



Wrangell Medical Center
Certificate of Need Application

November 2009

Section I
General Applicant Information



CERTIFICATE OF NEED APPLICATION

APPLICANT IDENTIFICATION AND CERTIFICATION OF ACCURACY

I. Applicant Identification

Facility Name	Medicaid Provider Number
Wrangell Medical Center	HS061P
Facility Address (Street/City/State/Zip Code)	Medicare Provider Number
Wrangell Medical Center 310 Bennett St. Wrangell, AK 99929	02-1305
Name and mailing address of organization that operates the facility (if different from above)	
Wrangell Medical Center	
Facility Administrator (Name, title, mailing address, including City/State/Zip Code)	Telephone
Noel D. Rea, Chief Executive Officer	907-874-7164
Wrangell Medical Center	Facsimile
310 Bennett St.	907-874-7100
Wrangell, AK 99929	E-mail
	nrea@wmcmail.org
Applicant (Name, title, mailing address, including City/State/Zip Code)	Telephone
Wrangell Medical Center	907-874-7000
310 Bennett St.	Facsimile
Wrangell, AK 99929	907-874-7122
	E-mail
Principal Contact Person (Name, title, physical address, mailing address, including City/State/Zip Code)	Telephone
Noel D. Rea, Chief Executive Officer	907-874-7164
Wrangell Medical Center	Facsimile
310 Bennett St.	907-874-7100
Wrangell, AK 99929	E-mail
	nrea@wmcmail.org

2. Ownership Information

A. Type of Ownership (check applicable category)

- ☐ For profit: individual ☒ Not for profit: government
☐ For profit: partnership ☐ Not for profit: corporation
☐ For profit: corporation ☐ Other (specify): _____

B. List of all Owners (Page 2 of application)

C. Accreditation Information (Page 2 of application)

3. Agreement to participate in the Uniform Statewide Reporting System

I hereby agree to participate in the uniform statewide reporting system required under AS 18.07.101 when requested to do so under 7 AAC 07.105(c).

4. Certification of Accuracy by Certifying Officer of the Organization

I hereby certify that the information contained in this application, including all documents that form any part of it, is true, to the best of my knowledge and belief. I agree to provide, within 60 days from receipt of a request from the department under 7 AAC 07.050(b), any additional information needed by the department to make a decision.

Name

Noel D. Rea

Title

Chief Executive Officer

Signature

Date

11-9-09

For Part 2.B. of the application form, provide the following ownership information under each requirement, using as much space as necessary to provide complete information:

For governmental or other nonprofit owners, list the names and addresses of hospital board members.

Wrangell Medical Center's (WMC) current board of directors is as follows:

Lynne Campbell, President

Linda Bjorge, Vice President

Dawn Hutchinson-Stevens, Secretary

Jacqueline Dozier, Member

Lurine McGee, Member

Jim Nelson, Member

Dee Norman, Member

LeAnn Rinehart, Member

Mark Robinson, Member

C. Accreditation Information

Is this facility accredited or certified by a recognized national organization? ☐ Yes ☒ No

If yes, identify the organization, the date of accreditation or certification, and attach as an appendix to this application a copy of the most current accreditation or certification.

Section II
Summary Project Description

1. Summary of Proposed Project

Wrangell Medical Center (WMC), a federally designated critical access hospital (CAH), is owned and operated by the City and Borough of Wrangell and governed by an elected Board of Directors. The hospital first opened at its current site in 1968. In 1976, WMC's long term care (LTC) unit was opened in a newly constructed addition. Minor renovations and expansions occurred in 1989 and 1996. Today, the 40+ year old hospital facilities include almost 28,000 total square feet total (24,000 square feet for the hospital and 3,400 square feet for the LTC unit), with much of the inpatient and ancillary services still housed in the original 1968 building. WMC operates 8 acute care/swing beds and 14 LTC beds.

WMC is the only provider of acute, emergency, outpatient surgery, LTC, home health, and ancillary services (diagnostic imaging, laboratory, physical therapy) in the service area (Wrangell Borough). WMC also offers sub-specialty clinics with visiting specialists. Co-located in leased space on the hospital campus is a community health center, Alaska Island Community Services, which provides outpatient care (including primary care with behavioral and dental services provided at another location).

WMC's existing physical plant is aging and inadequately sized. Some spaces within the hospital have become obsolete, others suffer from awkward layouts, and support areas are generally deficient or non-existent. A facility assessment undertaken with funding from the Alaska Native Tribal Health Consortium (ANTHC) and the Denali Commission in 2006 identified a need for a substantial increase in building space just to meet current industry standards for WMC's 2006 actual patient volumes. This assessment also identified needed upgrades to the electrical and mechanical systems.

Following this assessment, WMC undertook a second evaluation process (June 2008) in which four potential sites were identified and evaluated to determine the feasibility of constructing a replacement hospital. WMC had determined that the cost of remodeling/renovating the existing hospital was simply not financially feasible.

Due to the cost of renovating on the existing site (and the disruption a renovation would cause), WMC has elected to construct a replacement hospital, and has selected a site located less than a mile from the current location. The planned replacement facility for WMC will contain approximately 39,000 square feet and will include expanded areas for all departments of the hospital. The new facility will provide 8 acute care/swing beds, 20 LTC beds, an expanded emergency department (ED), an operating room, and expanded ancillary service departments.

It is estimated that the replacement facility will cost about \$25.4 million. WMC intends to finance approximately \$16.8 million of the cost by issuing debt to be repaid by hospital operations. The remainder of the funds will come from reserves and grants.

Following certificate of need (CN) approval, we will move forward to complete design and financing and anticipate having the new facility ready for occupancy by July 1, 2013.

Section III
Description of Facilities and Capacity Indicators

A. Proposed changes in service capacity. Provide either the number of beds, surgery suites, rooms, pieces of equipment, or other service.

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	Total Proposed Capacity
IN-PATIENT ACUTE CARE HOSPITALS			
Med/Surg Beds			
1-bed room/unit	4	8	8
2-bed room/unit	2 (4 beds)	0	0
Other (list)			
ICU Beds	0	0	0
Obstetrics Beds	0	0	0
Pediatric Beds	0	0	0
Acute Rehab Beds	0	0	0
Ancillary Services (list)			
Laboratory	1	1	1
Pharmacy room	1	1	1
BEHAVIORAL HEALTH CARE			
In-patient Acute Psychiatric Beds	0	0	0
RPTC Beds	0	0	0
In-patient Substance Abuse Beds	0	0	0
LONG-TERM CARE			
Acute Beds/Swing Beds			
1-bed room/unit	4	8 ¹	8 ²
2-bed room/unit	2 (4 beds)	0	0
Other (list)			
Nursing Beds			
1-bed room/unit		18	18
2-bed room/unit	7 (14 beds)	1	1
Other (list)	0	0	0
DIAGNOSTIC AND DIAGNOSTIC IMAGING SERVICES			
CT Scanner	1	1	1
MRI	0	0	0
PET or PET/CT	0	0	0
Cardiac Catheterization	0	0	0
Emerging Med. Tech. (list)	0	0	0
SURGICAL CARE			
Ambulatory Surgery or Dedicated OP Suites	0	0	0
Suites for IP & OP	1	1	1
Endoscopy Suites	0	1	1
Open-Heart Surgery	NA	NA	NA
Organ Transplantation	NA	NA	NA
Other Services (list)	1	0	1

¹ WMC will replace the existing 2-bed patient rooms with all private rooms.

² Acute care beds will also be used as swing beds.

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	Total Proposed Capacity
Procedure Room			
THERAPEUTIC CARE			
Radiation Therapy	NA	NA	NA
Lithotripsy	NA	NA	NA
Renal Dialysis	NA	NA	NA
Other (List)	NA	NA	NA
Total Capacity	8 acute care/swing beds (semi-private rooms) 14 LTC beds 1 CT Scanner 1 IP/OP OR 1 Procedure Room	8 acute care/swing beds (private rooms) 20 LTC beds (18 private rooms + 1 semi-private room)	8 acute care/swing beds (private rooms) 20 LTC beds (18 private rooms + 1 semi-private room) 1 CT Scanner 1 IP/OP OR 1 Procedure Room

B. Provide a detailed narrative description of each service identified in "A" above, including the type of change (addition, expansion, conversion, reduction, replacement, elimination). Include, as appropriate, detailed information relative to the scope and level of service.

Inpatient Acute Care

WMC is not proposing to increase its acute care bed capacity; we will continue to operate 8 acute/swing beds. WMC's existing facility has 6 rooms that it uses for acute care. While all 6 rooms can accommodate 2 beds, only 8 beds are consistently set up. Due to the high occupancy of the existing LTC unit, the 8 acute care beds are also used as swing beds.

The new facility will provide for 8 private acute/swing inpatient rooms. The availability of single rooms provides the utmost flexibility in managing the demand for acute care beds (it eliminates gender issues and concerns about cross contamination or infection in bed assignment and fosters quality) and provides for improved patient satisfaction.

The existing acute care unit, with just under 6,500 square feet, is deficient in patient and staff spaces. The existing unit does not have adequate private spaces for family and is lacking in necessary support services/spaces (multipurpose spaces, equipment storage, nourishment area, etc.).

Emergency Services:

WMC's ED provides nearly 1,000 visits annually, or an average daily census (ADC) of about 3. However, annual peak census is about 8 visits per day. WMC's existing ED is located on the first floor of the hospital in space across from the laboratory and imaging departments. The primary treatment area includes a procedure room (which is too small) and two bays (created with a curtain that divides a single room). The current waiting area for the ED is in the hallway (outside of the laboratory). The ED is only 350 square feet and is woefully undersized.

Space needs for the service have been based on national healthcare industry design standards. The proposed expanded ED will be about 2,100 square feet and will include space for two exam/treatment rooms, a trauma room, as well as, the necessary support spaces (medication room, decontamination station, and an interview room). The current ED lacks these required support areas.

Laboratory:

The existing laboratory contains about 900 square feet and is located adjacent to the imaging department. Waiting space is small and inadequate. The proposed laboratory, in addition to having a dedicated laboratory space, will also have a separate space for blood draws and specimen preparation. The new laboratory will also have its own reception/waiting area and will have the additional work space needed to operate more efficiently.

Imaging:

Although WMC is not proposing to add any imaging modalities, the new hospital will have an improved imaging department. WMC's existing imaging department provides general x-ray, mammography, and ultrasound, and WMC is in the process of acquiring a CT scanner (operational by June 2010). The existing imaging rooms are undersized, and have poor staff and patient access. Access to Room #2 is through Room #1, which causes operational inefficiencies. We envision placing the CT scanner in a mobile trailer because the existing facility cannot support the weight of a CT scanner. In addition, all of the imaging rooms are undersized for current technology. Because the rooms are inadequately sized, they are also poorly ventilated. Vents and fans have been added to each of the rooms but they are still too hot, even in the winter. The mammography room was formerly a closet. When the mammography room and the imaging room are in use, there is no access to the reading area for clinical staff to read images.

The imaging department at the new hospital will be designed for optimal access and efficiency, and will be sufficiently sized to house all of WMC's equipment, including a CT scanner.

Surgery:

WMC currently has a single operating room in its surgical department, located adjacent to the unused delivery room. In March 2009, WMC began to perform some outpatient surgical procedures (umbilical and inguinal hernia surgeries, lipoma excisions, breast biopsies, skin biopsies, and hemorrhoidectomies). These procedures, along with scope procedures, are currently being performed in the unused delivery room while surgical and dental procedures are performed in the surgical suite. While the existing surgery department is more adequately sized than most of the other departments in the hospital, it is slightly deficient in terms of support spaces. In the replacement facility, the surgery department will be expanded by about 20%.

Long Term Care Unit:

WMC's existing LTC unit, despite significant physical plant shortcomings, is highly utilized and well regarded. Current occupancy is averaging almost 100%³. The existing square footage of about 3,400 square feet has all double rooms, a general institutional feel and lacks a sufficient day room/dining room. Just recently, due to resident dissatisfaction with the lack of private spaces in the LTC unit, WMC converted the charting room to a patient quiet/reading room. Residents and families had noted that there was no place to go within the unit for quiet conversation (the dayroom is neither quiet nor private).

In addition to providing private rooms, the proposed LTC unit will offer a family room, greenhouse, a dayroom, an activity room and an outside deck for residents. The LTC unit will be sufficiently sized to provide the required support areas for storage, charting, etc. Having these additional spaces available directly within the unit will improve staff efficiencies.

C. Provide in the following table information regarding equipment to be purchased.

Known equipment purchases include⁴:

Equipment to be Purchased			
Equipment Description	Make	Model	Cost
Surgery Table	Midland		\$35,000
Surgical light	Harmony		\$25,000
PACU Pt Monitors	GE		\$25,000
Defibrillator	Zoll	R-Series	\$7,500
Steam sterilizer	Steris		\$83,000
Low Temp Sterilizer	Steris		\$23,000
Laproscope System	Stryker		\$185,000
Anthroscopic system	Stryker		\$7,500
Surgical Instruments	Various	various	\$15,000
Second Monitor	GE		\$7,500
Intubator	Glidescope		25,000
Heart Monitor	Datascope		\$95,000
Cardio Upgrade Ultrasound	Siemens		\$25,000
Plow Truck	Ford		\$40,000
O2 Generator	OGSI	MOGS-100	110,000
Air conditioning Units	Various	Vaious	115,000
LCD	PDI		\$24,000
Office Copiers/Scanner	Various	various	\$35,000
2 Servers	IBM		\$350,000
Conference Room Furniture	various	various	\$45,000

³ WMC will hold a bed for a LTC patient when they are admitted into acute care.

⁴ Please note that WMC intends to make most of its equipment purchases in advance of the replacement project. These costs are, therefore, not included with the replacement facility.

D. Provide in the following table information regarding equipment to be replaced or retired.

Equipment to be Replaced or Retired			
Equipment Description	Make/Model	Date Placed Into Service	Reason for Replacement or Retirement
Carpet Extractor	Polaris	12/21/93	End of useful life
Cautery	Valley Lab	1/1/1991	End of useful life
Coag Analyzer	Siemens	7/1/2000	End of useful life
Defibrillator	Zoll	5/21/1993	End of useful life
Dishwasher	GE	12/1/1988	End of useful life
Fetal Monitor	Hewlett-Packard	1983	End of useful life
Mammo Unit	Toshiba	2/1/2001	End of useful life
Office Furniture (20 Offices)	Various	12/1/1988	End of useful life

E. Describe replacement or upgrading of utilities including the electrical, heating, ventilation, and air conditioning systems.

WMC is proposing to replace its entire facility, including all electrical, heating, ventilation, and air conditioning systems. The existing building's systems are old and well beyond their useful lives. Due to the changes in technology (addition of a computer server and other larger pieces of equipment), none of the rooms are sufficiently sized to be able to adequately ventilate the equipment. For example, in the business office (which has 6 staff members), the room is always too warm and this impacts staff productivity. WMC's existing conference/training room has no ventilation (wall circulation has been added but it doesn't help much) and it, too, becomes unbearable, particularly in the summer months. The existing LTC dayroom/dining room is also very warm, particularly in the summer. WMC has added fans and put up blinds but it is often too hot for residents.

The heating system is outdated and it is becoming exceedingly more difficult to find replacement parts. In addition, there are many electrical fixtures that are not properly wired.

A report prepared by PPE/Salmon Bay Design Group (included in Exhibit 1) provides additional detail about the inadequacies of the existing heating and ventilation system. As noted in this report, WMC does not have a centralized cooling system.

F. Describe the structural framing, floor system, and number of floors (including the basement).

WMC's existing facility consists of one floor and a basement. The original building (which includes the acute care spaces, surgery suite, labor and delivery area, and mechanical spaces) is wood frame on a wood piling foundation.

The LTC unit and physical therapy spaces were built on a conventional foundation atop rock fill with an occupied basement. It has a composite metal and concrete floor atop the foundation walls within a wood superstructure.

The ED, lab, x-ray and entry (which were added in 1989) were constructed of wood-framed modular units on wood pilings.

G. Total square footage in current facility/project.

The current facility is approximately 28,000 square feet (24,000 for the hospital and 3,400 for the LTC unit).

H. Total square footage of proposed facility/project.

The proposed replacement facility will be about 39,000 square feet, or about 40% more than the current facility.

I. Area per bed, service unit, or surgery suite (if applicable).

The replacement hospital is expected to contain about 39,000 square foot. Of this amount, about 12,000 square feet will be for the acute care and long term care nursing units (441 square feet per bed).

J Percentage of total floor area used for direct service (non-bed activity).

WMC has a total of 28,000 square feet for the hospital. Of this number, about 9,850 square feet houses the acute care and LTC beds or about 35% of the space. Currently, WMC has 65% of its space that it uses for non-bed activity. In the replacement hospital, the acute care and LTC units are expected to contain 12,000 square feet. The total hospital will have 39,000 square feet (of which 69% will be used for non bed activity).

K. Additional volume of service (non-bed activity) expected.

All outpatient and ancillary services are expected to continue to grow at about 2% per year. Specific detail is provided in Table 5.

L. Provide a brief history of expansion and construction for the past five years, including new equipment purchases, additional beds, and new services. Describe how this project fits into the facility's long-range plans, including potential projects planned for development within the next five years.

Developing a new facility is WMC's long range plan, and the new facility is key to WMC's long range financial plan. Beyond the new construction, no other major facility plans have yet been developed.

Other than minor renovations, WMC has not made any significant physical plant changes within the past five years. WMC staff and board have determined that the existing hospital building is reaching the end of its useful life. Based on a facility assessment performed by the Alaska Native Tribal Health Consortium (ANTHC) and the Denali Commission, in 2006, it was identified that WMC's need for substantial increases in square footage just to meet current industry standards for 2006 actual patient volumes. Since that time, WMC explored several options, including replacing the facility in its existing location, as well as, exploring other sites within the community on which to construct a new hospital. In preparation for the replacement hospital, WMC is prepared to replace much of the existing equipment as it, too, is nearing the end of its useful life. In fact, much of the equipment replacement will occur before the new facility is constructed.

With the expansion of LTC beds, WMC will be well poised to care for the aging population. WMC believes that the expanded LTC capacity will provide several benefits to community residents including keeping residents in the community and expanding the level of services that are available.

Section IV
Narrative Review Questions

A. Relationship to applicable plans and national trends.

Indicate how the application relates to any relevant plans, including the applicant's long-range plans, appropriate local, regional, or state government plans, the current *Alaska Certificate of Need Review Standards and Methodologies*, adopted by reference in 7 AAC 07.025, and current planning guidelines of recognized national medical and health care groups. If the proposal is at variance with any of these documents, explain why. (See the department's website for state planning processes and materials and links to federal websites.)

The decision to develop a new health care facility for the City of Wrangell is founded in several years of careful analysis and planning at the local level. In 2006, the Alaska Native Tribal Health Consortium and the Denali Commission commissioned an exhaustive Service Delivery and Health Facility Space Plan for the Wrangell-Alaska Region. This plan, completed in August 2006, was based on provider surveys, space analysis, and facility assessments by NBBJ Architecture of Seattle. In short, the analysis underlies WMC's and the City of Wrangell's determination that our community is served by an undersized, inadequate, and substandard hospital physical plant and LTC facility that increasingly compromises access to care and makes consistent high quality care more challenging to deliver.

This is in direct contrast to the goal set forth in Healthy Alaskans 2010 to *"Improve access to comprehensive, high quality health care services"*. This goal was more recently restated by the governor's Alaska Health Care Strategies Planning Council that *"Quality health care will be accessible to all Alaskans to meet their health care needs"*.⁵

Healthy Alaskans 2010 in fact places a special emphasis on vital healthcare resources like WMC, *"Tertiary services, such as hospital and specialty care, are not included in the national Healthy People 2010 objectives. In Alaska, however, small - hospitals are essential providers of preventive services and primary care, as well as links to emergency care and transport."*⁶

⁵ *Final Report: Summary and Recommendations*, Alaska Health Care Strategies Planning Council. Dec. 23, 2007.

⁶ *Chapter 15, Volume I - Targets for Improved Health*. Healthy Alaskans 2010 - Targets and Strategies for Improved Health:

For any hospital, but especially a small rural hospital, the primary driver of almost all facility services and space needs – including emergency treatment capacity, lab space, clinic space, imaging equipment, and surgery and procedure rooms – is the hospital’s inpatient bed complement; the number of acute beds is the most basic indicator of whether the hospital is ‘right sized’ for the community it serves. Healthy Alaskans 2010 emphasized the importance of this measure when it noted that, “*With 202 hospital beds per 100,000 population in 1998, Alaska fell far below the national average of 311.*”⁶ Since Healthy Alaskans 2010 was compiled; a more recent national study has found that the national average of hospital beds per 100,000 population is 358⁷. Importantly, the new hospital will keep the Wrangell community right in line with this national benchmark, as WMC’s 8 current acute care beds, to be replaced with the same number of beds in the new facility, mean that Wrangell has a current (2008) bed-to-population ratio of 379 per 100,000.

Importantly, WMC’s planned expansion and replacement of the LTC unit will occur in the context of a broader system of care for seniors – a system in which our LTC unit and care providers plays a vital part, and in which we coordinate with other providers on a daily basis. Our LTC expansion will complement Wrangell’s system of senior care by meeting the community’s increasing demand for the LTC level of care, and is consistent with the State Commission on Aging’s updated goals to ensure that “*Older Alaskans have access to an integrated array of health and social supports along the continuum of care*”, and that “*A range of adequate, accessible, secure and affordable housing options is available to seniors.*”⁸

In June 2008, Salmon Bay Design Group of Seattle produced facility programming, space requirements, and a conceptual design for the new WMC hospital facility. Alaska State law indicates that hospital facilities should be designed to conform with the “Guidelines for Design and Construction of Healthcare Facilities” published by the Facilities Standards Institute (FSI) and the American Institute of Architects (AIA). WMC’s existing facility does not meet most of these standards but the planning efforts for the new hospital do.

Throughout this application, WMC demonstrates that the new replacement hospital facility is right-sized for our isolated rural community. The planned acute care beds, LTC beds, surgery, lab and imaging spaces, ED, and all other clinical, ancillary, and support spaces are necessary to provide essential, appropriate, high quality hospital services to Wrangell’s population, and are supported by CN review standards.

⁷ *The National Report Card on the State of Emergency Medicine*. American College of Emergency Physicians, 2009 Edition.

⁸ *State Plan for Senior Services, FY 2008 – FY 2011*, Alaska Commission on Aging.

B. Demonstrate Need

- 1. Identify the problems being addressed by the project. For example, identify whether this project is for (a) a new service; (b) an expanded service; or (c) an upgrade of an existing service.**

This project conforms with item (b) and (c), as it will upgrade (replace) the existing WMC facility and provided for expanded LTC capacity. The problem this addresses is the Wrangell region's current reliance on undersized, inadequate, and substandard facilities for their essential health care needs.

- 2. Describe whether (and how) this project (a) addresses an unmet community need; (b) satisfies an increasing demand for services; (c) follows a national trend in providing this type of service; or (d) meets a higher quality or efficiency standard.**

Primarily this project will meet higher quality and efficiency standards for hospital care by replacing the current 40+ year old undersized, inadequate, and substandard WMC facility. As demonstrated later, any aspects of the new facility that might be viewed as service expansions when compared to the current facility – including enhanced emergency, diagnostic, and expanded LTC capacities – are, in fact, necessary to support WMC's existing volumes, and to deliver these services with the quality and efficiency that the Wrangell community needs and deserves. As such, the scope of the facility and services to be provided by the new WMC are supported by CN standards.

- 3. Describe any internal deficiencies of the facility that will be corrected, and document which of these deficiencies have been noted by regulatory authorities. Note any deficiencies that will not be corrected by this project, what efforts have been taken to correct the deficiencies, and how this project will affect the deficiencies. Attach any pertinent inspection records and other relevant reports as an appendix to the application.**

By replacing the hospital and LTC facility, this project will correct all of the deficiencies identified in the assessment prepared by Salmon Bay Design Group. This report identified many code deficiencies and areas where WMC is out of compliance with industry standards. This report, included in Exhibit 1, details, by department, the specific areas in which WMC is deficient and in violation of the current codes.

- The hospital was built on pilings and has experienced differential settlement (uneven floors).
- Architectural finishes such as walls, floors, and door hardware are not compliant with current standards.
- Patient rooms and bathrooms don't meet many Americans with Disabilities Act requirements.
- The plumbing system is failing and is causing interruptions in services.

- Improvements to the electrical and mechanical systems are necessary to support current and future clinical best practices and technology.
- The ventilation system is inadequate; cooling system is non-existent.
- The LTC unit has inadequate space for families and for resident day activities and dining.

WMC is due for a CAH survey. In anticipation of this survey, WMC has undertaken its own self-survey, conducting an unannounced mock survey. These two surveys have helped prep WMC in the event of a real survey.

4. **Identify the target population to be served by this project. The "target population" is the population that is or may reasonably be expected to be served by a specific service at a particular site. Explain whether this is a local program, or a program that serves a population outside of the proposed service area. Use the most recent Alaska Department of Labor and Workforce Development statistics for population data and projections. Explain and document any variances from those projections. The population may be defined in one or more ways:**
 - a. Document the service area by means of a patient origin analysis.
 - b. Justify the customary geographical area served by the facility using trade and travel pattern information. Indicate the number and location of individuals using services who live out of the primary service area.
 - c. Use Alaska Department of Labor and Workforce Development information, including current census data on cities, municipalities, census areas, or census sub-areas, to describe trends, age/sex breakdowns, and other characteristics pertinent to the determination of need.
 - d. The population to be served can be defined according to the unique needs of patients requiring specialized or tertiary care (e.g. heart, cancer, kidney, alcoholism, etc.) or the needs of under-served groups.

WMC's service area and target population is the Wrangell Borough/City. Geography dictates that this is the logical service area for WMC. Located on the northern tip of Wrangell Island, the town had been part of the broader Wrangell-Petersburg census area, but Wrangell's physical isolation from other communities is such that, the population voted in May 2008 to incorporate Wrangell as its own Borough.

Due to this history, the Alaska Department of Labor and Workforce Development (DLWD) has only recently begun to make updated population estimates for Wrangell by itself. DLWD's most recent available population projections for the future are for the former, larger, Wrangell-Petersburg Borough. Therefore, we projected Wrangell's population by applying the same growth rates by age cohort growth rates found in DLWD's projections for 2010 and 2015 projections for Wrangell-Petersburg.

