



HOSPITAL EXPANSION AND MODERNIZATION PROJECT (PHASE VI)

Certificate of Need Application

Submitted to the Alaska Department of Health and Social Services

June 2017

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SECTION I

General Applicant Information

	CERTIFICATE OF NEED APPLICATION APPLICANT IDENTIFICATION AND CERTIFICATION OF ACCURACY	
1. Applicant Identification		
Facility Name Central Peninsula Hospital (CPH)	Medicaid Provider Number HS01	
Facility Address (<i>Street/City/State/Zip Code</i>) 250 Hospital Place/Soldotna/Alaska/99669	Medicare Provider Number 02-0024	
Name and mailing address of organization that operates the facility (if different from above) Central Peninsula General Hospital, Inc. (same address)		
Facility Administrator (<i>Name, title, mailing address, including City/State/Zip Code</i>) Richard L. Davis, Chief Executive Officer (same mailing address)	Telephone (907) 714-4721 Facsimile (907) 714-4969 E-mail rdavis@cpgh.org	
Applicant (<i>Name, title, mailing address, including City/State/Zip Code</i>) Central Peninsula General Hospital, Inc. 250 Hospital Place/Soldotna/Alaska/99669	Telephone (907) 714-4721 Facsimile (907) 714-4969 E-mail rdavis@cpgh.org	
Principal Contact Person (<i>Name, title, physical address, mailing address, including City/State/Zip Code</i>) Richard Davidson, Support Services Director 250 Hospital Place/Soldotna/Alaska/99669	Telephone (907) 714-4747 Mobile Phone Facsimile (907) 714-4688 E-mail rdavidson@cpgh.org	
2. Ownership Information		
A. Type of Ownership (<i>check applicable category</i>) <input type="checkbox"/> For profit: individual <input checked="" type="checkbox"/> Not for profit: government <input type="checkbox"/> For profit: partnership <input type="checkbox"/> Not for profit: corporation <input type="checkbox"/> For profit: corporation <input type="checkbox"/> Other: B. List of all Owners (<i>Page 2 of application</i>) C. Accreditation Information (<i>Page 2 of application</i>)		
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 Richard L. Davis	Title CEO Central Peninsula Hospital	
Signature	Date	

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:

**CENTRAL PENINSULA GENERAL HOSPITAL, INC.
BOARD OF DIRECTORS**

Trena Richardson, President 250 Hospital Place Soldotna, AK 99669	John Bramante, MD 250 Hospital Place Soldotna, AK 99669
Jim McHale, Vice President 250 Hospital Place Soldotna, AK 99669	Sal Mattero 250 Hospital Place Soldotna, AK 99669
Irv Carlisle, Secretary 250 Hospital Place Soldotna, AK 99669	Mark Dixon 250 Hospital Place Soldotna, AK 99669
Mark Premo 250 Hospital Place Soldotna, AK 99669	Debbie Shuey 250 Hospital Place Soldotna, AK 99669
Candy Columbia 250 Hospital Place Soldotna, AK 99669	Gregg Motonaga, MD 250 Hospital Place Soldotna, AK 99669
Steve Manley 250 Hospital Place Soldotna, AK 99669	

For Part 2.C. of the application form, provide the following information:

Is this facility accredited or certified by a recognized national organization? X 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.

Central Peninsula Hospital (CPH) was accredited by The Joint Commission on March 26, 2016.
Please see APPENDIX A.

SECTION II.

Summary Project Description

Section II. General applicant information. Provide a one page summary of the proposed project including a brief description of each proposed service, including whether equipment will be purchased or replaced and a list of that equipment; the number of square feet of construction/renovation; number and type of beds/surgery suites/specialty rooms; services to be expanded, added or reduced; the total cost of the project; how it will be financed; and completion date.

The Central Peninsula Hospital Phase VI Project is an expansion and renovation project consisting of approximately 28,000 Square Feet (SF) of new building floor area and 26,000 SF of renovated/replacement space to house a new Obstetrics Department (OB Department) and new Cardiac Catheterization Laboratory (cath lab) and impacted departments from demolishing an existing 7,500 SF wood construction wing built in 1985. The cath lab will be located on the first floor adjacent to the existing Radiology Department. The cath lab suite will include the procedure room, 4 pre/post recovery bays, and the ancillary support and equipment spaces to support the program.

The replacement OB Department on the second floor will be adjacent to the Medical Surgical Department (med/surg) floor. The new OB Department will have a C-Section room, five (5) labor/delivery rooms and four (4) postpartum rooms. Three of the 4 postpartum rooms will be located directly adjacent to the med/surg department and can “swing” between departments as needed. In addition, the project will include relocating the existing inpatient Pharmacy in order to add three (3) additional ICU patient rooms to handle the anticipated increase in volume.

Because new construction will replace an old wing of the existing hospital, and be joined on three sides by existing buildings, some departments will be displaced and/or impacted during construction. These include the permanent relocation of the Administrative offices, cardiac rehab gym, physical therapists offices, medical staff services, sleep lab, outpatient lab and some ancillary space. These areas are intended to be permanently relocated to other space in the hospital, or off site. The outpatient lab (not the hospital laboratory which is in a separate location and not impacted by the proposed project), cardio-pulmonary clinic, and materials management/loading dock, will require temporary locations to accommodate their services during construction, as their departments will be adjacent to construction areas and renovated as part of the project.

In addition to providing expanded services to the people of the Kenai Peninsula Borough (KPB), the project addresses several critical long term master plan goals for the facility. These improvements include: a) the completion of a staff/patient transport corridor to create a “back-of-house” corridor to connect the entire first floor of the hospital and allow staff and patient movement without traversing the main public corridor; and b) the removal of the early eighties constructed single-story wood framed addition and the replacement of the OB Department, which has significant security and building code issues. A portion of the first floor of the new construction will include a shelled-in outpatient OB clinic. This will allow OB/GYN’s to be

close the OB Department, insuring patient safety via superior physician access early in the labor process.

The project only includes electrical and mechanical systems necessary for supplying the new building.

Obstetrics Modernization and Expansion

The Central Peninsula Hospital OB Department is currently housed in the second oldest section of the hospital (wood frame construction – built in early 1980's). It has not been significantly updated or modernized for decades. The proposed Phase VI project would modernize and expand the footprint of the OB Department to meet community need and to ensure that families and infants receive the best care in the most appropriate environment. Not only is the department dated, but it is in need of upgrade to meet current safety, security and regulatory requirements. The new obstetrics space will be located on the top floor of the proposed two story structure and will have a C-Section room, five (5) labor/recovery rooms, and four (4) postpartum rooms. Under this application, it is important to note that the number of OB beds in Section III (A) will be reduced from nine (9) to four (4) as the design will no longer classify the replacement of the nine (9) existing beds as post-partum beds. Only four (4) will be post-partum. The new space will occupy 12,356 SF and include all new equipment for the department.

Cardiac Catheterization Lab Expansion

The cath lab suite will include the procedure room, four (4) pre/post recovery bays, and the ancillary support and equipment spaces to support the program for its operation. This is a new service line for Central Peninsula Hospital and will occupy 4,166 SF of the proposed new structure.

Intensive Care Unit Expansion

This modernization and expansion project includes the expansion of ICU beds by three (3) with the purchase of all associated equipment for these rooms. This expansion is necessary to accommodate growing patient volumes in addition to the need associated with the addition of the proposed cath lab. The new ICU beds will occupy 960 SF which will be vacated by the pharmacy department which is relocating to the first floor of the new proposed building.

Pharmacy Expansion

The existing Pharmacy unit will be relocated to the first floor of the new proposed building and expanded from 1437 SF to 2,047 SF. Currently the pharmacy is located adjacent to the ICU on the med/surg floor. In order to make room for the expansion of the new ICU beds it will be relocated into the new building.

Ancillary Support / Site Upgrades Modernization and Expansion

The proposed Phase VI project would include the modernization and expansion of critical support departments as stated above.

These improvements are essential to ensuring that the facility has the capacity to meet community health care needs. Central Peninsula Hospital will prudently phase all portions of the proposed “Phase VI” project to ensure adequate capacity and minimal disruption throughout the construction period. In total, the proposed project cost is \$32,058,270.00. The project will be financed with revenue bonds (\$28.9 million) and the remainder from accumulated savings contained in the hospital plant replacement and expansion fund. Construction would start immediately after approval of the Certificate of Need, and completion/occupancy is planned for no later than January of 2020.

Construction of the new 28,727 SF facility will displace cardiac rehabilitation, administration, medical staff, employee wellness staff, materials management/loading dock, outpatient lab, volunteers, physical therapy and clinical/quality resources. Those departments located in the footprint of the new building (including existing basement) will be temporarily displaced during construction. Others will be permanently relocated in other space in the hospital or off campus.

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	34		34
2-bed room/unit			
Other (list)			
ICU Beds	6	3	9
Obstetrics Beds	9	-5 (converted to delivery)	4 (post-partum)
Pediatric Beds			
Acute Rehab Beds			
Ancillary Services (list)			
BEHAVIORAL HEALTH CARE			
In-patient Acute Psychiatric Beds			
RPTC Beds			
In-patient Substance Abuse Beds	16	0	16
LONG-TERM CARE			
Acute Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
Nursing Beds			
1-bed room/unit	9	0	9
2-bed room/unit	21	0	21
Other (list)			
3 - Bedroom	3	0	3
DIAGNOSTIC AND DIAGNOSTIC IMAGING SERVICES			
CT Scanner	3	0	3
MRI	2	0	2
PET/CT			
Cardiac Catheterization	0	1	1
Emerging Med. Tech. (list)			
SURGICAL CARE			

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	TOTAL PROPOSED CAPACITY
Ambulatory Surgery or Dedicated OP Suites			
Suites for IP & OP			
Endoscopy Suites	3	0	3
Open-Heart Surgery			
Organ Transplantation			
Other Services (list)			
THERAPEUTIC CARE			
Radiation Therapy			
Lithotripsy			
Renal Dialysis			
Other (List)			
Total Capacity			

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.

OB Department Relocation

As discussed in the prior narrative, the OB relocation into a newly constructed addition is proposed for multiple reasons, including: age of plant (built in the early 1980's), code issues (wood frame construction), infant security regulatory issue, and the inability of patients to transition through the hospital due to the OB security corridor. The department is not offering any new services and will have the same number of beds. It is important to note that currently all nine (9) beds are licensed for post-partum beds; this will change under the proposed application where five (5) of the beds are being re-categorized to labor and delivery beds. This allows CPH to add three (3) ICU beds contained in this proposal and remain at 50 beds or less. This is important as CPH participates in a federal Medicare demonstration program that requires the hospital to be at or below 50 beds.

ICU Expansion

Diagnostic Catheterization and Primary Angioplasty

Central Peninsula Hospital proposes to construct a cardiac catheterization lab as part of the "Phase VI" project. The cath lab is used for diagnostics and interventional procedures to treat cardiovascular conditions. Most commonly, the procedure is used to determine if there are blockages in one or more coronary arteries that may need angioplasty or heart surgery. Blockages/obstructions may lead to a heart attack.

Cardiac Catheterization. Catheterization will be used to identify whether coronary artery disease (plaque buildup) is present, that restricts blood flow to the heart. In addition, catheterization will be used to measure pressures while recording the pictures, and to identify numerous heart defects or disease, such as cardiomyopathies, valve problems, or ventricular aneurysms. It will also help evaluate pulmonary hypertension, pulmonary or aortic valve stenosis, anomalies of the great vessels, tricuspid or mitral regurgitation, and congenital ventricular or atrial septal defects.

Primary Angioplasty. CPH also seeks to establish a primary angioplasty service. Primary angioplasty is an emergency technique for unblocking arteries carrying blood to the heart muscle. The aim of any heart attack treatment is to clear the blockage in an artery as quickly as possible. Primary angioplasty is one way to do this and we seek to use this procedure as a means of urgent revascularization in the treatment of certain patients with acute ST-segment elevation myocardial infarction (STEMI).

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

See Figure 1 beginning on next page:

Figure 1

Equipment to be Purchased

Description	Vendor	Model	Unit Cost	Quantity	Total Cost
Analyzer, Coagulation	Medtronic	ACT PLUS SYSTEM	\$4,200.00	1	\$4,200.00
Aspirator, General Purpose	Laerdal Medical Corp	LSU	\$1,090.00	2	\$2,180.00
Barrier, Radiation, Mobile	Fluke Biomedical	56-603	\$2,910.00	2	\$5,820.00
Bed, ICU	Hill-Rom	PROGRESSA	\$39,260.00	3	\$117,780.00
Boom, ICU	Stryker Communications	FLEXIS	\$0.00	2	\$0.00
Cart, Blood Draw	CustomComfort Medtek	SC6041	\$660.00	1	\$660.00
Cart, Blood Draw	CustomComfort Medtek	SC6041	\$660.00	1	\$660.00
Cart, Case, Perinatal	Amico Corporation	Leo Delivery	\$2,000.00	3	\$6,000.00
Cart, Crash	Herman Miller	CT142.60N	\$2,300.00	2	\$4,600.00
Cart, Housekeeping	Royce Rolls Ringer	F36-08E	\$1,490.00	1	\$1,490.00
Cart, Linen- Ipc Transport	Medicus Health	20D 48W 45H	\$206.31	1	\$206.31
Cart, Procedure	Armstrong Medical	AMC-1-B	\$980.00	3	\$2,940.00
Cart, Utility	Lakeside Manufacturing	311	\$300.00	2	\$600.00
Cart, Utility	Lakeside Manufacturing	311	\$300.00	2	\$600.00
Cart, Wire 18D 36W 72H	Intermetro Industries Corp	SUPER ERECTA	\$321.43	2	\$642.86
Cart, Wire 18D 36W 72H	Intermetro Industries Corp	SUPER ERECTA	\$321.43	3	\$964.29
Cart, Wire 18D 48W 72H	Intermetro Industries Corp	SUPER ERECTA	\$353.61	5	\$1,768.05
Cart, Wire 18D 48W 72H	Intermetro Industries Corp	SUPER ERECTA	\$353.61	4	\$1,414.44
Cart, Wire 18D 48W 72H	Intermetro Industries Corp	SUPER ERECTA	\$353.61	3	\$1,060.83
Cart, Wire 18D 48W 72H	Intermetro Industries Corp	SUPER ERECTA	\$353.61	4	\$1,414.44
Cart, Wire 24D 60W 72H	Intermetro Industries Corp	SUPER ERECTA	\$436.43	20	\$8,728.60
Chair W/Back, Cleanroom	Cole-Parmer	S86309-32	\$250.00	2	\$500.00
Chair, Anesthesia	Armstrong Medical	AC975FA	\$720.00	1	\$720.00
Chair, Blood Draw, Bariatric	CustomComfort Medtek	1202 LXL	\$1,060.00	1	\$1,060.00
Chemistry Delivery System, EVS	Sealed Air Diversey Care	J-Fill Duo	\$0.00	1	\$0.00
Coffee Brewer W/Plumbing	Bunn-O-Matic	CWTF15-3	\$450.00	1	\$450.00
Description	Vendor	Model	Unit Cost	Quantity	Total Cost

