-supported outreach efforts.

For the Rural Northern California Medical School initiative, Ms. Libongco-Barbour's potential value is in helping Simpson University strengthen the project's community-health narrative, stakeholder engagement strategy, understanding of underserved-population needs, and grant-readiness framing.

Ms. Libongco-Barbour is not being presented as the project's technical expert in GME financing, HRSA programs, Title VII health professions funding, congressional appropriations, or large-scale federal medical school development funding. Those specialized areas will require additional technical expertise as the project advances.

• **Keller and Associates is a Washington, D.C.**—based government relations and consulting firm that specializes in federal advocacy, appropriations strategy, and regulatory navigation. The firm works with healthcare organizations, educational institutions, and public agencies to identify funding opportunities, secure federal resources, and position large-scale initiatives within the federal policy landscape, providing both strategic counsel and execution support in Washington.

There are several grant opportunities, including the HCAI Song-Brown and CalRHT grants that may be used to join forces with partner hospitals and clinical sites to fund third- and fourth-year rotations as well as residencies. The consultants have been successful in securing these grants previously. We see this as an important pathway to building the capacity of our clinical partners. These efforts are part of a larger plan to build an ecosystem surrounding the medical school to provide psychologists (through a PsyD program); nurse practitioners (through an MSN-FNP program); expanding the number of BSN and RN nurses in the area, and developing other allied health professionals in concert with partners.

The North State possesses a strong and underutilized network of approximately 29 hospitals and clinical agencies with the capacity to support residency and clinical training, forming the backbone of a distributed clinical education model. Anchor institutions in Redding will provide core rotations and higher-acuity experiences, while regional and rural partner sites extend geographic reach and expose students to the full spectrum of community-based care. Over time, this network is expected to expand significantly—both deeper into rural Northern California and into strategically aligned partner systems across neighboring regions and states—creating a broader, integrated clinical training platform capable of supporting long-term growth in both undergraduate medical education and residency development.

A central component of our engagement with SALUD Education is the design and formalization of a distributed clinical training network, including affiliation agreements, rotation structure, and alignment with accreditation requirements. This work is supported by a development team with extensive experience in the accreditation and launch of osteopathic medical schools, bringing a proven framework for building scalable, community-based clinical training systems.

SALUD provides a turnkey development and operational model, leading the hiring and management of faculty and staff, development of clinical education and residency programs, and oversight of accreditation and licensing, while also supporting communications and marketing in partnership with Simpson. From project initiation, the anticipated timeline includes approximately three years to opening, three additional years to reach positive cash flow, one additional year to graduate the first class, and two further years to reach stable, fully approved enrollment.

Simpson University has already begun informal conversations with potential clinical partners and will build upon an existing network of approximately 29 North State hospitals and agencies capable of supporting training. While select specialty rotations will be supplemented through out-of-region or out-of-state partnerships, priority will remain on maximizing placements within the North State to meet accreditation standards and establish a durable, community-based physician pipeline. This model ensures both clinical depth and geographic continuity, in contrast to programs that rely heavily on decentralized, student-sourced rotations.

A strong precedent exists in the development of the Burrell College of Osteopathic Medicine in New Mexico, where members of the SALUD leadership team helped establish a hub-and-spoke network that produced more than 400 residency positions and over 900 clinical preceptors—approximately three times the required minimum—significantly increasing regional physician supply. Building on this model, Simpson would target approximately 1,200 preceptors across a Northern California-centered network extending into Oregon, the Central Valley, and the East Bay, positioning the program for both accreditation success and long-term regional impact.

Simpson University is currently in discussions with George Mychaskiw, a principal of SALUD Education, regarding his potential service as the inaugural medical school Dean. Dr. Mychaskiw brings extensive experience in the development, accreditation, and launch of new medical schools across both for-profit and nonprofit models. He served as Founding Dean of the Burrell College of Osteopathic Medicine, where he played a central role in establishing the institution's academic, operational, and accreditation framework. His leadership contributions also include the development of the Idaho College of Osteopathic Medicine and California Health Sciences University College of Osteopathic Medicine in Fresno, as well as the establishment of a branch campus for New York Institute of Technology College of Osteopathic Medicine at Arkansas State University. In collaboration with his broader development team, Dr. Mychaskiw has supported additional projects such as the Orlando College of Osteopathic Medicine, the Meritus School of Osteopathic Medicine in Maryland, and emerging initiatives including a proposed program at the University of Dubuque. Collectively, his associates have contributed to the development of additional international and U.S.-based programs, including Ponce Health Sciences University (Puerto Rico and St. Louis), St. Luke School of Medicine, and the University of Nicosia Medical School in Cyprus, reflecting a depth of experience that is highly aligned with the successful launch and long-term operation of a new medical school.

This body of work reflects a rare combination of experience across feasibility, capital structuring, accreditation, and operational launch, positioning SALUD as a uniquely capable partner in translating a medical school concept into a fully accredited and operational institution.

It will be the responsibility of the inaugural dean to lead in the development and implementation of a phased residency plan with committed residency slots, signed hospital commitments, and target counts

by specialty. These actions will move from the current informal conversations with partners to the establishment of signed memorandums of understanding, hospital commitments, residency guarantees and finalized clinical affiliation agreements.

Good, validated data show that about 45% of medical students remain in practice in the region where their medical school is located. This increases to >65% if they also complete residency in the same area. While some students will complete their residency outside of the North State area, the hub-and-spoke model with dedicated residencies in the region will help ensure that a significant percentage will stay and practice in the region.