As shown in Table 1, this data indicates that the current (2008) population of Wrangell totals over 2,100, which is 300 fewer than the 2000 Census. Wrangell is expected to lose another 75 people by 2015. Note, however, that most of this decline occurred among the younger population cohorts. The 65-74 year old population grew by more than 30% and the 85+ population grew by almost 15% during the 2000-2008 timeframe. These two age groups have higher utilization rates for health care services than younger age cohorts.

Table 1
Wrangell City and Borough
2000, 2008, 2015 Population

	<u>2000 Census*</u>	<u>Pct of Tot Pop</u>	<u>2008 Est.</u>	<u>Pct of Tot Pop</u>	<u>Pct Chg 2000- 2008</u>	<u>2015 Proj</u>	<u>Pct of Tot Pop</u>	<u>Pct Chg 2008-2015</u>
Tot. Pop.	2,422	100.0%	2,112	100.0%	-12.8%	2,037	100.0%	-3.6%
<u>Pop. By Age</u>								
0-17	697	28.8%	471	22.3%	-32.4%	428	21.0%	-9.1%
18-44	777	32.1%	600	28.4%	-22.8%	584	28.7%	-2.6%
45-64	668	27.6%	703	33.3%	5.2%	597	29.3%	-15.0%
65-74	155	6.4%	203	9.6%	31.0%	278	13.6%	36.9%
75-84	90	3.7%	95	4.5%	5.6%	111	5.4%	16.4%
85+	35	1.4%	40	1.9%	14.3%	38	1.9%	-4.2%
Tot. 0-64	2,142	88.4%	1,774	84.0%	-17.2%	1,610	79.0%	-9.3%
Tot. 65 +	280	11.6%	338	16.0%	20.7%	427	21.0%	26.3%

Source: Alaska Department of Labor and Workforce Development. (2015 projections are based on projections for the prior, broader Wrangell-Petersburg Borough.)

In addition to service area residents, Wrangell is an increasingly popular destination for Alaska Marine Highway passengers, and for visitors arriving by air, by private yacht, and by small and large cruise ships. Cruise ship annual totals have approached 50,000 visitors in recent years⁹.

⁹ Source: *Sitka Visitor Traffic Indicators and Trends, 1991-2005*, Sitka Economic Development Association, April, 2006.

5. Describe the projected utilization of the proposed services and the method by which this projection was derived. Do not annualize utilization data. It must include the last complete year of operation (indicate if it is a calendar year or fiscal year) and as many prior years as is feasible to show trends. If graphs are used to depict this information, and they do not include the actual utilization numbers, numerical charts must be included. In providing this information:
 - a. Include evidence of the number of persons from the target population who are currently using these services and who are expected to continue to use the service, including individuals served out of the service area or out of state;

Available data for Medicare enrollees (below in Table 2) indicates that, due to the community's isolation, Wrangell itself accounts for fully 88% of WMC's patient activity.

Table 2
Wrangell Medical Center
2007 Medicare Inpatients and Market Share

Zip Code - City	Total WMC Medicare Discharges	Pct. of WMC Medicare Discharges	Total Medicare Discharges for Zip Code	WMC Market Share
99929 Wrangell	58	87.9%	121	47.9%
99835 Sitka	2	3.0%	360	0.6%
33952 Port Charlotte	1	1.5%	2,911	0.0%
56672 Remer	1	1.5%	157	0.6%
95603 Auburn	1	1.5%	812	0.1%
98221 Anacortes	1	1.5%	1,015	0.1%
99927 Point Baker	1	1.5%	1	100.00%
99950 Ketchikan	1	1.5%	16	6.30%
Total	66	100.0%	—	—

Source: Medicare MedPAR data, prepared by InfoTechnics, LLC-data only available for Medicare

The above data indicates that WMC currently has about a 48% market share of the Wrangell market¹⁰. WMC has not undertaken the project contained in this application simply to increase over all utilization and market share. However, other data suggests that replacement facilities lead to increases in patient census and overall utilization¹¹. As such, we are analyzing specific factors, particularly as designs for the new facility are finalized, to identify opportunities to increase market share/retention of Wrangell patients with the new facility. These factors include:

- The current facility's new outpatient surgery and CT scan services, which are currently in 'start-up mode' and building patient volumes, will carry over to the new facility.

¹⁰ The hospital with the 2nd largest market share (14.9%) was Virginia Mason Medical Center in Seattle. Ketchikan General Hospital and the University of Washington Medical Center (Seattle) each had a market share of 5.8% (the 3rd highest market share).

¹¹ Stroudwater Associates, "Rural Hospital Replacement Facility Study, 2008."

- Characteristics of the new facility that can be expected to enhance local patient retention, such as its greater efficiency, and more qualitative factors such as the facility's perceived 'newness'; private rooms, additional amenities (outdoor space, greenhouse, high tech, etc.).

- b. Include evidence of the number of persons who will begin to use any new services that are not now available, accessible, or acceptable to the target population.**

This project will replace the existing hospital and its current scope of services. While new services are contemplated, WMC is proposing to expand its LTC capacity.

- c. Provide annual utilization data and demand trends for the five most recent years and monthly utilization data for the most recent incomplete year prior to the application for each existing facility offering a similar service in the service area. Provide projections for utilization for three years (or the appropriate planning horizon set out in the review standards related to this project) after construction, and show methodology used to determine use, including the math.**

Comprehensive WMC utilization data for the most recent 5 years is presented in Table 3.

Detailed demand/utilization projections are presented in response to question 6 below.

Table 3
Wrangell Medical Center Historical Utilization
2005-2009 (Fiscal Year Data July-June)

	2005	2006	2007	2008	2009
Acute Inpatient Care					
Discharges	171	138	132	140	141
Days	412	294	333	304	356
Observation					
Discharges	83	71	92	96	92
Days	38	36	44	47	59
Swing Bed Care					
Discharges	22	20	38	36	51
Days	379	430	715	622	917
LTC					
Discharges	15	16	23	18	11
Days	2,914	4,365	4,757	4,750	5,046
Emergency Dept. Visits	1,011	1,017	811	899	953
Procedure Room Visits	1,200	1,191	950	1,243	791
Laboratory Tests					
Inpatient	2,698	1,543	2,085	2,015	2,138
Outpatient	18,116	15,300	16,769	20,071	19,093
Total	20,814	16,843	18,854	22,086	21,231
Mammogram	261	240	259	246	235
Ultrasound					
Inpatient	22	17	23	20	25
Outpatient	346	325	348	341	354
LTC	2	8	7	7	7
Total	370	350	378	368	386
X-Ray					
Inpatient	87	80	85	75	127
Outpatient	863	727	1,311	1,226	1,372
LTC	50	26	43	42	46
Total	1,000	833	1,439	1,343	1,545
Physical Therapy Visits					
Inpatient	125	274	785	827	1,168
Outpatient	388	511	855	698	843
LTC	43	14	96	41	51
Total	556	799	1,736	1,566	2,062

Source: Applicant

- d. If the project is an acquisition of a new piece of major equipment or a new service, provide utilization data for similar services, existing equipment, or older technology. Indicate whether similar existing equipment will continue to be used and the project's effect on utilization of similar services. If this service or equipment was not in place in the service area, compare the expected utilization with other similar communities in Alaska or in other states.

This project will replace the existing hospital and its current scope of services. While new services are contemplated, WMC is proposing to expand its LTC capacity.

- e. If an increase in utilization is projected, list the factors that will affect the increase. Provide annual utilization projections for three to five years in the future, as applicable, for each specific service in the proposal (in general, equipment projections are for three years, and new beds and facility construction are for five years). Include each of the following data when applicable:

- (1) number of admissions/discharges
- (2) number of patient days
- (3) average length of stay
- (4) percent occupancy
- (5) average daily census
- (6) number of licensed beds
- (7) number of beds set up
- (8) number of inpatient and outpatient surgeries and surgery minutes
- (9) number of existing surgery suites in the service area
- (10) number of procedures
- (11) number of treatment rooms
- (12) number of patients served
- (13) number of outpatient visits
- (14) number of laboratory tests
- (15) number of x-rays
- (16) number of ER visits
- (17) number of CT, MRI, PET or PET/CT scanners

Table 4 details the assumptions used to develop the future projections:

Table 4
Underlying Assumptions for Utilization Projection

	Assumption
Admissions/Discharges	Acute: Calculated by using current average length of stay applied to projected acute days. Observation: Calculated by applying 1 day length of stay to projected observation days (1 day = 1 discharges). Swing Bed: NA LTC: Per CN methodology
Patient days	Acute: Assumes 55% WMC market share of 2017 total acute days projected per CN methodology. Observation: Uses FY2009 actual ratio of 0.3732 observation-to-acute average daily census (ADC). Applies ratio to projected acute ADC X 365. Swing Bed: 2010 conservatively projected at 717 days (22% reduction from 2009). 2011 increased by 28% (to 2009 levels). 2012 increase by 2%. Beginning in 2013, 60% of projected swing days are assigned to LTC. LTC: Per CN methodology
Average length of stay	Acute: Held at FY2009 actual Swing Bed: Held at FY2009 actual LTC: Per CN methodology
Percent occupancy	Acute/Swing: Assumed target occupancy of 50% LTC: Assumed target occupancy of 90%
Licensed/Set Up Beds	Acute/Swing: No change from current (8 licensed/set up beds) LTC: Assumed 14 2010-2013; assumed 20 2013-2015
ED Visits	Assumes increase of 2%/year over 2009
Outpatient Surgeries/Procedures	Assumes increase of 2%/year over 2009
Number of surgery suites in the service area	Included only capacity at WMC
Laboratory Tests:	Inpatient: Avg 2004-2009 ratio to Acute Care Days, held constant Outpatient: Assumes increase of 2%/year over 2009
Mammogram	Assumes increase of 2%/year over 2009
CT Scans	Assumes increase of 2%/year over 2010
Ultrasound	Inpatient: Avg 2004-2009 ratio to Acute Care Days, held constant Outpatient: Assumes increase of 2%/year over 2009 LTC: Avg 2004-2009 ratio, LTC Ultrasound to IP Ultrasound, held constant
X-Ray	Inpatient: Avg 2004-2009 ratio to Acute Care Days, held constant Outpatient: Assumes increase of 2%/year over 2009 LTC: Avg 2004-2009 ratio to LTC days, held constant
Physical Therapy Visits	Inpatient: Avg 2004-2009 ratio to Acute Care Days, held constant Outpatient: Assumes increase of 2%/year over 2009 LTC: Avg 2004-2009 ratio to LTC days, held constant

Source: Applicant

Table 5 details the projected utilization for 2010-2017 based upon the above assumptions:

Table 5
Wrangell Medical Center
Patient Activity Projections for Certificate of Need

	2010	2011	2012	2013	2014	2015	2016	2017
Acute Care								
Discharges	151	161	172	184	196	210	224	240
Days	380	407	434	464	496	530	567	605
ADC	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7
ALOS	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5
Observation								
Discharges	142	152	162	173	185	198	211	226
Days	142	152	162	173	185	198	211	226
ADC	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6
ALOS	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Swing Bed Care								
Discharges	40	51	52	42	42	43	44	45
Days	717	917	935	748	762	777	793	809
ADC	2.0	2.5	2.6	2.0	2.1	2.1	2.2	2.2
ALOS	18.0	18.0	18.0	18.0	18.0	18.0	18.0	18.0
	21.8%	27.9%	2.0%	-20.0%	1.9%	2.0%	2.1%	2.0%
LTC								
Discharges	11	11	12	13	13	13	14	14
Days	5,131	5,217	5,304	5,981	6,082	6,184	6,287	6,352
ADC	14.1	14.3	14.5	16.4	16.7	16.9	17.2	17.4
ALOS	458.7	458.7	458.7	458.7	458.7	458.7	458.7	458.7
Emergency Dept. Visits	992	1,011	1,032	1,052	1,073	1,095	1,117	1,139
Procedures/Surgeries	823	839	856	873	891	909	927	945
Laboratory Tests								
Inpatient	2,226	2,379	2,543	2,717	2,903	3,103	3,316	3,543
Outpatient	19,864	20,262	20,667	21,080	21,502	21,932	22,370	22,818
Total	22,091	22,641	23,209	23,797	24,405	25,035	25,686	26,361
Mammogram	244	249	254	259	265	270	275	281
CT Scan	255	260	265	271	276	282	287	293
Ultrasound								
Inpatient	24	26	28	30	32	34	36	39
Outpatient	368	376	83	391	399	407	415	423
LTC	6	7	7	8	8	9	10	10

Total	399	409	419	429	439	450	461	472
X-Ray								
Inpatient	102	109	116	124	133	142	152	162
Outpatient	1,427	1,456	1,485	1,515	1,545	1,576	1,608	1,640
LTC	56	57	58	65	66	67	68	69
Total	1,585	1,622	1,659	1,704	1,744	1,785	1,828	1,871
Physical Therapy Visits								
Inpatient	897	958	1,024	1,094	1,170	1,250	1,336	1,427
Outpatient	877	895	912	931	949	968	988	1,007
LTC	44	45	46	52	52	53	54	55
Total	1,818	1,898	1,982	2,077	2,171	2,271	2,378	2,489

Source: Applicant

- f. If any services will be reduced, indicate how the proposed reduction will affect the service area needs and patient access.**

This question is not applicable.

- g. Provide any other information that may be pertinent to establishing the need for this project.**

WMC projected need for acute beds (even though we are not proposing to add any) and LTC beds, laboratory, ED. Specific support rationale as to the need for the project is presented with our demand/utilization projections in response to question 6 below.

- h. Attach letters of support from local and regional agencies, other health care facilities, individuals, governmental bodies, etc.**

WMC understands that the following letters of support for the replacement hospital project have already been provided to the CN Program from the following entities:

- Ketchikan General Hospital
- Bartlett Regional Hospital and
- Mt. Edgecumbe Hospital

We also anticipate letters of support (which will be provided under separate cover) from:

- Sitka Community Hospital and
- Petersburg Medical Center

6. Include your calculations of numerical need for each proposed activity for your service area. If the proposed project is expected to have a larger capacity than that projected by (and available from) the department, explain the rationale and provide documentation to support the larger capacity.

To project the numerical need for each CN covered service in this project, WMC employed the methodologies found in the Alaska CN Review Standards and Methodologies.¹² Any necessary modifications to the methodologies are noted.

Acute Care Bed Need

STEP ONE: Determine the projected inpatient caseload for the population to be served using the formula:

$$C = (P_s \times UR_s) \times SAS$$

- UR (Use Rate) is defined as the current average annual number of statewide inpatient days of hospital care used during the preceding three years divided by the population. The most recent available statewide hospital data is for the period 2001-2003¹³. Instead, WMC has elected to employ more recent published use rates for Alaska:

Table 6
Inpatient Days per 1,000 Population

2005	461
2006	450
2007	493
Average	468

Source: Kaiser Family Foundation. statehealthfacts.org

- SAS is defined as the service area's current share of the population. The Wrangell Borough's 2008 population (2,112) represents 0.31% of the State's total 2008 population (679,720)¹⁴.

(Note that the relevant projection year is 2017, or 5 years after project completion.)

¹² Alaska CN Review Standards and Methodologies, AK Dept. of Social and Health Services, Dec. 9, 2005.

¹³ *Highlights of Alaska's Hospital Discharge Data, 2001-2003*. AK Dept. of Social and Health Services, Jan. 12, 2005.

¹⁴ AK Dept. of Labor and Workforce Development, July 1, 2008 estimates.

Table 7
Acute Care Bed Need
Step 1 Calculations

Ps (projected 2017 AK pop.)	749,585
X URs (use rate per 1,000)	468
÷ 1,000	
= Total 2017 AK patient days	350,806
X SAS (service area share)	0.31%
= C (caseload, or inpatient days required by Wrangell pop.)	1,090

Source: Applicant

STEP TWO: Determine the projected average daily inpatient census (ADC) for the service using the formula.

- The projected ADC is $1,090 \div 365 = 2.99$

STEP THREE: Determine the projected number of hospital beds needed for the service area.

- The defined target occupancy for hospitals with fewer than 50 beds is 50%.
- The projected number of hospital beds needed is $3.02 \text{ (ADC)} \div 50\% = 6.03$

MODIFICATION TO METHODOLOGY:

- Available patient data indicates that WMC currently has about a 48% market share of the Wrangell market¹⁵. We are projecting that this share will grow to **56%** by 2017 due to our new hospital facility.
 - 56% of the total projected service area inpatient days (1,090) are 605 days in 2017 for WMC, and our projected inpatient ADC is **1.7**.
 - At the target occupancy of 50%, or projected hospital bed need for acute care is **3.3**.

STEP FOUR: Calculate the unmet bed need by subtracting the existing inventory from the total hospital bed need.

- This step is not applicable, as WMC will be replacing the service area's existing bed supply (8) with the same number of beds (8).

¹⁵ 2007 Medicare MedPAR data, prepared by InfoTechnics, LLC

MODIFICATION TO METHODOLOGY:

WMC is planning for 4.7 additional beds beyond the 3.3 projected by the methodology, or 8 total beds, for the following reasons.

- These 8 beds in the new facility will simply replace the 8 existing beds in the current facility.
- All 8 beds will be designated as swing beds. This number of swing beds prudently accommodates WMC actual historical patient volumes. This is because, in addition to accommodating acute inpatients, WMC also provides short stay/observation care, and we provide sub-acute skilled nursing care (or swing bed care). Please note that due to the size of the facility, it is simply neither efficient nor feasible to have a dedicated observation unit.
 - Short stay/Observation. Data for July 1, 2008-May 31, 2009 (341 total days), shows:
 - WMC provided a total of 159 observation days, for an average daily census of 0.5 patients.
 - During this period, the actual ratio of average observation census to acute inpatient census was **0.3727**.
 - Applying this ratio to our projected acute inpatient ADC for 2017 results in an observation ADC of **0.6** for 2017.
 - Accommodating this observation ADC at the Department's target occupancy of 50% will require **1.2** beds.
 - Swing Bed Care.
 - In FY2009, WMC provided a total of 917 swing bed days, for an average daily census of 2.5 patients.
 - We project our current swing bed days will grow at the same rate as our projected LTC days, below (+13.4% total growth through 2017).
 - Beginning in 2013 (when the new hospital opens) 60% of these projected swing bed days annually are assigned to our expanded LTC facility (i.e. – a more appropriate care setting for some swing bed patients), leaving 419 projected swing bed days remaining in the hospital beds in 2017.
 - The resultant swing bed ADC for 2017 is **1.1**.
 - Accommodating this swing bed ADC at the Department's target occupancy of 50% will require **2.3** beds.
 - Accommodation of peak census: Finally, during the July 08-May 09 period, WMC's actual peak total combined census (acute + observation + swing) was 10 patients, and the combined census was a least 8 patients (100% occupancy) on a total 24 of days.
- The above inpatient bed need projections are summarized in Table 8:

Table 8
Wrangell Medical Center
Projected 2017 Average Acute Care/Inpatient Bed Need

Bed Type	Need
Acute Care	3.3
Observation	1.2
Swing	2.3
Total Bed Need	6.8
Bed Need at Peak Census (variance 129%)	8.8

Source: Applicant

For these reasons, we believe WMC's total complement of 8 acute/sing beds is fully justified/supported under CN Standards.

Hospital Laboratory Department Services

WMC provides the service area's only hospital laboratory services. The new hospital's laboratory capacity is justified under the CN standards for lab services as follows:

- CN Standard III – A. 1. 1. requires that *“The population served by a laboratory to be moved will continue to have reasonable access to the service at the new site.”*

Like the current WMC, the new hospital will be located in the town of Wrangell; access for the population to be served will not be impacted.

- Accreditation reports and a visual inspection of WMC's laboratory show a defined need to add space and to redesign the laboratory to make it more efficient and safe, and correct functional problems that affect quality and efficiency.
- In FY2009, WMC provided 21,558 total lab tests. Based on our historical ratios of inpatient and outpatient lab tests to inpatient days, we are projecting that WMC will provide 26,361 lab tests in 2017.
- The Department's numerical methodology for lab space simply says that laboratory size may not exceed 50 net square feet per patient bed based on the projected number of beds that would be served by the laboratory. WMC is planning for 8 inpatient beds and 20 LTC beds, which would allow up to 1,400 square feet (28 beds X 50). Although specific numbers have yet to be finalized, WMC does not expect its laboratory will exceed 1,400 square feet.

Hospital Emergency Department Services

As WMC experiences approximately 1,000 ED visits annually (Table 9) the CN numerical need methodology – which requires 1,500 projected annual visits per ED Treatment Room (EDTR) – would not support even the 1 EDTR at the current hospital facility.

Table 9
Wrangell Medical Center
Total Emergency Department Visits

	Visits
2006	1,017
2007	811
2008	899
2009	953
Avg.	920

Source: Wrangell Medical Center internal data

However, the Hospital ED review standards recognize that circumstances at WMC justify the 2 EDTRs we are planning, as follows:

- *Standard III – B. 1. The applicant demonstrates that the project promotes, or otherwise helps ensure, the maintenance of a stable and efficient emergency medical system.*

WMC is the centerpiece of the emergency medical system for the Wrangell Borough. Patients in need of urgent or emergent medical care come to – or are transported to – WMC for treatment and, if necessary, stabilization prior to transport to Juneau or Seattle. As we document below with regard to WMC’s ED patient census, 2 EDTRs are necessary to support efficient delivery of emergency care.

- *Standard III – B. 2. The department may approve additional space if the applicant documents use patterns, and submits data and analysis that show seasonal high peak use rates warranting additional treatment rooms,*

As demonstrated in Table 10, WMC currently provides about 2.5 ED visits on an average day. On more than two-thirds of all days, we care for at least 2 patients, and on some days we see as many as 8 patients.

Table 10
Wrangell Medical Center
Emergency Department Visits per Day
July 1, 2008-May 31, 2009 (341 total days)

Visits	Days Occurring	Pct.
0	49	14.4%
1	58	17.0%
2	83	24.3%
3	72	21.1%
4	35	10.3%
5	21	6.2%
6	12	3.5%
7	7	2.1%
8	4	1.2%
Total	341	100.0%
<i>Average per Day</i>	<i>2.5</i>	

Source: Wrangell Medical Center internal data

Most of the time, when WMC treats more than a single patient on a given day, these patients arrive one-at-a-time and can be treated individually. Often, however, multiple patients will arrive in need of care simultaneously (frequently these patients are involved in the same incident, such as a traffic accident). Clearly, in these circumstances, the availability of just 1 EDTR, even a modern EDTR of the type we are planning for the new facility, is not much better than the emergency treatment space currently available at WMC, which is screened only by a curtain. Basic standards of care, including patient privacy, demand that WMC have the ability to appropriately treat at least 2 ED patients simultaneously¹⁶.

- *Standard III – B. 4. For a proposal for additional space in the hospital emergency department, the applicant must perform a size-by-functional-need survey and analysis for additional space that demonstrates efficient use of the space.*

The 2 EDTRs we are planning are efficiently and appropriately sized at 140 square feet each. This is based on programming for the new facility developed by Salmon Bay Design Group, in conformance with the “Guidelines for Design and Construction of Healthcare Facilities” published by the Facilities Standards Institute (FSI) and the American Institute of Architects (AIA), per Alaska State law.

- To project ED volumes, WMC has grown our FY2009 actual volumes by 2% annually, for a total of 1,139 total projected ED visits in 2017.

¹⁶ 2006 AIA Guidelines for Design and Construction of Health Care Facilities. 5.1.2.6 requires that at least one airborne infection isolation room be provided. In a situation where there are multiple patients it would then be necessary to have at least one additional Treatment Room other than the A.I.I. room.

Long Term Care Bed Need

In Tables 11 through 13, WMC has applied and presented the LTC need methodology in the same manner as the Department in actual recent CN decisions¹⁷.

Table 11
Wrangell Borough Historical and Projected Population

Age	2006	2007	2008*	2009	2010	2011	2012	2013	2014	2015	2016	2017
0-64	1,859	1,816	1,774	1,749	1,725	1,701	1,678	1,655	1,632	1,610	1,587	1,565
65-74	189	196	203	212	222	232	243	254	266	278	291	305
75-84	94	95	95	97	99	102	104	106	109	111	113	116
85+	39	40	40	40	40	39	39	38	38	38	37	37
Total	2,182	2,146	2,112	2,099	2,086	2,074	2,064	2,054	2,045	2,037	2,029	2,023

Source: Alaska Department of Labor and Workforce Development. (Projections beyond 2008 are based on projections for 2010 and 2015 for the prior, broader Wrangell-Petersburg Borough.)

Table 12 details the bed days per year for the existing LTC unit at WMC. As noted, in Table 12, over the past three years, the average daily census has been 12 patients.

Table 12
Long Term Care Facility: Wrangell Medical Center
Bed Days per Fiscal Year

	Total	0-64	65-74	75-84	85+	July 1 Census
2008	5,352	1,010	592	1,640	2,110	9
2007	5,491	545	787	1,357	2,802	12
2006	4,800	396	742	1,809	1,853	14
2006-2008	15,643	1,951	2,121	4,806	6,765	35
Avg. Days	5,214	650	707	1,602	2,255	11.7

Source: Wrangell Medical Center

As detailed in Table 13, the projected bed need, under a strict application of the methodology is 17 in 2017.

¹⁷ Review of the Wildflower Court CN Application to Add Eight Nursing Home Beds, July, 15, 2008. and Review of South Peninsula Hospital's CN Application to Add three Nursing Home Beds, June 2, 2009.