Coffee Brewer W/Plumbing	Bunn-O-Matic	CWTF15-3	\$450.00	2	\$900.00
Container, RCRA Hazardous Waste, 8 Gal	Covidien-Kendall Brands	8607RC	\$30.00	1	\$30.00
Co-Oximeter, Whole Blood	Accriva Diagnostic	A VOXIMETER 4000	\$6,950.00	1	\$6,950.00
Defibrillator	Physio-Control	LIFEPAK 20E	\$12,040.00	2	\$24,080.00
Diagnostic Set, Desk Model	Welch Allyn	71641-M	\$900.00	1	\$900.00
Diagnostic Set, Integrated	Welch Allyn	77792-MNOBP	\$940.00	1	\$940.00
Dispenser, Medication - 2 Dwr Main	Carefusion (Medication Mgmt)	MEDSTATION 4000 2 DWR	\$32,280.00	1	\$32,280.00
Dispenser, Medication - 2 Dwr Main	Carefusion (Medication Mgmt)	MEDSTATION 4000 2 DWR	\$32,280.00	1	\$32,280.00
Dispenser, Medication - 6 Dwr Main	Carefusion (Medication Mgmt)	MEDSTATION 4000 6 DWR	\$53,160.00	1	\$53,160.00
Dispenser, Supply, Auxiliary, 2 Column	Carefusion (Medication Mgmt)	SUPPLYSTATION 30	\$24,410.00	2	\$48,820.00
Dispenser, Supply, Main, 2 Column	Carefusion (Medication Mgmt)	SYSTEM 30	\$22,800.00	2	\$45,600.00
EKG	GE Healthcare (Pat. Monitoring)	MAC 5500HD	\$17,120.00	1	\$17,120.00
Electrosurgical Unit	Covidien-Valleylab	FORCETRIAD	\$29,870.00	1	\$29,870.00
Flowmeter, Air 0-15 LPM	Ohio Medical Corporation	7700 SERIES	\$70.00	6	\$420.00
Flowmeter, Air 0-15 LPM	Ohio Medical Corporation	7700 SERIES	\$70.00	6	\$420.00
Flowmeter, Oxygen 0-15 LPM	Ohio Medical Corporation	7700 SERIES	\$60.00	10	\$600.00
Flowmeter, Oxygen 0-15 LPM	Ohio Medical Corporation	7700 SERIES	\$60.00	6	\$360.00
Footstool, Stacking	Blickman	8862SS	\$200.00	1	\$200.00
Freezer, Domestic- 1 Dr 16 CUFT	GE Appliances	FUF17DHRWW	\$850.00	1	\$850.00
Freezer, Medication, U/C, -20C, 3.9 CUFT,	Follett Corporation	FZR4P	\$3,720.00	1	\$3,720.00
Glove Box, Triple- Vertical/Wall	Health Care Logistics	7461-01	\$55.19	9	\$496.71
Glove Box, Triple- Vertical/Wall	Health Care Logistics	7461-01	\$55.19	3	\$165.57
Glove Box, Triple- Vertical/Wall	Health Care Logistics	7461-01	\$55.19	4	\$220.76
Glove Box, Triple- Vertical/Wall	Health Care Logistics	7461-01	\$55.19	19	\$1,048.61
Glove Box, Triple- Vertical/Wall	Health Care Logistics	7461-01	\$55.19	1	\$55.19
Glove Box, Triple- Vertical/Wall	Health Care Logistics	7461-01	\$55.19	5	\$275.95
Hamper, Linen w/Lid - Plastic	Innovative Products Unlimited	CustomLH21	\$360.00	2	\$720.00
Hamper, Linen w/Lid - Plastic	Innovative Products Unlimited	CustomLH21	\$360.00	3	\$1,080.00
Headwall, Horizontal	Wittrock Healthcare	INTEGRIS 2002C	\$8,490.00	3	\$25,470.00
Description	Vendor	Model	Unit Cost	Quantity	Total Cost

Hemodynamic Monitoring System	GE Healthcare	MAC-LABIT	\$146,000.00	1	\$146,000.00
Hood, Biosafety- 4Ft Exhaust Class II Type B2	NuAire	NU-430-400 STANDING	\$9,750.00	1	\$9,750.00
Icemaker, Countertop,10Lb	Hoshizaki America	DCM270BAH-OS	\$3,560.00	1	\$3,560.00
Immobilization Device, Infant	Natus Medical	OLYMPIC CIRCUMSTRAINT	\$330.00	1	\$330.00
Injector, Contrast- Pedestal	Bayer Healthcare	MARK 7 ARTERION	\$30,800.00	1	\$30,800.00
Interventional/Cardiac Cath Lab, Single Plane	Three vendors	Ceiling Mount	\$1,122,000.00	1	\$1,122,000.00
Kick Bucket	Blickman	7766SS Lenox	\$190.00	1	\$190.00
Light Controller	Stryker Communications	VISUM LED	\$0.00	1	\$0.00
Light Controller, Wall/Recessed	Skytron	Lucina	\$0.00	6	\$0.00
Light, Birthing - Recessed	Skytron	Lucina 4 LED	\$15,810.00	6	\$94,860.00
Light, Surgical, Dual LED	Stryker Communications	Berchtold F528/F528	\$25,960.00	1	\$25,960.00
Lock, Remote Medication Management	Carefusion (Medication Mgmt)	SMART REMOTE MAN	\$3,490.00	1	\$3,490.00
Monitor Mount, Wall Channel Only	GCX Corporation	WC-0002-05	\$50.00	4	\$200.00
Monitor, Blood Glucose	Nova Biomedical	STATSTRIP	\$730.00	1	\$730.00
Monitor, Central Station, 8bed	Spacelabs Medical	Xhibit	\$21,038.67	1	\$21,038.67
Monitor, PACS - Flat Panel 19"	Barco	MDRC-1119	\$1,570.00	2	\$3,140.00
Monitor, Patient - 8 Waveforms - Wall	Spacelabs Medical	XPREZZON	\$32,912.66	5	\$164,563.30
Monitor, Patient - 8 Waveforms - Wall	Spacelabs Medical	XPREZZON	\$32,912.66	3	\$98,737.98
Patient Transfer Device	Wright Products Inc.	Slipp - Full Size	\$289.95	1	\$289.95
Pedestal, Service	Modular Services Company	P100	\$2,190.00	1	\$2,190.00
Pump, Infusion - w/IV Pole	B. Braun Medical	INFUSOMAT SPACE	\$2,070.00	6	\$12,420.00
Pump, Intra-Aortic Balloon	Maquet USA	CS300	\$58,090.00	1	\$58,090.00
Pump, Suction Cannister	Medela	BASIC	\$0.00	1	\$0.00
Recliner, Patient	Winco	CARE CLINER	\$1,220.00	1	\$1,220.00
Recliner, Patient	Winco	CARE CLINER	\$1,220.00	1	\$1,220.00
Recliner, Phlebotomy	Marketlab	ML10666	\$1,870.00	1	\$1,870.00
Refrig/Freezer, UC- Domewstic ADA 32.5"	Summit Appliance	FF41ESADA	\$620.00	1	\$620.00
Refrigerator, Medication, U/C, 32.25" H	Summit Appliance	FF7LBIMEDADA	\$1,300.00	2	\$2,600.00
Refrigerator, Medication, U/C, 32.25" H	Summit Appliance	FF7LBIMEDADA	\$1,300.00	1	\$1,300.00
Description	Vendor	Model	Unit Cost	Quantity	Total Cost

Refrigerator, Pharmacy - 1 Door	Follett Corporation	REF20-PH	\$4,510.00	1	\$4,510.00
Refrigerator/Freezer, Domestic 18 CUFT	Sears Contract Sales	70632	\$750.00	1	\$750.00
Refrigerator/Freezer, Domestic 18 CUFT	Sears Contract Sales	70632	\$750.00	1	\$750.00
Regulator, Suction, Intermittent/Continuous	Ohio Medical Corporation	PTS-ISU	\$900.00	10	\$9,000.00
Regulator, Suction, Intermittent/Continuous	Ohio Medical Corporation	PTS-ISU	\$900.00	12	\$10,800.00
Regulator, Surgical Free Flow	Ohio Medical Corporation	1247	\$680.00	1	\$680.00
Scrub Sink w/Infrared, 1 Bay	Steris	FLEXMATIC	\$6,690.00	1	\$6,690.00
Scrub Sink w/Infrared, 1 Bay	Steris	FLEXMATIC	\$6,690.00	1	\$6,690.00
Scrub Sink w/Infrared, 2 Bay	Steris	FLEXMATIC	\$9,130.00	1	\$9,130.00
Sequential Compression Device	Medical Compression Systems	ACTIVECARE	\$0.00	3	\$0.00
Sharps Container, 2 & 3 Gallon	Covidien-Kendall Brands	85301H	\$70.00	4	\$280.00
Sharps Container, 5 QT - Wall	Covidien-Kendall Brands	85161H	\$130.00	8	\$1,040.00
Sharps Container, 5 QT - Wall	Covidien-Kendall Brands	85161H	\$130.00	3	\$390.00
Sharps Container, 5 QT - Wall	Covidien-Kendall Brands	85161H	\$130.00	16	\$2,080.00
Sharps Container, 5 QT - Wall	Covidien-Kendall Brands	85161H	\$130.00	1	\$130.00
Sharps Container, 5 QT - Wall	Covidien-Kendall Brands	85161H	\$130.00	2	\$260.00
Sharps/Trolley, Red- 19 GAL	Becton Dickinson	305609/305093	\$420.00	1	\$420.00
Sharps/Trolley, Red- 19 GAL	Becton Dickinson	305609/305093	\$420.00	3	\$1,260.00
Sharps/Trolley, Red- 19 GAL	Becton Dickinson	305609/305093	\$420.00	1	\$420.00
Sharps/Trolley, Yellow- 19 GAL	Becton Dickinson	305613/305093	\$420.00	1	\$420.00
Shelf, Utility- SS 12D 36W 8H	Blickman	WS3612	\$270.00	1	\$270.00
Shelf, Utility- SS 12D 36W 8H	Blickman	WS3612	\$270.00	1	\$270.00
Sphygmomanometer w/Roll Stand	Welch Allyn	7670-03	\$180.00	1	\$180.00
Sphygmomanometer, Pocket	Welch Allyn	PLATINUM SERIES	\$220.00	5	\$1,100.00
Stand, IV	Blickman	1370-4	\$180.00	4	\$720.00
Stand, IV	Blickman	1370-4	\$180.00	6	\$1,080.00
Stand, Mayo- 16" x 21"	Blickman	8869SS	\$680.00	1	\$680.00
Stool, Adjustable - W/O Back	Blickman	1113	\$160.00	1	\$160.00
Stool, Adjustable With Backrest	Blickman	1212	\$260.00	5	\$1,300.00
Description	Vendor	Model	Unit Cost	Quantity	Total Cost

Stretcher, Procedural	Hill-Rom	P8000 26" WIDE	\$4,960.00	4	\$19,840.00
Table, Cardiac Tilt	Medical Positioning	HUT	\$12,000.00	1	\$12,000.00
Table, Instrument - 20D 36W 34H	Blickman	7832SS	\$580.00	1	\$580.00
Table, Instrument - 24D 48W 34H	Blickman	7835SS	\$780.00	1	\$780.00
Table, Instrument - 24D 48W 34H	Blickman	7835SS	\$780.00	1	\$780.00
Table, Instrument - 24D 60W 34H	Blickman	7836SS	\$1,140.00	1	\$1,140.00
Table, Overbed	Hill-Rom	ART OF CARE 0BT636	\$730.00	4	\$2,920.00
Table, Overbed	Hill-Rom	ART OF CARE 0BT636	\$730.00	3	\$2,190.00
Table, Surgical	Steris	3085 SP	\$45,650.00	1	\$45,650.00
Thermometer, Electronic W/Stand	Welch Allyn	SURETEMP PLUS 692	\$690.00	1	\$690.00
Thermometer, Electronic, Wall Mount	Welch Allyn	SURE TEMP PLUS 692	\$460.00	3	\$1,380.00
Thermometer, Temporal Artery	Exergen	TAT-5000	\$500.00	2	\$1,000.00
Truck, Trash/Linen	R&B Wire Products	4618	\$390.00	1	\$390.00
Ventilator, Adult	Philips Respironics	V200	\$27,250.00	1	\$27,250.00
Warmer, Patient	Stryker Medical	Gaymar TP700C	\$0.00	1	\$0.00
Warming Cabinet, 1 Comp, Countertop, 3.5	Enthermics Medical Systems	DC350	\$5,500.00	1	\$5,500.00
Warming Cabinet, 1 Comp, Countertop, 3.5	Enthermics Medical Systems	DC350	\$5,500.00	1	\$5,500.00
Waste Receptacle, 7 Gallon, UL Listed	Rubbermaid Commercial	2543	\$40.00	3	\$120.00
Waste Receptacle, 7 Gallon, UL Listed	Rubbermaid Commercial	2543	\$40.00	2	\$80.00
Waste Receptacle, Confidential	Shred-It	Standard	\$0.00	1	\$0.00
Waste W/O Lid, 24" Dia Gray (Linen)	Rubbermaid Commercial	FG264300 GRAY/2640-43	\$49.57	1	\$49.57
Waste W/O Lid, 24" Dia Gray (Linen)	Rubbermaid Commercial	FG264300 GRAY/2640-43	\$49.57	2	\$99.14
Waste W/O Lid, 24" Dia Red (Bio)	Rubbermaid Commercial	FG264300 RED/2640-43	\$80.50	1	\$80.50
Waste W/O Lid, 24" Dia Red (Bio)	Rubbermaid Commercial	FG264300 RED/2640-43	\$80.50	2	\$161.00
Waste W/O Lid, 24" Dia White (Trash)	Rubbermaid Commercial	FG264300 WHT/2640-43	\$80.50	1	\$80.50
Waste W/O Lid, 24" Dia White (Trash)	Rubbermaid Commercial	FG264300 WHT/2640-43	\$80.50	2	\$161.00
Waste W/O Lid, Slim 23 Gallon	Rubbermaid Commercial	SLIM JIM	\$46.23	2	\$92.46
Waste W/O Lid, Slim 23 Gallon	Rubbermaid Commercial	SLIM JIM	\$46.23	6	\$277.38
Waste W/O Lid, Slim 23 Gallon	Rubbermaid Commercial	SLIM JIM	\$46.23	8	\$369.84
Waste W/O Lid, Slim 23 Gallon	Rubbermaid Commercial	SLIM JIM	\$46.23	3	\$138.69
Description	Vendor	Model	Unit Cost	Quantity	Total Cost

Waste, Step-On- 13 Gal Biohazard	Rubbermaid Commercial	1883566	\$100.00	7	\$700.00
Waste, Step-On- 13 Gal Biohazard	Rubbermaid Commercial	1883566	\$100.00	3	\$300.00
Waste, Step-On- 13 Gal Biohazard	Rubbermaid Commercial	1883566	\$100.00	4	\$400.00
Waste, Step-On- 13 Gal Biohazard	Rubbermaid Commercial	1883566	\$100.00	1	\$100.00
Waste, Step-On Red 12 Gallon	Rubbermaid Commercial	6144 RED	\$98.90	1	\$98.90
Waste, UL Rated - 7 Gallon	Rubbermaid Commercial	2543 BLACK	\$41.29	11	\$454.19
Waste, UL Rated - 7 Gallon	Rubbermaid Commercial	2543 BLACK	\$41.29	3	\$123.87
Waste, UL Rated - 7 Gallon	Rubbermaid Commercial	2543 BLACK	\$41.29	7	\$289.03
Waste, UL Rated - 7 Gallon	Rubbermaid Commercial	2543 BLACK	\$41.29	1	\$41.29
Waste, UL Rated - 7 Gallon	Rubbermaid Commercial	2543 BLACK	\$41.29	8	\$330.32
Waste, UL Rated - 7 Gallon	Rubbermaid Commercial	2543 BLACK	\$41.29	2	\$82.58
Water Filter, Icemaker	Hoshizaki America	H9320-51	\$180.00	1	\$180.00

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

Not Applicable. No major equipment will be replaced or retired.

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

The proposed project is new construction and will only include new utilities for the new space. There are no upgrades of any of listed items as they are all new. The project does require additional electrical services (higher voltage capacity) to be brought to the facility as the current service is at maximum capacity.

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

The building will consist of a structural steel frame with a steel pan deck and concrete floors. It will be a total of three (3) floors including the basement.

G. Total square footage in current facility/project.

280,570 GSF

H. Total square footage of proposed facility/project.

The proposed project consists of adding 28,727 SF of new construction

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

Area for the cath lab is 3,089 SF, Area per ICU bed is 280 SF (3 new), and area per post-partum bed is 263 SF (4 replacement beds – no new beds)

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

Approximately ninety-five percent (95%) of gross square footage is for direct service (i.e., usable space).

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

None

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.

Five year history

The proposed project is part of CPH's long range plan that was developed in 2003 and updated in 2006, 2009, and 2012. This project is part of a "phased" approach, commonly referred to as Phase VI by CPH and the KPB. Previous and future phases were/are:

- Phase I: Completion - 2004 Site preparation for inpatient Mountain Tower.
- Phase II: Completion - 2007 Addition of the three level Mountain Tower.
- Phase III: Completion - 2008 Renovation of Emergency Department.
- Phase IV: Completion - 2013 Addition of leased Radiation Oncology Center.
- Phase V: Completion - 2016 Specialty Clinics Building (SCB). Includes imaging services, endoscopy rooms, oncology infusion center, specialty clinics, and rehab space

Central Peninsula Hospital has a five-year strategic plan that was updated in 2014 which includes the current project that was under concept design at the time. It has since been approved by the CPGH, Inc., Board of Directors and the KPB. The professional design services contract is nearly 40% complete and is timed to be completed approximately the same time this application review period is completed.