7. Market Demand and Student Pipeline

Statistics published by the Association of American Medical Colleges show that California medical schools produce far fewer students per capita than the national average, having just 21.1 students per 100,000 persons, compared to the United States average of 37.9 students per 100,000 persons. This places California 43rd out of 46 states for medical student enrollment per capita. This is despite the fact that California consistently ranks among the states with the highest number of students applying for medical school. The net result is that California is by far the largest exporter of medical students in the United States. There is, therefore, substantial room for more medical school seats in California. Demand for mission-aligned medical education continues to grow. Simpson's existing academic programs provide a strong internal pipeline, while external recruitment will attract service-oriented students.

8. Financial Model and ROI

The financial model detailed in Appendix B reflects a disciplined, phased investment approach designed to support both accreditation requirements and long-term financial sustainability. Appendix B specifically outlines the baseline model for launching the medical school, predicated on an initial cohort of 100 students and scaling to 200 students over the subsequent three years. This model assumes the leasing and modification of an existing facility as the most efficient and cost-effective entry point. It should be noted that all modeled scenarios—regardless of facility approach—require a \$60 million escrow in alignment with accreditation standards. The structure of this escrow, along with alternative development pathways including new facility construction, is addressed in greater detail later in this document.

During the pre-accreditation and initial build-out period, the project requires significant upfront investment in personnel, program development, accreditation, infrastructure, working capital, and related start-up expenses, while generating limited tuition revenue prior to the matriculation of the first class. As modeled, the program transitions to positive annual operating performance as enrollment matures; however, that transition depends on Simpson University successfully securing and deploying substantial early-stage support, including philanthropic operating support, capital gifts, debt financing, and other institutional commitments needed to carry the project through launch and enrollment ramp-up.

Accordingly, the model demonstrates that Simpson University must assemble and manage a substantial launch-period financing package before the program reaches sustainable enrollment scale. This includes significant fundraising requirements and debt obligations that remain part of the University's financial responsibility even as annual operating performance improves.

Within this context, the requested investment from Shasta County serves as a critical early anchor. These funds are foundational, supporting the initial development window prior to first matriculation and offsetting a meaningful portion of early personnel, accreditation, program development, and infrastructure costs. By reducing the upfront capital burden, this contribution strengthens the project's financial position during its most capital-intensive phase and helps create the confidence necessary to attract additional philanthropic, healthcare, educational, and federal partners.

As the program matures and reaches steady-state enrollment, the financial model demonstrates the ability to generate consistent positive operating margins. These margins are expected to support long-term financial stability and provide the capacity to absorb and service debt obligations associated with construction, start-up costs, and early-stage financing. In this way, the model is designed to move from launch-period investment to sustained operational strength without relying on continued external subsidy once the program reaches scale.

Together, this structure reflects a balanced and responsible approach: Simpson University leads with significant institutional commitment, while local partnership helps stabilize the earliest and most capital-intensive phase of development. Over time, the model transitions from upfront investment and launch-period financing to sustained operating performance, supporting both institutional durability and the long-term healthcare and economic needs of the region.

9. Regional Economic Impact

Over a ten-year horizon, the program is projected to generate \$700M–\$1B in economic activity through job creation, healthcare stability, and regional investment. Validated economic outcome data show that the construction of a medical school would provide a \$120 million impact and 350 jobs during construction with a sustained direct economic impact of at least \$80 million per year and over 100 new permanent jobs. Every physician who stays in the region has an economic impact of \$2 million annually and 9 new jobs. Certainly, the establishment of a medical school will not eliminate poverty or population decline by itself. However, the medical school can help make healthcare an anchor industry that provide resources to address these contextual factors.

A 2023 Tripp Umbach report produced for a potential osteopathic school proposed for a faith-based school in Kansas estimated an annual national economic impact of approximately \$100 million annually by 2030 and \$149 million annually by 2050. Similarly, they projected the net savings in emergency room utilization to grow from \$1.2 million annually in 2035 to \$6.7 million in 2050. Finally, the report projected creating and supporting 662 jobs in 2030, growing to 994 by 2050.

In 2025, Tripp Umbach conducted a study for the Philadelphia College of Osteopathic Medicine (PCOM) in Georgia. Founded in 2005, it now has an annual economic impact of \$292.5 million and supports 1580 jobs. The report also found that on average each DO practitioner produced by the school had an economic impact of \$2.2 million, supported 17 jobs, and contributed over \$100,000 in state and local taxes.

10. Funds required

This section summarizes the capital required to establish the medical school. It does not reflect the operating financial model. That model can be found in Appendix B.

Option 1.

- a. \$60M accreditation escrow is required by COCA for a class starting at 100 and eventually graduating to 200 students at \$60,000 annual tuition plus \$5000 fees
- b. \$42M Curriculum, program, faculty and development capital

Option 2.

- a. \$60M accreditation escrow is required by COCA for a class of 100 and eventually graduating 200 students at \$60,000 annual tuition plus \$5000 fees
- b. \$42M Curriculum, program, faculty and development capital
- c. Project includes a new building add \$62M

Escrow Defined - funds held in accordance with Commission on Osteopathic College Accreditation requirements, representing approximately four years of tuition exposure. These funds are fully invested and continue to generate returns, serving as a restricted guarantee rather than an expense, and are substantially recaptured upon the graduation of the inaugural class.