Table 13
Wrangell Medical Center
Projected LTC Bed Need in 2017

A	B	C	D	E	F	G
Age Group	Population Estimate 2006-2008	Average Bed Days/ Year 06-08	Average Bed Days Per Person	2017 Population Projection	Forecast Bed Days = D X E	Forecast 2017 Bed Need 90% Occupancy
0-64	1,816	650	0.358	1,565	560	1.7
65-74	196	707	3.608	305	1,100	3.3
75-84	95	1,602	16.951	116	1,966	6.0
85+	40	2,255	56.859	37	2,097	6.4
Total	2,147	5,214	2.429	2,023	5,723	17.4

Source: Wrangell Medical Center

MODIFICATIONS TO METHODOLOGY:

WMC is planning for additional beds beyond the 17.4 projected by the methodology, or 20 total, for the following reasons:

- Data for the period July 1, 2008-May 31, 2009 (341 total days) shows that WMC's LTC census was virtually 100% – 14 patients in 14 beds – on a total of 319 days, or 95% of the time.
- WMC currently provides sub-acute skilled nursing care in our hospital swing beds. Data for the same period shows:
 - In FY2009, WMC provided a total of 917 swing bed days, for an average daily census of 2.5 patients.
 - We project our current swing bed days will grow at the same rate as our projected LTC days, above (+13.4% total growth through 2017).
 - Beginning in 2013 (when the new hospital opens), 60% of these projected swing bed days annually are assigned to our expanded LTC facility (i.e. – a more appropriate care setting for some swing bed patients). A total of 629 days of (formerly) swing bed care will be assigned to the LTC facility, for an additional ADC of 1.7 patients.
- Clearly, demand for LTC at WMC exceeds the 17.4 beds projected by the methodology. WMC plans to accommodate this demand as summarized below in Table 14:

Table 14
Wrangell Medical Center
2017 Long Term Care Bed

DHSS Methodology Projected LTC days	5,723
Additional former swing bed patients	629
Total Projected Days	6,352
Average Daily Census (ADC)	17.4 patients
Total Need @ 90% Target Occupancy	19.3 (20 beds)

General Surgery Services

We are not proposing any new surgery capacity; WMC currently has a single CN-approved general purpose operating room, as will the new replacement facility.

We note for the record that in March 2009, WMC began offering some new outpatient surgical procedures (umbilical and inguinal hernia surgeries, lipoma excisions, breast biopsies, skin biopsies, and hemorrhoidectomies) performed by visiting surgeons. Examples of services we could potentially add in our surgery department include laparoscopic surgeries (gall-bladder surgeries, etc.), gynecological procedures, urological procedures, orthopedic procedures, ENT-related procedures, pediatric circumcisions, skin biopsies, and vasectomies.

While we expect our current surgery service to grow significantly over time, we do not anticipate that the CN numerical need methodology – which requires 900 projected annual surgeries per general operating room – would support the operating room at the current hospital facility.

C. Availability of less costly or more effective alternatives

- 1. Describe the different alternatives considered in developing this project. Explain why the particular alternative for providing the services proposed by this application was selected. Include as an alternative a discussion of the effect of doing nothing.**

The decision to develop a new health care facility for Wrangell is founded in several years of careful analysis and planning at the local level. The 2006 Service Delivery and Health Facility Space Plan commissioned by the Alaska Native Tribal Health Consortium and the Denali Commission provided the impetus to proceed with this project.

The alternative of doing nothing was quickly rejected, as the 2006 Plan demonstrated that Wrangell is served by an undersized, inadequate, and substandard hospital and LTC facility. While the costs associated with addressing this problem in a meaningful way are significant, WMC's Board and the City of Wrangell both concurred that the problems with the current facility are such that doing nothing is simply unacceptable. It is much less costly to both patients and payers to have services provided locally. In fact, the Southeast Alaska Regional Health Consortium (SEARHC) has indicated that, when it is clinically feasible, they prefer to be able to purchase locally based services. SEARHC has found that a local provider, such as WMC, has costs and charges that are often lower than the larger, more distant providers. To the extent that WMC can continue to provide locally based services, we believe that the overall cost to patients and payers will be reduced. For example, patients and payers will not incur any travel related costs.

The 2006 Plan identified three other primary scenarios to address the problem:

- Renovation/expansion of the existing WMC facility.
- Construction of a new facility on the existing WMC site.
- Construction of a new facility on a new site.

Identified advantages of renovating the current facility include that no land would need to be acquired, but the significant disadvantages included the need for highly coordinated phasing of the project (if even possible), a longer development timeline that could impact costs, and substantial disruption of existing services during renovations.

Advantages to building a new facility on the existing site included no move would be needed, and the existing location is familiar to Wrangell residents, with the disadvantages being high development costs, difficult and costly soil conditions, and added costs to demolish the current facility.

While the identified disadvantages to the selected alternative – building a new facility on a new site – also included higher development costs, as well as, the need to acquire land, the advantages included, significantly, that all facility upgrade, design, and space needs will be met in a single step, there would be no construction-related disruptions to existing services, and the sale of existing facility assets could offset costs.

- 2. Describe any special needs and circumstances. Special needs may include special training, research, Health Maintenance Organizations (HMOs), managed care, access issues, or other needs.**

This question is not applicable.

D. The relationship of the proposed project to existing healthcare system and to ancillary or support services

- 1. Identify any existing comparable services within the service area and describe any significant differences in population served or service delivery. If there are no existing comparable services in the area, describe the unmet need and how the target population currently accesses the services. Describe significant factors affecting utilization, including cost, accessibility, and acceptability.**

As this project will simply replace the existing WMC facility, this question is not applicable, with the exception of LTC, as detailed in response to the next question.

- 2. Describe the probable effect on other community resources, including any anticipated impact on existing facilities offering the same/similar services or alternatives locally or statewide if applicable. Describe how each proposed new or expanded service will:**
 - a. complement existing services**
 - b. provide an alternative or unique service**
 - c. provide a service for a specific target population**
 - d. provide needed competition**

WMC is the only provider of acute, emergency, outpatient surgery, LTC, home health, and ancillary services (diagnostic imaging, laboratory, physical therapy) in the service area (Wrangell Borough). As this project will simply replace the existing WMC facility, this question is not applicable, with the exception of LTC, which WMC will expand from the current 14 beds to 20 beds in the new facility. The community of Wrangell, despite its small size, boasts a continuum of care services for its senior residents. In addition to the LTC unit at WMC, the community has assisted living, independent senior housing, meal services, a senior center, transportation services, home health services, as well as, home visits by WMC medical providers. As part of these services, residents may be eligible for the Medicaid Choice Waiver program. This program supports in home services to eligible individuals through services like home remodeling, equipment purchases, chore services, and personal care services. Therefore, WMC's planned expansion of the LTC unit will occur in the context of a broader system of care for seniors – a system in which our LTC unit and care providers plays a vital part, and in which we coordinate with other providers on a daily basis. Our LTC expansion will further complement Wrangell's system of senior care by meeting the community's increasing demand for the LTC level of care, and is consistent with the State Commission on Aging's updated goals to ensure that "*Older Alaskans have access to an integrated array of health and social supports along the continuum of care*", and that "*A range of adequate, accessible, secure and affordable housing options is available to seniors.*"¹⁸

¹⁸ State Plan for Senior Services, FY 2008 – FY 2011, Alaska Commission on Aging.

3. **Identify existing working relationships the applicant has with hospitals, nursing homes, and other resources serving the target population in the service area. Include a discussion of cooperative planning activities, shared services (i.e. agreements assigning services such as emergency or obstetrics), and patient transfer agreements. If other organizations provide ancillary or support services to your facility, describe the relationship. Attach copies of relevant agreements in an appendix in the application. If a service requires support from another agency but does not have an agreement, explain why.**

WMC is the only provider of acute, emergency, outpatient surgery, LTC, home health, and ancillary services (diagnostic imaging, laboratory, physical therapy) in the service area. WMC also offers sub-specialty clinics with visiting specialists. WMC works closely with the local providers of long term care services as either a referral source or a discharge option for acute care patients and long term care residents. WMC is the only provider of acute and long term care (nursing home) services.

As noted previously, WMC's planned expansion of the LTC unit will occur in the context of a broader system of care for seniors – a system in which our LTC unit and care providers plays a vital part, and in which we coordinate with other providers on a daily basis. Our LTC expansion will complement Wrangell's system of senior care by meeting the community's increasing demand for the LTC level of care, and is consistent with the State Commission on Aging's updated goals to ensure that *"Older Alaskans have access to an integrated array of health and social supports along the continuum of care"*, and that *"A range of adequate, accessible, secure and affordable housing options is available to seniors."*¹⁹

E. Financial Feasibility

1. **Demonstrate how the project will ensure financial feasibility, including long-term viability, and what the financial effect will be on consumers and the state, region, or community served.**

This project has been developed with two primary goals: 1) to provide the residents of the Wrangell community with continued access to acute, LTC, and needed ancillary and support services in a modernized and up to date critical access hospital, and 2) to ensure that the overall financial viability of WMC can be maintained even with the construction of a new facility. To this end, WMC has carefully planned and developed a facility that will, upon opening, be financially sound. The amount of debt to be undertaken is based upon what WMC can reasonably support.

For health care consumers, WMC is confident that its new facility will provide necessary services in the local community. Without a hospital in Wrangell, residents would be forced to travel outside of the service area to access all services, incurring additional costs and inconvenience.

¹⁹ *State Plan for Senior Services, FY 2008 – FY 2011*, Alaska Commission on Aging.

- 2. Discuss how the project construction and operation is expected to be financed. Demonstrate access to sufficient financial resources and the financial stability to build and operate this project.**

It is estimated that the replacement facility will cost about \$25.4 million. WMC intends to finance approximately \$16.8 million of the cost by issuing debt to be repaid by hospital operations. The remainder of the funds will come from reserves and grants. Included in Exhibit 2 is a letter from InnoVative Capital regarding the ability of WMC to secure the necessary financing for the project. WMC is planning to solicit other funds (totaling \$5million) from the following entities/organizations:

MJ Murdock Charitable Trust
United States Department of Agriculture
Rasmuson Foundation
Paul G. Allen
State of Alaska
Congressional delegation
Numerous federal grant programs

- 3. Provide a description and estimate of:**

- a. the probable impact of the proposal on the annual increase on the overall costs of the health services to the target population to be served;**

WMC does not anticipate increases in costs for services for acute care services. As WMC is able to retain patients in the community; at minimum, travel costs will be reduced. For LTC residents, WMC will be paid a higher Medicaid rate (than it is currently paid). However, these additional LTC beds are expected to reduce out of area travel for residents to access nursing home services.

- b. If applying to build a residential psychiatric treatment centers, nursing homes, or additional nursing home beds the annual increase to Medicaid required to support the new project, and the projected cost of and charges for providing the health care services in the first year of operation (per diem rate, scan, surgery etc);**

While the costs to the Medicaid program are projected to increase (due to higher rates paid to WMC), having locally based services will reduce travel costs.

In FY2009, WMC's daily room and board rate for Medicaid LTC residents was \$474.07. This is expected to increase to \$805.70 in FY2014 due to the new facility.

- c. **the immediate and long-term financial feasibility of continuing operations of the proposal.**

As noted in response to other sections of this application, the underlying financial assumptions (estimated capital costs) have been predicated on ensuring long term financial sustainability. Although WMC has long recognized a need for new facilities, this project has been carefully sized and configured to reflect the financial realities of WMC. Therefore, WMC is confident that immediate and long term financial feasibility of continuing operations will be maintained.

F. Access to service by the general population and under-served groups

1. **Provide information on service needs and access of under-served groups of people such as low-income persons, racial and ethnic minorities, women, and persons with a disability. Discuss any plans to overcome language and cultural barriers of groups to be served.**

WMC is committed to serving all patients regardless of race, color, creed, sex, national origin, disability, or ability to pay. Included as Exhibit 3 is a copy of WMC's non-discrimination policy from the patient handbook.

Importantly, the new hospital facility will meet and exceed all requirements of the Americans with Disabilities Act (ADA). Salmon Bay Design Group's analysis of the current WMC facility found that patient rooms and bathrooms don't meet many ADA requirements.

2. **Indicate the annual amount of charity care provided in each of the last five years with projections for the next three years. Include columns for revenue deductions, contractual allowances, and charity care.**

This information is provided in Exhibit 4 (Schedule I).

3. **Address the following access issues:**

- a. **transportation and travel time to the facility;**
- b. **special architectural provisions for the aged and persons with a disability;**
- c. **hours of operation; and**
- d. **the institution's policies for nondiscrimination in patient services.**

92% of the Wrangell Borough's total population of 2,112 lives in the City of Wrangell itself²⁰. The new hospital site is located within a mile of the city center and about a half-mile from the current WMC facility, meaning that transportation/travel time to access health care at the hospital is not an issue for almost the entire population.

²⁰ Source: Alaska Dept. of Labor and Workforce Development July 1, 2008 population estimates.

WMC's hours of operation for outpatient services are and will continue to be 9am to 5pm Monday through Friday, with the ED open 24 hours a day, 7 days a week. Similarly, our inpatient and LTC beds are staffed 24/7.

The new facility will be AIA compliant.

Section V
Consideration of Quality, Effectiveness, Efficiency, and
Benefits of the Applicant's Services

Please discuss the following in narrative form:

1. ACCREDITATION AND LICENSURE: The current status, source, date, length, etc., of the applicant's license and certification. Include information on Medicaid and Medicare Certification.

WMC is licensed by the State of Alaska, Department of Health and Social Services, Health Facilities Licensing & Certification. WMC is currently certified by Medicare and Medicaid. A copy of WMC's current license is included in Exhibit 5.

2. QUALITY CONTROL: How the applicant plans to ensure high quality service.

WMC has an active quality improvement (QI) program that collects data, monitors, and evaluates the quality and appropriateness of patient care and the clinical performance of health care providers. It is WMC's goal to have 100% QI compliance in all departments and activities of the hospital. WMC is consistently evaluating clinical compliance, patient satisfaction, resolution of patient complaints, and overall QI goals. In addition, WMC is one of six hospitals in Alaska participating in Frontiers in Health Care Quality, a two-year intensive program to improve small rural hospital sustainability by strengthening performance. As part of this program, WMC's clinical data is routinely compared against 100+ like hospitals.

Responsibility for the QI program is housed with the Director of Development and Quality, as well as, the Quality Committee. The Quality Committee meets monthly and consists of representation from administration, nursing, QI, and the medical staff. Each Department reports to the QI Committee on a quarterly basis. The focus of these reports is in two areas: 1) ongoing monitoring to assure compliance with all state and federal requirements, and 2) areas that have been identified as being not necessarily out of compliance, but needing improvement. The Quality Committee has found that developing formal plans for improving these areas has led to more successful improvement efforts.

Each department is responsible, on a quarterly basis, for reporting all compliance and QI activities to the Quality Committee. All QI activities and any incidents (situations which place a department out of compliance, particularly those related to patient safety) are also noted on a master calendar. The department is responsible for developing a correction plan that is also shared with and approved by the Quality Committee.

In addition, WMC also participates in CMS' Ninth Scope of Work, which is another quality improvement program that began in August 2008 and runs through July 2011. WMC's focus is on reducing the number of pressure ulcers for its acute care patients and LTC residents.

3. PERSONNEL: Plans for optimum utilization and appropriate ratios of professional, sub-professional and ancillary personnel.

WMC is committed to providing appropriate ratios of professional, sub-professional and ancillary personnel. Recruiting and retaining staff can often be a challenge for small isolated hospitals. Staffing is determined by patient acuity and the appropriate staffing needed to provide high quality patient care. Staffing efficiencies are expected to be gained in the new facility by locating staff support functions within a department – for example, in contrast to the current facility; the ED nurses station will actually be located in the ED. In addition, the new hospital will have an ED that is sufficiently sized to provide all necessary support areas including space for the EMTs and medical records (neither of which is available in the current space). By adequately sizing all of the departments, WMC staff will become more efficient in several ways: 1) charting space available within department (staff will be able to chart as needed not as space is available), 2) supplies stored in the department (staff will no longer need to spend time away from the department just to get supplies), and 3) maintain the positive and successful attributes of the existing WMC facility such as core nursing stations.

4. APPROPRIATE UTILIZATION: Development of programs such as ambulatory care, assisted living, home health services, and preventive health care that will eliminate or reduce inappropriate use of inpatient services.

WMC's goal is to provide services to patients in the least restrictive setting/lowest acuity possible. The new replacement facility will offer updated ambulatory spaces including outpatient surgery, imaging, and a new ED. By maximizing our ability to meet a patient's needs on an ambulatory basis, we can avoid unnecessary inpatient hospitalizations.

In addition, WMC is proposing to expand its LTC bed capacity. WMC recognizes that there are other, less restrictive levels of senior care, and works closely with patients and families to ensure that the patient's maximum independence is a foremost consideration. However, our current LTC bed supply is already at maximum occupancy, and we are admitting and caring for patients in need of 24/7 skilled nursing care in our swing beds. Given the more resident focused nature of LTC, these residents are more appropriately cared for in an LTC setting.

5. NEW TECHNOLOGY AND TREATMENT MODES: Plans to use modern diagnostic and treatment devices to enhance the accuracy and reliability of diagnostic and treatment procedures.

WMC has expanded our telehealth/remote imaging capabilities such that we have been able to eliminate the need and cost of a second Medivac for some patients. Previously, the images would have been sent via Goldstreak to a radiologist in Sitka. Patients would have had to wait a day or 2 for the results. If needs were more urgent, patients would have been sent, via Medivac, with their images to Sitka and once there, a determination would have been made regarding the need for a second Medivac to Seattle. Images can now be immediately read by a remote radiologist, allowing patients to be directly referred to Seattle or another tertiary facility immediately, if necessary.

In addition, WMC is expanding its imaging services to include a CT scanner, which will be relocated to the new replacement hospital. This too reduces the need for patients to leave the community. In 2008, there were at least 11 Medivacs that could have been avoided had a CT scanner been available. All of these patients were cleared by the CT scan and then had to wait a day for a return ferry to Wrangell. In this manner, just the addition of CT services at WMC is likely to reduce system-wide health care spending by \$330,000 to \$440,000 per year (assuming 11 Medivacs at \$30,000 to \$40,000 per transport).

6. LABOR SAVING DEVICES AND EFFICIENCY: The employment of labor-saving equipment and programs to provide operating economies.

Right sizing the proposed replacement facility will improve operating efficiencies. Specifically, staff travel time through the facility will be reduced by co-locating supplies and equipment within each department. Also, with the expanded facility, each department will have space that promotes patient and staff flow. Currently, some departments (such as the ED and imaging) have multiple entrances that must be utilized depending upon which rooms within the department are occupied. As another example, the nurses' station for the ED is actually down the hall from the ED. The new ED will have a nurses station located within the department.

While not specific to operating efficiencies, patient privacy will be enhanced with the expanded space. Currently, for example, the billing department has no private spaces for patient conferencing, and the waiting area for the ED consists of two chairs located just outside the exam rooms.

7. PROGRAM EVALUATION: Future plans for evaluation of the proposed activity to ensure that it fulfills present expectations and benefits.

With the new facility, WMC will continue its Quality Improvement/Performance Improvement program which provides for ongoing monitoring of clinical outcomes, patient satisfaction, resident satisfaction, and physician peer review – i.e., key indicators of the replacement facility's functional success. Also, of course, the overall financial performance of the new facility will be closely monitored. As part of this process, WMC is working towards a 'balanced scorecard' on financial and clinical measures.

WMC conducts a comprehensive organizational self-assessment called the "Performance Pyramid Readiness Assessment" on an annual basis. This helps WMC assess the strengths and weaknesses that exists in its systems and structures and how they can be strengthened. The tool evaluates 1) leadership, 2) the impact of its mission, vision, values, 3) the strength of WMC's approach to quality and performance improvement, 4) the reach of WMC's strategic plan for its future, and 5) the ability and willingness of the workforce to make the organizational strategic plan happen. The results of this assessment are used by WMC leadership to set the course of the organization for the following year.

8. ORGANIZATIONAL STRUCTURE: Include an organizational chart, descriptions of major position requirements and board representation; show representation from community economic and ethnic groups.

A copy of WMC's current organizational chart is included in Exhibit 6. WMC is governed by a 9-member Board of Directors. The members are elected in the City and Borough of Wrangell elections. WMC's current board of directors are representative of the socioeconomic groups within the community as well as the different age cohorts and ethnic groups.

9. STAFF SKILLS: Provide descriptions of major position requirements, appropriate staff-to-patient ratios to maintain quality, and the minimal level of utilization that must be maintained to ensure that staff skills are maintained. Provide a source for the staffing standards.

While staff to patient ratios does vary by acuity, WMC does adhere to industry standards for staffing ratios for all of its services. Outlined below is a brief job description for key positions at WMC:

Administrator –

- Education – must have a baccalaureate or higher degree in a health-care or business related field from an accredited college or university.
- License – must hold a nursing home administrator license for the State of Alaska.
- Experience – must have, as a minimum, three (3) years of experience in health care facility management.

Director of Nursing –

- Education – must have a nursing degree from an accredited college or university.
- License – must hold a license to practice as a registered nurse in the State of Alaska.
- Experience – must have, as a minimum, three (3) years of experience as a supervisor in a hospital, nursing-care facility or other related health care facility.

Director of Development and Quality –

- Education – must have a baccalaureate degree in business administration from an accredited college or university; master's degree is preferred but not required.
- Experience – must have, as a minimum, three (3) years of experience in development and quality.

Social Service Director –

- Education – must have a baccalaureate or higher degree in social work from an accredited college or university.
- License – must hold a social work license for the State of Alaska.
- Experience – must have, as a minimum, three (3) years of experience in a supervisory capacity, in a social work services position.

Chief Financial Officer/Comptroller –

- Education – preference for a baccalaureate in accounting or in a business administration with a major in accounting from an accredited college or university. Education may be substituted with actual work experience.
- Experience – must have, as a minimum, three (3) years of experience in a supervisory capacity, in a financial administration position.

Director of Activities –

- Education – two (2) years of study in occupational therapy, recreational therapy, or a related field from an accredited college or university is preferred, but not necessary.
- License – must hold certification as a therapeutic recreation specialist or an activity director certified.
- Experience – must have, as a minimum, two (2) years of experience in a social or recreation program within the last five (5) years, one (1) of which was in an activities program in a health care setting.

Director of Facilities–

- Education – must have a high school diploma or its equivalent. Courses in environmental control practices and procedures, and building codes and safety regulations preferred
- Experience – must have, as a minimum, two (2) years of experience in supervisory capacity, in an environmental services, in a maintenance/plant related position.

Licensed Nurse (RN/LPN) –

- Education – must have a nursing degree from an accredited college or university.
- License – must hold a license to practice as a registered nurse or a licensed practical nurse in the State of Alaska.
- Experience –None. On-the-job training provided.

Certified Nursing Assistant (CNA) –

- Education – must have a high school diploma or its equivalent.
- License – must hold a license to practice as a certified nursing assistant in the State of Alaska.
- Experience – None. On-the-job training provided.

Administrative Assistant –

- Education – must have a high school diploma or its equivalent.
- Experience – must have, as a minimum, two (2) years of experience in a clerical/secretary position.

Physical Therapist

- Education – must have a postbaccalaureate degree.
- Experience – must have, as a minimum, two (2) years of experience in a hospital or long term care setting.

10. ECONOMIES OF SCALE: The minimum and maximum size of facility or unit required to ensure optimum efficiency. If the planned project is significantly smaller or larger, explain the effect and why the size was chosen.

The new facility – while not offering significant new equipment or programs – will be larger (right sized) than the existing facility. Because the existing facility is undersized, the right sized facility will improve overall staffing and operating efficiencies. Currently, none of the existing departments are sufficiently sized and do not meet current code requirements. Because of a lack of storage space in the existing departments, WMC has four shipping containers (each measuring 40 feet) located behind the hospital in which to store equipment and supplies. With more space in each department, adequate departmental storage space will be available. This will reduce the amount of time that staff is away from the department.

Since space is so limited, WMC recently converted the LTC charting room to a quiet reading/sitting room for residents. Staff must now find other space to do their charting which is challenging given the lack of designated space. The proposed replacement facility will have sufficient staff spaces.

An additional example of a staffing inefficiency is that the LTC facility currently has only one bathing room for residents. This is extremely inefficient as staff must completely drain and clean the tub before filling it for the next resident. In the new facility, the bathing area will have 2 tubs. This means that staff can be draining/cleaning the first tub while the second tub is filling.

As discussed in earlier sections of this document, some departments currently have multiple entrances that must be monitored or accessed depending upon which rooms within the department are occupied. As another example, the nurses' station for the ED is actually down the hall from the ED. The new ED will have a nurses station located within the department.

Section VI.
Narrative Description of How Project Meets Applicable Review Standards

Describe in this section of the application how the proposed project meets each review standard applicable to all activities, and each specific review standard applicable to the proposed activity. *Some of this information will duplicate information required elsewhere in the application packet; that duplication is intentional.*

General Review Standards

- 1. The applicant documents need for the project by the population served, or to be served, including, but not limited to, the needs of rural populations in areas having distinct or unique geographic, socioeconomic, cultural, transportation, and other barriers to care.**

The City of Wrangell is located on Wrangell Island in the Alaska Panhandle of Southeast Alaska. Wrangell Island is separated from the mainland by the Blake Channel. The Island is served by the Alaska Marine Highway which is a ferry system operated by the State of Alaska. A second ferry system, the Inter-Island Ferry System suspended operations in April of this year due to low ridership and lack of funding. Currently, residents of Wrangell can travel via ferry to Petersburg about three times per week (travel time of 3 hours each way). The ferry schedule is such that residents need to stay overnight at least one night when traveling to and from Petersburg. The entire population of Wrangell is reliant upon public transportation in the form of the Alaska Marine Highway system and/or private transportation (plane, helicopter, and boat). This means that access to and from Wrangell is impacted not only by weather-related delays and cancellations, but by fixed transportation schedules and/or equipment availability. The isolation of Wrangell would place its residents and visitors in a unique category of challenged accessibility to needed healthcare services if WMC was not available.

Given the geographic isolation of Wrangell, WMC provides vital acute, emergency, outpatient surgery, LTC, home health, and ancillary services (diagnostic imaging, laboratory, physical therapy) in the service area (Wrangell Borough). Without access to these locally based services, residents of Wrangell and surrounding communities would be forced to travel to another community, presumably Petersburg, and incur significant costs (time, money and inconvenience) just to receive basic inpatient and diagnostic care.

As WMC has thoroughly documented, detailed expert analysis has determined that the existing hospital physical plant is aging and inadequately sized. Some spaces within the hospital have become obsolete, others have awkward layouts, and support areas are generally deficient or non-existent. A facility assessment prepared by Salmon Bay Design (Exhibit 1) identified the areas in which the facility was not in compliance with current codes; including spaces that WMC lacks. This assessment also identified needed upgrades to the electrical and mechanical systems. The new facility will provide 8 acute care/swing beds, 20 LTC beds, an expanded ED, and an operating room.

2. The applicant demonstrates that the project, including the applicant's long-range development plans, augments and integrates with relevant community, regional, state, and federal health planning, and incorporates or reflects evidence-based planning and service delivery. A demonstration under this standard should show that the applicant has checked with the department regarding any relevant state plan, with appropriate federal agencies for relevant federal plans, and with appropriate communities regarding community or regional plans.