In addition to the major phased expansions, below are additional smaller construction projects and purchases within the last five years:

- Added two Med/Surg rooms and decreased 2 OB rooms (2010)
- Purchase/renovations of two medical office buildings for primary care (2010)
- Purchase of Mobile Medtronic O-Arm 3-D Imaging Scanner (2011)
- Completed shelled in 4th Operating room (2012)
- Purchase/renovations of two physical rehabilitation spaces, one of which is serving as a hospital owned Internal Medicine Practice. The other is used for physical rehab (2013)
- Renovation of existing Imaging Department space (Multi phased imaging renovation project currently under way; CON approved 2014)

Central Peninsula Hospital maintains a five-year strategic plan as a directional compass for hospital services and operations for service area residents. The plan is based on Community Health Needs Assessments, service lines currently offered, demographics, trends, age of physical plant and market analysis.

The OB Department facility replacement has been considered for several years due to security, age of plant, and operational efficiency issues. This project has not been submitted prior to this application as we were unable to discern a way to increase security, renovate and modernize the space and maintain operations in its existing location all at the same time. In addition, we have determined the cost of upgrading one of the oldest portions of the hospital (that is really best suited for demolition in the not too distant future) is not a wise use of resources. The department has not seen any measurable modernization for decades and is in grave need of upgrade. More importantly the ability to increase infant security is paramount as it currently places the hospital in an untenable liability position and risks The Joint Commission accreditation approval for security reasons. Volumes for this department are expected have slight increases with the exception of the proposed large scale LNG plant currently being considered for construction in Nikiski.

With regard to the cath lab, it has been known for quite some time that the Kenai Peninsula will see an enormous increase in our senior population. Recent projections from the Alaska Department of Labor indicate a massive increase in the sixty-five (65) and older age cohorts. The CDC reports the leading cause of death for persons age 65 and over is heart disease.¹ With the 65 and older population projected to increase by twenty-six percent (26%), CPH can expect to see a significant volume increase for heart related diseases. As a result, CPH has recently partnered with the AHI to provide full-time cardiology services for peninsula residents including future cath lab services. Heart disease and malignant neoplasms alternate as the number one leading cause of death on the Kenai Peninsula according to the Department of Health and Social Services Vital Statistics Division.²

Due to high census rates coupled with this proposal of a cath lab, long range planning would indicate the necessity of adding ICU beds. Through the installation of eICU services with Providence Hospital and the addition of a highly trained hospitalist group, CPH is able to keep higher acuity patients at the hospital. These two actions alone have increased our ICU census enough that it frequently operates at 100% capacity. The addition of the cath lab will add to this volume and necessitates remodeling of existing space (which currently houses the Pharmacy Department) into three additional ICU beds and nurse station/work area.

¹ Centers for Disease Control and Prevention: 2014 Older Persons' Health <https://www.cdc.gov/nchs/fastats/older-american-health.htm>

² http://dhss.alaska.gov/dph/VitalStats/Documents/stats/death_statistics/leading_causes_census/body11.html

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.)

Overview

The proposed project is not at variance with any known state, regional or local plans or guidelines according to research performed by DHSS, Division of Public Health, or Certificate of Need standards and methodologies. Plans reviewed include Healthy Alaskans 2020 and the recently released Alaska Comprehensive Cancer Control Plan. The Cancer Control Plan is not relevant to the CPH CON request but does supply helpful health statistics. During the writing of this application, the CON Coordinator was contacted on May 30, 2017 via email and asked if there were any relevant state plans pertaining to our application. None were identified; however, we were referred to the already reviewed Healthy Alaskans 2020 report.

Consistency with Local and Regional Plans

Central Peninsula Hospital (CPH) is a 49-bed acute care hospital that was opened in 1971. CPH is owned by the KPB and operated by Central Peninsula General Hospital, Inc. a 501 (c)(3) non-profit. This operating model provides for local and regional health planning to be completed in a collaborative manner through the inclusion of residents, local government, the hospital service area board (now the KPB Assembly), and the nonprofit hospital operating board. The proposed project has been through a public hearing process in all of the aforementioned venues.

This review process is consistent with CPH's Mission:

We are a community-initiated and community-nurtured organization dedicated to promoting wellness and providing high quality healthcare that ensures the confidence and loyalty of our customers.

Due to the community emphasis, any major proposed project at CPH will always involve a broad range of stakeholders and unlike many hospitals – a thorough public process.

Local CPH Planning

CPH conducts regular Community Health Needs Assessments (CHNA) every three years. This practice was in place prior to being mandated in the Patient Protection and Affordable Care Act (ACA). These assessments enable CPH to develop and plan health care services which meet the needs of the 37,414 primary service area residents and approximately 21,000 secondary service area residents (southern and eastern Kenai Peninsula). The CPGH Inc., Board of Directors

regularly reviews each new CHNA and produces an implementation plan. In addition, CPH has a strategic plan (current version is 2014-2018), and has a facility master plan.

The CPH Board of Directors reviewed the January 2016 CHNA³ data from a sample of 639 service area residents and evaluated each focus area to determine recommended priorities based on the following evaluation criteria:

- Severity of the issue and size of affected population
- Ability of hospital to affect change
- Ability to evaluate outcomes
- Community and system resources available

The health needs identified in the CHNA have been integrated into the design of the CPH three-year implementation plan. After reviewing current community collaborations/partnerships and internal resources, the CPH Board of Directors identified its strengths and weakness for the prioritized health needs. By stewarding existing resources, strengthening partnerships, and creating innovative programs both on the hospital campus and within the community, CPH hopes to make a positive impact on identified needs.

Due to limited services in the community, cardiology services were identified by fifty-six percent (56%) of those surveyed in the 2016 CHNA as a service lacking availability for service area residents. Additionally, of those who would travel, twenty-five percent (25%) listed “cardiologist” as the number one service they would travel outside of the hospital service area for.⁴

The proposed project will continue to address identified unmet needs in the CHNA by providing comprehensive additional cardiovascular services. CPH has partnered with the AHI to provide full-time cardiology services for Kenai Peninsula residents.

The proposed project has been reviewed and scrutinized through the lens of an open community process. The plans to move forward were unanimously approved by multiple boards, work groups, committees and ultimately the local KPB Assembly. The KPB Assembly represents the people of the Service Area and are the owners of the hospital. They include: the nonprofit hospital operator, Central Peninsula General Hospital, Inc. (CPGH, Inc.) Board of Directors (self-perpetuating board created by the KPB); the Central Kenai Peninsula Hospital Service Area Board, (elected board of hospital service area citizens); KPB Planning Commission (elected borough residents); and the ultimately the KPB Assembly.

In addition to the approvals of the various governing boards mentioned above, a substantial internal stakeholder process took place specific to the proposed project. During 2016, over fifty

³ “Central Kenai Peninsula Community Health Needs Assessment (submitted 2016),” www.cpgh.org

⁴ *ibid*

meetings and 72 hours of direct staff participation were needed to complete the schematic design process. These meetings were conducted by an architect at the hospital to formulate the conceptual design of the proposed project. Participants included CPH Administration, KPB Capital Works Department, and steering committees for all services included in the project.

Consistency with State Plans

The Healthy Alaskans 2020 initiative for identifying Alaska's twenty-five leading health indicators to guide Alaska through the next decade is currently underway. Healthy Alaskans 2010 provided targets for improved health.⁵ There are 25 identified targets which are grouped under four separate categories. CPH has made significant strides under many of the targets identified in the plan. Examples (while not all inclusive) include:

Health Promotion

CPH has increased communication with local residents to inform them of options to improve their health through diet, exercise, and tobacco cessation efforts. Communications occur through quarterly newsletters, website announcements, social media, and instructional classes and presentations.

Health Protection

CPH provides several outlets under the health protection section which include a robust safe kids program aimed at bicycle, boating safety (Kids Don't Float), snow machine and ATV safety, baby sitter classes, and child safety seat inspections and education. All of this is done through a robust media campaign and hands on training of local residents. Multiple support groups are conducted at the hospital monthly.

Preventive Services

CPH provides a multitude of services in this category and on all of the targets in the report. Access to quality health care is available without regard to ability to pay as well as Medicare access. In addition, free flu shots are administered via a drive through vaccination effort. Prenatal, child health and parenting classes are available for expectant parents. Examples this month include preventive events scheduled for diabetic patients and HIV education.

Public Health

As outlined above, CPH is proactive concerning public health and continues to improve. The proposed project will advance CPH's commitment as a community owned safety-net hospital to meet the needs of the uninsured and underinsured, as well as services to patients with Medicaid and Medicare.

Providing patient-centered, high quality care regardless of ability to pay at home is and has always been a core responsibility for CPH. This proposal extends the reach of that mission.

⁵ "HealthyAlaskans 2010, Volume I: Targets for Improved Health," dhss.alaska.gov/dph/Pages/default.aspx

CON Standards and Methodologies

Services required to meet specific CON review standards in the proposed project include new Acute Care Hospital Services (ICU Beds and replacement Obstetrical Beds), and Diagnostic Imaging Services (Cath Lab). Section VII of the Alaska Certificate of Need Review Standards and Methodologies adopted December 9, 2005 does not contain review methodologies for other services proposed e.g. relocating existing services within the hospital or to off campus locations.

General Standards (1 – 6)

Please see Section VI.

Acute Care Hospital Services: Review Standards and Methodology

Please see Section VI.

Cardiac Catheterization Laboratory

Please see Section VI.

B. DEMONSTRATION OF 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.

(a) New Service:

- Cardiac Catheterization Lab

(b) Expanded Service

- Intensive Care Bed increase by three (3) beds

(c) Upgrade of Existing Service

- Replacement and modernization of current OB Department reduce post-partum beds by four (4)

The dynamics leading to the need for the proposed project are multifaceted and include but are not limited to:

- CPH Mission
- Community need/unmet need
- Patient demand
- Out migration of specialty services/market share

- Changing demographics
- Clinical alignment
- Existing operational space constraints and condition of physical plant

The problems addressed by the proposed project are explained in further detail below. It should be noted that CPH has been growing rapidly over the last decade. Increases in services offered and patient volumes continue to place a significant strain on the physical plant. The result is constraint on existing operations and the inability to provide services to patients and address their unmet local needs due to lack of space.

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.

Construction of a catheterization lab fills an unmet need and increasing demand for diagnostic and therapeutic catheterization services for the nearly 60,000 residents of the KPB. Providing this service follows a national trend of expanding interventional cardiology services in areas that do not provide on-site open-heart surgery backup.

In rural areas, traveling to a facility with open heart surgery is often unrealistic and fatal in some cases for a patient experiencing a myocardial infarction. There is extensive research available that demonstrates that Percutaneous Coronary Intervention (PCI) without on-site backup can be performed safely and that it benefits rural communities. In 2011, the Cardiology Societies published the 2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention⁶ (the “2011 Guidelines”), a comprehensive set of guidelines for PCI programs in the United States. According to the 2011 Guidelines, “Primary and elective PCI can be performed at hospitals without on-site surgical back-up with a high success rate, low in-hospital mortality rate, and low rate for emergency Coronary Artery Bypass Graft.” Additionally, in 2012, the American College of Cardiology stated that “the remarkably low risk is now associated with diagnostic cardiac catheterization suggests that only a few cardiovascular patients cannot safely undergo procedures in laboratories [without on-site surgical backup].”⁷ They have gone further in their “Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup” (the 2014 Consensus Document), the Cardiology Societies have stated that where transport to a hospital with on-site surgical backup is less than thirty (30) minutes, then it is safe to transport the patient to the nearest PCI center. However, in areas where transport to the nearest hospital with on-site surgical backup is greater than thirty (30) minutes, it is safer for the patient if the facility performs PCI on-site. Further, several studies have examined both primary and elective PCI without on-site surgical backup and found no difference for in-hospital mortality or 30-day mortality between sites with and without surgical back-up. Based on the data

⁶ *Journal of the American College of Cardiology* Vol. 58, No. 24, 2011

⁷ *Journal of the American College of Cardiology* Vol. 59, No. 24, 2012

and understanding that this life-saving therapy can now be delivered safely to rural communities, a majority of states (including Alaska) have embraced both primary and elective PCI and allow adequately prepared hospitals to perform these procedures.

Because in-hospital mortality or 30-day mortality between sites shows no detectable difference, CPH believes the main focus and criteria for permitting a cath lab should focus on protocols, quality, performance, data submission, satisfactory outcomes based on national benchmark data, strict laboratory director requirements, and peer review. Many, if not all, of these criteria are included in the Alaska CON review standards for a cath lab.

While Central Peninsula Hospital meets the performance requirements of providing a minimum of 500 cardiac catheterizations per year by the third year (see Section IV.5), it should be noted that this number appears arbitrarily selected and is not supported by current published academic and medical society studies. Instead, researchers and professional societies focus on the issues in the previous paragraph and more importantly, focus on the experience, skills, judgment and outcomes of cardiologists who provide services to geographically isolated populations that are >30 minutes away from a PCI center with on-site surgical backup with a case volume of >200. Studies indicate that PCI centers who conduct fewer than 200 cases begin to show increases in mortality. The following is from the 2014 Consensus Document:

***SCAI/ACC/AHA Expert Consensus Document: 2014
Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup***

***TABLE III. Facility Requirements for PCI Programs Without On-Site Surgery
General Recommendations***

“Full service laboratories [both primary and elective PCI, with and without on-site cardiac surgery] performing <200 cases annually must have stringent systems and process protocols with close monitoring of clinical outcomes and additional strategies that promote adequate operator and catheterization laboratory staff experience through collaborative relationships with larger volume facilities. Both physicians and staff should have the opportunity to work at a high volume center to enhance their skills. The continued operation of laboratories performing <200 procedures annually that are not serving isolated or underserved populations should be questioned and any laboratory that cannot maintain satisfactory outcomes should be closed. Geographic isolation exists if the emergency transport time to another facility for a STEMI patient is >30 min.”⁸

The 2014 Consensus Document goes on to show that the concentration of new PCI centers have primarily been located in more urban settings which only increases access for those who are less than a one hour drive away. With a 44% increase in centers in just a five year period from 2000 to 2005, data show there was little increase in access for rural areas.

⁸ *Journal of the American College of Cardiology* Vol. 63, No. 23, 2014

Access to Primary PCI in the United States

Data from the American Hospital Association and the 2000 US Census were used to estimate the proportion of the adult population (+18 years of age) who lived within 60 min of a PCI hospital. An estimated 79.0% lived within a 1 hour drive of a PCI hospital, with a median driving time of 11.3 min. Even among those living closer to non-PCI hospitals, 74% would experience <30 min of additional delay with a direct referral to a PCI hospital. Approximately 5 years later, Concannon et al., using similar data sources and methodology, showed that despite a 44% relative increase in the number of facilities capable of performing PCI, the number of adults within a 1 hour drive of a PCI facility increased to only 79.9%, with the median driving time reduced by <1 min to 10.5 min.

Access in rural areas remained far less than in urban areas, with driving times reduced for only 9% of the population compared with the earlier survey. These findings mirrored a smaller experience in Michigan where expansion of primary PCI to 12 hospitals without on-site surgery increased access for only 4.8% of the population. Finally, Horwitz et al. showed that hospitals are more likely to introduce new invasive cardiac services when neighboring hospitals already offer such services and confirmed that the increase in the number of hospitals offering invasive cardiac services has not led to a corresponding increase in geographic access. In total, these data support the argument that the addition of more PCI centers has not substantially improved access to PCI services for most patients. (emphasis added)

This scenario is true for Alaska as well. All new cath labs approved in the last decade have been located in the largest cities with Anchorage having at least eight (8) labs for a population of just over 300,000 residents or one lab per 38,000 people. The KPB with a population of nearly 60,000 has no cath lab services. Another example is a cath lab located in the Mat-Su valley which was approved when their population was 62,400 and their median age was 34.1 which is much closer to Anchorage than the KPB and much younger.