11. First Funds -The initial \$10 million investment from the County is a **critical catalytic commitment** that allows this project to move from concept to execution. These funds will be deployed in the earliest and highest-impact phase—supporting accreditation readiness, architectural and engineering work, site development, legal structuring, and the initial build-out required to matriculate the first class. Just as importantly, this commitment serves as a **signal of local partnership and confidence**, unlocking significantly larger private investment—including the \$50–\$60 million escrow required by the Commission on Osteopathic College Accreditation—as well as philanthropic and institutional capital. In practical terms, the County’s \$10 million is not simply funding a portion of the project; it is the **keystone investment** that makes the entire effort viable, positioning the North State to secure a generational asset in healthcare, workforce development, and economic growth.

12. Facilities Plan

Option 1. The first option discussed is the least expensive in that administration will be housed on campus and requires purchase or lease of a building with at least 85,000 square feet with an anticipated investment of at least \$5-10M if purchased plus \$10-15M for renovation. Ideally, an 85,000 square foot building would support classrooms, labs, simulation, and student services There are excellent examples

of such renovations. For instance, the picture below is a Walmart repurposed as a city hall in Westland Michigan.



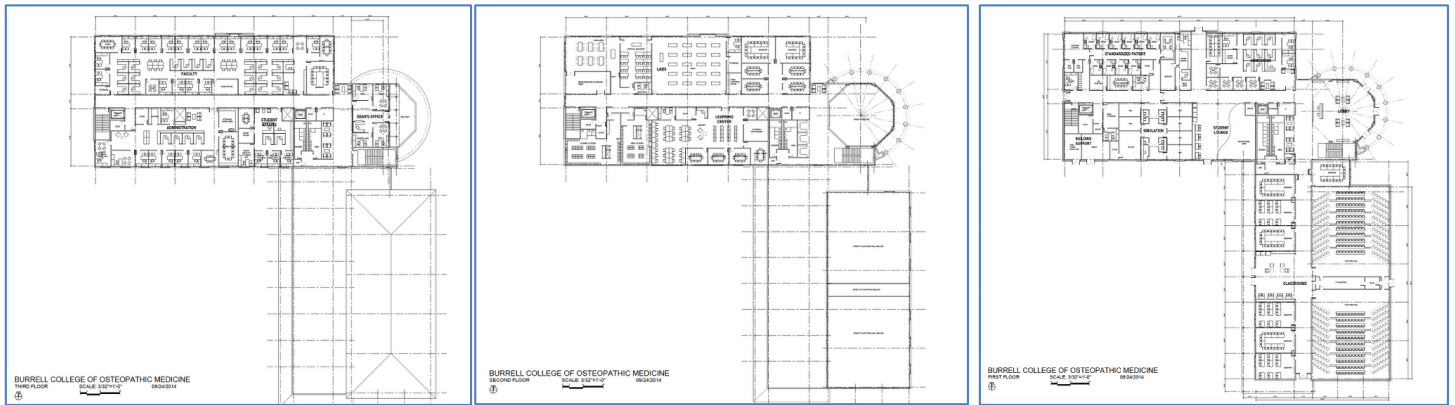
Option 2. The University again would house some of the administration in current office space on campus. A new medical school building would include construction of an 80,000 square foot building to support classrooms, labs, simulation, and student services. The anticipated cost is

Construction	42,880,000	80K x \$536
A&E (9%)	3,859,200	Soft costs
Permits	1,000,000	City/fees
FF&E	8,000,000	Furniture/equip
Contingency (10%)	4,288,000	On construction
Parking	2,100,000	280 spaces @ \$7,500
Total	62,127,200	All-in

\$62,127,200 at \$536 sq ft is \$42,880,000 plus \$4,288,000 for contingency, \$3,859,200 for architectural & engineering, \$8M for furniture/fixtures/equipment. With a bond for \$60M, leaving \$4,288,000 for contingency, and permitting, \$7M for furniture, \$2,100,000 for parking and \$1,000,000 for city required permitting and curb appeal improvements. The building is proposed to inhabit flat undeveloped 6-acre parcel of land on Simpson University's campus at 2211 Shasta View Drive, Redding CA. Note that the university will stay open to other locations should one be presented that would be financially advantageous. The university will also stay open to a partnership that will allow for addition of a clinic to the space.

Because of our partnership with SALUD the university is afforded the opportunity to consider facilities based upon prior associated projects such as the one below constructed at Burrell College of Osteopathic Medicine at New Mexico State University. Picture are attached here for reference:





13. Funding Strategy

Funding will be secured through philanthropy, public investment, and institutional commitment. While it is too early to be precise about the exact fund sources and amounts, the following describes early funding framework aimed at supporting accreditation readiness and development.

Fund sources include pursuit of the following:

- **Private Bonds** for building development broken down below – via Consultation with Mesirow - a national financial services firm that provides investment banking, public finance advisory, and capital markets expertise to institutions undertaking large, complex projects. In the context of bond financing, Mesirow serves as a strategic advisor and underwriter—helping structure tax-exempt bond offerings, assess market conditions, secure credit ratings, and connect issuers with investors. They guide organizations through the full process, from initial feasibility and financial modeling to pricing and closing the bond, ensuring the deal is attractive to the market and aligned with long-term financial goals. For a medical school project, Mesirow would help translate the vision into a credible, financeable bond structure that can successfully raise capital at competitive rates.
- **Private or public funding for escrow** – Public or Private persons often assist with establishing the escrow in order to satisfy the COCA requirement. These funds are fully invested and continue to generate returns, serving as a restricted guarantee rather than an expense, and are substantially recaptured upon the graduation of the inaugural class.
- **Funds will be raised privately and through government funds to launch academic program** - including but not limited to:
 - **HCAI** – The California Department of Health Care Access and Information is a state agency that funds and supports healthcare infrastructure and workforce development through grant programs, data resources, and targeted initiatives aimed at improving access to care—especially in underserved and rural communities. Unlike financing authorities, HCAI often provides **direct grant funding** for projects that expand clinical capacity, grow the healthcare workforce, and strengthen regional delivery systems. We believe a medical school in Northern California is a strong candidate for HCAI support because it directly addresses documented physician shortages across a multi-county underserved region, aligns with state priorities around workforce pipeline development, and creates a sustainable, community-based solution to improving long-term access to care.