The decision to develop a new health care facility for Wrangell is founded in several years of careful analysis and planning at the local level. In 2006, the Alaska Native Tribal Health Consortium and the Denali Commission commissioned an exhaustive Service Delivery and Health Facility Space Plan for the Wrangell-Alaska Region. This plan, completed in August 2006, was based on provider surveys, space analysis, and facility assessments by NBBJ Architecture of Seattle. In short, this analysis underlies WMC's and the City of Wrangell's determination our community is served by an undersized, inadequate, and substandard hospital and LTC facility.

A review of Health Planning Resources identified by the Department²¹ demonstrates the current WMC facility contradicts the goal set forth in Healthy Alaskans 2010 to "*Improve access to comprehensive, high quality health care services*". This goal was more recently restated by the governor's Alaska Health Care Strategies Planning Council that "*Quality health care will be accessible to all Alaskans to meet their health care needs*".²²

Healthy Alaskans 2010, in fact, places a special emphasis on vital healthcare resources like WMC. "Tertiary services, such as hospital and specialty care, are not included in the national Healthy People 2010 objectives. In Alaska, however, small rural hospitals are essential providers of preventive services and primary care, as well as links to emergency care and transport."²³

²¹ <http://hss.state.ak.us/dph/healthplanning/resources/default.htm>

²² *Final Report: Summary and Recommendations*, Alaska Health Care Strategies Planning Council. Dec. 23, 2007.

²³ *Chapter 15, Volume I - Targets for Improved Health*. Healthy Alaskans 2010 - Targets and Strategies for Improved Health:

For any hospital, but especially a small rural hospital, the primary driver of almost all facility services and space needs – including emergency treatment capacity, lab space, clinic space, imaging equipment, and surgery and procedure rooms – is the hospital’s inpatient acute care bed complement; the number of acute beds is the most basic indicator of whether the hospital is ‘right sized’ for the community it serves. Healthy Alaskans 2010 emphasized the importance of this measure when it noted that, “With 202 hospital beds per 100,000 population in 1998, Alaska fell far below the national average of 311.⁶⁴” Since Health Alaskans 2010 was compiled, a more recent national study has found that the national average of hospital beds per 100,000 population is 358²⁴. Importantly, the new hospital will keep the Wrangell community right in line with this national benchmark, as WMC’s 8 current acute care beds, to be replaced with the same number of beds in the new facility, mean that Wrangell has a current (2008) bed-to-population ratio of 379 per 100,000.

Importantly, WMC’s planned expansion of the LTC unit will occur in the context of a broader system of care for seniors – a system in which our LTC unit and care providers plays a vital part, and in which we coordinate with other providers on a daily basis. Our LTC expansion will complement Wrangell’s system of senior care by meeting the community’s increasing demand for the LTC level of care, and is consistent with the State Commission on Aging’s updated goals to ensure that *“Older Alaskans have access to an integrated array of health and social supports along the continuum of care”*, and that *“A range of adequate, accessible, secure and affordable housing options is available to seniors.”*²⁵

In June 2008, Salmon Bay Design Group of Seattle produced facility programming and space requirements and a conceptual design for the new WMC hospital facility. Alaska State law indicates that hospital facilities should be designed to conform with the “Guidelines for Design and Construction of Healthcare Facilities” published by the Facilities Standards Institute (FSI) and the American Institute of Architects (AIA). These are the national/industry standards that the current WMC facility does not meet, and that WMC’s and Salmon Bay’s planning efforts for the new hospital aspire to.

Throughout this application, WMC demonstrates that the new replacement hospital facility is right-sized for our isolated rural community. The planned acute care beds, LTC beds, surgery, lab, and imaging spaces, ED, and all other clinical, ancillary, and support spaces are necessary to provide essential, appropriate, high quality hospital services to Wrangell’s population, and are supported by CN review standards.

²⁴ *The National Report Card on the State of Emergency Medicine*. American College of Emergency Physicians, 2009 Edition.

²⁵ *State Plan for Senior Services, FY 2008 – FY 2011*, Alaska Commission on Aging.

3. The applicant demonstrates evidence of stakeholder participation in planning for the project and in the design and execution of services.

Every step of the evaluation of WMC's current facility, and the planning for the proposed facility, including site selection, has been, and continues to be, directed and overseen by WMC's 9- member Board of Directors, which is elected from the Wrangell community in the City and Borough of Wrangell elections. Similarly, WMC's administration and leadership work closely with the elected Mayor and Assembly of Wrangell.

4. The applicant demonstrates that they have assessed alternative methods of providing the proposed services and demonstrates that the proposed services are the most suitable approach.

As discussed in other sections of this application, WMC (prior to evaluating the feasibility of constructing a replacement hospital) did undertake an evaluation of the current facility and the estimated cost associated with a remodel and renovation. A preliminary assessment indicated that the cost to remodel the existing facility and/or construct new facilities on the existing site was considerably more expensive than the cost to build a new facility on another site. In addition, the disruption to services during construction was expected to be significant.

5. The applicant briefly describes the anticipated impact on existing health care systems within the project's service area that serve the target population in the service area, and the anticipated impact on the statewide health care system.

While we do not expect any significant impact on the statewide health care system, WMC – as Wrangell's only provider of acute, emergency, outpatient surgery, LTC, home health, and ancillary services, and as home to Wrangell's primary care clinic (Alaska Island Community Services) – the current hospital essentially is the service area's health care system. Replacing the current outdated facility will tremendously improve the efficiency and quality of health care for the service area. The new facility is also expected to be an attractive marketing tool for staff/provider recruitment.

6. The applicant demonstrates that the project's location is accessible to patients and clients, their immediate and extended families and community members, and to ancillary services. This includes the relocation of existing services or facilities.

92% of the Wrangell Borough's total population of 2,112 lives in the City of Wrangell itself²⁶. The new hospital site is located within a mile of the city center and about a half-mile from the current WMC facility, meaning that transportation/travel time to access health care at the hospital is not an issue for almost the entire population.

²⁶ Source: Alaska Dept. of Labor and Workforce Development July 1, 2008 population estimates.

Review Standards for Specific Services

To project the numerical need for each CN covered service in this project, WMC employed the methodologies found in the Alaska CN Review Standards and Methodologies.²⁷ Any necessary modifications to the methodologies are noted.

Acute Care Bed Need

STEP ONE: Determine the projected inpatient caseload for the population to be served using the formula:

$$C = (P_s \times UR_s) \times SAS$$

- UR (Use Rate) is defined as the current average annual number of statewide inpatient days of hospital care used during the preceding three years divided by the population. The most recent available statewide hospital data is for the period 2001-2003²⁸. Instead, WMC has elected to employ more recent published use rates for Alaska:

Table 6
Inpatient Days per 1,000 Population

2005	461
2006	450
2007	493
Average	468

Source: Kaiser Family Foundation. statehealthfacts.org

- SAS is defined as the service area's current share of the population. The Wrangell Borough's 2008 population (2,112) represents 0.31% of the State's total 2008 population (679,720)²⁹.

(Note that the relevant projection year is 2017, or 5 years after project completion.)

²⁷ Alaska CN Review Standards and Methodologies, AK Dept. of Social and Health Services, Dec. 9, 2005.

²⁸ *Highlights of Alaska's Hospital Discharge Data, 2001-2003*. AK Dept. of Social and Health Services, Jan. 12, 2005.

²⁹ AK Dept. of Labor and Workforce Development, July 1, 2008 estimates.

Table 7
Acute Care Bed Need
Step 1 Calculations

Ps (projected 2017 AK pop.)	749,585
X URs (use rate per 1,000)	468
÷ 1,000	
= Total 2017 AK patient days	350,806
X SAS (service area share)	0.31%
= C (caseload, or inpatient days required by Wrangell pop.)	1,090

Source: Applicant

STEP TWO: Determine the projected average daily inpatient census (ADC) for the service using the formula.

- The projected ADC is $1,090 \div 365 = 2.99$

STEP THREE: Determine the projected number of hospital beds needed for the service area.

- The defined target occupancy for hospitals with fewer than 50 beds is 50%.
- The projected number of hospital beds needed is $3.02 \text{ (ADC)} \div 50\% = 6.03$

MODIFICATION TO METHODOLOGY:

- Available patient data indicates that WMC currently has about a 48% market share of the Wrangell market³⁰. We are projecting that this share will grow to **56%** by 2017 due to our new hospital facility.
 - 56% of the total projected service area inpatient days (1,090) are 605 days in 2017 for WMC, and our projected inpatient ADC is **1.7**.
 - At the target occupancy of 50%, or projected hospital bed need for acute care is **3.3**.

STEP FOUR: Calculate the unmet bed need by subtracting the existing inventory from the total hospital bed need.

- This step is not applicable, as WMC will be replacing the service area's existing bed supply (8) with the same number of beds (8).

³⁰ 2007 Medicare MedPAR data, prepared by InfoTechnics, LLC

MODIFICATION TO METHODOLOGY:

WMC is planning for 4.7 additional beds beyond the 3.3 projected by the methodology, or 8 total beds, for the following reasons.

- These 8 beds in the new facility will simply replace the 8 existing beds in the current facility.
- All 8 beds will be designated as swing beds. This number of swing beds prudently accommodates WMC actual historical patient volumes. This is because, in addition to accommodating acute inpatients, WMC also provides short stay/observation care, and we provide sub-acute skilled nursing care (or swing bed care). Please note that due to the size of the facility, it is simply neither efficient nor feasible to have a dedicated observation unit.
 - Short stay/Observation. Data for July 1, 2008-May 31, 2009 (341 total days), shows:
 - WMC provided a total of 159 observation days, for an average daily census of 0.5 patients.
 - During this period, the actual ratio of average observation census to acute inpatient census was **0.3727**.
 - Applying this ratio to our projected acute inpatient ADC for 2017 results in an observation ADC of **0.6** for 2017.
 - Accommodating this observation ADC at the Department's target occupancy of 50% will require **1.2** beds.
 - Swing Bed Care.
 - In FY2009, WMC provided a total of 917 swing bed days, for an average daily census of 2.5 patients.
 - We project our current swing bed days will grow at the same rate as our projected LTC days, below (+13.4% total growth through 2017).
 - Beginning in 2013 (when the new hospital opens) 60% of these projected swing bed days annually are assigned to our expanded LTC facility (i.e. – a more appropriate care setting for some swing bed patients), leaving 419 projected swing bed days remaining in the hospital beds in 2017.
 - The resultant swing bed ADC for 2017 is **1.1**.
 - Accommodating this swing bed ADC at the Department's target occupancy of 50% will require **2.3** beds.
 - Accommodation of peak census: Finally, during the July 08-May 09 period, WMC's actual peak total combined census (acute + observation + swing) was 10 patients, and the combined census was a least 8 patients (100% occupancy) on a total 24 of days.
- The above inpatient bed need projections are summarized in Table 8:

Table 8
Wrangell Medical Center
Projected 2017 Average Acute Care/Inpatient Bed Need

Bed Type	Need
Acute Care	3.3
Observation	1.2
Swing	2.3
Total Bed Need	6.8
Bed Need at Peak Census (variance 129%)	8.8

Source: Applicant

For these reasons, we believe WMC's total complement of 8 acute/sing beds is fully justified/supported under CN Standards.

Hospital Laboratory Department Services

WMC provides the service area's only hospital laboratory services. The new hospital's laboratory capacity is justified under the CN standards for lab services as follows:

- CN Standard III – A. 1. 1. requires that *"The population served by a laboratory to be moved will continue to have reasonable access to the service at the new site."*

Like the current WMC, the new hospital will be located in the town of Wrangell; access for the population to be served will not be impacted.

- Accreditation reports and a visual inspection of WMC's laboratory show a defined need to add space and to redesign the laboratory to make it more efficient and safe, and correct functional problems that affect quality and efficiency.
- In FY2009, WMC provided 21,558 total lab tests. Based on our historical ratios of inpatient and outpatient lab tests to inpatient days, we are projecting that WMC will provide 26,361 lab tests in 2017.
- The Department's numerical methodology for lab space simply says that laboratory size may not exceed 50 net square feet per patient bed based on the projected number of beds that would be served by the laboratory. WMC is planning for 8 inpatient beds and 20 LTC beds, which would allow up to 1,400 square feet (28 beds X 50). Although specific numbers have yet to be finalized, WMC does not expect its laboratory will exceed 1,400 square feet.

Hospital Emergency Department Services

As WMC experiences approximately 1,000 ED visits annually (Table 9) the CN numerical need methodology – which requires 1,500 projected annual visits per ED Treatment Room (EDTR) – would not support even the 1 EDTR at the current hospital facility.

Table 9
Wrangell Medical Center
Total Emergency Department Visits

	Visits
2006	1,017
2007	811
2008	899
2009	953
Avg.	920

Source: Wrangell Medical Center internal data

However, the Hospital ED review standards recognize that circumstances at WMC justify the 2 EDTRs we are planning, as follows:

- *Standard III – B. 1. The applicant demonstrates that the project promotes, or otherwise helps ensure, the maintenance of a stable and efficient emergency medical system.*

WMC is the centerpiece of the emergency medical system for the Wrangell Borough. Patients in need of urgent or emergent medical care come to – or are transported to – WMC for treatment and, if necessary, stabilization prior to transport to Juneau or Seattle. As we document below with regard to WMC's ED patient census, 2 EDTRs are necessary to support efficient delivery of emergency care.

- *Standard III – B. 2. The department may approve additional space if the applicant documents use patterns, and submits data and analysis that show seasonal high peak use rates warranting additional treatment rooms,*

As demonstrated in Table 10, WMC currently provides about 2.5 ED visits on an average day. On more than two-thirds of all days, we care for at least 2 patients, and on some days we see as many as 8 patients.

Table 10
Wrangell Medical Center
Emergency Department Visits per Day
July 1, 2008-May 31, 2009 (341 total days)

Visits	Days Occurring	Pct.
0	49	14.4%
1	58	17.0%
2	83	24.3%
3	72	21.1%
4	35	10.3%
5	21	6.2%
6	12	3.5%
7	7	2.1%
8	4	1.2%
Total	341	100.0%
<i>Average per Day</i>	2.5	

Source: Wrangell Medical Center internal data

Most of the time, when WMC treats more than a single patient on a given day, these patients arrive one-at-a-time and can be treated individually. Often, however, multiple patients will arrive in need of care simultaneously (frequently these patients are involved in the same incident, such as a traffic accident). Clearly, in these circumstances, the availability of just 1 EDTR, even a modern EDTR of the type we are planning for the new facility, is not much better than the emergency treatment space currently available at WMC, which is screened only by a curtain. Basic standards of care, including patient privacy, demand that WMC have the ability to appropriately treat at least 2 ED patients simultaneously³¹.

- *Standard III – B. 4. For a proposal for additional space in the hospital emergency department, the applicant must perform a size-by-functional-need survey and analysis for additional space that demonstrates efficient use of the space.*

The 2 EDTRs we are planning are efficiently and appropriately sized at 140 square feet each. This is based on programming for the new facility developed by Salmon Bay Design Group, in conformance with the “Guidelines for Design and Construction of Healthcare Facilities” published by the Facilities Standards Institute (FSI) and the American Institute of Architects (AIA), per Alaska State law.

- To project ED volumes, WMC has grown our FY2009 actual volumes by 2% annually, for a total of 1,139 total projected ED visits in 2017.

³¹ 2006 AIA Guidelines for Design and Construction of Health Care Facilities. 5.1.2.6 requires that at least one airborne infection isolation room be provided. In a situation where there are multiple patients it would then be necessary to have at least one additional Treatment Room other than the A.I.I. room.

Long Term Care Bed Need

In Tables 11 through 13, WMC has applied and presented the LTC need methodology in the same manner as the Department in actual recent CN decisions³².

Table 11
Wrangell Borough Historical and Projected Population

Age	2006	2007	2008*	2009	2010	2011	2012	2013	2014	2015	2016	2017
0-64	1,859	1,816	1,774	1,749	1,725	1,701	1,678	1,655	1,632	1,610	1,587	1,565
65-74	189	196	203	212	222	232	243	254	266	278	291	305
75-84	94	95	95	97	99	102	104	106	109	111	113	116
85+	39	40	40	40	40	39	39	38	38	38	37	37
Total	2,182	2,146	2,112	2,099	2,086	2,074	2,064	2,054	2,045	2,037	2,029	2,023

Source: Alaska Department of Labor and Workforce Development. (Projections beyond 2008 are based on projections for 2010 and 2015 for the prior, broader Wrangell-Petersburg Borough.)

Table 12 details the bed days per year for the existing LTC unit at WMC. As noted, in Table 12, over the past three years, the average daily census has been 12 patients.

Table 12
Long Term Care Facility: Wrangell Medical Center
Bed Days per Fiscal Year

	Total	0-64	65-74	75-84	85+	July 1 Census
2008	5,352	1,010	592	1,640	2,110	9
2007	5,491	545	787	1,357	2,802	12
2006	4,800	396	742	1,809	1,853	14
2006-2008	15,643	1,951	2,121	4,806	6,765	35
Avg. Days	5,214	650	707	1,602	2,255	11.7

Source: Wrangell Medical Center

As detailed in Table 13, the projected bed need, under a strict application of the methodology is 17 in 2017.

³² *Review of the Wildflower Court CN Application to Add Eight Nursing Home Beds, July, 15, 2008. and Review of South Peninsula Hospital's CN Application to Add three Nursing Home Beds, June 2, 2009.*

Table 13
Wrangell Medical Center
Projected LTC Bed Need in 2017

A	B	C	D	E	F	G
Age Group	Population Estimate 2006-2008	Average Bed Days/ Year 06-08	Average Bed Days Per Person	2017 Population Projection	Forecast Bed Days = D X E	Forecast 2017 Bed Need 90% Occupancy
0-64	1,816	650	0.358	1,565	560	1.7
65-74	196	707	3.608	305	1,100	3.3
75-84	95	1,602	16.951	116	1,966	6.0
85+	40	2,255	56.859	37	2,097	6.4
Total	2,147	5,214	2.429	2,023	5,723	17.4

Source: Wrangell Medical Center

MODIFICATIONS TO METHODOLOGY:

WMC is planning for additional beds beyond the 17.4 projected by the methodology, or 20 total, for the following reasons:

- Data for the period July 1, 2008-May 31, 2009 (341 total days) shows that WMC's LTC census was virtually 100% – 14 patients in 14 beds – on a total of 319 days, or 95% of the time.
- WMC currently provides sub-acute skilled nursing care in our hospital swing beds. Data for the same period shows:
 - In FY2009, WMC provided a total of 917 swing bed days, for an average daily census of 2.5 patients.
 - We project our current swing bed days will grow at the same rate as our projected LTC days, above (+13.4% total growth through 2017).
 - Beginning in 2013 (when the new hospital opens), 60% of these projected swing bed days annually are assigned to our expanded LTC facility (i.e. – a more appropriate care setting for some swing bed patients). A total of 629 days of (formerly) swing bed care will be assigned to the LTC facility, for an additional ADC of 1.7 patients.
- Clearly, demand for LTC at WMC exceeds the 17.4 beds projected by the methodology. WMC plans to accommodate this demand as summarized below in Table 14:

Table 14
Wrangell Medical Center
2017 Long Term Care Bed

DHSS Methodology Projected LTC days	5,723
Additional former swing bed patients	629
Total Projected Days	6,352
Average Daily Census (ADC)	17.4 patients
Total Need @ 90% Target Occupancy	19.3 (20 beds)

General Surgery Services

We are not proposing any new surgery capacity; WMC currently has a single CN-approved general purpose operating room, as will the new replacement facility.

We note for the record that in March 2009, WMC began offering some new outpatient surgical procedures (umbilical and inguinal hernia surgeries, lipoma excisions, breast biopsies, skin biopsies, and hemorrhoidectomies) performed by visiting surgeons. Examples of services we could potentially add in our surgery department include laparoscopic surgeries (gall-bladder surgeries, etc.), gynecological procedures, urological procedures, orthopedic procedures, ENT-related procedures, pediatric circumcisions, skin biopsies, and vasectomies.

While we expect our current surgery service to grow significantly over time, we do not anticipate that the CN numerical need methodology – which requires 900 projected annual surgeries per general operating room – would support the operating room at the current hospital facility.

Section VII
Construction Data

A. Please check appropriate boxes:

- | | | | |
|----------------------|--|------------------------------------|-------------------------------------|
| 1. Construction type | <input checked="" type="checkbox"/> New | <input type="checkbox"/> Expansion | <input type="checkbox"/> Renovation |
| 2. Basement | <input checked="" type="checkbox"/> Full | <input type="checkbox"/> Partial | <input type="checkbox"/> None |

B. Project Development Schedule

Date

- | | |
|--|------------------|
| 1. Estimated completion of final drawings and specifications | October 1, 2011 |
| 2. Estimated construction begun by | December 1, 2011 |
| 3. Estimated construction complete by | June 1, 2013 |
| 4. Estimated opening of proposed services | July 1, 2013 |

C. Facility site data: Provide the following as attachments (referenced by the subsection and item number):

1. A legal description and area of the proposed site. Is the site now owned by the facility? If not, how secure are the arrangements to acquire the site?

A legal description of the proposed site is 6 Alaska State Land Survey 84-83. The site is owned by the City of Wrangell, the owner of the hospital. The proposed site is approximately 431,110 square feet (9.9 Acres).

2. Diagrammatic plan showing:

- a. dimensions and location of structures, easements, rights-of-way or encroachments;
- b. location of all utility services available to the site; and
- c. Location of service roads, parking facilities, and walkways within site boundaries.

A diagrammatic plan is included in Exhibit 7.

- 3. Document clearances regarding zone restrictions, fire protection, sewage, and other waste disposal arrangements (under special circumstances, it is acceptable to present evidence of conditional approvals from local government and regulatory agencies).**

In June 2008, WMC undertook an evaluation of potential site options for its proposed replacement hospital. At that time, all four sites under consideration were evaluated regarding zoning, sewage, utilities, and fire protection. The site selected has sufficient water, sewage, and other utilities. The site is zoned Open Space/Public. The City of Wrangell does not have a planning department. Therefore, upon submittal of final construction drawings and specifications, the project will undergo project review by the Fire Marshall as well as the Alaska Department of Health and Social Services.

- 4. An architectural master plan including long-range concept and development of total facility.**

Included as Exhibit 8 are single line drawings of the proposed replacement facility.

- 5. Schematic floor plan drawings (or conceptual drawings) of proposed activity, including functional use of various rooms.**

Single line drawings for the proposed replacement hospital are included in Exhibit 8.

D. Describe the plan for completing construction and the effect (disruption) construction activities will have on existing services.

One of the primary reasons WMC has elected to develop a replacement facility in lieu of attempting to renovate/expand the existing facility is the unacceptable (near total) disruption of existing services that would be caused by renovation activities. Constructing the replacement facility on a different site will ensure no impact on current operations, and we will plan for and implement a seamless transition of operations – including patient transfers – between the old and new facilities.

Section VIIIA
Financial Data - Acquisitions

1. Acquisition type: (Please check applicable boxes)

☐ Lease ☐ Rent ☒ Donation ☐ Purchase ☐ Stock Transaction

2. Cost data

(Omit cents)

- | | |
|---|----------------------|
| a. Total acquisition cost* | \$100,000 |
| b. Amount to be financed | \$0 |
| c. Difference between items (a) and (b) (list available resources to be used, e.g. available cash, investments, grants, etc.) | \$100,000 (donation) |
| d. Anticipated interest rate _____%, term ____ years. | |
| e. Total anticipated interest amount | \$ NA |
| f. Total of (a) and (e) | \$ NA |
| g. Estimated annual debt service requirements | \$ NA |

3. Describe how you expect to finance the project.

Note: Acquisition costs must include (as appropriate):

- Total purchase price of land and improvements (if donated, the fair market value**)
- "Goodwill" or "purchase of business" costs
- The net present value of the lease calculated on the total lease payments over the useful life of the asset as set out in the 2004 version of *Estimated Useful Lives of Depreciable Hospital Assets*, published by the American Hospital Association.
- Consultant or brokers fees paid by person acquiring the facility
- Other pre-development costs to date.

Site acquisition should be stated as "book" value, i.e. actual purchase price plus costs of development. If desired, the applicant may elect to state the acquisition as "fair market value" (in which case, give reason and basis).**

**** A form for use in calculating fair market value is included on page 31 of this packet. Include your calculations as part of this section of your application.**

It is estimated that the replacement facility will cost about \$25.4 million. WMC intends to finance approximately 50% of the cost by issuing debt to be repaid by hospital operations. The remainder of the funds will come from reserves and grants. Included in Exhibit 2 is a letter from InnoVative Capital regarding the ability of WMC to secure the necessary financing for the project.

Section VIII B
Financial Data – Construction Only

1. Construction Method (Please check)

- a. ☐ Conventional bid ☐ Contract management **X** Design and build
b. ☐ Phased **X** Single project ☐ Fast Track

2. Construction Cost (New Activity) (Omit cents)

- a. Site acquisition (Section VIIIA.2.f) \$
\$100,000³³
- b. Estimated general construction** \$19,743,311
- c. Fixed equipment, not included in a** \$403,155
- d. Total construction costs (sum of items a, b, and c)** \$20,246,466
- e. Major movable equipment** \$1,277,500
- f. Other cost: ** \$
- (1) Administration expense \$850,000
- (2) Site survey, soils investigation, and materials testing \$ 63,695
- (3) Architects and engineering fees \$2,200,000
- (4) Other consultation fees (preparation of application included) \$ 163,271
- (5) Legal fees \$26,664
- (6) Land development and landscaping \$450,000
- (7) Building permits and utility assessments
 (including water, sewer, electrical, phones, etc.) \$125,000
- (8) Additional inspection fees (clerk of the works) \$25,147
- (9) Insurance (required during construction period) \$
- g. Total project cost (sum of items d, e, f) \$25,427,743
- h. Amount to be financed \$16,835,000
- i. Difference between 2.g and 2.h (list, as Schedule 1, available
resources to be used, e.g., available cash, investments, grants funds,
community contributions, etc.) \$8,592,743
- j. Anticipated long-term interest rate 6%
- k. Anticipated interim (construction) interest rate 6%
- l. Anticipated long-term interest amount \$15,705,444
- m. Anticipated interim interest amount \$1,319,345³⁴
- n. Total items g, l, and m \$41,133,187
- o. Estimated annual debt service requirement \$108,468
- p. Construction cost per sq. ft. \$519.14
- q. Construction cost per bed \$723.09
- r. Project cost per sq. ft. \$651.99
- s. Project cost per bed (if applicable) \$908,134

*Site acquisition should be stated as "book" value, i.e., actual purchase price (or estimate of value if donated) plus costs of development. If desired, the applicant may elect to state as "fair market value" (in which case, so indicate). A form for use in calculating fair market value is included on page 31 of this packet. Include your calculations as part of this section of your application.