The 2014 Expert Consensus Document is clearly resistant to new PCI programs without on-site surgery unless they are rural:

Requirements for Off-Site Surgical Backup

*This writing group reaffirms the statement from the 2011 ACCF/AHA/SCAI PCI Guidelines that “desires for personal or institutional financial gain, prestige, market share, or other similar motives are not appropriate considerations for initiation of PCI programs without on-site cardiac surgery” and suggests that new programs offering PCI without on-site surgery are inappropriate **unless they clearly serve geographically isolated populations** [emphasis added]. The writing group recognizes the need for ongoing study and surveillance of all PCI programs through participation in national databases encourages public reporting of their results and acknowledges that further declines in PCI volumes might necessitate the closure of PCI programs in the future.*

In short, Central Peninsula Hospital interprets the 2014 Expert Consensus Document as supporting our applications in many areas. This is because it will save lives of those Alaskans

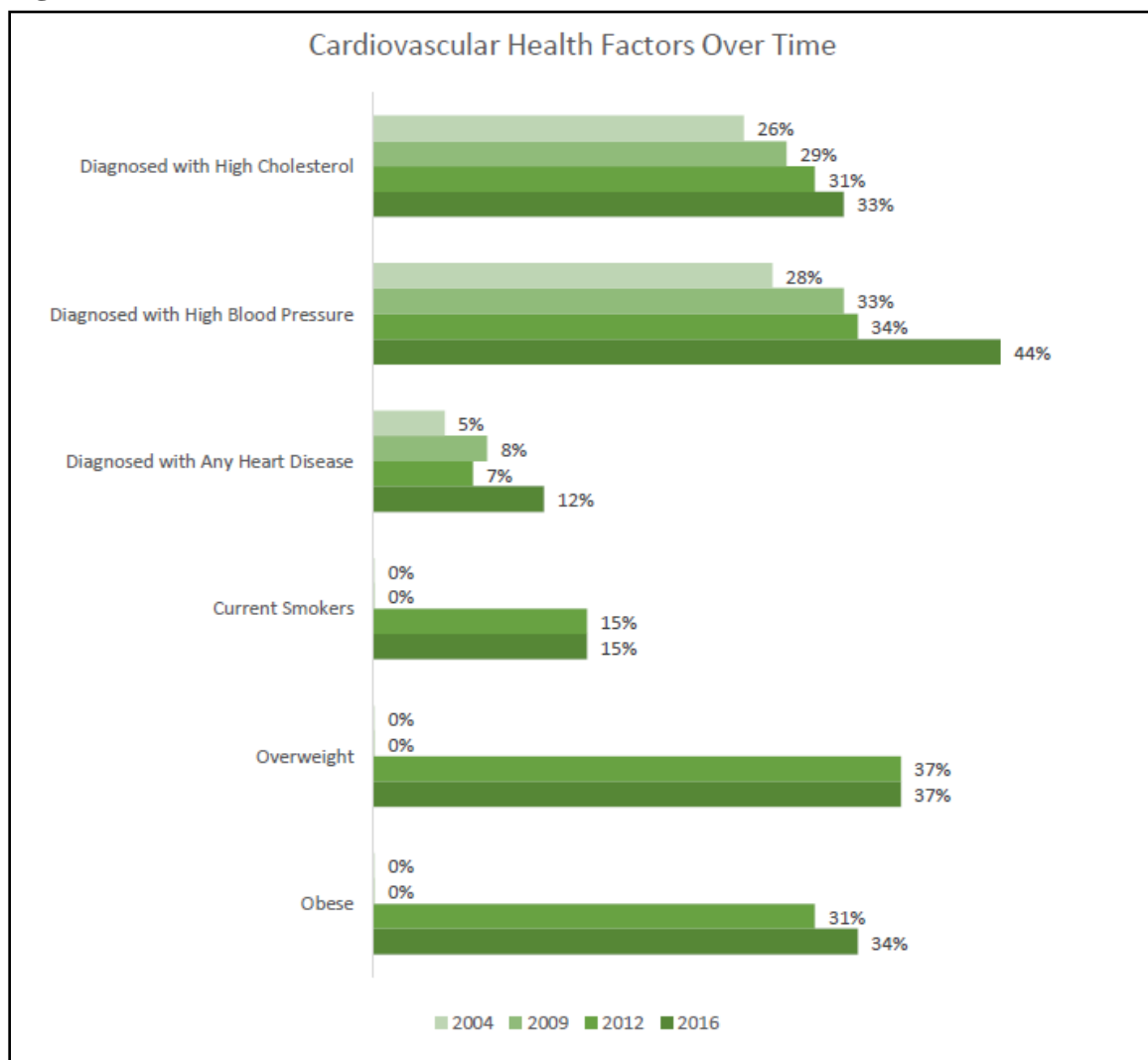
who live in geographically isolated populations that are simply too far away from Anchorage to receive timely reperfusion.

With regard to additional ICU beds, CPH has been running an average occupancy of 62% in ICU bed days over the last three years. Frequently CPH hits 100% occupancy of the existing six (6) beds. This frequently happens in conjunction with CPH med/surg beds hitting 100% occupancy, creating unmet needs for our service area residents. Adding three (3) additional beds in existing space of the ICU will provide CPH the capacity necessary to care for our service area residents. Following a national trend, CPH implemented electronic ICU (eICU) services with Providence Alaska Medical Center in 2014. In addition, CPH contracted with the Alaska Hospitalist Group (which includes intensivists) which, combined with the eICU, has resulted in fewer expensive medevacs while allowing patients to stay in the community with their family and support group.

The new proposed OB Department will not only modernize the decades old department but will also provide additional overflow med/surg rooms (when OB is not occupied at 100%). The new OB department will be connected to the existing med/surg floor allowing med/surg to “flex” into the OB department when all med/surg beds are filled to capacity and space is available in OB. This innovation, coupled with the expansion of ICU, will stave off the need to add on to the med/surg wing for at least a decade. In addition, the OB Department will be more efficient, allow clinical staff to flex between OB and med/surg, and will also rectify our security issue discussed elsewhere in this application.

Central Peninsula Hospital recently completed (conducted in 2015 and submitted in 2016) the triennial Community Health Needs Assessment (CHNA). Responses to this survey indicate a deteriorating population health concern. Main risk factors for heart disease include: high cholesterol, high blood pressure, smoking, and being overweight or obese. The most recent survey conducted on the Kenai Peninsula indicate that all of these factors are on the rise.

Figure 2: 2016 CPH Service Area CHNA Cardiovascular Health⁹



Note significant increase in residents diagnosed with Heart Disease and High Blood Pressure

Figure 3: Cardiac Risk Factors¹⁰

Alaska*	Cardiac Risk Factors	Kenai Peninsula
35%	High Cholesterol	33.2%
28%	High Blood Pressure	44.2%
19.9%	Smoking	15%
67%	Overweight/Obese	71%
7.5%	Diabetes	17.7%

In addition, the 2016 CHNA indicates that Kenai Peninsula residents are reporting a significant increase (12%) and possible upward trend for those **diagnosed** with any heart disease.

⁹ “Central Kenai Peninsula Community Health Needs Assessment 2016” www.cpgh.org

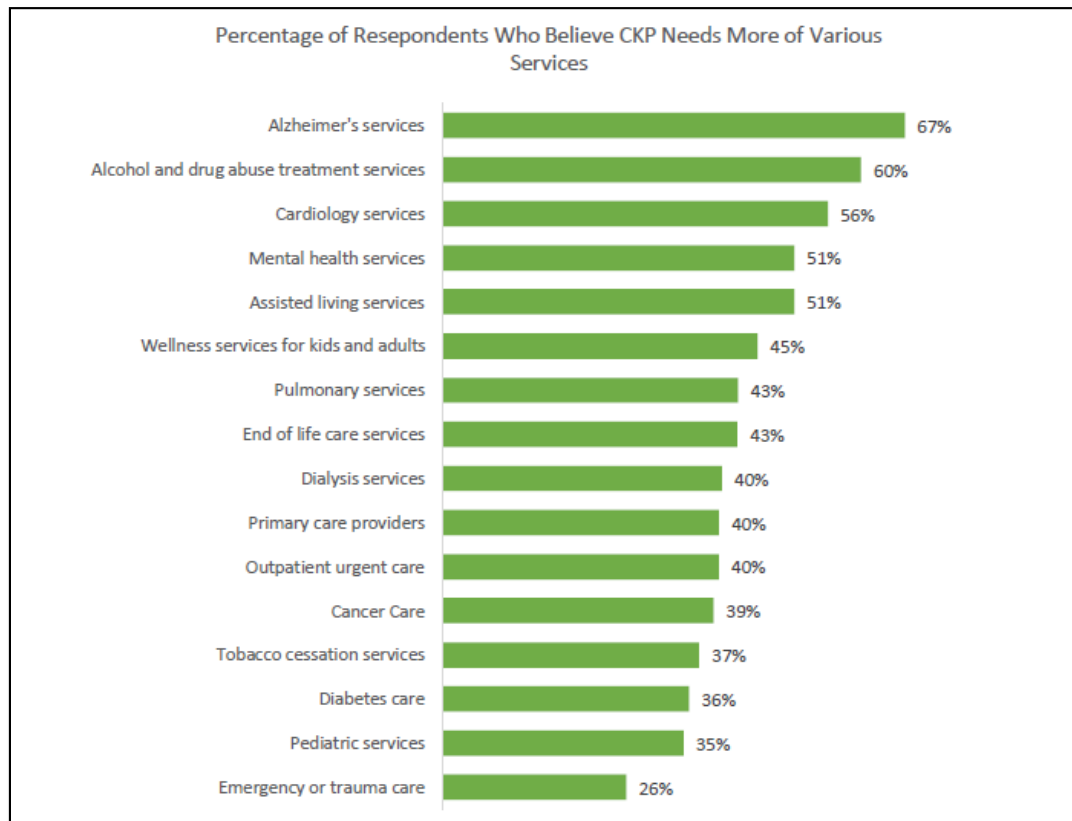
¹⁰ “Chronic Disease In Alaska – 2017 Brief Report” -

http://dhss.alaska.gov/dph/Chronic/Documents/Publications/assets/2017_CDBriefReport.pdf

Unmet community needs

Multiple Community Health Needs Assessments (CHNA) have demonstrated the need from service area residents for specialty services. The 2016 CHNA table for the response to community need is below¹¹.

Figure 4: KPB Service Needs



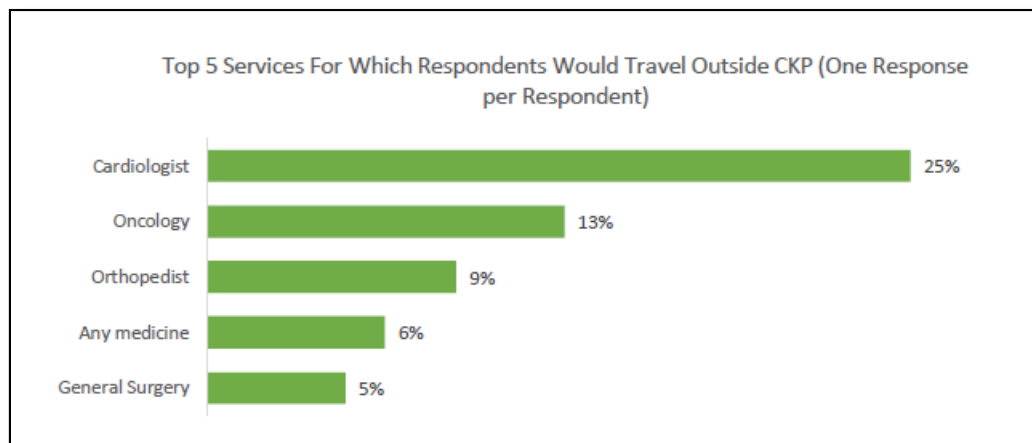
The most recent CHNA has confirmed CPH's long term and strategic plans are addressing identified needs in the community.

Central Peninsula Hospital continues to address needs identified in the CHNA. Our last CON project included a specialty clinics building which now houses our cancer treatment center. A direct result of this new facility is highlighted in the CHNA by showing that Cancer Care has fallen from the number one service requested in 2013 (71% of respondents) to twelfth (39% of respondents) in the current 2016 CHNA. Cardiology, substance abuse (addressed later in this application) and Alzheimer's remain at the top of the needs identified by the community and are also consistently identified as reasons residents in the service area travel outside of the borough to receive services.

¹¹ "Central Kenai Peninsula Community Health Needs Assessment 2016" www.cpg.org

The table below from the 2016 CHNA reports the most common services residents expect to travel to receive.¹²

Figure 5: KPB Residents Top 5 Services Would Travel to Recieve



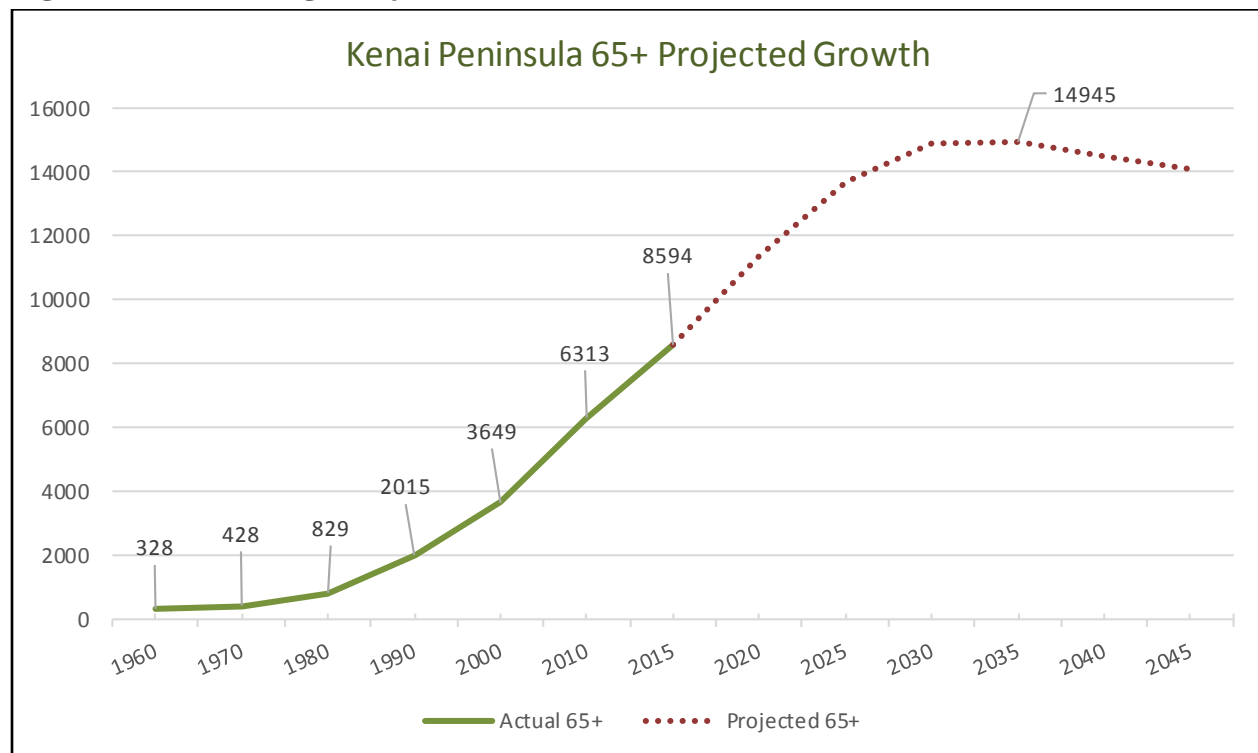
This project will begin to address the number one service that patients travel outside of the service area (out migration). Fulltime cardiology services combined with catheterization lab services will reduce outmigration of patients and increase CPH market share just as our cancer treatment center has reduced oncology down from the 2013 number one reason. CPH expects this to continue to improve as more residents become aware of cancer services that have recently been added. One-hundred percent of catheterizations and the majority of interventional radiology procedures now leave the community.

Increasing demand: changing demographics

The percentage of seniors (age 65 and older) on the Kenai Peninsula is midstream of a large growth cycle. Because seniors are heavy utilizers of healthcare services, these projections create urgency to respond to increasing demand for services. Increasing the availability of cardiology services including catheterization and interventional radiology services will save lives on the Kenai Peninsula which has no catheterization lab to perform emergency or elective procedures. Lives will be saved if catheterization services are provided in the regional hub of the KPB. This extreme growth also bolsters the case for adding additional ICU beds as the majority of patients in the ICU come from this growing age cohort.

¹² *Ibid*

Figure 6: KPB 65+ Age Projected Growth



Source: CPH graph based on Alaska Dept. of Labor: "Alaska Population Projections 2015 to 2040"

According to the Deloitte Center for Health Solutions, seniors (defined as 65 and older) account for 36% of total health care costs. When added to the "Baby Boomer" generation which began retiring in 2011, seniors and baby boomers combine for a sixty-four percent share of total health care spending.¹³ A July 2011 Data Brief on health care spending shows that 5 percent of Americans are responsible for nearly half (47.5%) of all health care spending in the United States.¹⁴ A principal reason why higher health care spending occurs among seniors is due to the fact that nearly half (45%) are suffering from two or more chronic conditions.¹⁵

Based on these and other data, the Kenai Peninsula will most likely experience a substantial increase in the utilization of health care services from a burgeoning senior population. The proposed project is in part designed to accommodate the needs required by the senior population in addition to remaining population needs. This will be accomplished by an increase in physical plant capacity and adding and expanding services that are highly utilized by seniors.