- **CEFA-** The California Educational Facilities Authority is a state financing authority that helps nonprofit colleges and universities fund academic facilities and infrastructure by providing access to tax-exempt bond financing and related financial tools. These programs are designed to lower borrowing costs and make it more feasible to develop high-impact educational projects, including those tied to workforce preparation and regional economic needs. While CEFA does not typically provide large direct grants, its financing structure can significantly reduce the long-term cost of capital. We believe a medical school qualifies strongly for CEFA support because it represents a major educational expansion, aligns with the state's priority to grow healthcare workforce capacity, and serves a critical regional need by preparing future physicians in an underserved part of California.
- **CHFFA-** The California Health Facilities Financing Authority is a state agency that supports nonprofit healthcare and workforce development projects by providing access to tax-exempt bond financing, credit enhancements, and targeted grant programs. These tools are designed to lower the cost of building and operating facilities that expand healthcare access, particularly in underserved and rural regions. While CHFFA does not typically fund projects outright, it enables institutions to finance major initiatives more affordably and, in some cases, provides direct grant support for workforce pipeline efforts. We believe a medical school in Northern California is a strong candidate because it directly addresses documented physician shortages across a multi-county underserved region, aligns with CHFFA's mission to expand healthcare capacity, and represents a long-term, community-based solution to improving access to care.
- **Federal Economic Development funds** - The U.S. Economic Development Administration provides competitive federal grants to support projects that drive regional economic growth, job creation, and workforce development. While not designed specifically for higher education, EDA funding is highly applicable to a medical school when positioned as a regional economic engine, creating healthcare jobs, expanding the physician workforce, and strengthening long-term economic stability in an underserved area. This makes a Northern California medical school a strong candidate when paired with clear economic impact metrics and broad regional partnerships.
- **Support from effected local county governments**— the first request of \$10 million from Shasta County
- **Partnership(s) to sublease housing** shall generate approx. \$1M annually
- **Congressional Directed Spending (CDS)**—often called earmarks—is funding that members of Congress can request for specific community projects through the annual federal appropriations process. These funds are **project-specific grants** (not loans) and typically require a clear public benefit, strong community support, and a credible sponsoring entity (such as a university or nonprofit). For a medical school initiative, CDS can be a powerful source of early capital when framed around **healthcare workforce development, rural access to care, and regional economic impact**. Successful requests usually include defined project scope (e.g., facilities, training programs), documented need (physician shortages), matching funds or partnerships, and endorsements from local governments and health systems—making them well aligned with a Northern California medical school positioned as both a public health and economic development priority.
- The **California Employment Development Department (EDD) workforce grants** are a set of state and federally funded programs designed to build regional talent pipelines in

- high-demand fields like healthcare. Through initiatives such as High Road Training Partnerships, Workforce Accelerator Funds, and WIOA-based regional grants, EDD provides funding—ranging from small pilot awards to multi-million-dollar partnerships—to support employer-driven training, career pathway development, and workforce coordination. While these funds do not typically support capital construction, they are highly strategic for initiatives like a medical school, as they can finance the surrounding ecosystem: clinical training networks, allied health pipelines, and rural workforce retention efforts. In regions like California’s North State, where workforce shortages are well documented, EDD grants can serve as a critical lever to build and sustain a distributed, employer-aligned healthcare workforce system.
- Additional funding considerations could include exploring large private foundations:
 - [Robert Wood Johnson Foundation](#): Major funder of health and healthcare initiatives.
 - [Josiah Macy Jr. Foundation](#): Focuses on health professional education and training.
 - [Howard Hughes Medical Institute](#) (HHMI): Provides grants to institutions for science education and research infrastructure.
 - [Bill & Melinda Gates Foundation](#): Focuses primarily on global health, but a potential source for innovative global health programs within a new institution.
 - MacKenzie Scott’s [Yield Giving](#) and [Lever for Change](#): Known for large, unrestricted gifts to educational institutions, including those with medical colleges.
 - [The Arnold P. Gold Foundation](#): Supports humanism in medicine and related educational programs.
 - [Arthur Vining Davis Foundations](#): Provides grants for educational and scientific institutions.

14. Accreditation Pathway

The program will follow COCA accreditation standards, including leadership hiring, curriculum development, and a \$60M escrow requirement. Timeline to launch is approximately 2–3 years.

Specifically, Simpson University is negotiating a partnership with SALUD Education, who provides particularly high value in the accreditation phase by aligning early feasibility work directly with accreditor expectations. In addition to the market analysis found in Appendix C, SALUD will develop a second set of rigorous market demand and feasibility demand analyses, covering student pipeline, regional workforce need, clinical training capacity, and long-term financial sustainability, structured to meet the evidentiary standards required by accreditors.