** Items must be certified estimates from an architect or other professional. Major medical equipment may be documented by bid quotes from suppliers.

³³ Estimated value of land to be donated by the City of Wrangell.

³⁴ Capitalized interest

Section IX
Financial Data – All Proposed Activities

Provide an accompanying narrative explanation for each of the schedules below if there are any significant trends or significant changes in any item or group of items from year to year.

Note: Indicate whether you are using a calendar year or other fiscal year period.

A. Attach Schedule I - Facility Income Statement

1. For the most recent five prior full fiscal or calendar years
2. Projections during construction or implementation period (if applicable)
3. Projection for three years following completion of construction, or implementation of the proposed activity.

Schedule I is contained in Exhibit 4.

B. Attach Schedule II - Facility Balance Sheet

1. For the most recent five prior fiscal or calendar years.
2. Current fiscal or calendar year to date

Schedule II is contained in Exhibit 4.

C. Attach Schedule III - Average Patient Cost Per Day (Per Diem Rate if applicable) and Revenue Amounts

Provide revenue and expense data FOR EACH SERVICE THAT IS IDENTIFIED AS CHANGING.

1. For the most recent five prior full fiscal or calendar years (information may be obtained on total patient load, directly from your respective years' Medicare Cost Reports)
2. Current fiscal or calendar year to date
3. Projection for five years following completion of construction or implementation.

Schedule III is contained in Exhibit 4 and includes revenue and expense information for acute, swing, LTC, and outpatient services.

D. Attach Schedule IV – Operating Budget

Current and projected line item capital and operating budgets for the proposed activity. Describe what alternative plans have been made if deficits occur.

Schedule IV is contained in Exhibit 4. As noted in other sections of this application, WMC has carefully developed a project consistent with its financial wherewithal. WMC will not undertake the project until it has all of the necessary financing in place. As such, since significant growth in utilization is not anticipated, WMC does not expect any deficits to occur.

E. Attach Schedule V – A. Debt Service Summary, and B. New Project Debt Service Summary

A debt service cash flow schedule over the life of the debt, if applicable, for all long-term debt of the facility. Identify each debt, including the proposed activity, and break out interest, principal, and other costs.

Included in Exhibit 4 is an amortization schedule for the proposed debt.

F. Attach Schedule VI - Reimbursement Sources

Showing reimbursement sources for the facility for the previous five full years and projected for three years after implementation.

Schedule VI is included in Exhibit 4.

G. Attach Schedule VII – Depreciation Schedule

Showing a depreciation schedule for all items acquired through the proposed project. Note that the straight-line method must be used. Indicate on the depreciation schedule or separately which major movable equipment is being purchased for the project (see Section VIIIB, Item 2e). Also, on a separate page, include a list of all equipment to be purchased through this project and the costs.

Schedule VII is included in Exhibit 4.

FAIR AIR MARKET VALUE CALCUALATION

Fair market value is the price that the property would sell for on the open market. It is the price that would be agreed on between a willing buyer and a willing seller, with neither being required to act, and both having reasonable knowledge of the relevant facts.

To determine the fair market value of equipment, using the formula below, first determine the number of years of estimated useful life of the equipment, as described in the AHA publication *Estimated Useful Lives of Depreciable Hospital Assets* to achieve an annual depreciation amount. Include your calculations as part of this section of your application.

Determining Fair Market Value of Equipment		
1	Purchase price of equipment (round to nearest dollar)	\$
2	AHA estimated useful life of equipment (in years)	
3	Annual Depreciation Expense (ADE) [Divide #1 by #2]	\$
4	Multiply ADE by age of equipment (new = 0)	\$
5	Fair Market Value (Subtract #4 from #1)	\$

The fair market value of land or buildings is the value contained in a current appraisal of the land or building from a licensed real estate appraiser who has no financial or other interest in the transaction. Attach the appraisal as an appendix to the application.

APPLICATION FEE – DETERMINATION AND CERTIFICATION OF AMOUNT

How to Determine the Amount of the Application Fee Required Under 7 AAC 07.079

(1) For a project that does not include a lease of a facility or equipment, the value of the project is:

- A. the amount listed on page 20 of this packet under Section VIIIA, Financial Data – Acquisitions, subsection (2), item “a” (total acquisition cost of land and buildings):

\$ _____

plus

- B. the amount listed on page 21 of this packet under Section VIIIB, Financial Data – Construction Only, item “g” (total project cost, which is the sum of items d, e, and f):

\$25,427,743

Estimated Value of the Activity for (1)
(sum of A & B above)

\$25,427,743

(2) For a project that has a component that is leased, the fair market value of the leased equipment, facility, or land must be considered in addition to the acquisition cost. See the form on page 31 of this packet for how to determine fair market value.

Estimated Fair Market Value for (2):

\$0 _____

Estimated Value for (1) from above:

\$0 _____

Total Estimated Value of the Activity
(sum of (1) and (2):

\$0 _____

Amount of Application Fee submitted with this application
(see 7 AAC 07.079 to calculate amount due):

\$25,427,74

Certification of Individual Determining Application Fee

I certify that, to the best of my knowledge, as of this date, the estimated value and fee for this CN activity are accurate.

Date: November 2, 2009

Facility Name and Address: Wrangell Medical Center
 310 Bennett Street
 Wrangell, AK 99929

Name and Title of Person Determining Application Fee:
Noel Rea, Chief Executive Office

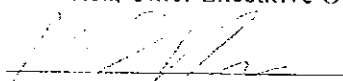
 _____

Exhibit 1
Report Prepared by PPE/Salmon Bay Design Group

WRANGELL MEDICAL CENTER



EXISTING CONDITION SUMMARY



July 22, 2009

ope

salmon bay design group

4501 shilshole ave nw
seattle, wa 98107
206-783-8582
206-783-6885 (fax)

WRANGELL MEDICAL CENTER EXISTING CONDITION SUMMARY

INTRODUCTION AND PPE/SALMON BAY DESIGN GROUP PROFESSIONAL QUALIFICATIONS

This summary was prepared by PPE/Salmon Bay Design Group at the request of Wrangell Medical Center. It is generally known by the staff and administration of Wrangell Medical Center that the facility has condition issues and is not compliant with some healthcare regulations. PPE/Salmon Bay Design Group has been tasked with assembling a summary of these issues to assist the hospital in its facilities planning process.

PPE/Salmon Bay Design Group is a healthcare facility planning and architecture firm based in Seattle, Washington. The firm was founded in 1967 and has been in continuous operation since that time. PPE/Salmon Bay Design Group has completed approximately 2,500 projects under the supervision of founder, President, and Lead Medical Planner John Crane and Lead Architect Daniel R. Dierks. Approximately 90% of projects completed have been facilities for medical and/or dental care. We are licensed to practice architecture in Alaska, Washington, Oregon, California, Idaho, Montana, Wyoming, Colorado, New Mexico, and Illinois.

In addition to our general medical experience and knowledge, PPE/Salmon Bay Design Group is uniquely positioned to assess the condition of Wrangell Medical Center, having been the architects of the most recent major renovation of the building in the late 1980's. It was that renovation that gave the building its current form. We have since completed a number of smaller projects and planning studies for the hospital and have been in continuous communication with the administration and staff of the hospital, and our personnel have visited the hospital periodically, for over 20 years.

This report is organized into sections as follows:

Methodology explains the context of this summary and explains how the data in this report was assembled.

Facility Background explains a thumbnail history of the current facility, which is necessary as context in understanding some of the facility's issues.

Community Background/Medical Background explains the context of this facility. This includes pertinent information about the Wrangell community. It also summarizes the evolution of healthcare over the lifetime of this hospital facility, both locally in Alaska and in the entire United States.

Building Envelope Issues discusses issues with the physical structure of the building, addressing such issues as foundations, floor loads, settling, heating and ventilation, and hazardous materials.

Codes and Standards Issues documents numerous ways in which the existing facility differs from current healthcare and building code standards.

Summary includes our professional summary and evaluation of the condition of the facility.

METHODOLOGY

This assessment is based on a series of on-site observations of Wrangell Medical Center over an extended period of time, commencing in the late 1980's. The majority of these on-site observations have been carried out by John Crane, Lead Medical Planner. All code and condition issues identified by Mr. Crane have been reviewed and validated by Mr. Dierks, as well.

For this report, a detailed comparison of the hospital floor plan was made to the standards adopted by the State of Alaska for hospital facilities. Primary standards used for this review include:

- *2006 Guidelines for Design and Construction of Healthcare Facilities*, (referred to as the *Guidelines*) published by the Facilities Guidelines Institute and the American Institute of Architects Academy for Health. As the

purpose of this study is to document the differences between this facility and current standards, the standards for new construction only are referenced. This facility was reviewed based on Section 2.1, "General Hospitals."

- *2006 International Building Code*, the building code adopted by the State Fire Marshal for plan review;
- *ANSI A117.1*, a standard created by the American National Standards Institute for the provision of access to buildings and facilities for the disabled. (This standard is adopted by reference by Chapter 11 of the *International Building Code*.)
- *The Americans with Disabilities Act Accessibility Guidelines (ADAAG)*, an accessibility guideline adopted by the United States Department of Justice as a companion to the Americans with Disabilities Act of 1990. (Note: the most recent editions of *ANSI A117.1* and the *ADAAG* are virtually identical.)
- This report also evaluates the facility against the standard of current practices of healthcare, which are not defined by any one published standard. Reference is also made to HIPAA, the Health Insurance Portability and Accountability Act. HIPAA does not include a facility standard, but has driven a number of changes in the "standard" design of health care facilities to promote and ensure patient privacy.

Our findings are documented in this summary.

FACILITY BACKGROUND

Wrangell General Hospital was originally constructed in 1968. The original structure is the northeast portion of the building that includes the inpatient (Med/Surg) rooms, surgery suite, labor and delivery area, and mechanical spaces. The structure of this portion of the building is wood frame on wood piling foundation.

Nursing home facilities were added to the building in 1974. The nursing home wing is the southeast portion of the building, including the Long-Term Care rooms and Physical Therapy. This wing is on a conventional foundation atop rock fill with an occupiable basement that houses offices and clinical spaces. This wing has a composite metal and concrete floor atop the foundation walls, and a wood superstructure.

In 1989, the Clinic, Emergency Department, Lab, X-Ray, and entry were added to the building. This portion of the building is constructed of wood-framed modular units on wood pilings. At that time, the 1968 portion of the building was reconfigured and a large metal roof that covers all three phases of construction was added to visually unite the building. The 1989 additions were designed to a very tight budget after a previous plan for a replacement hospital had failed due to an unaffordable cost. As such, much of the configuration of the 1968 and 1974 portions of the building remained unaltered. Other than a maintenance and storage facility added in 1992, the building retains its 1989 configuration virtually unchanged for the past 20 years.

The 1989 addition and remodel included some renovation of the existing portions of the building to bring it up to the standards that were then current for building codes, life safety codes, and accessibility to the disabled. However, the limited budget at that time precluded full renovation of the building. As a result, many key spaces within the building – particularly the patient rooms, surgery suite, resident rooms, and support areas such as kitchen and laundry – essentially retain their original configurations. As noted elsewhere in this study, the federal and state governments have continued to adopt newer revisions of the healthcare standards applicable to this building, and have created an entirely new law, HIPAA, that fundamentally affects the design of many medical spaces and departments. Also, shortly after the renovation was completed, the federal government adopted the Americans with Disabilities Act, which has had the effect of significantly broadening the applicability of accessibility standards to new and existing healthcare structures.

COMMUNITY BACKGROUND/MEDICAL BACKGROUND

The population of Wrangell is relatively stable in terms of total numbers.¹ However, the population of Wrangell is aging, as are the populations of Alaska and the United States in general. The implication is an increased demand for both healthcare and nursing home/long term care, both services provided by this facility.

Since original construction of this facility in 1968, medical care has changed profoundly. The development of new healthcare technologies, adoption of new healthcare treatments, and shift from inpatient-oriented care to outpatient oriented care all tend to “age” a facility functionally, even in a community where the population has remained relatively stable.

Driven in part by changes in modality, but also in part by a drive to increase the quality of healthcare, the standards that apply to this facility have continued to evolve. For example, it is now “standard” to provide patients with private rooms rather than shared ones. It is now accepted that single rooms promote healing, in addition to the benefits of improving patient privacy and promoting infection control.

To fully understand the degree to which standards have evolved since construction of the hospital, the following can be considered: The current configuration of the hospital is basically unchanged since the 1989 remodel and addition. That remodel dramatically changed the appearance of the hospital and extended its useful life for approximately 20 years. The core concept of that project, however, was to retain the costly core and inpatient spaces dating from the original 1968 construction in order to make the project affordable. Much of those important core spaces and systems – including the building’s heating and ventilation system – dates from the original construction of each wing. During that same period of time, the *Guidelines*, the governing facilities standards document for hospitals in Alaska, has undergone at least six revision cycles. Four of those revision cycles have occurred since construction of the 1989 addition and remodel. The cumulative effect of those revisions has been to significantly change the configuration and function of a hospital facility.

BUILDING ENVELOPE ISSUES

The building is currently experiencing several issues, which can be broadly categorized in the areas of foundation/differential settlement, original design floor loading, heat and ventilation condition, and hazardous materials.

Foundation/Differential Settlement

The building was constructed in three different phases in 1968, 1974, and 1989. The original 1968 section is constructed on wood pilings and is wood-framed construction. The 1974 section uses a conventional foundation with basement atop rock fill, a concrete/metal composite floor system, and a wood superstructure. The 1989 section consists of factory-built modular units placed atop a system of wood pilings and glu-lam beams. All sections of the building are topped with a metal roof system installed as a part of the 1989 addition and renovation. (A matching metal roof was included in the 1992 storage building project.)

The three sections of the building are all apparently settling toward the ground. This settlement is occurring at different rates, causing damage to the points where the different sections of the building join together. According to staff, settlement of the building is sufficiently advanced that frequent adjustment and replanning of fire doors separating the sections are necessary. In addition, the 1974 portion of the building has evidently moved enough that

¹ State and U.S. Census figures show a percentage decline in the population of Wrangell since 1990. Since the base population is relatively small, a decline of a few numbers results in a relatively high percentage decrease.

copper plumbing pipes have come in contact with the steel floor structure². Galvanic action between the dissimilar metals has caused damage to the plumbing that has spread beyond the actual point of contact.

Each of the three sections of the building was designed by a structural engineer at the time of construction. Each of the existing portions of the building has been re-examined at the time the subsequent phases were constructed. Two variations of pilings and one section of conventional foundation have been used under the various structures. The various structures have not been successful in preventing the various sections of the building from moving independently from one another nor at maintaining the original floor elevation in some sections of the building. It should be emphasized that this is a long-term problem and is not thought to constitute any immediate danger to the occupants of the building.

Floor Loading

A separate structural issue in the building is the issue of floor loading. Wood frame construction in a hospital, even in 1968, is relatively unusual. The structure of the building is relatively lightweight, in part to address the limited capacity of the soils on the site to support building loads. (See previous section.)

The 1968 portion of the building includes floor joists that may be undersized, as exhibited by excessive deflection over many years. This condition is especially noticeable in mid-span areas.

The 1974 construction includes a metal/concrete composite floor that has a greater loading capacity than the wood-framed sections of the building. This section is occupied by the Long-Term Care wing, which has the least heavy medical equipment. The departments where the heaviest equipment is located and where floor vibration is most an issue – Radiology and Surgery – are located in the wood-framed portion of the building.

The inability of the flooring to support heavy loads has limited the ability of the hospital to obtain and use heavy medical equipment. Each project that has been considered faces a “cascade effect” of issues – insufficient structure, utilities, etc. – that renders the project prohibitively expensive.

Heat and Ventilation

The acronym normally used to describe heat and ventilation in a hospital setting – HVAC – cannot be applied to Wrangell Medical Center. HVAC stands for Heat, Ventilation, and Air Conditioning; Wrangell Medical Center has no centralized cooling.

Each of the phases includes a mechanical heating and ventilation system dating to original construction of that phase in 1968, 1974, and 1989. All systems are supplied with hot water from the boilers in the 1968 portion of the hospital. Each of the systems is a two-pipe, hot-water fan-coil terminal unit system, except that much of the heat in the LTC wing is supplied through baseboard radiator units rather than fan-coil units.

The original section of the hospital was at one time equipped with a swamp cooler, a crude kind of cooling system that is not used today. That system was disabled many years ago. The subsequent phases of the hospital have never had cooling, except for small through-wall units that have been added at the kitchen and laundry areas.

The building lacks cooling. The building includes many interior spaces that house heat-generating equipment, such as computers and medical equipment, as well as people. Even in the relatively cool environment of Wrangell, Alaska, the inability to cool these interior spaces leads to comfort issues for the occupants as well as less-than-ideal conditions for the maintenance of equipment and computers. Patients of the hospital and residents of the Long-Term Care wing do not have the ability to leave the building to escape oppressive heat.

The systems are currently functional, but the systems in the original two phases of the building are past their expected useful life. Parts are no longer available for the systems, so each repair becomes an exercise in

² It is not clear in the absence of a detailed structural analysis if this is an issue of differential settlement or one of excessive deflection due to the inability of the floor structure to support heavy loads. (See “Floor Loading,” following.)

improvisation for the hospital facilities staff. At any time, a mechanical failure could cause a serious issue for the operation of the hospital.

An energy audit has not been performed as a part of this summary; however, with buildings and systems that are 40, 35, and 20 years old, energy efficiency and insulation can be expected to be below today's standards for fuel energy efficiency.

Hazardous Materials

The building is known to contain asbestos in floor tiles and ceiling tiles. It is possible that drywall joint compound and insulation in the building also contain asbestos. These materials constitute a hazard when disturbed to patients and staff, especially fragile patients and LTC residents for whom exposure to even non-hazardous dust can be harmful.

Although not surveyed, it is likely that a building of this age could contain lead paint and possibly PCB-containing oils in light fixture ballasts.

The known presence of hazardous materials in the hospital complicates many relatively routine maintenance procedures at the hospital. Hospital maintenance staff has been certified as hazardous materials abatement personnel in order to carry out maintenance and repairs. Many repairs at this building require the setting up of full containment fields and hazardous materials showers in order to protect the medical environment, patients, and staff from contamination.

CODES AND STANDARDS ISSUES

This section details instances where the existing facility differs from currently applicable codes and standards. (See *Introduction and . . . Qualifications* for the list of standards used for this evaluation.) There are many possible design solutions to bring a facility into compliance with required standards. This list is intended to be a reasonable evaluation of the facility against the standards of healthcare one would reasonable desire to find in most hospital facilities. In general, "new construction" standards have been applied for the purpose of this evaluation (as opposed to exceptions permitted in remodel situations.)

Code references in parenthesis are references to the *2006 Guidelines for Design and Construction of Healthcare Facilities*. Other references are named in each citation.

Imaging Suite

1. No Control Desk or Reception Area is present. (2.1.5.5.8.1)
2. No office space is provided for radiologists and assistants. (2.1.5.5.8.2)
3. No Consultation area is provided. (2.1.5.5.8.4)
4. No Patient Holding Area is provided (2.1.5.5.8.5)
5. No Clean Storage Room is present. (2.1.5.5.8.11)
6. No Soiled Holding Room is provided. (2.1.5.5.8.12)
7. The Guidelines call for a staff toilet and a patient toilet. (2.1.5.5.9.2 and 2.1.5.5.10.2). Only one toilet is provided, accessible only through the X-Ray Room. That toilet is not handicapped-accessible (ANSI A117.1, ADAAG.)
8. No handicapped-accessible dressing room is present. (ANSI A117.1, ADAAG)
9. The following doors do not have sufficient handicapped-accessible latch-side clearance (ANSI A117.1, ADAAG):

- a. 115
- b. 118
- c. 121
- d. 122

Emergency Department

1. The reception area is small and open to the Emergency Corridor. There is no provision for patient privacy for interview or triage. (2.1.5.1.3.4, HIPAA)
2. No designated wheelchair/stretchers storage is provided (2.1.5.1.3.9.8).
3. The public waiting area does not have toilet facilities, drinking fountains, or a telephone. (2.1.5.1.3.6)
4. The Exam Room (labeled Procedure in existing plans) has approximately 115 square feet clear floor space, less than the current minimum of 120 square feet. (2.1.5.1.3.7.1.a)
5. Trauma/Cardiac Rooms (labeled Treatment in existing plans) have approximately 140sq.ft. clear floor space, less than the current minimum of 250sq.ft. clear floor space. (2.1.5.1.3.7.2.a)
6. Trauma Room doors are 4'-0" wide. Five-foot-wide doors are required (2.1.5.1.3.7.2.e)
7. A single staff station serves as nurse station, reception, and triage. Current standards call for a Nurse Station with access to hand-washing station provided. (2.1.5.1.3.9.1.a)
8. No dedicated Clean Workroom or Clean Supply room are provided for the Emergency Department. (2.1.5.1.3.9.6)
9. No Equipment Storage Room is provided. (2.1.5.1.3.9.8 and 2.1.5.1.2.7.)
10. No Staff Lounge is provided. (2.1.5.1.3.10)
11. No Decontamination Area is provided. (2.1.5.1.3.7.4)
12. No Bereavement Room is provided. (2.1.5.1.3.11.1)
13. A Patient Toilet Room is provided, but it is accessible only from the Procedure Room and one Treatment Room. There is no access to the toilet from the remaining Treatment Room. Current standards call for one toilet room per eight Treatment Rooms. The toilet should be accessible to all patients. (2.1.5.1.3.11.2 and 2.1.5.1.2.9)
14. No airborne infection isolation room is provided. (2.1.5.1.2.6)
15. Public toilet, handwashing facilities, and drinking fountain are not provided at the waiting area. (2.1.5.1.2.8)
16. Not all treatment areas are compliant with minimum space requirements (2.1.5.1.3.7.1.a and 2.1.5.1.3.7.2.a.i.)
17. No decontamination area is provided (2.1.5.1.3.7.5)
18. No scrub stations are provided adjacent to trauma rooms (2.1.5.1.3.9.4)
19. Wheelchair, stretcher, and equipment storage areas are not provided (2.1.5.1.3.9.8)
20. No housekeeping room is directly accessible from the unit (2.1.5.1.3.9.9)
21. The following doors do not have sufficient handicapped-accessible latch-side clearance (ANSI A117.1, ADAAG):
 - a. 127
 - b. 134A
 - c. 134B

Subspecialty Clinic

1. The following doors do not have sufficient handicapped-accessible latch-side clearance (ANSI A117.1, ADAAG):
 - a. 165
 - b. 164
 - c. 163
 - d. 152
 - e. 147
 - f. 148
 - g. 168
 - h. 141
 - i. 140
 - j. 139
 - k. 144

Surgery

1. The numbered items below cite specific regulatory standards issues with the surgery suite. A general issue with the suite is the lack of facilities for outpatient procedures. Many surgical hospital procedures performed, even in a hospital setting, are outpatient procedures and this is especially likely to be true in a small community setting such as Wrangell. The lack of outpatient reception, pre-op, post-op, step-down and support spaces forces the use of inpatient rooms for pre-and post-op activities. Use of inpatient-type facilities for outpatient procedures tends to decrease efficiency and increase cost; it is also not desirable for outpatients to travel through inpatient areas. Even though this is a small community, the hospital generally uses a strategy of bringing in specialists on a rotating basis to serve the needs of the local population; it is possible that lack of proper facilities is limiting the services available in the local area.
2. The existing Operating Room has approximately 380 square feet of clear floor space. Current standards call for a minimum of 400 square feet of clear floor space. (2.1.5.3.2.1.1.a)
3. The existing Operating Room is approximately 19'-6" x 19'-6". Current standards call for an operating room to have minimum dimensions of 20'-0" clear. (2.1.5.3.2.1.1.a)
4. No Post Anesthesia Care Unit (PACU) is provided in existing Surgery Suite. (2.1.5.3.3.2)
5. No Phase II Recovery provided in existing Surgery Suite. (2.1.5.3.3.3)
6. Soiled work area and Housekeeping are currently shared between Surgery and Delivery Rooms. Standards call for dedicated spaces for each function. (2.1.5.3.5)
7. The Surgery Suite has no Control Station. (2.1.5.3.5.1)
8. The Surgery Suite lacks a Supervisor's Office. (2.1.5.3.5.2)
9. No Documentation/Dictation area exists within the Surgery Suite. (2.1.5.3.5.3)
10. The Surgery Suite lacks a properly secured room for the storage of Medications. (2.1.5.3.5.5).
11. No Anesthesia Workroom is provided in the Surgery Suite. (2.1.5.3.5.11).
12. An Equipment Storage Room is provided, but at 50 square feet is approximately 1/3 the required size of 150 square feet. (2.1.5.3.5.14).
13. The Surgery Suite lacks a dedicated staff break area. (Staff break areas cannot be shared with break areas outside the surgery suite to prevent contamination of gowned staff. The staff lockers/changing areas and

- lounge (outside the suite) do not provide for one-way traffic pattern of entering/exiting the surgical suite (2.1.5.3.6.2).
14. No Outpatient Patient Dressing Rooms are provided in existing surgical suite (2.1.5.3.7.1).
 15. The surgery corridor is 7'-6" wide, narrower than the required clear width of 8'-0".
 16. The following doors do not have sufficient handicapped-accessible latch-side clearance (ANSI A117.1, ADAAG):
 - a. 169
 - b. 183A
 - c. 183B
 - d. 184A
 - e. 184B
 - f. 187
 - g. 182A
 - h. 181A
 - i. 181B
 - j. 190
 - k. 190A
 - l. 190B
 - m. 189A
 - n. 192B

Central Sterile

1. The existing spaces are small and were set up for the hand-cleaning methods that were predominant at the time of original construction of the hospital. Although separate soiled and clean work spaces are provided, space is limited for modern washer/decontaminator equipment, scope cleaners, and the like. (2.1.6.3.1)

Registration

1. No wheelchair storage is provided (2.1.7.2.1.3)
2. No private interview space is provided (2.1.7.2.2, HIPAA)
3. No wheelchair-accessible transaction counter is provided (ANSI A117.1, ADAAG.)