Adding cardiology services with a catheterization lab and ICU beds will address an unmet community need and address the increasing demand of a rapidly growing population of 65+ residents who are at high risk and community health surveys suggest is trending towards declining heart health.

¹³ "The hidden costs of U.S. health care for consumers: A comprehensive analysis March 2011"

¹⁴ "Understanding U.S. Health Care Spending," NIHMC Foundation Data Brief July 2011

¹⁵ "Multiple Chronic Conditions Among Adults Aged 45 and Over," Centers for Disease Control 2012

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.

This response is directly related to findings from The Joint Commission Finding (see Figure 7) during the accreditation process. Specifically, CPH was cited with a finding under the Environment of Care Chapter for security risk.

Figure 7: Joint Commission Security Risk Finding - CPH

The Joint Commission Findings	
Chapter:	Environment of Care
Program:	Hospital Accreditation
Standard:	EC.02.01.01
Standard Text:	The hospital manages safety and security risks.
Primary Priority Focus Area:	Physical Environment
Element(s) of Performance:	<p>1. The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities.</p> <p>Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. (See also EC.04.01.01, EP 14)</p>
Scoring	
Category :	A
Score :	Insufficient Compliance
Observation(s):	<p>EP 1</p> <p>§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings</p> <p>The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.</p> <p>This Standard is NOT MET as evidenced by:</p> <p>Observed in EOC Tracer at Central Peninsula Hospital (250 Hospital Place, Soldotna, AK) site for the Hospital deemed service.</p> <p>During an EOC Tracer involving Safety And Security Management it was noted that the OB/Baby Unit was accessible to the public, and the wound care unit was entered through the OB Unit. This needs to be looked at and assessed as to how the OB unit could be locked down in its entirety.</p>

Page excerpted from 2013 Joint Commission Survey of CPH

As a result of this finding, CPH was required to come into compliance and increase security for the OB department. The resulting action (the only option available) was to install new badge access security doors which effectively divided the hospital into two zones with “secure only access” in the middle. Non-Obstetric Patients can now no longer traverse the hospital from one end to the other. Inside access to the new Specialty Clinics Building that was completed last April is no longer accessible after entering the main entrance of the hospital. Patients must either

go outside of the facility to enter through a different entrance or they must be escorted through the “secure zone” by CPH authorized staff. This is not only a significant inconvenience, but also adds cost in lost staff time due to escorts. We also had a recent example where a patient went outside to the other entrance and subsequently fell on the ice resulting in a broken hip. The cost of the resulting surgery was borne by CPH.

This project seeks to relocate the OB department which will allow for the secure zone to be deactivated and allow for uninterrupted access to the remainder of the hospital. It should be noted this is not the only reason for relocating the OB department as discussed elsewhere in this application. This response is specific to answering the question about deficiencies noted by regulatory agencies and how they were addressed or planned to be addressed.

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 Central Peninsula Hospital primary service area was approved by KPB voters on October 7, 1969.¹⁶ The service area encompasses 9,126 square mile of the 25,600 square miles that comprise the KPB.¹⁷ The service area has an estimated population of approximately 37,414 residents for 2016.¹⁸ A map depicting the primary service area boundaries for CPH follows.¹⁹

¹⁶ “Kenai Peninsula Borough Ordinance 69-19,”

<http://www2.borough.kenai.ak.us/AssemblyClerk/Assembly/Ordinances/1969/O69-19.pdf>

¹⁷ “Kenai Peninsula Borough Ordinance 69-3,”

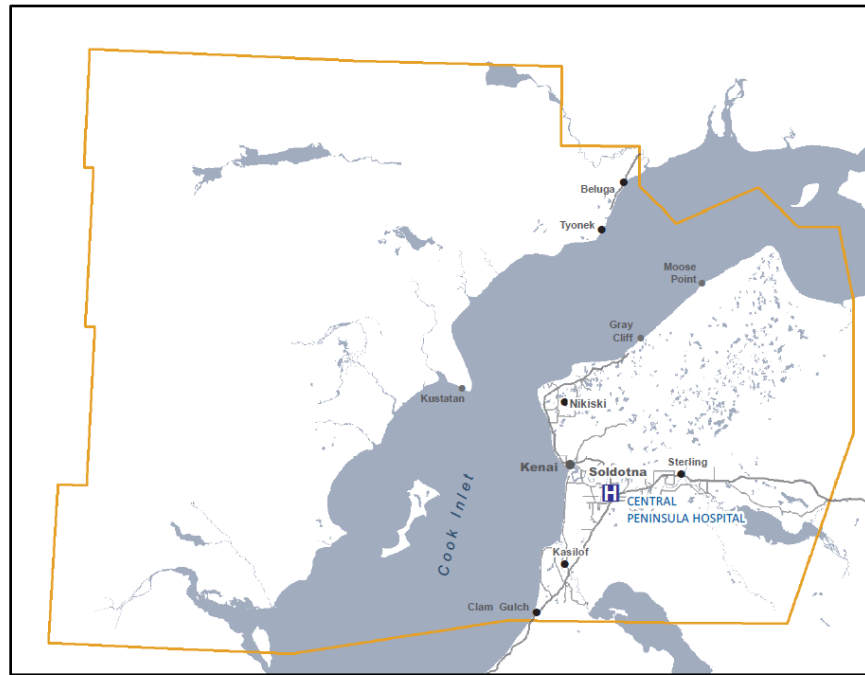
<http://www2.borough.kenai.ak.us/AssemblyClerk/Assembly/Ordinances/1969/O69-03.pdf>

¹⁸ Data from Alaska Department of Labor and Workforce Development, Research and Analysis Section; and U.S. Census Bureau – with CPH analysis

¹⁹ “Central Kenai Peninsula Hospital Service Area,” MAP

<http://www2.borough.kenai.ak.us/GISDept/images/PrintMaps/Hospital/CPHSA.pdf>

Figure 8: CPH Service Area Map



Because the service area was created by legal description, it is necessary to determine population by means of communities located within the borough. The most recent population estimates (primary service area) are shown in the following table.

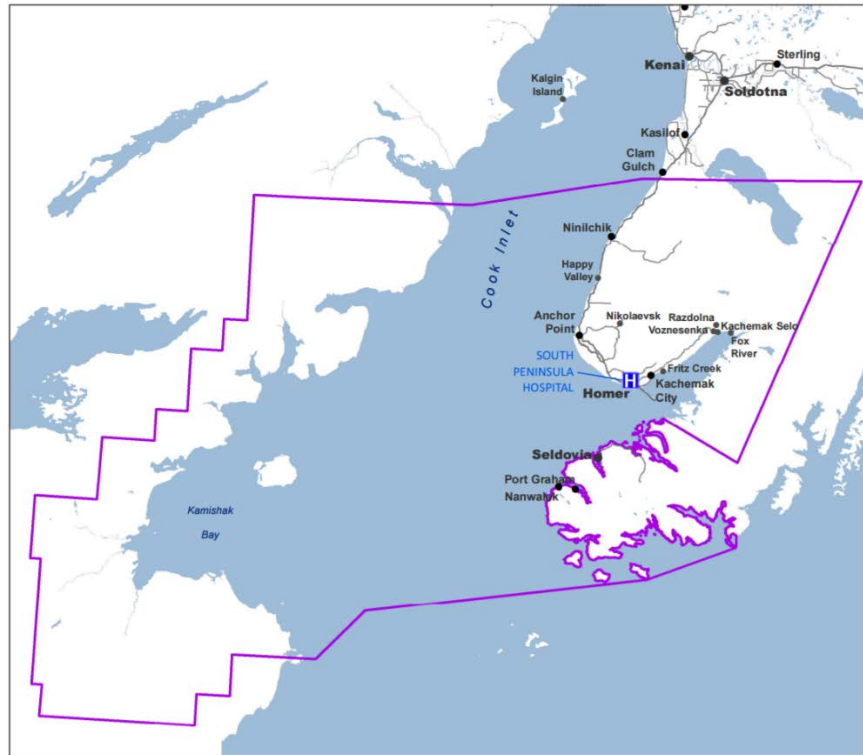
Figure 9: Primary Service Area Population 2016

Alaska Population Estimates by Borough, Census Area, City, and Census Designated Place (CDP)		
Primary Service Area (PSA) for CPH		
Area Name	July 2016 Est	CPH PSA
Kenai Peninsula Borough	58,060	-
Beluga CDP		16
Clam Gulch CDP		167
Cohoe CDP		1,489
Funny River CDP		951
Kalifornsky CDP		8,675
Kasilof CDP		532
Kenai city		7,098
Nikiski CDP		4,616
Ridgeway CDP		2,204
Salamatof CDP		1,097
Soldotna city		4,376
Sterling CDP		6,011
Tyonek CDP		182
CPH Primary Service Area Population		37,414
Source: http://live.laborstats.alaska.gov/pop/estimates/data/TotalPopulationPlace.xls		

The secondary service area for CPH comprises the remainder of the KPB and largely consists of the southern and eastern portions of the borough. The average population density for the entire borough is 3.4 people per square mile.²⁰

Secondary Service Area for CPH targeted for ICU and the Catheterization lab are shown below:

Figure 10: CPH Secondary Service Area



²⁰ “State and County QuickFacts,” U.S. Census Bureau <http://quickfacts.census.gov/qfd/states/02/02122.html>

Figure 11: CPH Secondary Service Area Population 2016

Alaska Population Estimates by Borough, Census Area, City, and Census Designated Place (CDP)		
Secondary Service Area (SSA) for CPH		
Area Name	July 2016 Est	CPH SSA
Kenai Peninsula Borough	58,060	-
Anchor Point CDP	-	2,043
Bear Creek CDP	-	2,066
Cooper Landing CDP	-	250
Crown Point CDP	-	63
Diamond Ridge CDP	-	1,230
Fox River CDP	-	674
Fritz Creek CDP	-	2,107
Halibut Cove CDP	-	85
Happy Valley CDP	-	624
Homer city	-	5,252
Hope CDP	-	189
Kachemak city	-	479
Lowell Point CDP	-	76
Moose Pass CDP	-	231
Nanwalek CDP	-	300
Nikolaevsk CDP	-	287
Ninilchik CDP	-	860
Point Possession CDP	-	0
Port Graham CDP	-	167
Primrose CDP	-	72
Seldovia city	-	206
Seldovia Village CDP	-	177
Seward city	-	2,663
Sunrise CDP	-	12
Balance	-	533
Secondary Service Area Total		20,646
Source: http://live.laborstats.alaska.gov/pop/estimates/data/TotalPopulationPlace.xls		
Primary Service Area Communities not shown		

Because the population is dispersed geographically, some patients travel great distances to receive specialty care where it is available. Examples include:

Homer to Anchorage 123 air miles – Driving Miles = 222 (4 hour 25 min drive)

Homer to Soldotna 61 air miles – Driving Miles = 75 (1 hour 30 min drive)

Soldotna to Anchorage 64 air miles – Driving Miles = 147 (2 hour 44 min drive)

CPH has become the regional center for the Kenai Peninsula because it is the largest acute care hospital on the Kenai Peninsula offering more specialty services than any other hospital on the

peninsula and as such, serves individuals from throughout the KPB and the Gulf Coast for certain specialty care.

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;**

Figure 12: CPH Service Area Population Past 5 Years

	Population Data					
CPH Service Area Populations ²¹	2012	2013	2014	2015	2016	Avg Growth
CPH Primary Service Area	36,331	36,919	37,129	37,302	37,414	
Growth		1.6%	0.6%	0.5%	0.3%	0.7%
CPH Secondary Service Area	20,327	20,079	20,300	20,383	20,646	
Growth		-1.2%	1.1%	0.4%	1.3%	0.4%
Combined Primary & Secondary	56,658	56,998	57,429	57,685	58,060	
Growth		0.6%	0.8%	0.4%	0.7%	0.6%

CPH Birth Data

Figure 13: CPH Birth Statistics

	CPH Birth Data Actuals					Projected Data		
CPH Birth Statistics*	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19
Births	447	459	429	416	463	468	473	478

*Statistics provided by CPH – Avg growth rate of 1.1% over five years - Projected on Average growth at 1.1%

ICU Occupancy Data

Figure 14: CPH Intensive Care Occupancy Data

ICU Occupancy Data (6 beds)				
ICU Data	FY15	FY16	FY17*	AVG
Occupancy	57%	68%	63%	63%

*FY17 Data is through April 2017

²¹ <http://live.laborstats.alaska.gov/pop/estimates/data/TotalPopulationBCA.xls> Data used by CPH for primary and secondary population numbers

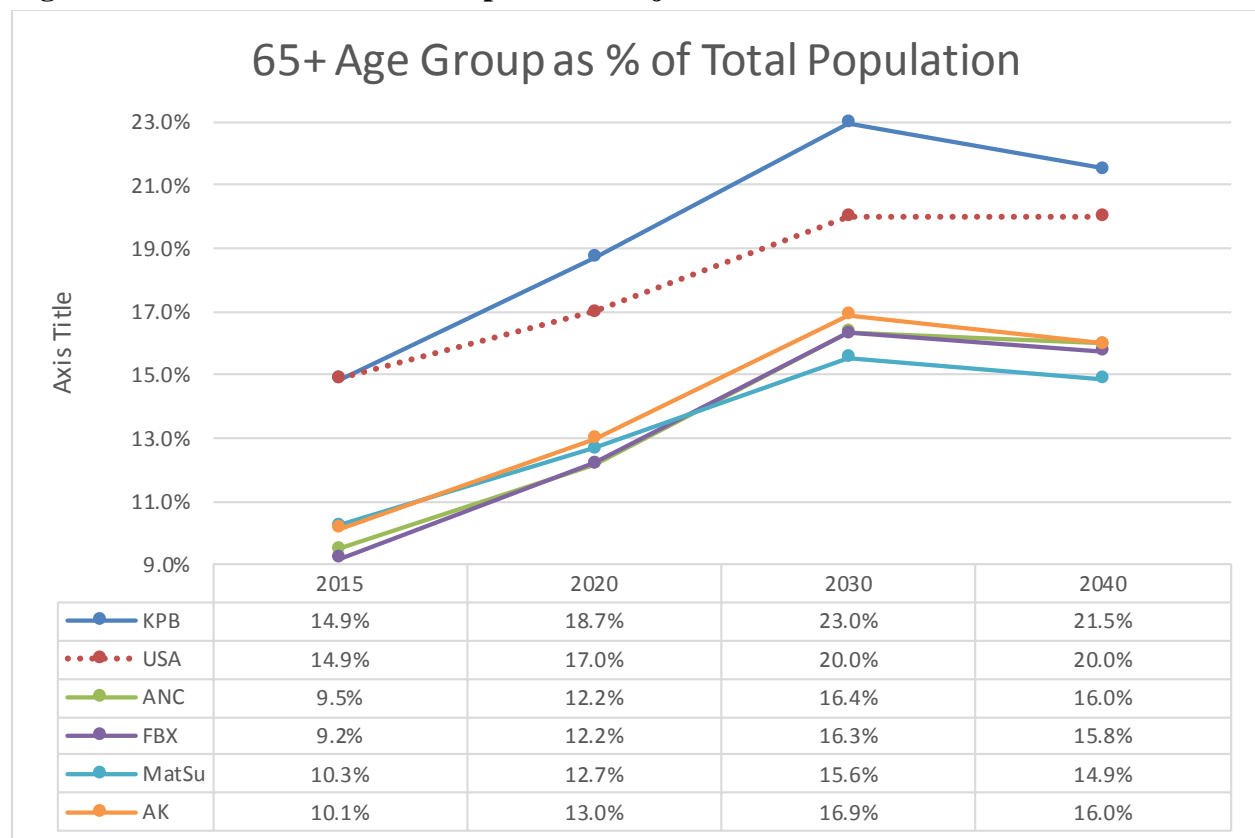
Days ICU Unit at 100% Capacity 2016												
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
14	11	17	20	18	6	15	7	16	12	10	17	

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.