SALUD Education represents one of the most experienced medical school development organizations currently operating in the United States. Its leadership and affiliated teams have been involved in the development of approximately 16% of existing osteopathic medical colleges nationally, with a demonstrated track record of delivering institutions on schedule and at or below projected cost. The team includes former medical school deans, presidents, chief financial officers, and individuals with direct experience in COCA accreditation and regulatory oversight.

This work is then translated into the formal documentation needed for the Commission on Osteopathic College Accreditation, including the pre-accreditation application, self-study, and readiness for site visits. As part of this engagement, SALUD provides comprehensive, end-to-end development support across the full accreditation lifecycle, including preparation and submission of all COCA-required documentation, management of the accreditation process and timelines, development of COCA-compliant financial models and audits, recruitment and vetting of key leadership (including the founding dean and academic officers), development of curriculum and faculty models, coordination of WASC and State of California approval processes, and design of clinical training and residency (GME) strategies. This integrated approach ensures that all components—academic, financial, operational, and clinical—are aligned with accreditor expectations from the outset.

By integrating financial modeling, facilities planning, governance structure, and clinical network development into a single coherent narrative, SALUD helps ensure that the institution is not only conceptually sound but demonstrably capable of meeting accreditation benchmarks from the outset, effectively bridging the gap between initial concept and a credible, approvable pathway to accreditation. From the point of initial application filing, the anticipated timeline to matriculation of the inaugural class is approximately 38–42 months, aligning with Simpson University’s targeted August 2030 launch. Timeline and specifics are detailed below.

Within this partnership, Simpson University retains full institutional responsibility for governance, employment of personnel, and financial commitments, including salaries, benefits, capital expenditures, and required third-party costs. SALUD assumes responsibility for development execution, process management, and delivery of an accreditation-ready institution. This clear delineation of roles ensures both institutional control and expert-led execution throughout the development process.

A detailed description of SALUD Education’s scope of services and institutional responsibilities is provided in **Appendix D**.

15. Implementation Timeline

Executive Summary

To achieve an August 2030 opening, the institution must reach COCA Pre-Accreditation by mid-2029, with Applicant Status by 2027 and Candidate Status by 2028, while completing WASC and state approvals in parallel

Critical Path

- COCA accreditation milestones
- Clinical rotation agreements
- Financial capacity and escrow requirements

2026 – Mid 2027: Feasibility and Institutional Readiness

- Formal project launch and governance structure
- Initiate WASC substantive change discussions
- Begin COCA applicant preparation
- Hire Founding Dean and accreditation leadership
- Advance site selection and facility planning

Benchmark (end of this phase): Enter WASC pipeline and be prepared to submit for COCA Applicant Status

Mid 2027 – Mid 2028: COCA Applicant to Candidate Status

- Submit COCA application for Applicant Status
- Complete initial site visit
- Achieve Applicant Status
- Submit feasibility study and self-study
- Complete second site visit
- Achieve Candidate Status

Benchmark (end of this phase): Applicant Status achieved and Candidate Status secured

Mid 2028 – Mid 2029: Pre-Accreditation Phase

- Submit full operational readiness documentation
- Demonstrate faculty hiring, clinical rotations, and financial sustainability
- Complete pre-accreditation site visit
- Achieve COCA Pre-Accreditation

Benchmark (end of this phase): Pre-Accreditation granted (required before recruitment begins)

2029 – August 2030: Recruitment and Launch

- Open application cycle (AACOMAS)
- Recruit and admit inaugural class
- Finalize faculty, operations, and facility readiness
- Matriculate first class

Benchmark (end of this phase): First class successfully enrolled August 2030

WASC Parallel Track

- 2026–2027: Engagement and concept development
- 2027–2028: Substantive change submission
- 2028–2029: Review and approval

Benchmark: WASC approval secured prior to COCA Pre-Accreditation

California State Approval

- Begin regulatory engagement in 2027
- Complete approvals by 2029

Benchmark: State approval secured prior to student recruitment.

16. Risk Analysis and Mitigation: Primary risks include financial exposure, accreditation uncertainty, and clinical training capacity. These are mitigated through phased capital deployment tied to accreditation milestones, partnership with SALUD Education to ensure accreditor alignment, and the development of a distributed clinical network anchored in the North State and supplemented as needed by out-of-state partners.

This partnership is further strengthened by SALUD's demonstrated track record in delivering accredited

Risk Category	Description	Mitigation Strategy
Financial Risk	High upfront capital requirements and long ramp to revenue	Phased investment tied to accreditation milestones; diversified funding (grants, bonds, partnerships); potential land contribution
Accreditation Risk	Failure to meet COCA/LCME standards could delay or halt program	Early alignment with SALUD; structured feasibility studies; accreditation-driven design of governance, curriculum, and facilities
Clinical Capacity Risk	Insufficient rotation/residency slots in region	Leverage ~29 North State agencies; formal affiliation agreements; hub-and-spoke model; supplement out-of-state as needed
Enrollment Risk	Failure to meet student recruitment targets	Strong mission positioning; bundled housing; regional pipeline programs
Operational Risk	Complexity of launching academic and clinical enterprise	Experienced leadership recruitment; phased staffing; proven rural training models
Market/Political Risk	Competing programs and regional dynamics	First-mover advantage; strong partnerships; clear economic and workforce impact narrative

medical school programs on schedule and within projected financial parameters, reducing execution risk during the most complex phases of development.

This structured approach limits upfront risk while positioning the program for sustainable growth. Reference chart at right.