Med/Surg Unit

1. Existing patient rooms are predominantly two-bed, instead of one-bed (infection control, HIPAA, 2.1.3.1.1.1.)
2. Existing two-bed patient rooms have approximately 180sq.ft. of clear floor space. New construction is required to have 100sq.ft. of clear floor area per bed. (2.1.3.1.1.2.3)
3. Toilet Rooms in Patient Rooms are required to have a water closet and a hand-washing station. Existing Toilet Rooms contain only a water closet (2.1.2.2.1.2).
4. Existing toilet rooms are not handicapped accessible. (ANSI A117.1, ADAAG.)
5. All patient toilet room doors lack sufficient handicapped-accessible latch-side clearance (ANSI A117.1, ADAAG) (Note: patient room doors also lack latch-side clearance, which is desirable but not mandated by the standards.)
6. Multipurpose rooms are not provided (2.1.2.3.3)
7. A Nourishment Area is not provided (2.1.2.3.5)
8. An Equipment Storage Room is not provided (2.1.2.3.9)
9. No staff toilets are provided on the unit (2.1.2.4.2)
10. Patient rooms do not comply with bed side-clearance requirements (2.1.3.1.1.1.2)

11. No exam room separate from patient rooms is provided (required if two-bed rooms are present.) (2.1.3.1.3)
12. Handwashing facilities are not provided convenient to the nurse station (2.1.3.1.5.5.)
13. No toilet is provided at the bathing station (2.1.3.1.5.9.2)
14. No lounge is provided for visitors (2.1.3.1.7.1)
15. No toilet facilities are provided for public/patient use (2.1.3.1.7.2.)

Obstetrical Facilities

1. Unit is not designed to be isolated from through traffic. Elements of the unit are scattered and unit is combined with surgical facilities. (2.1.4.1.1)
2. No exam/treatment room is provided (2.1.4.2.3)
3. Nurse station for obstetrical facilities is combined with nurse station for Med/Surg. (2.1.4.2.4.1)
4. Existing Soiled Workroom is shared with Surgery Suite. A Soiled Workroom must be provided for the exclusive use of the Obstetrical Suite (2.1.4.2.4.8).
5. Standards require a minimum 10 square foot Storage Room per post-partum room and 20 square foot per each LDRP room (2.1.4.2.4.9.2.a).
6. Existing Housekeeping Room is shared with Surgery Suite. A Housekeeping Room must be provided for the exclusive use of the Obstetrical Suite (2.1.4.2.4.10).
7. Only one Labor room is provided. In facilities that have only one cesarean/delivery room, two labor rooms are required (2.1.4.3.1.1).
7. Existing Delivery Room has approximately 280sq.ft. clear floor area. Cesarean/Delivery Room must have a minimum 360sq.ft. clear floor area and a minimum dimension of 16' (2.1.4.3.3.2).

Long-Term Care Facility

1. The Long-Term Care Facility shares a corridor with Physical Therapy, a space used by other patients. This compromises resident privacy and a supportive/residential environment. (4.1.1.3.2)
2. Resident Toilet Rooms are not handicapped accessible (ANSI, ADAAG, 4.1.1.3.2.1)
3. Resident toilet rooms do not facilitate staff assistance due to lack of side clearance at the toilet (A2.2.7.4)
4. Toilet rooms do not include a handwashing station (4.1.2.2.7.2). (Note: this is required by standards in addition to a hand washing station in the room.)
5. Resident rooms do not have adequate wheelchair maneuvering space (4.1.2.2.2.1.1)
6. Resident rooms do not permit options for furniture locations (4.1.2.2.2.1.2.)
7. Resident rooms do not permit movements of bed and equipment without disturbing residents (4.1.2.2.2.2.1)
8. Provisions for resident privacy (curtains) block most of the access to the window for the "inboard" patient when deployed for the patient closer to the window (4.1.2.2.5)
9. Staff work areas lack charting and areas for confidential conversations (4.1.2.4)
10. Equipment/supply storage and wheelchair storage are not provided (4.1.2.4.6)
11. Staff/resident toilets are not provided on the unit (4.1.2.5.3)
12. Bathing facility lacks a toilet (4.1.2.6.1.4)
13. Small group activity spaces are not provided (4.1.4.2.3.)
14. No toilets are provided near the dayroom (4.1.4.2.5)
15. No dedicated space is provided for personal services (4.1.4.3)
16. A housekeeping room is not provided on the unit (4.1.6.4.1.1)
17. All resident room doors and resident toilet room doors lack sufficient handicapped-accessible latch-side clearance (ANSI A117.1, ADAAG)

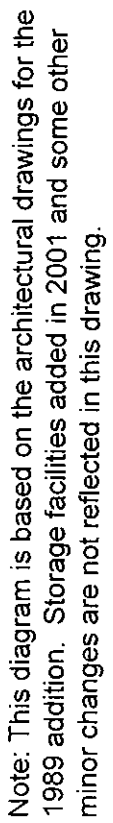
SUMMARY

Wrangell Medical Center is now in its 41st year of serving the medical needs of Wrangell and the surrounding area in this facility. The 1974 Long Term Care addition expanded the services available in the local community, and the 1989 addition and renovation extended the life of the facility for 20 years beyond the point where the facility had at one time been considered at the end of its useful life.

Though the Wrangell community has been frugal and innovative in its ability to extend the life of this facility, and today continues to provide quality medical care within its walls. However, the differential settlement, undersized structure, HVAC at the end of its useful life, and presence of hazardous materials are daunting obstacles to the continued use of this building.

In addition to the building's physical issues, virtually every department in the building is out of compliance with current facilities standards and codes, including the Guidelines, handicapped accessibility standards, and HIPAA. It is difficult to imagine any facilities solution that would create compliance with those standards that would require less than wholesale replacement of the facility.

In combination, the physical and regulatory issues indicate that replacement of the entire facility on a different site with more stable soils is the most effective solution to replacement of the facility. Several city-owned sites are available within the City and Borough of Wrangell that could accommodate a replacement hospital. Further, construction of a new hospital would allow care to continue in the existing facility until the new building is ready for occupancy.



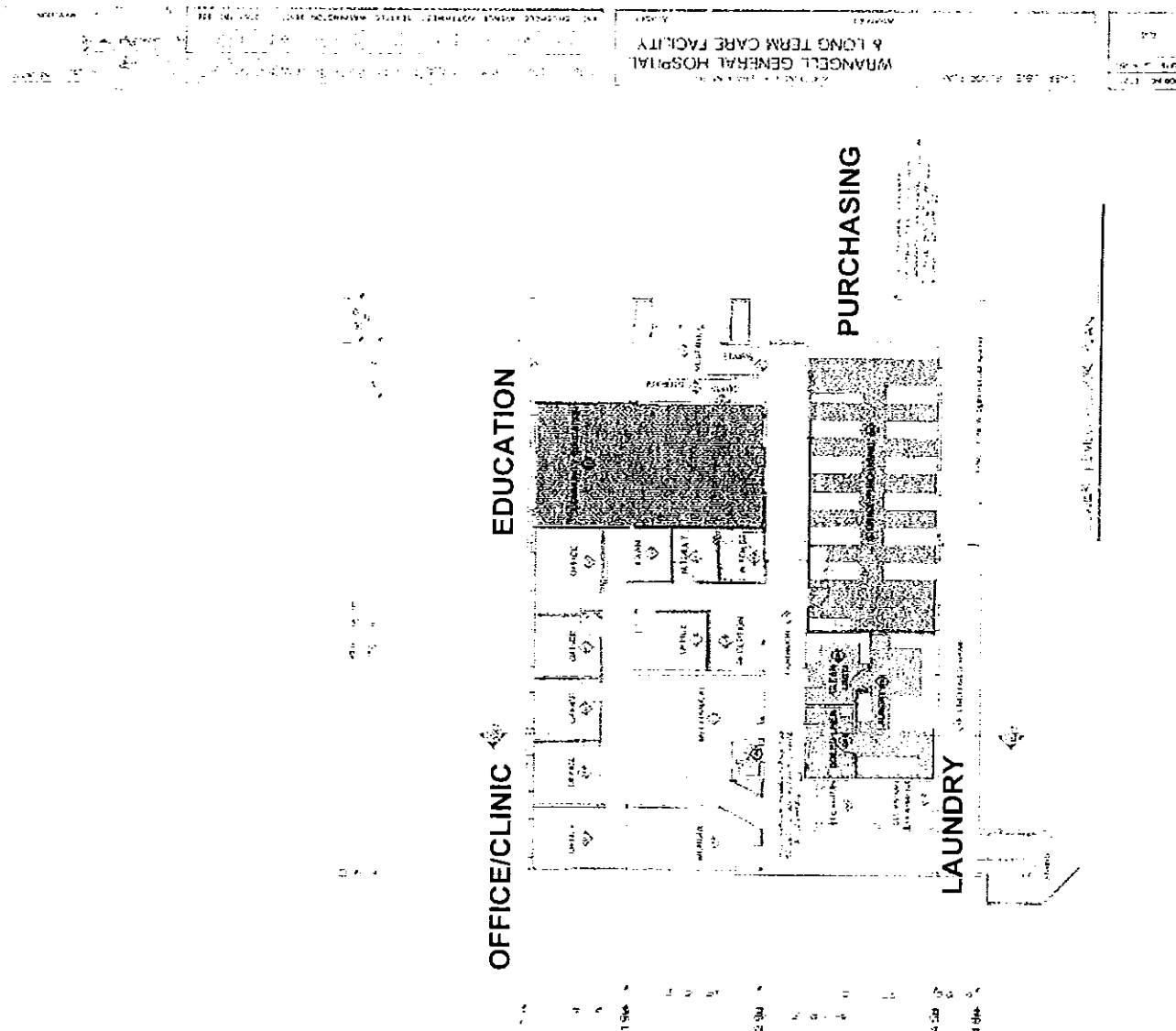


Exhibit 2
Letter from InnoVative Capital

November 3, 2009

Noel D. Rea
Chief Executive Officer
Wrangell Medical Center
310 Bennett Street
Wrangell, Alaska 99929

Re: Financing Commitment Letter - FHA Section 242 Mortgage Insured Project Financing

Dear Mr. Rea:

InnoVative Capital, LLC ("InnoVative Capital") understands that Wrangell Medical Center ("WMC") is requesting approval from the State of Alaska - Health Planning & Systems Development Unit for its planned hospital modernization project (the "Project"). The current budget forecasts a not-to-exceed limit of \$25,427,743, inclusive of project-related and financing costs, as well as necessary reserves. The plan of financing for the Project will require the construction and permanent loan (the "Loan") be an insured financing by the U.S. Department of Housing and Urban Development ("HUD") acting through the Federal Housing Commissioner ("FHA"), pursuant to Section 242 of the National Housing Act.

Funding for the Loan will be provided by one of two options: (1) the placement of a Ginnie Mae ("GNMA") collateralized FHA Section 242 insured taxable mortgage loan; or, (2) the sale of GNMA collateralized Build America Bonds. In either case, the debt financing will be in an amount not to exceed \$16,835,000. In order to fund the Project, WMC will contribute cash in an amount not to exceed \$3,592,743 and contributions in an amount not to exceed \$5,000,000.

During our initial due diligence financial review of WMC, InnoVative Capital reviewed WMC's debt capacity, forecasted financial performance, and operating and project budgets. Our preliminary findings indicate that WMC meets the underwriting requirements of the FHA Section 242 Mortgage Insurance Program for applicant hospitals. Further, when assessing the current and forecasted liquidity position of WMC, we are comfortable they will have sufficient cash to fund their required equity component of the Project financing. Additionally, based on representations of WMC, we believe that they will be successful in obtaining the necessary contributions to fund the balance of the Project cost. For these reasons, we are optimistic that, following WMC's receipt of an Alaska Certificate of Need ("CON"), InnoVative Capital, acting in its capacity as a HUD-licensed FHA mortgage lender, will be successful in obtaining an FHA Section 242 mortgage insurance commitment from HUD (the "FHA 242 Commitment"). Upon the issuance of the FHA 242 Commitment, InnoVative Capital will work in conjunction with a licensed investment banking firm to expeditiously undertake and complete the financing of the Project through the issuance of "AAA" caliber FHA 242 mortgage insured Build America Bonds collateralized by GNMA securities. It is anticipated that the Build America Bonds will be issued through the Alaska Industrial Development and Export Authority, or an eligible alternative. However, should an FHA 242 Ginnie Mae collateralized mortgage loan financing, without the use of Build America Bonds, provide a more favorable funding opportunity for WMC, InnoVative Capital commits to complete the financing through the direct placement of the mortgage loan without the issuance of bonds.

Mr. Noel D. Rea
Chief Executive Officer
Wrangell Medical Center
November 3, 2009
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As a licensed FHA mortgage lender, InnoVative Capital processes and underwrites hospital mortgage loans under the FHA Section 242 Mortgage Insurance Program through HUD's issuance of FHA Section 242 mortgage insurance commitments. In this capacity, InnoVative Capital is an industry leader in the financing of community and critical access hospitals. Over the past five years, through the FHA 242 Program, USDA, rated and non-rated bonds and direct loans, InnoVative Capital's healthcare clients have successfully received low-cost funding for the construction of new hospitals and major renovations in Idaho, Montana, Texas, Alabama, Pennsylvania, Georgia, Indiana, Florida, North Carolina, New York and Colorado. It is our firm's niche expertise and past accomplishments in financing replacement facilities for community and critical access hospitals, under the FHA Section 242 Program, which assures future success in Wrangell, Alaska.

As WMC's mortgage banker, following receipt of the FHA 242 Commitment from HUD to insure WMC's mortgage loan, pursuant to Section 242 of the National Housing Act, InnoVative Capital expects to procure funding for the Project based on the following terms and conditions:

- Loan Amount:** \$16,835,000 (based on our preliminary analysis and subject to FHA underwriting and issuance of HUD's issuance of the FHA 242 Commitment.)
- Interest Rate:** To be set based upon prevailing market conditions at the time of HUD's issuance of the FHA 242 Commitment and placement of the Loan occurs. While it is presently anticipated that the Loan will be funded with FHA mortgage insured Build America Bonds collateralized by GNMA securities, should market conditions change, we are also prepared to consummate the financing through the placement of a GNMA collateralized FHA 242 mortgage insured loan, or other means necessary or advantageous.
- Loan Maturity:** Upon the completion of the construction period, the Loan will commence amortization and will mature no more than 25 year thereafter.
- Funding:** In accordance with the construction draw schedule and Loan requisitions submitted to and approved by HUD over the construction period. Draws will not be funded more often than monthly.
- Payment Method:** Level debt payments made monthly in arrears, calculated to retire 100% of the Loan by the stated maturity date.
- FHA Mortgage Insurance Premium:** 50 basis points p.a. based on the outstanding principal balance of the Loan.
- Other Terms and Conditions:** Compliance in full with all terms and conditions (i) required by HUD under the FHA Program, in order to secure mortgage insurance under Section 242 of the National Housing Act; (ii) required by GNMA to secure its guaranty under Section 306(g) of the National Housing Act; (iii) in the event of Build America Bonds, any requirements of the bond issuing authority in connection with the sale of the bonds; or (iv) required or customary in connection with similar transactions.



Mr. Noel D. Rea
Chief Executive Officer
Wrangell Medical Center
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In conclusion, if WMC is successful in receiving a CON for its Project, InnoVative Capital will serve tirelessly on behalf of the hospital with HUD's Office of Insured Health Care Facilities to procure HUD's FHA Section 242 Mortgage Insurance Commitment and thereafter work to finance the construction and permanent long-term funding of the Project. If I can be of any further assistance, or provide further clarification on this matter, please feel free to contact me at (907) 543-2490, ext. 101.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan P. Richman". The signature is fluid and cursive, with a long horizontal line extending from the end.

Alan P. Richman
President & Chief Executive Officer
InnoVative Capital, LLC

cc: Lori Aoyama, Health Facilities Planning and Development

Exhibit 3
Non-discrimination Policy from the Patient Handbook

We Care

It is extremely important to us to make your stay as comfortable as possible. If you have any concerns about your stay, please voice them to our qualified staff.

If you have a complaint or a concern about how you are treated while a patient at WMC, please contact Anna Curtis, our Director of Nursing Services at extension 114.

WMC is committed to serving all patients regardless of race, color, creed, sex, national origin, disability, or ability to pay.

We value your feedback

At your discharge, you will be asked to fill out a short survey about your visit. We greatly appreciate your feedback on this survey so we may learn how to serve you better.



Sue Nelson, R.N., Assistant
Director of Nursing Services
and Discharge Planner
with Long Term Care
Resident Swede.

Your Patient Rights

As a patient at Wrangell Medical Center, you have a right:

1. To associate and communicate privately with persons of your choice;
2. To have reasonable access to a telephone and make and receive confidential calls;
3. To mail and receive unopened correspondence ;
4. To be informed of the facility's grievance procedure for handling complaints relating to patient care;
5. To be free from physical or chemical restraints except as authorized in writing by a physician for a specified and limited period of time, or as authorized by law;
6. To be treated with consideration and recognition of your dignity and individuality;
7. To confidentiality of your medical records and treatment;
8. To be free from unnecessary or excessive medical procedures;

Exhibit 4
Certificate of Need
Financial Schedules

Schedule I

Schedule I. Facility Income Statement

Provide Last Five Years Actual and

Projections For Three Years Beyond Project Completion

	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Gross Patient Revenue:											
Inpatient Routine	466,650	266,701	172,262	274,536	393,523	462,275	485,421	510,795	535,862	563,407	592,124
Inpatient Ancillary	658,980	658,116	535,376	214,759	632,583	741,333	778,448	819,136	859,336	894,736	940,337
Outpatient	2,466,256	2,907,490	3,207,465	3,375,158	3,805,101	4,432,398	4,566,236	4,796,696	4,990,956	5,235,390	5,492,153
Long-Term Care	1,960,603	2,573,529	3,041,355	2,972,674	3,338,465	3,462,563	3,567,132	3,674,146	4,002,837	5,011,579	5,448,719
Swing Beds	477,356	230,679	395,470	536,545	577,800	598,989	773,732	812,583	669,566	702,560	737,886
Other	12,192	9,728	20,309	24,500	24,888	24,000	24,000	24,000	24,000	24,000	24,000
Total Patient Revenue	6,042,037	6,646,243	7,372,237	7,398,172	8,772,360	9,721,558	10,194,969	10,637,356	11,082,557	12,431,672	13,235,219
Less Deductions											
Charity Care	44,068	64,610	183,777	60,331	56,330	60,500	67,191	73,429	82,729	93,226	103,616
Contractual	638,956	597,717	694,683	992,713	873,422	1,418,969	1,520,000	1,600,000	1,520,000	1,420,000	1,420,000
Bad Debts-below											
Total Deductions	683,024	662,327	878,460	1,053,044	929,752	1,479,469	1,587,191	1,673,429	1,602,729	1,513,226	1,523,616
Net Operating	5,359,013	5,983,916	6,493,777	6,345,128	7,842,608	8,242,089	8,607,778	8,963,927	9,479,828	10,918,446	11,711,603
All Other Revenues	204,529	365,206	190,223	501,846	276,045	300,000	4,200,000	200,000	200,000	1,000,000	200,000
EXPENSES:											
Salaries	2,304,542	2,561,959	2,817,771	3,024,300	3,216,668	3,446,552	3,549,949	3,656,447	3,772,858	3,930,783	4,068,360
Benefits	765,275	831,648	918,472	1,095,823	1,358,012	1,472,406	1,619,647	1,781,612	1,959,773	1,965,392	2,074,864
Supplies	599,378	596,933	675,417	788,325	771,932	703,404	717,472	738,996	753,776	780,158	807,464
Utilities	99,419	122,433	159,534	212,123	178,561	189,484	198,958	204,927	209,026	204,000	204,000
Property Tax	42,500	42,500	42,500	42,500	42,500	42,500	42,500	42,500	42,500	85,000	85,000
Bad Debts	177,236	151,255	186,112	180,218	169,068	306,435	250,000	310,000	350,000	360,000	355,000
Lease	3,422	1,574	2,863	1,637	854	582	600	600	700	1,000	1,000
Other Expenses	925,787	1,121,799	1,123,082	1,086,494	1,080,520	1,100,149	1,122,152	1,155,817	1,178,933	1,220,196	1,262,903
Depreciation	243,960	238,645	273,568	292,358	260,518	246,867	321,867	321,867	321,867	1,817,617	1,817,617
Interest			9,295	9,404	5,309	5,550	1,000	0	0	834,988	834,988
Total Expenses	5,161,519	5,668,746	6,208,614	6,733,182	7,083,942	7,513,929	7,824,145	8,212,766	8,589,433	11,199,134	11,511,196
Excess (Shortage) of											
Over Expenditures	402,023	680,376	475,386	113,792	1,034,711	1,028,160	4,983,633	951,161	1,090,395	719,312	400,407

Schedule II

Schedule II. Facility Balance Sheet

Provide Last Five Years Actual and

CURRENT ASSETS	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Cash & Cash Equivalent	1,398,274	1,986,276	2,349,378	2,681,775	3,456,699	4,386,377	5,756,305	6,874,509	8,325,307	745,764	7,931,569
Net Patient Accounts Receivable	1,018,551	1,020,393	1,305,492	1,140,990	1,502,256	1,305,492	1,140,990	1,305,492	1,140,990	1,405,990	1,305,492
Other Accounts Receivable	23,000	34,500	34,500	167,703	70,415						
Inventories	125,083	148,313	144,550	134,727	166,523	146,523	146,523	146,523	146,523	149,453	149,453
Prepaid Expenses	60,736	68,906	45,544	43,191	12,594	43,200	45,544	43,200	45,544	43,200	45,544
Other											
Total Current Assets	2,625,644	3,258,388	3,879,464	4,168,386	5,208,487	5,881,592	7,089,362	8,369,724	9,658,364	2,344,407	9,432,058
Property and Equipment											
Land & Improvements	28,412	28,412	28,412	28,412	28,412	28,412	28,412	28,412	28,412	0	0
Building/Fixed Equipment	5,652,513	5,671,214	5,685,964	5,310,892	5,320,828	5,320,828	5,320,828	5,320,828	5,320,828	22,427,743	22,427,743
Major Movable Equipment	1,879,704	2,373,696	2,469,719	1,872,646	2,068,960	2,768,960	2,868,960	2,868,960	3,000,000	3,000,000	3,000,000
Accumulated Depreciation	6,651,343	6,889,988	7,163,556	6,216,169	6,476,687	6,723,554	7,045,421	7,367,280	7,689,147	1,817,617	3,635,234
Net Property & Equipment	909,286	1,183,334	1,020,539	995,781	941,513	1,394,646	1,172,779	850,920	660,093	23,610,126	21,792,509
Other Assets											
TOTAL ASSETS	3,534,930	4,441,722	4,900,003	5,164,167	6,150,000	7,276,238	8,262,141	9,220,644	10,318,457	25,954,533	31,224,567
LIABILITIES/FUND BALANCE											
Current Liabilities											
Accounts Payable	64,550	98,801	86,376	179,559	151,901	181,901	155,559	181,901	165,559	181,901	151,901
Accrued Expenses											
Accrued Compensation	309,265	365,314	429,837	487,511	519,423	506,813	533,025	520,525	534,785	533,930	567,207
Other Accruals	26,268	43,688	36,234	52,936	55,792	45,600	53,000	46,500	56,000	48,000	60,000
Total Current Liabilities	400,083	507,803	552,447	720,006	727,116	734,314	741,584	748,926	756,344	763,831	779,108
Long Term Liabilities											
Long Term Debt											
Other	33,757	152,453	90,699	73,516	17,529	5,000	0	0	0	14,909,277	14,719,480
Total Long Term Liabilities	33,757	152,453	90,699	73,516	17,529	5,000	0	0	0	14,909,277	14,719,480
Fund Balance	3,101,090	3,781,466	4,256,852	4,370,644	5,405,355	6,536,924	7,520,557	8,471,718	9,562,113	10,281,425	15,725,973
Total Liabilities & Fund Balance	3,534,930	4,441,722	4,899,998	5,164,166	6,150,000	7,276,238	8,262,141	9,220,644	10,318,457	25,954,533	31,224,561

Schedule III

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and Revenue Amounts				
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion				
FYE 2009	I/P	Swing	LTC	O/P
Revenues	1,026,106	577,800	3,338,465	3,805,101
Expenses				
Patient Days	356	917	5,046	
Revenue Per Patient Day	2,882	630	662	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense	456,024	318,295	864,863	
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	3,297.27		474.07	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and

Provide Last Five Years Actual and
Projections For Three Years Beyond Project Completion

FYE 2008	I/P	Swing	LTC	O/P
Revenues	489,295	536,545	2,972,674	3,375,158
Expenses				
Patient Days	308	612	4,750	
Revenue Per Patient Day	1,589	877	626	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	4,351.98		523.34	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and				
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion				
FYE 2007	I/P	Swing	LTC	O/P
Revenues	707,638	395,470	3,041,355	3,207,465
Expenses				
Patient Days	333	714	4,777	
Revenue Per Patient Day	2,125	554	637	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	4,235.53		508.71	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and				
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion				
FYE 2006	I/P	Swing	LTC	O/P
Revenues	924,817	230,679	2,573,529	2,907,490
Expenses				
Patient Days	288	414	4,367	
Revenue Per Patient Day	3,211	557	589	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	4,122.35		494.49	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and				
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion				
FYE 2005	I/P	Swing	LTC	O/P
Revenues	1,125,630	477,356	1,960,603	2,466,256
Expenses				
Patient Days	412	411	2,914	
Revenue Per Patient Day	2,732	1,161	673	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	4,012.19		480.67	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and

Provide Last Five Years Actual and
Projections For Three Years Beyond Project Completion

FYE 2010	I/P	Swing	LTC	O/P
Revenues	1,203,608	598,989	3,462,563	4,432,398
Expenses				
Patient Days	363	717	5,110	
Revenue Per Patient Day	3,316	835	678	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	3,396.19		488.29	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and				
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion				
FYE 2011	I/P	Swing	LTC	O/P
Revenues	1,263,869	773,732	3,567,132	4,566,236
Expenses				
Patient Days	370	917	5,110	
Revenue Per Patient Day	3,416	844	698	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	3,498.07		502.94	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and				
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion				
FYE 2012	I/P	Swing	LTC	O/P
Revenues	1,329,931	812,583	3,674,146	4,796,696
Expenses				
Patient Days	378	935	5,110	
Revenue Per Patient Day	3,518	869	719	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	3,603.02		518.03	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and				
Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion				
FYE 2013	I/P	Swing	LTC	O/P
Revenues	1,395,198	669,566	4,002,837	4,990,956
Expenses				
Patient Days	385	748	5,405	
Revenue Per Patient Day	3,624	895	741	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	3,711.11		533.57	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and

Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion				
FYE 2014	I/P	Swing	LTC	O/P
Revenues	1,458,143	702,560	5,011,579	5,235,390
Expenses				
Patient Days	393	762	6,570	
Revenue Per Patient Day	3,710	922	763	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	4,770.49		805.70	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

**Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and
Provide Last Five Years Actual and
Projections For Three Years Beyond Project Completion**

FYE 2015	I/P	Swing	LTC	O/P
Revenues	1,532,461	737,886	5,448,719	5,492,153
Expenses				
Patient Days	412	411	6,935	
Revenue Per Patient Day	3,720	1,795	786	
Operating & Capital Budget Summary:				
Gross Revenues				
Deductions from Revenue				
Net Revenue				
Direct Expense				
Indirect Expense				
Net Income Projected				
Rate Computation				
Annual Medicaid Rate	4,885.16		822.18	100%
Base Year Cost				
Less Ancillary				
Plus Admin. Overhead				
Cost Basis for Rate				
Base Year Patient Days				
Cost per Patient Day				

Schedule IV

Schedule IV. Operating Budget ACUTE AND SWING BED Provide Last Five Years Actual and Projections For Three Years Beyond Project Completion												
Description:	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	
Number of Beds	8	8	8	8	8	8	8	8	8	8	8	
Days in a year	365	365	365	365	365	365	365	365	365	365	365	
Available bed days	2,920	2,920	2,920	2,920	2,920	2,920	2,920	2,920	2,920	2,920	2,920	
Resident bed days	823	702	1,047	920	1,273	1,080	1,287	1,313	1,133	1,155	1,178	
Percent growth												
Occupancy	28.18%	24.04%	35.86%	31.51%	43.60%	36.99%	44.08%	44.97%	38.80%	39.55%	40.34%	
Average length of stay												
Patient Bed Days	823	702	1,047	920	1,273	1,080	1,287	1,313	1,133	1,155	1,178	
Number of Residents												
Daily Room and Board Rate*	4,012	4,122	4,236	4,352	3,297	3,396	3,498	3,603	3,711	4,770	4,885	
Nursing Revenue	399,148	583,821	738,588	664,699	971,323	848,782	1,041,809	1,094,742	973,003	1,021,653	1,073,257	
Nursing Services												
Payer Mix:												
Medicaid	52	61	170	216	299	254	302	308	266	271	277	
Medicare	480	531	561	499	690	586	698	712	615	626	639	
Other	291	110	316	205	284	241	287	293	252	257	262	
Ancillary Revenue	1,203,838	571,675	364,520	361,141	632,583	552,777	678,488	712,961	633,677	665,361	698,969	
Total Revenue	1,602,986	1,155,496	1,103,108	1,025,840	1,603,906	1,401,559	1,720,297	1,807,702	1,606,680	1,687,014	1,772,226	
Rate Computation												
Annual Medicaid Rate												
Base Year Cost												
Less Ancillary												
Plus Admin. Overhead												
Cost Basis for Rate												
Base Year Patient												
Cost per Patient Day												

**Schedule IV. Operating Budget
LONG TERM CARE ONLY**
Provide Last Five Years Actual and
Projections For Three Years Beyond Project Completion

Description:	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Number of Beds	14	14	14	14	14	14	14	14	14	20	20
Days in a year	365	365	365	365	365	365	365	365	365	365	365
Available bed days	5110	5110	5110	5110	5110	5110	5110	5110	5110	7300	7300
Resident bed days	2,914	4,367	4,777	4,750	5046	5,110	5,110	5,110	5,405	6,570	6,935
Percent growth											
Occupancy	57.03%	85.46%	93.48%	92.95%	98.75%	100.00%	100.00%	100.00%	105.77%	90.00%	95.00%
Average length of stay											
Patient Bed Days	2914	4367	4777	4750	5046	5110	5,110	5,110	5,405	6,570	6,935
Number of Residents											
Daily Room and Board Rate*	480.67	494.49	508.71	523.34	474.07	488.29	502.94	518.03	533.57	805.70	822.18
Nursing Revenue											
Nursing Services	1,732,901	2,320,091	2,774,149	2,744,759	3,079,142	3,211,742	3,308,094	3,407,337	3,712,163	4,647,656	5,053,035
Payer Mix:											
Medicaid	2,825	3,856	4,552	4,706	5,046	5,063	5,063	5,063	5,355	6,509	6,871
Medicare	41	30	5	11	0	12	12	12	13	15	16
Other	48	481	220	33	0	36	36	36	38	46	48
Ancillary Revenue	227,702	253,438	267,206	227,915	259,323	270,490	278,605	286,963	312,636	391,422	425,563
Total Revenue	1,960,603	2,573,529	3,041,355	2,972,674	3,338,465	3,482,232	3,586,699	3,694,300	4,024,799	5,039,078	5,478,597
Rate Computation											
Annual Medicaid Rate											
Base Year Cost											
Less Ancillary											
Plus Admin. Overhead											
Cost Basis for Rate											
Base Year Patient											
Cost per Patient Day											

Schedule V-A and V-B

Period	Interest Paid	Principal Paid	Remaining Balance
1	84 175.00\$	24 293.14\$	16 810 706.86\$
2	84 053.53\$	24 414.61\$	16 786 292.25\$
3	83 931.46\$	24 536.68\$	16 761 755.57\$
4	83 808.78\$	24 659.36\$	16 737 096.21\$
5	83 685.48\$	24 782.66\$	16 712 313.55\$
6	83 561.57\$	24 906.57\$	16 687 406.98\$
7	83 437.03\$	25 031.11\$	16 662 375.87\$
8	83 311.88\$	25 156.26\$	16 637 219.61\$
9	83 186.10\$	25 282.04\$	16 611 937.57\$
10	83 059.69\$	25 408.45\$	16 586 529.11\$
11	82 932.65\$	25 535.50\$	16 560 993.62\$
12	82 804.97\$	25 663.17\$	16 535 330.44\$
13	82 676.65\$	25 791.49\$	16 509 538.96\$
14	82 547.69\$	25 920.45\$	16 483 618.51\$
15	82 418.09\$	26 050.05\$	16 457 568.46\$
16	82 287.84\$	26 180.30\$	16 431 388.16\$
17	82 156.94\$	26 311.20\$	16 405 076.96\$
18	82 025.38\$	26 442.76\$	16 378 634.21\$
19	81 893.17\$	26 574.97\$	16 352 059.24\$
20	81 760.30\$	26 707.84\$	16 325 351.39\$
21	81 626.76\$	26 841.38\$	16 298 510.01\$
22	81 492.55\$	26 975.59\$	16 271 534.42\$
23	81 357.67\$	27 110.47\$	16 244 423.95\$
24	81 222.12\$	27 246.02\$	16 217 177.93\$
25	81 085.89\$	27 382.25\$	16 189 795.68\$
26	80 948.98\$	27 519.16\$	16 162 276.51\$
27	80 811.38\$	27 656.76\$	16 134 619.75\$
28	80 673.10\$	27 795.04\$	16 106 824.71\$
29	80 534.12\$	27 934.02\$	16 078 890.70\$
30	80 394.45\$	28 073.69\$	16 050 817.01\$
31	80 254.09\$	28 214.06\$	16 022 602.95\$
32	80 113.01\$	28 355.13\$	15 994 247.83\$
33	79 971.24\$	28 496.90\$	15 965 750.92\$
34	79 828.75\$	28 639.39\$	15 937 111.54\$
35	79 685.56\$	28 782.58\$	15 908 328.95\$
36	79 541.64\$	28 926.50\$	15 879 402.46\$
37	79 397.01\$	29 071.13\$	15 850 331.33\$
38	79 251.66\$	29 216.48\$	15 821 114.85\$
39	79 105.57\$	29 362.57\$	15 791 752.28\$
40	78 958.76\$	29 509.38\$	15 762 242.90\$
41	78 811.21\$	29 656.93\$	15 732 585.97\$
42	78 662.93\$	29 805.21\$	15 702 780.76\$
43	78 513.90\$	29 954.24\$	15 672 826.52\$
44	78 364.13\$	30 104.01\$	15 642 722.52\$

Period	Interest Paid	Principal Paid	Remaining Balance
45	78 213.61\$	30 254.53\$	15 612 467.99\$
46	78 062.34\$	30 405.80\$	15 582 062.19\$
47	77 910.31\$	30 557.83\$	15 551 504.36\$
48	77 757.52\$	30 710.62\$	15 520 793.74\$
49	77 603.97\$	30 864.17\$	15 489 929.57\$
50	77 449.65\$	31 018.49\$	15 458 911.07\$
51	77 294.56\$	31 173.59\$	15 427 737.49\$
52	77 138.69\$	31 329.45\$	15 396 408.03\$
53	76 982.04\$	31 486.10\$	15 364 921.93\$
54	76 824.61\$	31 643.53\$	15 333 278.40\$
55	76 666.39\$	31 801.75\$	15 301 476.65\$
56	76 507.38\$	31 960.76\$	15 269 515.89\$
57	76 347.58\$	32 120.56\$	15 237 395.33\$
58	76 186.98\$	32 281.16\$	15 205 114.17\$
59	76 025.57\$	32 442.57\$	15 172 671.60\$
60	75 863.36\$	32 604.78\$	15 140 066.82\$
61	75 700.33\$	32 767.81\$	15 107 299.01\$
62	75 536.50\$	32 931.65\$	15 074 367.36\$
63	75 371.84\$	33 096.30\$	15 041 271.06\$
64	75 206.36\$	33 261.79\$	15 008 009.27\$
65	75 040.05\$	33 428.09\$	14 974 581.18\$
66	74 872.91\$	33 595.24\$	14 940 985.94\$
67	74 704.93\$	33 763.21\$	14 907 222.73\$
68	74 536.11\$	33 932.03\$	14 873 290.70\$
69	74 366.45\$	34 101.69\$	14 839 189.02\$
70	74 195.95\$	34 272.20\$	14 804 916.82\$
71	74 024.58\$	34 443.56\$	14 770 473.26\$
72	73 852.37\$	34 615.77\$	14 735 857.49\$
73	73 679.29\$	34 788.85\$	14 701 068.64\$
74	73 505.34\$	34 962.80\$	14 666 105.84\$
75	73 330.53\$	35 137.61\$	14 630 968.23\$
76	73 154.84\$	35 313.30\$	14 595 654.93\$
77	72 978.27\$	35 489.87\$	14 560 165.06\$
78	72 800.83\$	35 667.32\$	14 524 497.75\$
79	72 622.49\$	35 845.65\$	14 488 652.09\$
80	72 443.26\$	36 024.88\$	14 452 627.21\$
81	72 263.14\$	36 205.00\$	14 416 422.21\$
82	72 082.11\$	36 386.03\$	14 380 036.18\$
83	71 900.18\$	36 567.96\$	14 343 468.22\$
84	71 717.34\$	36 750.80\$	14 306 717.42\$
85	71 533.59\$	36 934.55\$	14 269 782.86\$
86	71 348.91\$	37 119.23\$	14 232 663.64\$
87	71 163.32\$	37 304.82\$	14 195 358.81\$
88	70 976.79\$	37 491.35\$	14 157 867.47\$
89	70 789.34\$	37 678.80\$	14 120 188.66\$
90	70 600.94\$	37 867.20\$	14 082 321.47\$

Period	Interest Paid	Principal Paid	Remaining Balance
91	70 411.61\$	38 056.53\$	14 044 264.93\$
92	70 221.32\$	38 246.82\$	14 006 018.12\$
93	70 030.09\$	38 438.05\$	13 967 580.07\$
94	69 837.90\$	38 630.24\$	13 928 949.83\$
95	69 644.75\$	38 823.39\$	13 890 126.43\$
96	69 450.63\$	39 017.51\$	13 851 108.93\$
97	69 255.54\$	39 212.60\$	13 811 896.33\$
98	69 059.48\$	39 408.66\$	13 772 487.67\$
99	68 862.44\$	39 605.70\$	13 732 881.97\$
100	68 664.41\$	39 803.73\$	13 693 078.24\$
101	68 465.39\$	40 002.75\$	13 653 075.49\$
102	68 265.38\$	40 202.76\$	13 612 872.72\$
103	68 064.36\$	40 403.78\$	13 572 468.95\$
104	67 862.34\$	40 605.80\$	13 531 863.15\$
105	67 659.32\$	40 808.83\$	13 491 054.32\$
106	67 455.27\$	41 012.87\$	13 450 041.45\$
107	67 250.21\$	41 217.93\$	13 408 823.52\$
108	67 044.12\$	41 424.02\$	13 367 399.50\$
109	66 837.00\$	41 631.14\$	13 325 768.35\$
110	66 628.84\$	41 839.30\$	13 283 929.05\$
111	66 419.65\$	42 048.50\$	13 241 880.56\$
112	66 209.40\$	42 258.74\$	13 199 621.82\$
113	65 998.11\$	42 470.03\$	13 157 151.79\$
114	65 785.76\$	42 682.38\$	13 114 469.41\$
115	65 572.35\$	42 895.79\$	13 071 573.61\$
116	65 357.87\$	43 110.27\$	13 028 463.34\$
117	65 142.32\$	43 325.82\$	12 985 137.52\$
118	64 925.69\$	43 542.45\$	12 941 595.06\$
119	64 707.98\$	43 760.17\$	12 897 834.90\$
120	64 489.17\$	43 978.97\$	12 853 855.93\$
121	64 269.28\$	44 198.86\$	12 809 657.07\$
122	64 048.29\$	44 419.86\$	12 765 237.21\$
123	63 826.19\$	44 641.95\$	12 720 595.26\$
124	63 602.98\$	44 865.16\$	12 675 730.09\$
125	63 378.65\$	45 089.49\$	12 630 640.60\$
126	63 153.20\$	45 314.94\$	12 585 325.67\$
127	62 926.63\$	45 541.51\$	12 539 784.15\$
128	62 698.92\$	45 769.22\$	12 494 014.93\$
129	62 470.07\$	45 998.07\$	12 448 016.87\$
130	62 240.08\$	46 228.06\$	12 401 788.81\$
131	62 008.94\$	46 459.20\$	12 355 329.61\$
132	61 776.65\$	46 691.49\$	12 308 638.12\$
133	61 543.19\$	46 924.95\$	12 261 713.17\$
134	61 308.57\$	47 159.58\$	12 214 553.60\$
135	61 072.77\$	47 395.37\$	12 167 158.22\$
136	60 835.79\$	47 632.35\$	12 119 525.87\$

Period	Interest Paid	Principal Paid	Remaining Balance
137	60 597.63\$	47 870.51\$	12 071 655.36\$
138	60 358.28\$	48 109.86\$	12 023 545.50\$
139	60 117.73\$	48 350.41\$	11 975 195.08\$
140	59 875.98\$	48 592.17\$	11 926 602.92\$
141	59 633.01\$	48 835.13\$	11 877 767.79\$
142	59 388.84\$	49 079.30\$	11 828 688.49\$
143	59 143.44\$	49 324.70\$	11 779 363.79\$
144	58 896.82\$	49 571.32\$	11 729 792.47\$
145	58 648.96\$	49 819.18\$	11 679 973.29\$
146	58 399.87\$	50 068.27\$	11 629 905.02\$
147	58 149.53\$	50 318.62\$	11 579 586.40\$
148	57 897.93\$	50 570.21\$	11 529 016.19\$
149	57 645.08\$	50 823.06\$	11 478 193.13\$
150	57 390.97\$	51 077.18\$	11 427 115.96\$
151	57 135.58\$	51 332.56\$	11 375 783.39\$
152	56 878.92\$	51 589.22\$	11 324 194.17\$
153	56 620.97\$	51 847.17\$	11 272 347.00\$
154	56 361.74\$	52 106.41\$	11 220 240.59\$
155	56 101.20\$	52 366.94\$	11 167 873.66\$
156	55 839.37\$	52 628.77\$	11 115 244.88\$
157	55 576.22\$	52 891.92\$	11 062 352.97\$
158	55 311.76\$	53 156.38\$	11 009 196.59\$
159	55 045.98\$	53 422.16\$	10 955 774.43\$
160	54 778.87\$	53 689.27\$	10 902 085.16\$
161	54 510.43\$	53 957.72\$	10 848 127.45\$
162	54 240.64\$	54 227.50\$	10 793 899.95\$
163	53 969.50\$	54 498.64\$	10 739 401.30\$
164	53 697.01\$	54 771.13\$	10 684 630.17\$
165	53 423.15\$	55 044.99\$	10 629 585.18\$
166	53 147.93\$	55 320.22\$	10 574 264.97\$
167	52 871.32\$	55 596.82\$	10 518 668.15\$
168	52 593.34\$	55 874.80\$	10 462 793.35\$
169	52 313.97\$	56 154.17\$	10 406 639.17\$
170	52 033.20\$	56 434.95\$	10 350 204.23\$
171	51 751.02\$	56 717.12\$	10 293 487.11\$
172	51 467.44\$	57 000.71\$	10 236 486.40\$
173	51 182.43\$	57 285.71\$	10 179 200.70\$
174	50 896.00\$	57 572.14\$	10 121 628.56\$
175	50 608.14\$	57 860.00\$	10 063 768.56\$
176	50 318.84\$	58 149.30\$	10 005 619.26\$
177	50 028.10\$	58 440.04\$	9 947 179.22\$
178	49 735.90\$	58 732.24\$	9 888 446.97\$
179	49 442.23\$	59 025.91\$	9 829 421.07\$
180	49 147.11\$	59 321.04\$	9 770 100.03\$
181	48 850.50\$	59 617.64\$	9 710 482.39\$
182	48 552.41\$	59 915.73\$	9 650 566.66\$

Period	Interest Paid	Principal Paid	Remaining Balance
183	48 252.83\$	60 215.31\$	9 590 351.35\$
184	47 951.76\$	60 516.38\$	9 529 834.97\$
185	47 649.17\$	60 818.97\$	9 469 016.00\$
186	47 345.08\$	61 123.06\$	9 407 892.94\$
187	47 039.46\$	61 428.68\$	9 346 464.27\$
188	46 732.32\$	61 735.82\$	9 284 728.45\$
189	46 423.64\$	62 044.50\$	9 222 683.95\$
190	46 113.42\$	62 354.72\$	9 160 329.23\$
191	45 801.65\$	62 666.49\$	9 097 662.73\$
192	45 488.31\$	62 979.83\$	9 034 682.90\$
193	45 173.41\$	63 294.73\$	8 971 388.18\$
194	44 856.94\$	63 611.20\$	8 907 776.98\$
195	44 538.88\$	63 929.26\$	8 843 847.72\$
196	44 219.24\$	64 248.90\$	8 779 598.82\$
197	43 897.99\$	64 570.15\$	8 715 028.67\$
198	43 575.14\$	64 893.00\$	8 650 135.67\$
199	43 250.68\$	65 217.46\$	8 584 918.21\$
200	42 924.59\$	65 543.55\$	8 519 374.66\$
201	42 596.87\$	65 871.27\$	8 453 503.39\$
202	42 267.52\$	66 200.62\$	8 387 302.77\$
203	41 936.51\$	66 531.63\$	8 320 771.14\$
204	41 603.86\$	66 864.29\$	8 253 906.86\$
205	41 269.53\$	67 198.61\$	8 186 708.25\$
206	40 933.54\$	67 534.60\$	8 119 173.65\$
207	40 595.87\$	67 872.27\$	8 051 301.38\$
208	40 256.51\$	68 211.63\$	7 983 089.75\$
209	39 915.45\$	68 552.69\$	7 914 537.05\$
210	39 572.69\$	68 895.46\$	7 845 641.60\$
211	39 228.21\$	69 239.93\$	7 776 401.66\$
212	38 882.01\$	69 586.13\$	7 706 815.53\$
213	38 534.08\$	69 934.06\$	7 636 881.47\$
214	38 184.41\$	70 283.73\$	7 566 597.73\$
215	37 832.99\$	70 635.15\$	7 495 962.58\$
216	37 479.81\$	70 988.33\$	7 424 974.25\$
217	37 124.87\$	71 343.27\$	7 353 630.99\$
218	36 768.15\$	71 699.99\$	7 281 931.00\$
219	36 409.65\$	72 058.49\$	7 209 872.51\$
220	36 049.36\$	72 418.78\$	7 137 453.73\$
221	35 687.27\$	72 780.87\$	7 064 672.86\$
222	35 323.36\$	73 144.78\$	6 991 528.09\$
223	34 957.64\$	73 510.50\$	6 918 017.59\$
224	34 590.09\$	73 878.05\$	6 844 139.53\$
225	34 220.70\$	74 247.44\$	6 769 892.09\$
226	33 849.46\$	74 618.68\$	6 695 273.41\$
227	33 476.37\$	74 991.77\$	6 620 281.63\$
228	33 101.41\$	75 366.73\$	6 544 914.90\$

Period	Interest Paid	Principal Paid	Remaining Balance
229	32 724.57\$	75 743.57\$	6 469 171.34\$
230	32 345.86\$	76 122.28\$	6 393 049.05\$
231	31 965.25\$	76 502.90\$	6 316 546.16\$
232	31 582.73\$	76 885.41\$	6 239 660.75\$
233	31 198.30\$	77 269.84\$	6 162 390.91\$
234	30 811.95\$	77 656.19\$	6 084 734.72\$
235	30 423.67\$	78 044.47\$	6 006 690.25\$
236	30 033.45\$	78 434.69\$	5 928 255.56\$
237	29 641.28\$	78 826.86\$	5 849 428.70\$
238	29 247.14\$	79 221.00\$	5 770 207.70\$
239	28 851.04\$	79 617.10\$	5 690 590.60\$
240	28 452.95\$	80 015.19\$	5 610 575.41\$
241	28 052.88\$	80 415.26\$	5 530 160.15\$
242	27 650.80\$	80 817.34\$	5 449 342.81\$
243	27 246.71\$	81 221.43\$	5 368 121.38\$
244	26 840.61\$	81 627.53\$	5 286 493.85\$
245	26 432.47\$	82 035.67\$	5 204 458.18\$
246	26 022.29\$	82 445.85\$	5 122 012.33\$
247	25 610.06\$	82 858.08\$	5 039 154.25\$
248	25 195.77\$	83 272.37\$	4 955 881.88\$
249	24 779.41\$	83 688.73\$	4 872 193.15\$
250	24 360.97\$	84 107.18\$	4 788 085.97\$
251	23 940.43\$	84 527.71\$	4 703 558.26\$
252	23 517.79\$	84 950.35\$	4 618 607.91\$
253	23 093.04\$	85 375.10\$	4 533 232.81\$
254	22 666.16\$	85 801.98\$	4 447 430.83\$
255	22 237.15\$	86 230.99\$	4 361 199.85\$
256	21 806.00\$	86 662.14\$	4 274 537.70\$
257	21 372.69\$	87 095.45\$	4 187 442.25\$
258	20 937.21\$	87 530.93\$	4 099 911.32\$
259	20 499.56\$	87 968.58\$	4 011 942.74\$
260	20 059.71\$	88 408.43\$	3 923 534.31\$
261	19 617.67\$	88 850.47\$	3 834 683.84\$
262	19 173.42\$	89 294.72\$	3 745 389.12\$
263	18 726.95\$	89 741.20\$	3 655 647.92\$
264	18 278.24\$	90 189.90\$	3 565 458.02\$
265	17 827.29\$	90 640.85\$	3 474 817.17\$
266	17 374.09\$	91 094.06\$	3 383 723.12\$
267	16 918.62\$	91 549.53\$	3 292 173.59\$
268	16 460.87\$	92 007.27\$	3 200 166.32\$
269	16 000.83\$	92 467.31\$	3 107 699.01\$
270	15 538.50\$	92 929.65\$	3 014 769.36\$
271	15 073.85\$	93 394.29\$	2 921 375.07\$
272	14 606.88\$	93 861.27\$	2 827 513.80\$
273	14 137.57\$	94 330.57\$	2 733 183.23\$
274	13 665.92\$	94 802.22\$	2 638 381.01\$

Period	Interest Paid	Principal Paid	Remaining Balance
275	13 191.91\$	95 276.24\$	2 543 104.77\$
276	12 715.52\$	95 752.62\$	2 447 352.15\$
277	12 236.76\$	96 231.38\$	2 351 120.77\$
278	11 755.60\$	96 712.54\$	2 254 408.24\$
279	11 272.04\$	97 196.10\$	2 157 212.14\$
280	10 786.06\$	97 682.08\$	2 059 530.06\$
281	10 297.65\$	98 170.49\$	1 961 359.57\$
282	9 806.80\$	98 661.34\$	1 862 698.22\$
283	9 313.49\$	99 154.65\$	1 763 543.57\$
284	8 817.72\$	99 650.42\$	1 663 893.15\$
285	8 319.47\$	100 148.68\$	1 563 744.47\$
286	7 818.72\$	100 649.42\$	1 463 095.06\$
287	7 315.48\$	101 152.67\$	1 361 942.39\$
288	6 809.71\$	101 658.43\$	1 260 283.96\$
289	6 301.42\$	102 166.72\$	1 158 117.24\$
290	5 790.59\$	102 677.55\$	1 055 439.69\$
291	5 277.20\$	103 190.94\$	952 248.74\$
292	4 761.24\$	103 706.90\$	848 541.85\$
293	4 242.71\$	104 225.43\$	744 316.41\$
294	3 721.58\$	104 746.56\$	639 569.85\$
295	3 197.85\$	105 270.29\$	534 299.56\$
296	2 671.50\$	105 796.64\$	428 502.92\$
297	2 142.51\$	106 325.63\$	322 177.29\$
298	1 610.89\$	106 857.25\$	215 320.04\$
299	1 076.60\$	107 391.54\$	107 928.50\$
300	539.64\$	107 928.50\$	-0.00\$
Totals:	15 705 442.28\$	16 835 000.00\$	

Schedule VI

Schedule VI. Reimbursement Sources

Show reimbursement sources for the previous five years and projections for three years after the new project opens.