Cath Lab Utilization Projection Methodology

Central Peninsula Hospital used the utilization rates for its proposed cath lab based on U.S. catheterization utilization rates (extensively discussed in Section IV.A.5). This is due to the KPB age demographics mirroring or exceeding the age cohorts of the U.S. population most likely to utilize catheterization services. Alaska Department of Labor statistics and projections combined with national U.S. Census data indicate the CPH target population far exceeds other major Alaska communities who already have cath labs. The KPB (target population for proposed cath lab) is the only Alaska location represented in the data below that does not have a cath lab for its residents. In addition, the KPB Median Age exceeds the U.S. average in addition to other AK locations that currently have cath labs. This is significant in that this age cohort are high utilizers of catheterization services and this population is growing at a rapid rate.

Figure 15: 65+ Percent of Total Population Projections



Sources: US Census Bureau, Alaska Dept. of Labor Population Projections

Figure 16: Median Age

Geography Name	Actual	Projections		
	2010	2020	2030	2040
*United States	37.2	38.1	38.9	39.0
**Alaska	33.8	35.2	36.6	36.3
**KPB	41.1	41.2	41.8	41.3
**FBKS	33	34.2	36.4	36.5
**ANC	33.7	34.8	37	37.3

Data Sources: *University of Virginia Demographics Research Group and **Alaska Dept. of Labor

The Kenai Peninsula has the highest percent of population of 65+ residents of anywhere on the road system except for the Haines Borough (2016 population 2,466) according to the 2010 Census data. This in conjunction with the fastest growing 65+ population of all major population centers confirms the unmet need for the target population for the proposed cath lab and further supports CPH use rate methodology discussed in Section IV.5.(b) for the U.S. national rates for cath lab procedures per 1,000 population.

Figure 17: Alaska Census Areas 65+ Percent of Population

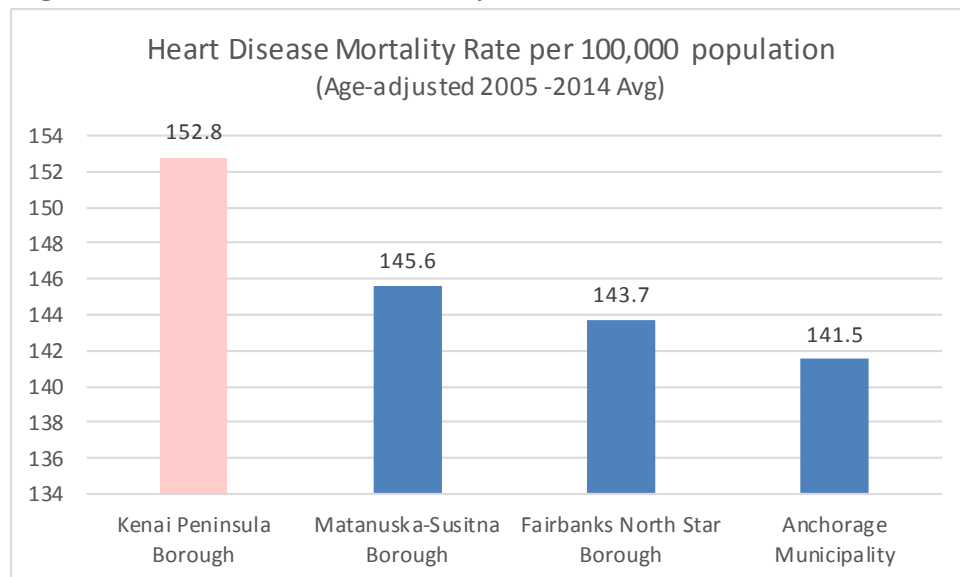
Area	State	2010 Census Percent of Population for 65+	2015 Ak Dept of Labor Percent of Population for 65+	2016 Pop	#Cath Labs
Wrangell City and Borough	AK	15.8%		2,458	0
Haines Borough	AK	13.8%		2,466	0
Hoonah-Angoon Census Area	AK	13.4%		2,193	0
Petersburg Census Area	AK	11.5%		3,179	0
Sitka City and Borough	AK	11.4%		8,920	0
Kenai Peninsula Borough	AK	11.3%	14.9%	58,060	0
Yukon-Koyukuk Census Area	AK	10.2%		5,459	0
Prince of Wales-Hyder Census Area	AK	10.1%		6,440	0
Ketchikan Gateway Borough	AK	10.1%		13,758	0
Yakutat City and Borough	AK	9.7%		594	0
Southeast Fairbanks Census Area	AK	9.4%		6,928	0
Skagway Municipality	AK	9.1%		1,065	0
Juneau City and Borough	AK	8.4%		32,739	0
Valdez-Cordova Census Area	AK	8.3%		9,503	0
Bristol Bay Borough	AK	8.3%		874	0
Matanuska-Susitna Borough	AK	7.9%	10.3%	102,598	1
Lake and Peninsula Borough	AK	7.8%		1,629	0
Dillingham Census Area	AK	7.6%		4,954	0
Denali Borough	AK	7.5%		1,810	0
Anchorage Municipality	AK	7.2%	9.5%	299,037	8
Kodiak Island Borough	AK	6.7%		13,563	0
Fairbanks North Star Borough	AK	6.5%	9.2%	98,957	1
Nome Census Area	AK	6.4%		10,080	0
Bethel Census Area	AK	6.1%		18,134	0
Northwest Arctic Borough	AK	6.0%		7,944	0
Kusilvak Census Area	AK	5.4%		8,200	0
Aleutians East Borough	AK	4.9%		3,001	0
North Slope Borough	AK	4.3%		9,803	0
Aleutians West Census Area	AK	3.5%		5,482	0
Alaska			10.1%		
USA			14.9%		

Legend (CPH Emphasis): No Cath Labs Have Cath Labs

Source: 2010 Census and Alaska Dept. of Labor Population Statistics

In addition to comparing the median age and 65+ population for the KPB to other boroughs and Alaska, an additional data point we have considered is the Heart Disease Mortality Rates which clearly demonstrates and links our graying population with poor heart health.

Figure 18: Heart Disease Mortality Rate



Source: <http://ibis.dhss.alaska.gov/indicator/view/HeaDisDth.Cnty.html> Retrieved on 5.22.17 from Alaska Department of Health and Social Services, Indicator-Based Information System for Public Health (AK-IBIS) website

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.

There are no cath labs in the entire Gulf Coast Region, which includes the KPB.

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.

There are no similar services, existing equipment or older technology comparable to the cardiac catheterization services being proposed in this application.

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:

Not applicable for a cath lab as there is no utilization of cath lab services in the entire region. It has a 100% outmigration rate. With regard to the new OB department, utilization is not anticipated to increase but volumes are expected to remain constant at just over 400 births annually.

With regard to ICU beds. CPH consistently exceeds the 50% target occupancy rate in the specific review standards for ICU beds. More importantly, CPH reached 100% capacity for over 100 days during 2016. Even if utilization didn't increase, specific review standards indicate that 3.4 additional beds are warranted under the state's CON standard formula.

Figure 19: ICU Occupancy

ICU Occupancy Data (6 beds)				
ICU Data	FY15	FY16	FY17*	AVG
Occupancy	57%	68%	63%	63%

*FY17 Data is through March 2017(partial FY)

Figure 20: 2016 ICU 100% Capacity Data

Days ICU Unit at 100% Capacity 2016											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
14	11	17	20	18	6	15	7	16	12	10	17

CPH is projecting mild increases in OB deliveries; however, we are not increasing the number of beds. In fact, it is worth repeat mention that we are reducing the number of licensed beds. This proposal is a replacement of the existing OB department due to regulatory security issues, patient access restrictions because of current temporary security corridor, the ability to flex OB beds as inpatient beds (hospital was at 100% capacity at the time of this writing) and the end of useful life of the current space (built in early 1980's).

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

We do not plan to reduce any services as part of this proposed project.

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

CPH is a community owned, not-for-profit hospital seeking to provide a full-continuum of high quality care to patients in our service area and those who seek care here from throughout the Gulf Coast region. This entire project is predicated on the belief that whenever possible, high quality care should be offered as close to home as possible if it makes sense from a patient perspective. Unlike CON's previously advanced throughout Alaska to create or expand for economic gain, CPH's principle motivation is simply to serve the very community that owns the hospital. This breadth of service is wide, and extends to a full continuum of care, including some services that are sometimes provided at a loss to benefit the community.

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

Advancing this project required considerable public discussion. This discussion included the hospital operating Board of Directors, the elected KPB Mayor and his administration, and finally the elected KPB Assembly. Support for this project was consistent, including unanimous votes of approval at every public vote. We anticipate letters of support will be provided during the public comment period.

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.

Please see the following tables for containing projections for the catheterization lab proposal. The methodology for computing them is discussed at length in Section VI.

**Summary of Annual Cath Lab Procedure Volume & Market Share Targets
Central Peninsula Hospital**

Service Area/Region	Cardiac		Vascular*		Conduction*		Total Cath Lab		
	Diagnostic Cath	PCI	Diagnostic	Intervention	Pacemaker	Defibrillators	Procedures		
Primary Service Area									
Procedures	250	81	-	-	-	-	331		
Market Share	75%	75%	75%	75%	75%	75%	75%		
Secondary Service Area									
Procedures	101	33	-	-	-	-	134		
Market Share	55%	55%	55%	55%	55%	55%	55%		
Service Area Totals	351	114	-	-	-	-	465		
In-migration**	28	9	-	-	-	-	37		
Market Share	8%	8%							
Grand Total Procedures	379	123					502		
	TOTAL Cath/PCI	502	*Estimated to add an additional 2% volume				10	TOTAL	512

Figure 21: Cath Lab Projections CPH

Section IV

Narrative Review Questions

Census Area	2020 Pop	2020 Adult Pop	% of SA Pop	Cath			PCI		
				18+ Adult Population	Market Share	Hospital Volume	18+ Adult Population	Market Share	Hospital Volume
Primary Service Area									
Beluga CDP	17	13	0.0%	0.15	75%	0.11	0.047	75%	0.04
Clam Gulch CDP	174	132	0.3%	1.49	75%	1.12	0.481	75%	0.36
Cohoe CDP	1,552	1,180	2.6%	13.27	75%	9.95	4.293	75%	3.22
Funny River CDP	991	753	1.6%	8.47	75%	6.35	2.742	75%	2.06
Kalifornsky CDP	9,039	6,870	14.9%	77.28	75%	57.96	25.005	75%	18.75
Kasilof CDP	554	421	0.9%	4.74	75%	3.55	1.533	75%	1.15
Kenai city	7,396	5,621	12.2%	63.24	75%	47.43	20.460	75%	15.35
Nikiski CDP	4,810	3,656	8.0%	41.13	75%	30.84	13.306	75%	9.98
Ridgeway CDP	2,297	1,746	3.8%	19.64	75%	14.73	6.354	75%	4.77
Salamatof CDP	1,143	869	1.9%	9.77	75%	7.33	3.162	75%	2.37
Soldotna city	4,560	3,466	7.5%	38.99	75%	29.24	12.615	75%	9.46
Sterling CDP	6,263	4,760	10.4%	53.55	75%	40.16	17.326	75%	12.99
Tyonek CDP	190	144	0.3%	1.62	75%	1.22	0.526	75%	0.39
Total	38,986	29,629	64.4%	333	75%	250	108	75%	81
Secondary Service Area									
Anchor Point CDP	2,125	1,615	4%	18.17	55%	9.99	5.879	55%	3.23
Bear Creek CDP	2,149	1,633	4%	18.37	55%	10.11	5.945	55%	3.27
Cooper Landing CDP	261	198	0%	2.23	55%	1.23	0.722	55%	0.40
Crown Point CDP	66	50	0%	0.56	55%	0.31	0.183	55%	0.10
Diamond Ridge CDP	1,282	974	2%	10.96	55%	6.03	3.547	55%	1.95
Fox River CDP	702	534	1%	6.00	55%	3.30	1.942	55%	1.07
Fritz Creek CDP	2,195	1,668	4%	18.77	55%	10.32	6.072	55%	3.34
Halibut Cove CDP	89	68	0%	0.76	55%	0.42	0.246	55%	0.14
Happy Valley CDP	650	494	1%	5.56	55%	3.06	1.798	55%	0.99
Homer city	5,473	4,159	9%	46.79	55%	25.74	15.141	55%	8.33
Hope CDP	197	150	0%	1.68	55%	0.93	0.545	55%	0.30
Kachemak city	499	379	1%	4.27	55%	2.35	1.380	55%	0.76
Lowell Point CDP	79	60	0%	0.68	55%	0.37	0.219	55%	0.12
Moose Pass CDP	241	183	0%	2.06	55%	1.13	0.667	55%	0.37
Nanwalek CDP	313	238	1%	2.68	55%	1.47	0.866	55%	0.48
Nikolaevsk CDP	299	227	0%	2.56	55%	1.41	0.827	55%	0.45
Ninilchik CDP	896	681	1%	7.66	55%	4.21	2.479	55%	1.36
Port Graham CDP	174	132	0%	1.49	55%	0.82	0.481	55%	0.26
Primrose CDP	75	57	0%	0.64	55%	0.35	0.207	55%	0.11
Seldovia city	215	163	0%	1.84	55%	1.01	0.595	55%	0.33
Seldovia Village CDP	184	140	0%	1.57	55%	0.87	0.509	55%	0.28
Seward city	2,775	2,109	5%	23.73	55%	13.05	7.677	55%	4.22
Sunrise CDP	13	10	0%	0.11	55%	0.06	0.036	55%	0.02
Balance	555	422	1%	4.75	55%	2.61	1.535	55%	0.84
Total	21,507	16,345	36%	183.88	55%	101	59	55%	33
Service Area Totals									
	60,493		100%	517		351	167		114
In-Migration*				n/a	8%	28 Cath	n/a	8%	9 PCI
Current Volumes						0	0		
Projected Procedures 2023						379	123		
						Cath & PCI procedures			502

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.

Alternatives for Cath Lab

Do Nothing: Central Peninsula Hospital partnered with AHI in (2016) to provide for expanded cardiology services for the Kenai Peninsula. Currently the only option for residents on the Kenai Peninsula to receive catheterization services is a helicopter for emergent cases and up to a four-hour (4) drive for elective cases. In 2005, primary service area residents alone (not including secondary service area) received 15,242 cardiology service line procedures (includes outmigration) and accounted for 751 patient days (10.5% of total patient days at CPH).²² Providing these services will improve quality for KPB patients and our over 730,000 seasonal visitors. Most importantly, providing cath lab services will absolutely save lives. For that reason alone, “doing nothing” is not an acceptable alternative.

There are no other alternatives remaining to consider for providing cath lab services. If a peninsula resident or visitor is having a myocardial infarction that cannot be treated without intervention, the only option for survival is a helicopter flight to Anchorage. Our service area residents deserve and expect more than hope when Central Peninsula Hospital could be providing this lifesaving service.

Alternatives with regard to the Obstetrics and ICU Beds

Do Nothing: CPH runs the risk of liability and being out of compliance for infant security if this department is not relocated and reconfigured. This is an infant security and safety issue known to regulators. In addition, this department is located in the oldest portion of the hospital which is constant need of repair and upkeep to maintain patient habitation.

Remodel OB in Place: One alternative considered was to remodel the current department in place. This proved to be a costly alternative that also required us to temporarily relocate a department that has approximately 400 births a year to a new location. CPH has no space to relocate the department while construction was completed. Thus this option was declined for cost and ongoing operational purposes.

Do Nothing for ICU bed expansion: CPH ICU beds average a 62% occupancy rate (10% higher than the Target Occupancy for hospitals with fewer than 100 beds). Of the 270 days in the 3 quarters of 2017, 104 of those days were operating at 100% capacity. CPH anticipates this will continue to grow and puts intensive care patients at risk of being transported and adding extensive cost to the system for medevac services to other tertiary care hospitals. This option was declined for patient safety and costs to the healthcare system including Medicaid.

²² *Stroudwater Associates service line planning document for Central Peninsula Hospital 2007*

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.

Central Peninsula Hospital is designated as a Sole Community Hospital. A sole community hospital is defined in federal statute as follows:

§ 412.92 Special treatment: Sole community hospitals.

(a)Criteria for classification as a sole community hospital. CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:

(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;

(ii) The hospital has fewer than 50 beds and the intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

(iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Central Peninsula Hospital meets all of the strict criteria contained in 412.92 (a)(1)(2) & (3) above. These criteria were specifically written to demonstrate that a certain special category of hospitals are indeed unique, rural, and to highlight that patients have few accessible nearby options.

Access is a significant issue with regard obstetrics, intensive care and catheterization lab services. CPH will be the only hospital in the Gulf Coast region to provide cardiac catheterizations, allowing a massive change in access. It will prove lifesaving for some.