17. Case Study: Rural Medical Education Models (Refined) Comparable rural medical schools demonstrate that regionally anchored training models can produce strong physician retention outcomes in underserved areas. In evaluating approaches that have successfully addressed these shortages, the committee reviewed both legacy institutions with demonstrated long-term impact and more recent schools that reflect contemporary design, scale, and regulatory realities.

One of the most instructive long-term examples is the University of Pikeville – Kentucky College of Osteopathic Medicine. Founded in 1997 in rural Appalachia, UPIKE-KYCOM was established specifically to address a significant deficit of primary-care physicians across eastern Kentucky and surrounding underserved counties. Its mission, admissions priorities, and distributed clinical training model were intentionally aligned to prepare graduates for sustained service in rural communities. Over time, this approach has proven that a mission-driven, community-embedded model can meaningfully improve physician supply in high-need regions.

While UPIKE provides compelling evidence of long-term impact, more recent institutions offer a closer structural comparison to the proposed model at Simpson. The Burrell College of Osteopathic Medicine reflects a modern, Western-based approach to medical education—built on distributed clinical partnerships, scalable infrastructure, and intentional alignment with regional workforce needs. Its model demonstrates how newer schools can rapidly develop multi-site clinical training networks while maintaining academic rigor and expanding access to underserved populations.

Taken together, these models—one proving durability over time, the other demonstrating modern execution—highlight three mutually reinforcing strategies that will define Simpson University’s approach:

- a. **Targeted Recruitment** – Prioritizing admission of students from rural, underserved, and mission-aligned backgrounds, particularly those with demonstrated ties to the North State, thereby increasing the likelihood of long-term regional retention.
- b. **Place-Based and Distributed Clinical Training** – Embedding students within a broad and expanding network of hospitals and clinical sites across rural Northern California and, over time, strategically aligned regions beyond, creating deep community ties while scaling clinical capacity.
- c. **Primary Care and Community Health Orientation** – Emphasizing family medicine, internal medicine, pediatrics, and other high-need disciplines, while preparing graduates to meet the full spectrum of rural healthcare needs.

The measurable outcomes of this approach are significant. At UPIKE-KYCOM, more than 70 percent of graduates enter primary-care residencies, and approximately 41 percent establish practice within the Appalachian region—substantially expanding physician access across underserved communities. This sustained impact has contributed to national recognition, including a #3 ranking for the number of graduates practicing in rural areas (U.S. News & World Report, 2024).

18. Why This Will Work Here

The North State mirrors other successful rural medical education regions, but with several distinct advantages that strengthen the likelihood of success. Unlike many rural models, this region combines a **meaningful population base, an existing network of approximately 29 hospitals and clinical agencies, and strong anchor institutions in Redding** capable of supporting core training. The area’s designation as a multi-county underserved region creates both a clear **workforce demand signal** and a compelling case for public and private investment. In addition, there is a high degree of **institutional alignment** among local government, healthcare providers, and educational partners—an essential ingredient that has been lacking in many unsuccessful efforts elsewhere.

Equally important, the distributed clinical model allows the program to **scale across a broad geographic footprint**, placing students in the very communities where long-term physician retention is most needed. This “train where you serve” approach has been proven to significantly increase the likelihood that graduates remain in-region. When combined with Simpson University’s mission-driven framework, available land, and ability to coordinate partnerships, the North State is not simply comparable to other rural training environments—it is uniquely positioned to sustain a medical school that is both operationally viable and transformational in its regional impact.

A medical school at Simpson University will not solve the physician and healthcare worker shortage by itself. Other initiatives will need to be engaged including retention incentives, housing for practicing physicians, compensation strategies, and healthcare system reform. Yet, all those strategies, without a medical school, with a steady pool of ‘home-grown’ doctors are likely to be ineffective. Further, the existence of the medical school will eventually result in reducing the need for retention incentives and/or beyond-market compensation strategies since many of the doctors will now be local.

19. Conclusion. This initiative represents a generational opportunity to transform healthcare access in the North State. This step positions us to shape healthcare in the North State for generations.

Appendix A Organizational Chart

Below is a draft organizational chart identifying the significant administrative and faculty positions and their reporting relationships. It is not exhaustive of all functions and positions since some of those will be shared with the University. It is color-coded to identify the year in which the positions will be in place (purple in Year 0-2, dark blue in Year 0-1, blue in Year 0, green in Year 1, and orange in Year 3).