FYE 2009 Inpatient				
Reimbursement Source	Number of Patients	Gross Patient	Deductions	Net Patient
Medicaid	50	253,427	763	252,664
Medicare	176	442,022	96,299	345,723
Private Insurance	112	274,705	0	274,705
Self Pay	18	55,952	0	55,952
Charity				
Other				
Total	356	1,026,106	97,062	929,044

FYE 2009 Swing				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	330	150,730	82,853	67,877
Medicare	423	339,143	-70,296	409,439
Private Insurance	13	50,243	0	50,243
Self Pay	151	37,684	0	37,684
Charity				
Other				
Total	917	577,800	12,557	565,243

FYE 2009 LTC				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	5,046	3,362,915	722,141	2,640,774
Medicare				
Private Insurance				
Self Pay				
Charity				
Other				
Total	5,046	3,362,915	722,141	2,640,774

FYE 2005 Inpatient acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient
Medicaid	52	107,980	-100,654	208,634
Medicare	480	686,018	-103,128	789,146
Private Insurance	291	808,988	0	808,988
Self Pay				
Charity				
Other				
Total	823	1,602,986	-203,782	1,806,768

FYE 2005 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	2,825	1,685,917	328,024	1,357,893
Medicare	41	126,541	112,460	14,081
Private Insurance	48	148,145	0	148,145
Self Pay				
Charity				
Other				
Total	2,914	1,960,603	440,484	1,520,119

FYE 2006 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	61	86,003	-33,580	119,583
Medicare	531	736,758	-203,648	940,406
Private Insurance	110	332,734	0	332,734
Self Pay				
Charity				
Other				
Total	702	1,155,496	-237,228	1,392,723

FYE 2006 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	3,856	2,271,545	495,276	1,776,269
Medicare	30	27,390	16,022	11,368
Private Insurance	481	237,850	0	237,850
Self Pay				
Charity				
Other				
Total	4,367	2,573,529	511,298	2,025,487

FYE 2007 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	169	168,409	-3,494	171,903
Medicare	561	708,721	-141,042	849,763
Private Insurance	317	225,978	0	225,978
Self Pay				
Charity				
Other				
Total	1,047	1,103,108	-144,535	1,247,643

FYE 2007 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	4,552	2,720,671	405,023	2,315,648
Medicare	5	4,013	3,142	871
Private Insurance	220	316,671	0	316,671
Self Pay				
Charity				
Other				
Total	4,777	3,041,355	408,165	2,633,190

FYE 2008 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	216	236,820	-18,769	255,589
Medicare	499	667,702	-303,206	970,908
Private Insurance	205	121,318	0	121,318
Self Pay				
Charity				
Other				
Total	920	1,025,840	-321,974	1,347,814

FYE 2008 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	4,706	2,833,256	370,418	2,462,838
Medicare	11	8,049	5,879	2,170
Private Insurance	33	131,369	0	131,369
Self Pay				
Charity				
Other				
Total	4,750	2,972,674	376,297	2,596,377

FYE 2010 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	254	294,937	-23,375	318,311
Medicare	586	831,559	-377,614	1,209,173
Private Insurance	241	275,064	0	275,064
Self Pay				
Charity				
Other				
Total	1,080	1,401,559	-400,988	1,802,548

FYE 2010 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	5,063	3,323,113	851,054	2,472,059
Medicare	12	9,186	6,782	2,404
Private Insurance	36	149,932	0	149,932
Self Pay				
Charity				
Other				
Total	5,110	3,482,232	857,836	2,624,396

FYE 2011 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	302	362,010	-28,690	390,700
Medicare	698	1,020,670	-463,490	1,484,159
Private Insurance	287	337,618	0	337,618
Self Pay				
Charity				
Other				
Total	1,287	1,720,297	-492,180	2,212,477

FYE 2011 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	5,063	3,422,807	876,586	2,546,221
Medicare	12	9,462	6,985	2,477
Private Insurance	36	154,430	0	154,430
Self Pay				
Charity				
Other				
Total	5,110	3,586,699	883,571	2,703,128

FYE 2012 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	308	380,403	-30,148	410,551
Medicare	712	1,072,528	-487,039	1,559,566
Private Insurance	293	354,771	0	354,771
Self Pay				
Charity				
Other				
Total	1,313	1,807,702	-517,187	2,324,889

FYE 2012 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	5,063	3,525,491	902,883	2,622,608
Medicare	12	9,746	7,195	2,551
Private Insurance	36	159,063	0	159,063
Self Pay				
Charity				
Other				
Total	5,110	3,694,300	910,078	2,784,222

FYE 2013 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	266	338,101	-26,795	364,897
Medicare	615	953,259	-432,878	1,386,137
Private Insurance	252	315,320	0	315,320
Self Pay				
Charity				
Other				
Total	1,133	1,606,680	-459,674	2,066,353

FYE 2013 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	5,355	3,840,888	983,657	2,857,231
Medicare	13	10,618	7,839	2,779
Private Insurance	38	173,293	0	173,293
Self Pay				
Charity				
Other				
Total	5,405	4,024,799	991,495	3,033,303

FYE 2014 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	271	355,006	-28,135	383,141
Medicare	626	1,000,922	-454,522	1,455,444
Private Insurance	257	331,086	0	331,086
Self Pay				
Charity				
Other				
Total	1,155	1,687,014	-482,657	2,169,671

FYE 2014 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	6,509	4,808,820	-435,576	5,244,396
Medicare	15	13,293	9,814	3,480
Private Insurance	46	216,964	0	216,964
Self Pay				
Charity				
Other				
Total	6,570	5,039,078	-425,762	5,464,839

FYE 2015 Inpatient Acute and Swing Bed				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	277	372,938	-29,556	402,494
Medicare	639	1,051,479	-477,481	1,528,960
Private Insurance	262	347,809	0	347,809
Self Pay				
Charity				
Other				
Total	1,178	1,772,226	-507,037	2,279,263

FYE 2015 LONG TERM CARE				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	6,871	5,228,256	-420,775	5,649,031
Medicare	16	14,453	10,670	3,783
Private Insurance	48	235,888	0	235,888
Self Pay				
Charity				
Other				
Total	6,935	5,478,597	-410,106	5,888,703

Schedule VII

Schedule VII. Depreciation Schedule

Use the straight-line method.

Provide a separate schedule for any pieces of major moveable equipment.

[illegible]

Exhibit 5
Current Hospital License

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Sarah Palin, Governor

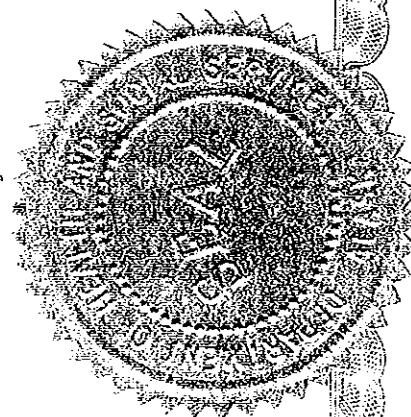
Wrangell Medical Center

to conduct and maintain an 8 Bed Rural Primary Care Hospital including 8 Swing Beds

in the premises located at 310 Bennett Street, Wrangell, Alaska

This License is effective July 1, 2008 through June 30, 2010, and is subject to the provisions of ALASKA STATUTES 47.32. This License shall not be assignable or transferable and shall be subject to revocation at any time by the Department of Health and Social Services for failure to comply with the laws of Alaska or rules and regulations as provided under the Alaska Administrative Code.

I, Witness Whereof I have hereunto set my hand and seal of the Department of Health and Social Services this First day of July, 2008



By *Jane Iwanowski*
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

This License Must Be Posted In A Conspicuous Place On The Premises

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Sarah Palin, Governor

Wrangell Medical Center

to conduct and maintain
a Home Health Agency

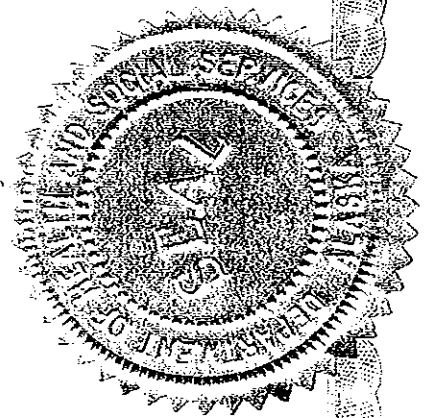
to the premises located at
310 Bennett Street, Wrangell, Alaska

This License is effective July 1, 2008 through June 30, 2010, and is subject to the provisions of ASKANA-EATG 19.47.32. This License shall not be assignable or transferable and shall be subject to revocation at any time by the Department of Health and Social Services, for failure to comply with the laws of Alaska or rules and regulations as provided under the Alaska Administrative Code.

In Witness Whereof I have hereunto set my hand and seal of the Department of Health and Social Services, this

First day of

July, 2008



BY *Jane Lubanowich*
DIRECTOR, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

This License Must Be Posted In A Conspicuous Place On The Premises

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Sarah Palin, Governor

Wrangell Medical Center

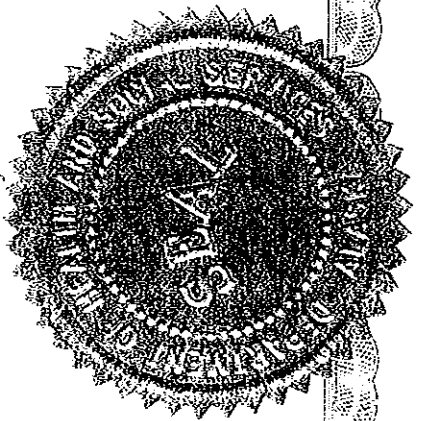
to conduct and maintain a 14 Bed Nursing Home
in the premises located at 310 Bennett Street, Wrangell, Alaska

This License is effective July 1, 2008 through June 30, 2010, and is subject to the provisions of ALASKA STATUTES 47.32. This License shall not be assignable or transferable and shall be subject to revocation at any time by the Department of Health and Social Services for failure to comply with the laws of Alaska or rules and regulations as provided under the Alaska Administrative Code

In Witness Whereof I have hereunto set my hand and seal of the Department of Health and Social Services this

First day of

July, 2008



By *Janie Williams*
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

This License Must Be Posted In A Conspicuous Place On The Premises

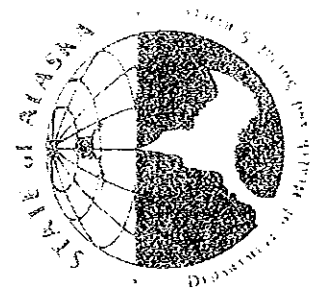


Exhibit 6
Organizational Chart

Wrangell Medical Center Organizational Chart

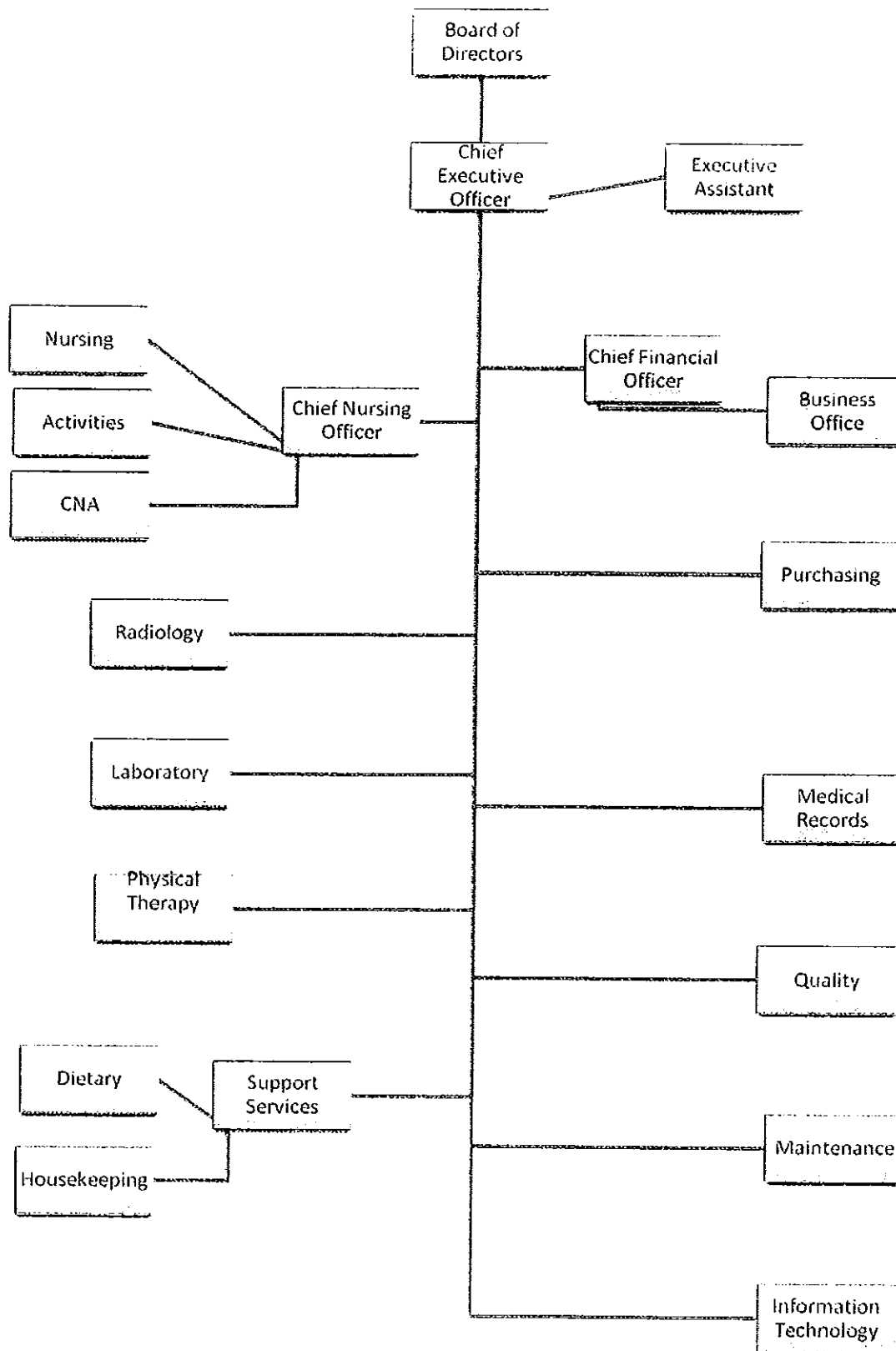


Exhibit 7
Diagrammatic Plan

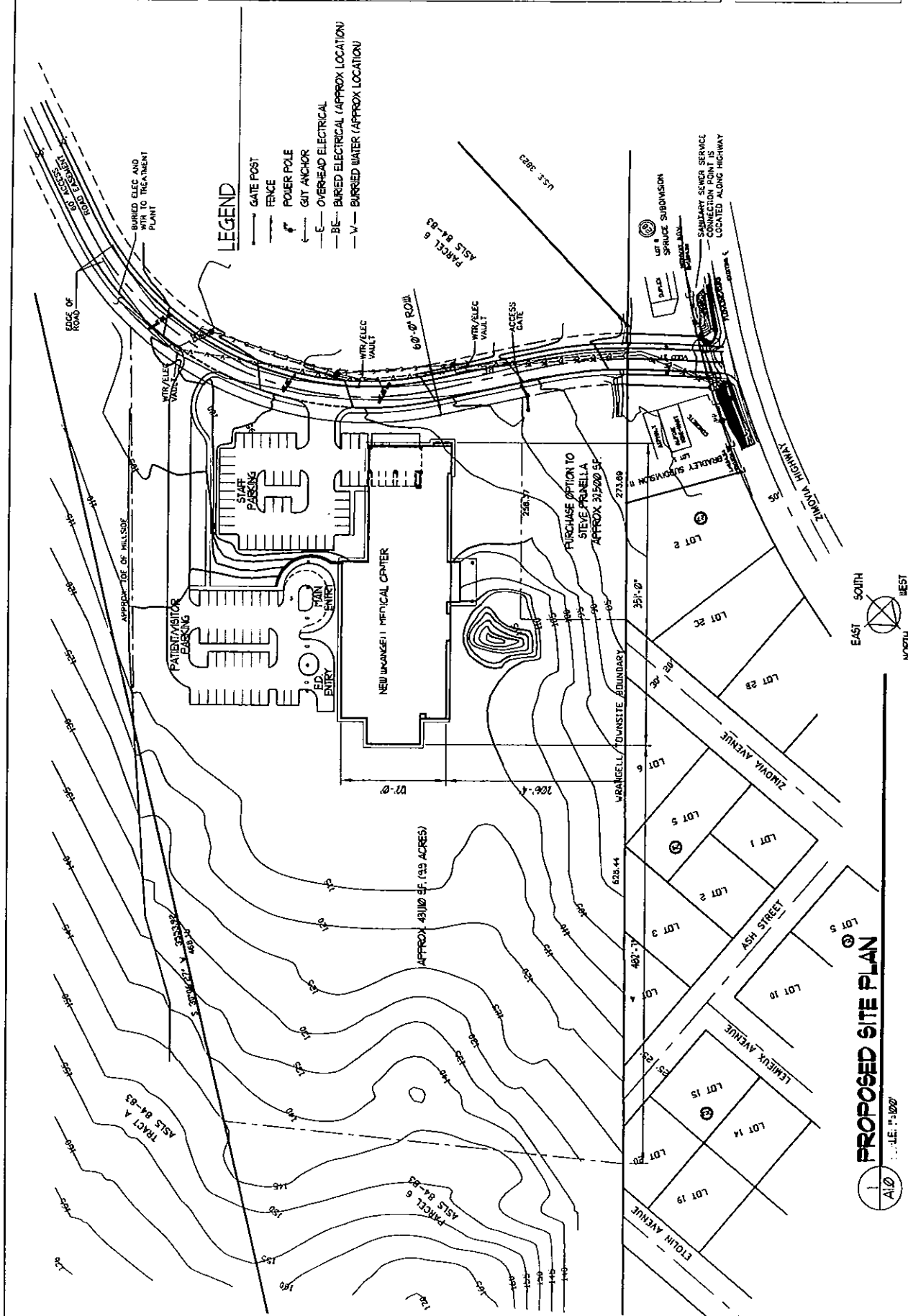
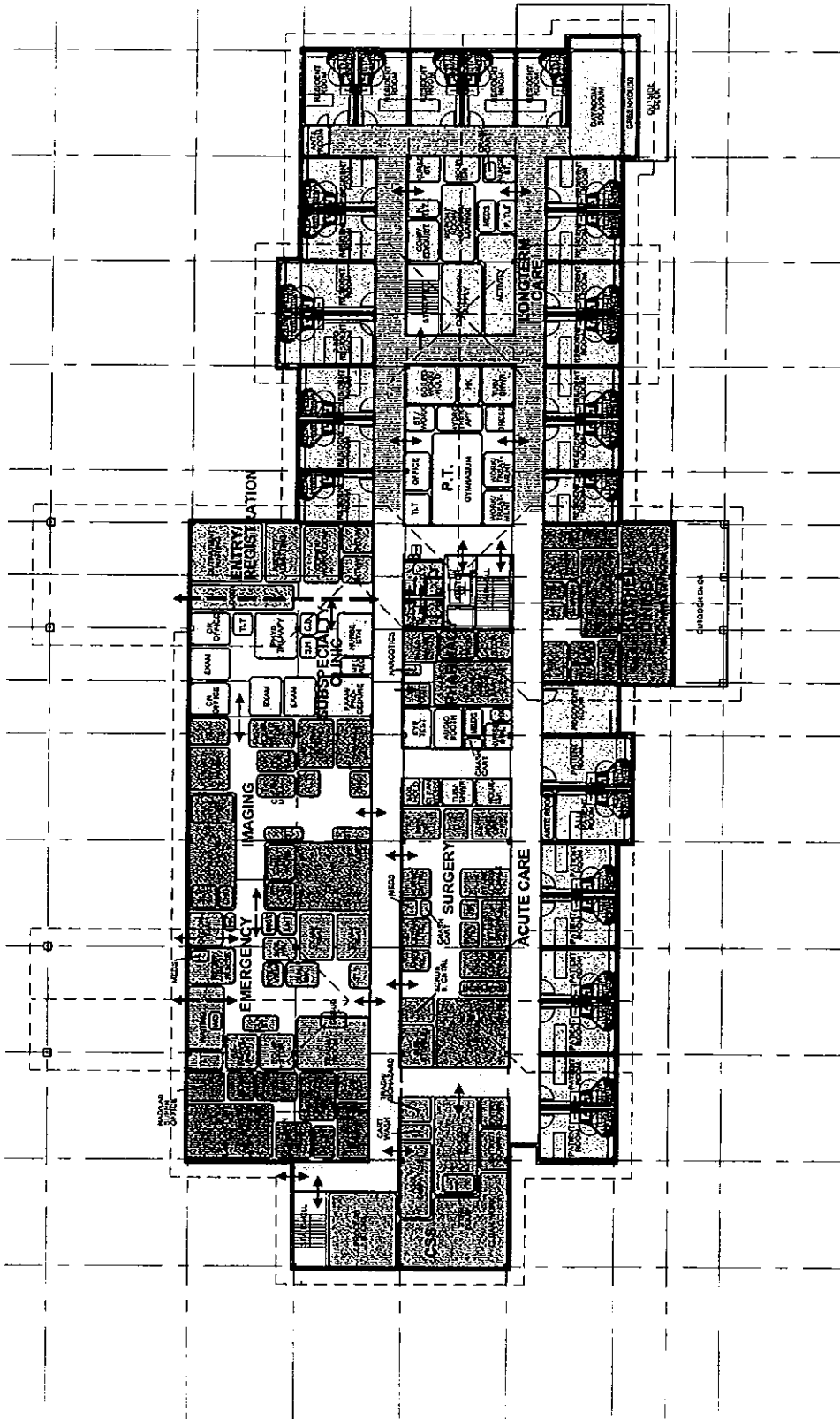


Exhibit 8
Line Drawings of Proposed Site

CONCEPTUAL FLOOR PLAN FOR WRANGELL MEDICAL CENTER

PROFESSIONAL PRACTICE ENVIRONMENTS INC.
SALMON BAY DESIGN GROUP
4501 SHILSHOLE AVENUE NORTHWEST, SEATTLE, WASHINGTON 98107 206-783-8582

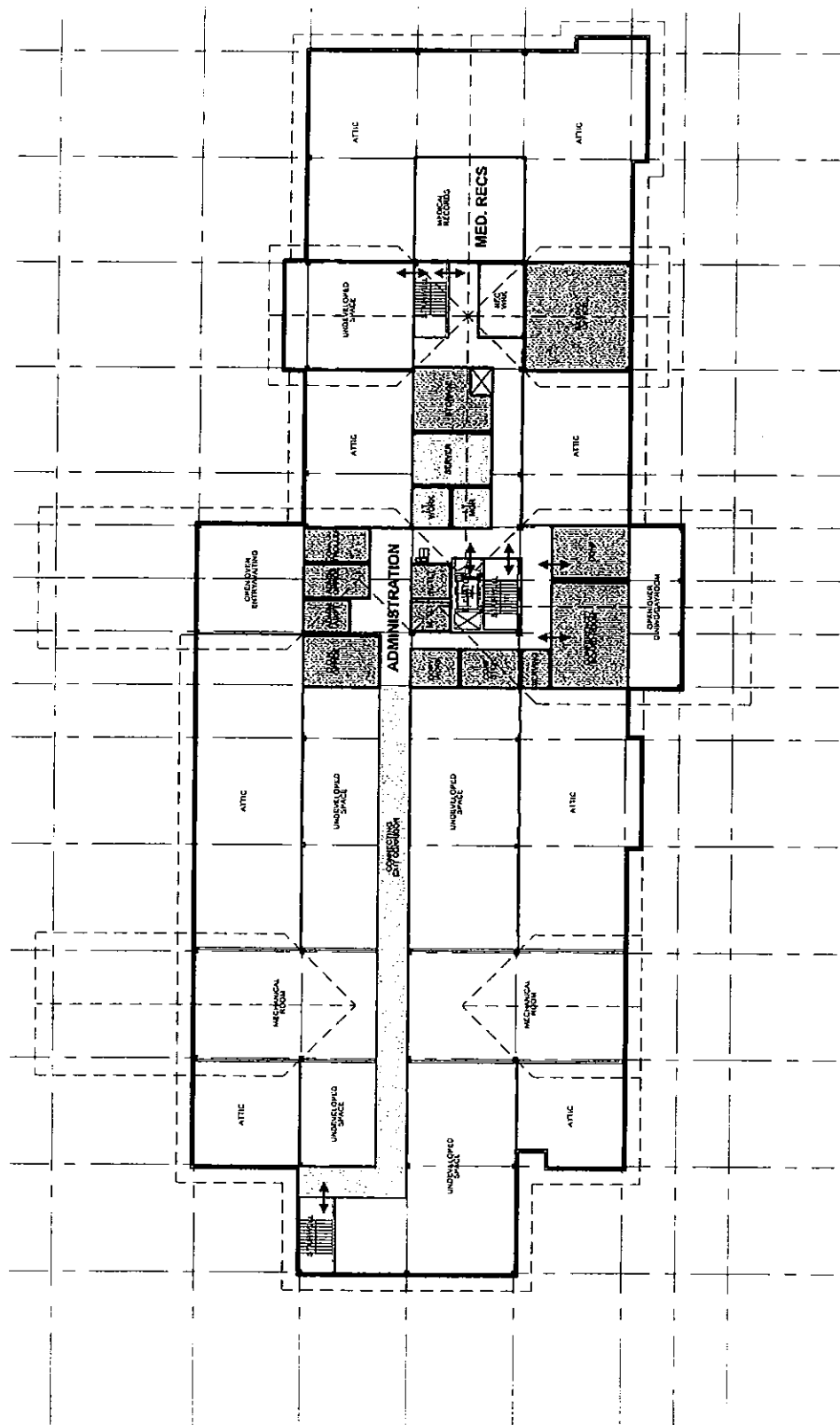
DATE: 10-21-09
JOB NUMBER: 091
REVISIONS:



FIRST FLOOR CONCEPTUAL PLAN

DATE: 10-21-09
 JOB NUMBER: 091
 REVISIONS

CONCEPTUAL FLOOR PLAN FOR WRANGELL MEDICAL CENTER
 PROFESSIONAL PRACTICE ENVIRONMENTS INC.
 SALMON BAY DESIGN GROUP
 4501 SHILSHOLE AVENUE NORTHWEST, SEATTLE, WASHINGTON 98107 206.783.8582



SECOND FLOOR CONCEPTUAL PLAN