D. THE RELATIONSHIP OF THE PROPOSED PROJECT TO EXISTING HEALTH CARE 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.

There are no existing comparable services in the primary service area with regard to Obstetric inpatient beds, Intensive Care beds and cath lab services. Central Peninsula Hospital has served the needs for all patients in these areas (except for cath lab) since 1971 when the hospital opened.

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***

There will be an effect on volumes for cath lab services in Anchorage and some out of state locations for elective cardiology services. While reducing volume to other providers is always a concern, the most important factor is that providing these services locally will not only benefit patients in many ways – it will save lives. Not all services should not be limited to the Anchorage bowl area when they can be performed safely in other locations. Denying rural hospitals the ability to provide lifesaving procedures to their patients for the sake of concentration of a single service to one urban location would be poor public policy if it leads to increased mortality. Currently Anchorage has no less than eight cath labs serving a population of 300,000. That equates to one lab for every 38,000 residents. Central Peninsula Hospital maintains that approving a cath lab to save lives on the KPB with a population of approximately 60,000 people would therefore be prudent public policy and puts patients' lives ahead of provider impact.

There will also be an impact on air ambulance and hospitalist services in Anchorage. However, both of these groups support the construction of a cath lab at Central Peninsula Hospital. The hospitalist group contracted to provide services at CPH is the same group that provides services at both Anchorage hospitals and their inpatient revenue should remain steady as a result. There are no existing facilities locally and therefore there is no impact. Positive impacts are expected for the recently opened full-time cardiology provider as well as local internal medicine practices who also manage care for patients with heart disease.

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.

CPH is the only hospital in the primary service area, and by far the largest on the Kenai Peninsula. In addition to our 49 bed hospital, our services include a 60-bed skilled nursing facility and numerous other key service lines e.g., primary care, emergency, obstetrics, pediatrics, sleep lab, surgical services, psychiatry, ENT, urology, surgical pediatric dentistry, residential substance abuse treatment, medical/surgical unit, ICU, wound care, cardiac rehabilitation, etc. and many community wellness programs.

CPH also has a helipad with a permanently stationed helicopter and transfer agreement with a tertiary medical facilities in Anchorage. The air ambulance is used regularly for trauma, cardiac, high acuity pediatric cases and stroke victims. In addition we have a collaborative agreement for electronic ICU monitoring by a group of intensivists in Anchorage, as well as cancer support personnel to assist with radiation oncology. Finally, we have a local board certified neuroradiologist with recent residency training in PET who is part of a team of nearly 20 other radiologists with numerous subspecialties located in Washington state and Fairbanks. These many collaborative relationships ensure that our patients have access to quality specialty care without having to leave the area.

In addition to transfer agreements (see APPENDIX A), CPH regularly collaborates with Alaska Regional Hospital, Providence Hospital, and Fairbanks Memorial Hospital on staff training, coordinated care and many other issues. CPH recently converted to the Epic electronic health record which allows our EHR to have complete interoperability with Anchorage hospitals. This recent conversion was completed in September 2016 and the data is hosted and administered at the Providence data center allowing for shared medical records.

In addition, CPH has a good working relationship with the local Federally Qualified Health Center and many other health related nonprofits e.g. Hospice of the Central Peninsula, Kenai Peninsula Network for Health and Wellness etc.

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.

Financial feasibility and long-term viability of the proposed project can be demonstrated through the profit and loss statement provided below for the only new service being offered which is the cardiac catheterization lab.

Figure 22: Cath Lab Profit and Loss

Cath Lab Profit and Loss Statement					
	50% Capacity	66% Capacity	100% Capacity		
Hospital Revenues	Year 1	Year 2	Year 3	Year 4	Year 5
Inpatient Hospital Net Patient Revenue	1,057,736	1,400,382	1,832,415	2,015,657	2,217,222
Outpatient Hospital Net Patient Revenue	2,138,758	2,851,677	4,429,449	4,872,394	5,359,634
Total Net Patient Revenue	3,196,493	4,252,059	6,261,864	6,888,051	7,576,856
Hospital Expenses					
Supply Costs	629,103	836,849	1,232,400	1,355,640	1,491,204
Labor Costs	367,538	488,909	720,000	792,000	871,200
Capital Equipment Expense	975,000	975,000	975,000	975,000	975,000
Bad Debt/Charity (% of NPR)	175,807	233,863	344,403	378,843	416,727
Other Direct Costs (% of NPR)	319,649	425,206	626,186	688,805	757,686
Total Direct Costs	2,467,098	2,959,828	3,897,989	4,190,288	4,511,817
Operating Income (Loss)	729,395	1,292,232	2,363,875	2,697,763	3,065,039

The proposed project does have a significant financial impact on the consumer, state, region and community served by the services provided. Patients currently in need of cath lab services are required to pursue such services in Anchorage, which is the closest location for receiving cath, PCI, angiography and interventional radiology services. This project significantly lowers the cost of receiving such services for the consumer, as patients will not be required to travel to Anchorage, thus avoiding expensive medevacs or travel expenses not covered by insurance but borne by the patient. The consumer benefits, and the community that is served benefits as well. The community benefits by avoiding significant lost work days resulting from patients and family members traveling and staying in Anchorage.

By retaining revenues in the region and community, there is a long term economic impact to the population, as avoiding unnecessary loss of finances resulting from travel and board are not required to receive services. Therefore, revenues can remain in the region, which positively impacts the local communities and populations inhabiting them. It is important to point out that some consumers are simply unable to obtain vital services to maintain their health status if such services cannot be obtained locally. Thus, lack of local services can result in some consumers neglecting to receive appropriate care, which leads to more costly healthcare for these

individuals in the future, as unaddressed issues turn into more costly illness and disease. This too impacts the consumer, state, region and community served.

Cost savings for Alaska Medicaid will be seen through the approval of the proposed project as well. Currently, patients requiring services more advanced than those available at Central Peninsula Hospital are often sent to Anchorage for such services. The cost of travel is absorbed by the Alaska Medicaid system for such patients, and therefore, this proposed project would assist in cutting such costs as they pertain to Intensive Care Beds, Obstetrics and Catheterization services. As noted previously, patients unable or unwilling to travel outside the region for services often neglect their healthcare needs, which results in more costly encounters in the future. The Alaska Medicaid system will benefit from such patients addressing appropriate healthcare needs in the present, rather than resorting to more costly services in the future.

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.

The proposed project construction will be funded through Revenue Bonds obtained through the Alaska Bond Bank and approved by the Borough Assemble. This amounts to \$26,918,933 in total project cost to be pursued through revenue bonds supported by the proposed project. The operations will be financed through revenues generated by the project. This includes all interest expense required to be paid on revenue bonds. With net income substantial enough to pay for interest expense and principle attached to the revenue bonds, CPH will be able to make bond payments without Borough tax revenue support.

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;

It has been consistently demonstrated since the public release of data (beginning in 2012) from the Centers of Medicaid and Medicare Services (CMS) that Central Peninsula Hospital charges less than the majority of hospitals in Alaska with regard to Diagnostic Related Groups (DRG's). As a result, patients who receive obstetric and Intensive Care service will continue to receive lower cost care with the replacement of OB and the addition of three (3) ICU beds. Those in the target population needing cath lab services will see a decrease for the cost of services provided locally due to decreased medevac, transportation, and lower charge costs. The impact on the uninsured patient will be extraordinary as they will not bear the cost of expensive medevac services as well as lower charges.

- 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.);*

Not Applicable

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

As described in part 1 of this section, accompanied with the 5-year income statement projections provided from FY16-FY20, the proposed project is projected to show long-term financial feasibility of continued operations, as gross patient revenues, net patient revenues and the overall net income of the proposed project show a positive trend line of increased trajectory. This can be demonstrated in the following figure.

Figure 23: Cath Lab Profit and Loss

Cath Lab Profit and Loss Statement

	50% Capacity	66% Capacity	100% Capacity		
	Year 1	Year 2	Year 3	Year 4	Year 5
Hospital Revenues					
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Labor Costs	367,538	488,909	720,000	792,000	871,200
Capital Equipment Expense	975,000	975,000	975,000	975,000	975,000
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Total Direct Costs	2,467,098	2,959,828	3,897,989	4,190,288	4,511,817
Operating Income (Loss)	729,395	1,292,232	2,363,875	2,697,763	3,065,039

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.*

Community hospitals have the remarkable privilege of getting to serve the entire community, regardless of ability to pay or any other demographic factors. We expect to provide over \$10.4 million in uncompensated care in FY17. This is possible due to a strong charity care policy. Furthermore, we have successfully developed many programs specifically for low-income

populations, especially in the area of behavioral health. This includes programs specifically designed to target women with children suffering the effects of addiction. We were also very invested in having comprehensive cardiac care services in an effort to ensure all people have access to cardiac care including catheterization and equally important interventional radiology, rather than making life-sustaining treatment decisions based largely on insurance status. This proposed project extends our values, and our desire to provide care to all residents is a fundamental part of our mission.

In addition, CPH has completed policy work and will soon implement to comply with Section 1557 of the Affordable Care Act. This policy requires the provision of free qualified sign interpreters and language services for people whose primary language is not English. Printed materials will include information in the top 15 different languages spoken in Alaska.

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.

Over the past two years CPH has seen a decrease in Charity Care due to the expansion of Medicaid. FY2017 projections indicate that Charity Care will decrease down to \$3.8 million. Although Medicaid Expansion is still unpredictable in Alaska, CPH does expect to continue to feel an impact from Medicaid programs outside Alaska, as tourists and the influx of seasonal workers from other states receive care at the facility. The following table identifies the Revenue Deductions, Contractual Allowances, Charity Care and Total Deductions from Gross Patient Revenue spanning from 2012 to the projected 2020.

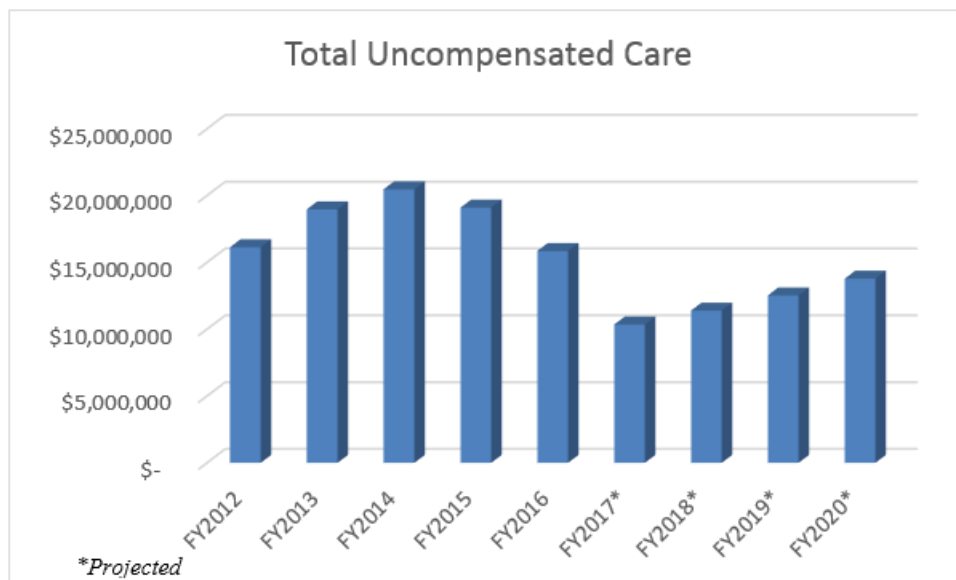
Figure 24: Deductions including Charity Care and Bad Debt

Historical and Projected Deductions				
	Charity Care	Bad Debt	Contractual Allowances	Total
FY2012	\$ 9,094,262	\$ 7,050,090	\$ 65,854,267	\$ 81,998,619
FY2013	\$ 9,941,179	\$ 9,031,980	\$ 77,001,359	\$ 95,974,518
FY2014	\$ 11,597,401	\$ 8,880,963	\$ 87,732,091	\$ 108,210,455
FY2015	\$ 12,811,570	\$ 6,296,353	\$ 111,607,452	\$ 130,715,375
FY2016	\$ 9,937,048	\$ 5,924,412	\$ 133,902,860	\$ 149,764,320
FY2017*	\$ 3,832,090	\$ 6,072,302	\$ 151,877,018	\$ 161,781,410
FY2018*	\$ 4,215,299	\$ 6,679,532	\$ 159,470,869	\$ 170,365,700
FY2019*	\$ 4,636,829	\$ 7,347,485	\$ 167,444,412	\$ 179,428,727
FY2020*	\$ 5,100,512	\$ 8,082,234	\$ 175,816,633	\$ 188,999,379
*Projected				

Central Peninsula Hospital expects to encounter continued increases year over year for Total Uncompensated Care. Uncompensated care provided to the community is defined as the total of Bad Debt and Charity Care combined. This uncompensated care trend can be seen in the

following chart labeled “Total Uncompensated Care”, which identifies a trend of increase in uncompensated care totals from \$9,227,621 in FY2008 to \$22,516,298 estimated for FY2018.

Figure 25: Uncompensated Care



3. Address the following access issues:

a. transportation and travel time to the facility;

Transportation and travel time to the facility will be largely unaffected by the proposed project. However, ease of parking, the ability to drop off patients under a covered canopy, and ease finding clinics have all been significantly improved by through our last major project. Travel for patients seeking catheterization/interventional radiology services will be significantly reduced for those who currently need to travel to Anchorage via medevac. This is a major lifesaving benefit to residents of the target service area.

b. special architectural provisions for the aged and persons with a disability;

We developed architectural plans to reduce walking distances for patients, especially those most likely to struggle ambulating. When possible, the most mobile patient populations are located furthest from the door or on higher floors. We attempted to place patients with access to natural light, pleasant views, and beautiful architecture, which is part of our patient-centered belief that the proper environment can facilitate healing. We emphasized this focus where patients will be stationary for extended periods of time (e.g., obstetrics and ICU patients). Great care has been taken to create operational efficiencies by reducing the number of steps necessary to arrive at key destinations. In all cases, we have maintained compliance with all Federal, State, and local laws/codes (e.g. the Americans with Disabilities Act).

c. hours of operation; and

Obstetrics and ICU beds will be available 24/7. CPH will begin operations of the catheterization lab in the first year as a normal business hours service. This will be gradually increased over the first three years to 24/7 capacity. This is being done out of an abundance of caution for an extremely complex service which requires a methodical approach to include education, training, and quality assurance for life saving procedures to be administered safely. It will also allow CPH time to work with our partners (AHI & Skagit Radiology) to place fulltime cardiologists and interventional radiologists on the Kenai Peninsula.

d. the institution's policies for nondiscrimination in patient services.

CPH corporate policy, CORP.101.020: See APPENDIX A

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.*

Please see APPENDIX A.

As a Joint Commission Accredited Hospital, all services provided within the entire proposed project will follow regulatory standards set by The Joint Commission. It is CPH's intent to continue as a Joint Commission Accredited Hospital, and therefore current practices and regulatory adherence will continue.

Copies of documents are provided in APPENDIX A. Central Peninsula Hospital is licensed by the State of Alaska (License #GACH-003) as a 49-bed General Acute Care Hospital. Certification of Accreditation was received from The Joint Commission following an on-site survey on May 10, 2016 and is valid for a period of up to 36 months.

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

The quality control program in place at CPH provides an effective mechanism to collect data, monitor and evaluate the quality and appropriateness of patient care and the clinical performance of health care providers. Continuous quality improvement activities are conducted daily for the improvement of patient care.

The primary focus of the quality control program is on opportunities to improve procedures instead of simply looking for isolated incidents. All isolated incidents are evaluated for trends and action taken to improve processes. The CPH quality control program is committed to the opportunity to improve care by examining the systems and processes by which care is provided.

The Board of Directors of Central Peninsula Hospital is directly accountable for safety in the organization stemming from their legal responsibility and operational authority for hospital performance. Governance and senior management set patient safety goals and ensure that adequate resources, including staff and technology, are provided to address goals and monitor progress toward goal achievement.

CPH hospital leaders are responsible for evaluation of the culture of safety of the organization on a regular basis, and for prioritizing and implementing changes identified by the evaluation. Additionally, leadership is responsible for creating a culture that supports patient safety by listening to patients and families.