Financial Model

Breakdown Analysis

Project Investment

Medical School												
Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2
2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28
Tuition	-	-	-	6,000,000	-	30,299,304	-	42,485,226	-	40,344,816	-	52,371,134
Fees	-	-	-	500,000	-	2,521,942	-	3,144,435	-	4,237,147	-	4,360,261
Books	-	-	-	500,000	-	2,521,942	-	3,144,435	-	4,237,147	-	4,360,261
Supplies	-	-	-	500,000	-	2,521,942	-	3,144,435	-	4,237,147	-	4,360,261
Student Services	-	-	-	70,000	-	227,115	-	531,055	-	638,322	-	664,630
Net Tuition and Fees	-	-	-	6,445,000	-	16,116,485	-	46,504,966	-	52,921,491	-	57,223,178
Auxiliary Enterprises	-	-	-	480,000	-	1,666,000	-	3,496,077	-	4,470,482	-	4,441,270
Other Revenues	-	-	-	500,000	-	600,000	-	596,506	-	631,238	-	709,240
Total Revenue	\$ 2,000,000	\$ 5,000,000	\$ 13,430,000	\$ 24,412,885	\$ 35,530,842	\$ 49,646,181	\$ 57,668,933	\$ 59,446,007	\$ 71,619,243	\$ 63,193,914	\$ 65,156,675	\$ 71,619,243
Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2
2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28
Instruction	-	-	-	2,700,000	-	7,900,000	-	10,150,000	-	12,400,000	-	12,400,000
Student Support	-	-	-	150,000	-	2,200,000	-	2,200,000	-	3,107,586	-	3,247,449
Student Services	-	-	-	180,000	-	1,650,000	-	2,960,333	-	3,302,445	-	3,351,224
Auxiliary Enterprises	-	-	-	240,000	-	733,200	-	1,292,269	-	1,748,039	-	2,220,635
Supporting Activities	-	-	-	1,900,000	-	3,450,000	-	4,450,000	-	4,450,000	-	4,450,000
Operations and Maintenance	-	-	-	800,000	-	410,000	-	460,754	-	670,327	-	614,937
Interest	-	-	-	1,530,000	-	1,975,900	-	1,677,476	-	1,772,088	-	1,861,907
Administrative Support	-	-	-	668,763	-	1,734,723	-	1,650,449	-	1,624,488	-	1,598,792
Other Expenses	-	-	-	400,000	-	733,200	-	1,006,195	-	1,270,768	-	1,353,407
Total Operating Costs	\$ 1,835,100	\$ 4,276,762	\$ 9,944,412	\$ 14,697,673	\$ 18,453,763	\$ 21,513,222	\$ 26,066,531	\$ 27,946,907	\$ 27,618,243	\$ 28,943,930	\$ 28,641,540	\$ 28,897,790
Total Operating Expenses	\$ 1,835,100	\$ 4,276,762	\$ 9,944,412	\$ 14,697,673	\$ 18,453,763	\$ 21,513,222	\$ 26,066,531	\$ 27,946,907	\$ 27,618,243	\$ 28,943,930	\$ 28,641,540	\$ 28,897,790
Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2
2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28
FFY - Student Services	-	-	-	300,000	-	1,500,000	-	1,500,000	-	1,500,000	-	1,500,000
Other Capital	-	-	-	1,000,000	-	200,000	-	50,000	-	50,000	-	50,000
Contingency	-	-	-	400,000	-	800,000	-	8,000	-	8,000	-	8,000
Total Capital Costs	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000
Total Capital Expenditures	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000								

Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2
2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28	2026-29	2027-28
Net Service	-	-	-	203,325	-	203,325	-	203,325	-	203,325	-	203,325
Net Staff	-	-	-	1,741,123	-	1,686,668	-	1,672,740	-	1,650,449	-	1,624,488
Net Over/Under	-	-	-	686,762	-	1,734,123	-	1,672,740	-	1,650,449	-	1,624,488
Total Debt Service	\$ -	\$ 788,863	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907
Total Capital Costs	\$ -	\$ 10,400,000	\$ 2,820,000	\$ 895,000	\$ 1,924,000	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907	\$ 1,995,907
Total Operating Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Debt Service	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Net Operating Revenue	\$ 164,500	\$ 22,216	\$ (4,944,612)	\$ (6,867,244)	\$ 491,338	\$ 14,000,158	\$ 30,050,868	\$ 67,728,685	\$ 86,953,342	\$ 132,302,677	\$ 167,252,661	\$ 242,137,486
Net Operating Revenue	\$ 164,500	\$ 22,216	\$ (4,944,612)	\$ (6,867,244)	\$ 491,338	\$ 14,000,158	\$ 30,050,868	\$ 67,728,685	\$ 86,953,342	\$ 132,302,677	\$ 167,252,661	\$ 242,137,486
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Cumulative Net Revenue	\$ 164,500	\$ 22,216	\$ (4,944,612)	\$ (6,867,244)	\$ 491,338	\$ 14,000,158	\$ 30,050,868	\$ 67,728,685	\$ 86,953,342	\$ 132,302,677	\$ 167,252,661	\$ 242,137,486
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Net Operating Revenue	\$ 164,500	\$ 22,216	\$ (4,944,612)	\$ (6,867,244)	\$ 491,338	\$ 14,000,158	\$ 30,050,868	\$ 67,728,				

Appendix C Preliminary Market Analysis

Results of the market analyses for the DO and MD programs at each of the 4 different market levels are provided in the table at right, with the figures given as a percentile in comparison with all other doctoral programs. The total score for student demand includes such data as new student enrollment volume, Google search volume, on-ground completions at in-market institutions, and online completions by in-market students. The total score for employment includes such data as Bureau of Labor Statistics current employment, BLS 3-year historic growth, job postings total, and job postings per graduate. The total score for competitive intensity includes such data as: campuses with graduates, median program completions, and Google completion index (in-market saturation). Since the total scores for both programs at each of the four market levels reveals a similar result, below is one example (Doctor of Osteopathic Medicine at the national market level) to show the categories involved in the market analysis.

PES Markets Scorecard

CIP: 51.1201 Medicine				Award Level: Doctoral				Market: National				Total Score: 62				Percentile: 99			
Student Demand Score: 21 Percentile: 99				Employment Score: 27 Percentile: 99				Degree Fit Score: 0 Percentile: 100				National Completions by Level Score: 0				National Workforce Ed. Attainment Score: 0			
Category	Pct	Criterion	Value	Score	Category	Pct	Criterion	Value	Score	Category	Pct	Criterion	Value	Score	Category	Pct	Criterion	Value	Score
Size	94	Google Search Volume (12 Months)*	1,571,260	2	Size: Entry Jobs	99	BLS Postings Total (12 Months)	77,463	4	Cost Benchmarking		Average Cost per SCH Index**	NA	NS	No College		Enrollment (Market)		0%
	97	International Page Views (12 Months)	7,807	NS		99	BLS Current Employment	441,280	1			Median Cost per SCH Index**	NA	NS			Completions (National)		0%
	99	New Student Enrollments Volume (12 Mo.)	25,145	0		99	BLS Annual Job Openings	18,606	1										
	99	On-ground Completions at In-Market Institutions	20,704	4		100	Underemployed Percent of Graduates**	11%	4										
	99	Online Completions by In-Market Students	20	2		2	BLS 1-Year Historical Growth	-4.1%	0										
Growth	99	Sum of On-ground and Online Completions	20,724	4	Growth: Entry Jobs	29	BLS 3-Year Historic Growth (CAGR)	3.0%	0	Certificate					Some College				
	99	Google Search YoY Change (Units)*	220,960	1		24	BLS 10-Year Future Growth (CAGR)	0.6%	0										
	99	New Student Enrollment Vol. YoY Change (Units)	1,522	2		65	Job Postings per Graduate	3.7	3										
	99	Completion Volume YoY Change (Units)	1,522	2		65	BLS Job Openings per Graduate	0.8	0										
	40	Google Search YoY Change (%)	-119	0		86	Entry 25th Percentile	\$102,151	6										
Growth	56	New Student Enrollment Vol. YoY Change (%)	15%	0	Weighted-Avg BLS Wages	100	Post Entry w/Associates Median	\$167,437	8	National American Community College Survey of Bachelors Degree Outcomes*					Bachelors				0%
	56	Completion Volume YoY Change (%)	-1%	0		100	Post Entry w/Bachelors Median	NA	NS										0%
						100	Post Entry w/Masters Median	NA	NS										0%
						100	Post Entry w/Doctoral Median	\$167,437	NS										0%
						100	% with Any Graduate Degree*	NA	NS										0%
Competitive Intensity Score: 14 Percentile: 99	1	Campuses with Graduates**	153	0	National American Community College Survey of Bachelors Degree Outcomes*		% with Masters*	NA	NS	Postgraduate Certificate					Masters				0%
	6	Campuses with Growth YoY Change (Units)**	1	NS			% with Doctoral Degree*	NA	NS										0%
	8	Institutions with Online In-Market Students**	1	1			% Unemp. (Age <30)**	NA	NS										0%
	99	Average Program Completions	135	4			% in Direct Prep Job*	NA	NS										0%
	99	Median Program Completions	135	4															0%
In-Market Program Sizes	41	YoY Median Prog. Compl. Change (Units)	-1	6	In-Market Saturation	47	YoY Median Prog. Compl. Change (%)	-1%	6	National Online Completion					Doctoral				93%
	47	YoY Median Prog. Compl. Change (%)	-1%	6		36	Google Search* Cost per Click**	\$8	2										99%
	67	Google Search* Cost per Click**	0.22	3		9	Google Completion Index**	0.22	3										99%
	67	Google Completion Index**	0.22	3		70	Natl Online % of Institutions	1%	NS										99%
	70	Natl Online % of Institutions	1%	NS		0	Natl Online % of Completions	0	NS										99%
Total Percentile				0	Total Score				-40	Total Percentile				100	Total Score				70

Appendix D: SALUD Education – Scope of Services and Institutional Responsibilities

Overview

SALUD Education is one of the most experienced medical school development organizations currently operating in the United States. Its leadership and affiliated teams have been involved in the development of approximately 16% of existing osteopathic medical colleges nationally. These institutions have consistently been delivered on schedule and at or below projected cost.

SALUD's team includes former medical school deans, presidents, chief financial officers, and professionals with direct experience in Commission on Osteopathic College Accreditation (COCA) processes and regulatory oversight.

Scope of Services

1. Accreditation and Regulatory Management

Preparation and submission of all COCA-required documentation through full accreditation; management of accreditation timelines, milestones, and site visits; development of accreditation narratives; coordination of California state licensing and WASC processes; retention and coordination of legal counsel as required.

2. Financial Modeling and Compliance

Development of COCA-compliant financial models; preparation for audits and financial documentation; alignment with Department of Education and California requirements; development of tuition and financial structures.

3. Leadership Recruitment and Organizational Development

Recruitment and vetting of key leadership (Dean, Associate Deans, Chairs); development of organizational structure; creation of compensation and hiring plans; coordination with Simpson HR; consultation on HR matters.

4. Academic Program and Curriculum Development

Development of curriculum; faculty staffing models; governance structures; admissions policies; admissions committee; student and faculty handbooks; academic catalog.

5. Clinical Training and GME Development

Design of clinical training networks; affiliation agreements; GME strategy and implementation; coordination of consultants.

6. Infrastructure and Operations

LMS evaluation; IT coordination; library resources; student support services; learning support resources.

7. Facilities Planning

Architectural coordination; construction consultation; accreditation alignment; student housing planning.

8. External Relations and Capital Strategy

PR and marketing support; stakeholder education; capital sourcing support if needed.

Development Timeline

Estimated 38–42 months from initial application to first class matriculation.

Institutional Responsibilities – Simpson University

Simpson University retains responsibility for employment, salaries, consultants, construction, and governance. Pre-contract costs are borne by Simpson; post-contract internal costs are borne by SALUD.

Summary

This partnership combines Simpson's mission with SALUD's execution expertise, ensuring a credible, accreditation-ready pathway to a fully operational medical school.