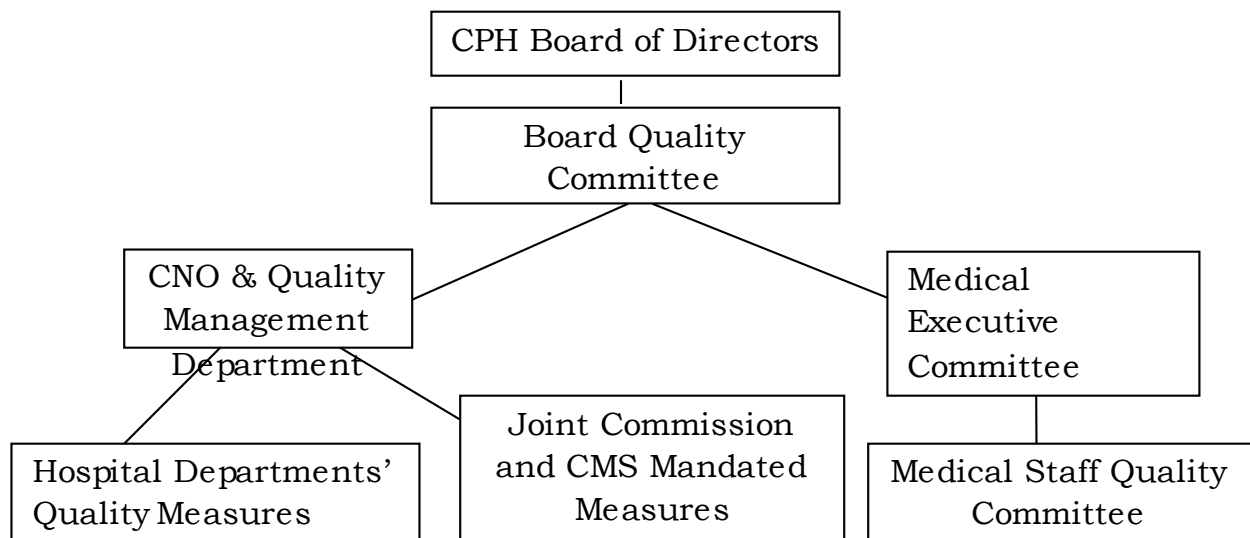
The Quality Department, which includes an RN-level Patient Safety Officer, is responsible for collecting and analyzing data pertaining to patient safety, for disseminating analyzed data to the Board Quality Committee, CPH administration, department directors, and to staff through a variety of established communication tools. The Quality Department is also responsible for investigating incidents of patient harm occurring at the hospital or as a result of care received at the hospital, for facilitating root cause analyses, and for assisting department directors in developing plans to improve patient safety.

Department Directors are responsible for identifying opportunities to improve safety through such means as feedback from staff during rounding, review of analyzed data that show either negative internal trends or unfavorable comparison to other organizations (i.e. benchmarking). Directors are also responsible for leading change, modifying processes, setting expectations, and monitoring effectiveness of interventions. They are also responsible for leading discussions about patient safety issues that either exist on their units, or discussing broader safety issues that have potential to impact their units. These department specific outcomes are reviewed at the organizational-wide Quality Council meetings.

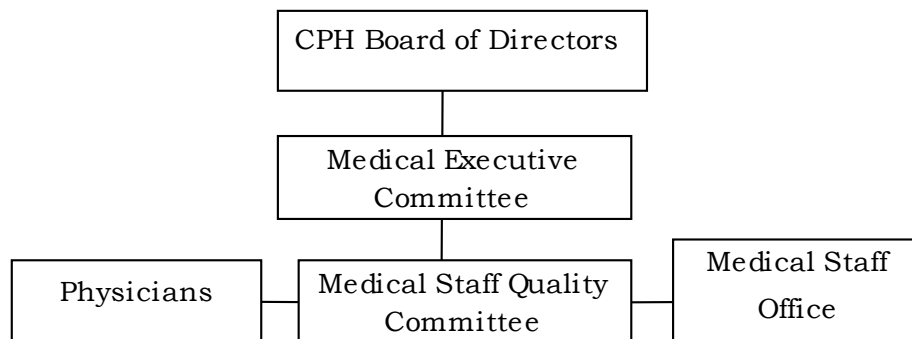
Staff are responsible for following established safety procedures and protocols such as hand washing, time outs, using two patient identifiers, etc. Staff are also responsible for identifying safety concerns and other opportunities for improvement, facilitating teamwork, practicing safe and effective communication, and for reviewing safety information such as case studies or data that is provided for them.

Physicians are also responsible for following established safety procedures and protocols such as hand washing, time outs, using two patient identifiers, site marking, facilitating teamwork, practicing effective hand off communication, etc. The medical staff is responsible to review cases involving safety concerns or cases involving patient harm, and to provide meaningful feedback or suggestions for improvement to peers. This information is reviewed in multiple committees of the medical staff, and advanced to the Medical Staff Quality Committee (MSQC) and Medical Executive Committee (MEC). Efforts from both these committees are shared directly with the Board of Directors of the hospital on a monthly basis. Physicians are also responsible for communicating to patients and/or families when patient harm has occurred. Additionally, when harm is classified as a sentinel event (see OP-154) the CEO is responsible for communicating with the patient/family on behalf of the Board of Trustees.

Quality Reporting Hospital



Quality Reporting Medical Staff



To ensure that patients receive high quality care, the processes and organizational structure outlined will encompass to the proposed project. High quality is a major element of the organizational culture at CPH as evidenced by our many local and national quality recognitions.²³

²³ “Top Performers in Key Quality Measures®,” (2011, 2012) The Joint Commission
http://www.jointcommission.org/accreditation/top_performers.aspx

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

There are no projected changes to the staffing of the relocated Obstetrics department as it will remain same size. There will be some efficiency gains as Obstetrics will be collocated with the med/surg unit allowing for RN staff flexing on low census days in OB as well as post-partum beds that can be used for med/surg overflow on high census days. In addition to interventional cardiologists providing services from the AHI, we propose to employ a total of 4 new FTEs for the cath lab. All staffing ratios will follow our existing staffing matrix.

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*

There are no programs associated with this proposal that will reduce inpatient services. CPH prides itself on the efficacy of the services offered for our patients and strive to provide only services that are necessary and appropriate for our patient population.

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.*

The proposed facility is being designed by architects who are experienced in health care facilities and are familiar with highly technical service lines. Modern diagnostic equipment is at the core of this proposal in all of the services including OB, ICU, and Catheterization services. CPH prides itself with the fact that modern technology for diagnostics and treatment is a core necessity for providers and clinicians to perform at the highest levels for patients. Through the direction of CPH leaders, thought is given to crafting an environment that facilitates the delivery of quality care in an efficient manner.

The latest in technology will be purchased for placement in the proposed project. Major diagnostic equipment is necessary for the catheterization lab. CPH has hosted the top three equipment vendors in this service line at our facility and we are continuing to perform due diligence in making a final selection. One of these vendors dominates with more than 90% of the cath lab equipment placed in Alaska cath labs.

ICU equipment is equally important for providing treatment and monitoring of our most acute patients. CPH will equip the three proposed rooms with the latest monitoring and telemetry equipment for patient safety and monitoring.

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

Labor and efficiency savings are built into the proposed project by collocation of specialty services coupled with the requisite ancillary and nursing services. As previously discussed, the CCS services will be located directly adjacent to the existing imaging and emergency departments. This location provides efficiencies both for staff and patient movement for emergent cases as those experiencing myocardial infarctions will arrive through the ED.

Obstetrics will be located on the second floor of the proposed new structure for two very important reasons. First and foremost is for previously discussed security and regulatory issues. CPH has been under pressure from federal regulators regarding infant security. We are also seeing a rise in cases where there is significant family turmoil surrounding some deliveries which include addiction issues as well as involvement of the DHSS Office of Children's Services. These difficult situations have required heightened security requiring emails going out to the entire hospital to highlight ongoing situations. Having OB located on the second floor will provide a much more secure setting. The current location being in the center of the main hospital with a secure lockdown preventing staff and patient transition through a hospital is inefficient and a vulnerability threat.

On low OB census days, the collocation of OB adjacent to med/surg will provide flex bed and nursing capacity making both departments more efficient. This planning for collocation will push the need for additional med/surg beds much further out in the future. CPH runs an average daily census in med/surg of 29. There are currently only 34 beds and many days med/surg reaches 100 percent capacity. Having the ability to flex into OB is not only efficient but makes sense in that it prevents additional expenditures in the near future for med/surg beds.

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

Programs located within the proposed project will be monitored and evaluated under processes currently utilized at Central Peninsula Hospital.

Central Peninsula Hospital's development activities are responsive to community input, and actions of the service area population. The need for the proposed project was identified by community feedback and is supported through local survey data, needs analysis, and strategic planning of the Borough, and hospital.

Through an interdisciplinary and integrated process, patient care and processes that affect patient care outcomes will be continuously monitored and evaluated to promote optimal achievement with appropriate accountability.

CPH will continue the assessment of patient satisfaction through standardized customer satisfaction surveys. These include measures relating to the facility, medical staff, nursing staff, cost, and quality of medical care received. CPH's active quality assurance program does and will

continue to measure occurrences and customer satisfaction. CPH is confident that utilization projection will be fulfilled and that consumers will be pleased with the expanded and modernized facility.

In addition to internal mechanisms that measure success, CPH will maintain JC certification, and State of Alaska licensing. Outcomes are monitored using JC standards and publicly reported quality and patient satisfaction measures provided by the Centers for Medicaid and Medicare Hospital Compare website.²⁴

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

Please see APPENDIX A.

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.*

In addition to the cardiologists from our partners at the AHI, there will be four new FTE positions to provide services in the cardiac catheterization laboratory:

Manager 1.0 FTE (existing)
Registered Nurse 2.0 FTE
Imaging Technician 2.0 FTE
Assistants 1.0 FTE (existing)

This staffing plan assumes an average of 4.0 catheterization laboratory clinical staff per case. All staff will be cross-trained to work in other areas when the laboratory is not in use. Staffing will increase over the first three years as we ramp up the service line to 100 percent capacity.

ICU staffing will be not change under our current model and nurse patient ratios. This is due to our existing nursing model which utilizes per diem and flex staffing pattern based on patient census.

OB staffing will remain the same as we are not creating a new or expanded department, only moving it to a new location within the hospital campus.

²⁴ “Medicare Hospital Compare,” <http://www.medicare.gov/hospitalcompare/>

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 size of the proposed spaces are within industry standards and are not significantly smaller or larger.

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 Standard #1- Documented Need:

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.

As presented in Section IV.B.4, the population served by the proposed project will include the primary service area (PSA) and the secondary service area (SSA) for services (e.g. Cath Lab, ICU, and OB). The PSA for CPH is defined by KPB code and was approved by residents of the PSA in 1969. The majority of the PSA population resides in Kenai and Soldotna and surrounding unincorporated communities of Nikiski, Sterling, and Kalifornsky outside their respective city limits. These areas have been identified by census tracts that were developed by the Alaska Department of Labor (DOL). The overwhelming majority of the population is on the road system with the exception of the Western Cook Inlet census tract. The SSA comprises the remainder of the KPB which is included in this proposal's target population. The need for OB services is currently established and we are not proposing an increase in the types of services already offered only a move of the department into a new location in the proposed new facility. The need for ICU beds is strongly supported by the population and demographic information contained in section IV in addition to the meeting the specific review standards.

Figure 26: Kenai Peninsula Borough Service Area Population Data

	Population Data					
CPH Service Area Populations ²⁵	2012	2013	2014	2015	2016	Avg Growth
CPH Primary Service Area	36,331	36,919	37,129	37,302	37,414	
<i>Growth</i>		1.6%	0.6%	0.5%	0.3%	0.7%
CPH Secondary Service Area	20,327	20,079	20,300	20,383	20,646	
<i>Growth</i>		-1.2%	1.1%	0.4%	1.3%	0.4%
Combined Primary & Secondary	56,658	56,998	57,429	57,685	58,060	
<i>Growth</i>		0.6%	0.8%	0.4%	0.7%	0.6%

Residents of the PSA have consistently communicated through multiple community health needs surveys the need for additional specialty services (see Section IV. B. 2). Cardiology services have consistently been in top three “needs” identified by service area residents since 2004. Cancer care was significantly addressed in our last approved CON which completed our cancer

²⁵ <http://live.laborstats.alaska.gov/pop/estimates/data/TotalPopulationBCA.xls> Data used by CPH for primary and secondary population numbers

treatment center. CPH will begin providing Medical Oncology services on June 30th of this year. It is the final component needed for completing our cancer treatment services plan. Substance abuse treatment continues to rank high and is being addressed. CPH, through a DHSS grant will be opening a six-bed Care Management facility for detoxification and therapeutic services in July 2016. Shortly thereafter, in September, CPH will open a sixteen-bed transitional housing facility for those who are graduating from our residential substance abuse treatment facility.

Having addressed those at the top of the community needs list, Cardiology and Alzheimer's remain at the top of the needs identified by the community and are also consistently identified as reasons residents in the service area travel outside of the borough to receive services. The methodology varied slightly between the different surveys, which accounts for the different categories (below).

Figure 27: CHNA Data – Multiple Years

2004 Community Health Report CPH Hospital Service Area²⁶	
<i>Community Perception “Needs More of”</i>	
Cancer Care	49.5% Needs more of
Specialty Elder Care	41.8% Needs more of
Cardiology	41.7% Needs more of
Emergency or Trauma Care	40.9% Needs more of
Drug/Alcohol Abuse Treatment	36.7% Needs more of
Pediatrics	37.8% Needs more of

2006 CPGH Community Health Needs Assessment ²⁷	
<i>Where would you go for treatment for:</i>	
Cancer Care	44% Anchorage/ somewhere else (combined)
Orthopedic Surgery	38 % Anchorage/ Somewhere else (combined)

2009 CPGH Community Health Needs Assessment ²⁸	
<i>Where would you go for treatment for:</i>	
Cancer Care	44% Anchorage & somewhere else (combined)
Orthopedic Surgery	38 % Anchorage & somewhere else (combined)
General Surgery	30% Anchorage somewhere else (combined)

²⁶ “Community Health Planning Report for Central Peninsula Hospital Service Area 2004,” Public Health Resource Group, Inc.

²⁷ “CPGH Community Health Needs Assessment 2006,” Craciun Research Group

²⁸ “Central Kenai Peninsula Community Health Planning Report 2009,” Center for Health Policy and Research

2013 CPGH Community Health Needs Assessment ²⁹	
<i>Community Perception “Needs More of”</i>	
Cancer Care	71% Needs more of
Alzheimer’s Services	62% Needs more of
Cardiology Services	59% Needs more of

2016 Central Kenai Peninsula Community Health Needs Assessment ³⁰	
Alzheimer’s services	67% Needs more of
Alcohol and drug abuse tx services	60% Needs more of
Cardiology services	56% Needs more of

The proposed project will begin to address the current absence of cardiac catheterization lab services combined with the recent addition of full time cardiology services offered at CPH to peninsula residents.

Barriers to care for residents of the target are simply due to the absence of specialists and/or diagnostic and treatment technology (e.g. cath lab). These absences create a geographic transportation barrier by requiring residents to travel 150 miles to Anchorage or be medevac’d under emergent conditions. Population growth and dramatic changes in demographics (particularly aging) are now at levels to support the growth occurring in an aging population.

Target population residents have no access to life saving cardiac catheterization lab services on the entire peninsula. One-hundred percent (100%) of the entire KPB residents must leave for cath lab services. A service that will save lives for a population where heart disease is second leading cause of death on the Kenai Peninsula and Alaska in 2015³¹.

Despite continued needs, the central peninsula made significant gains to reducing barriers in the area of specialists. Recent examples include the addition of radiation oncology, orthopaedic spine surgery, urology, neurology, podiatric surgery, medical oncology (June 2017), and pain management. However, there are still several specialty areas where growth is needed (e.g., cardiology diagnostic/intervention, ENT etc.).

General Review Standard #2 – Relationship to Applicable Plans:

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

²⁹ Ibid

³⁰ “Central Kenai Peninsula Community Health Needs Assessment 2016” www.cpgn.org

³¹ Alaska Vital Statistics 2015 Annual Report – Visited May 30, 2016
http://dhss.alaska.gov/dph/VitalStats/Documents/PDFs/VitalStatistics_Annualreport_2015.pdf

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.

CPH contacted the state Certificate of Need Coordinator and asked for any relevant state plans with regard to cath labs, ICU and/or Obstetrics beds. The response we received indicates there aren't any specific plans and we were directed to the Healthy Alaskans 2020 which we have reviewed and referenced elsewhere in this application. CPH has demonstrated in Section IV.A that our long-range development plans augment and integrate with relevant community, regional, state and federal health plans. Planning at the local level is typically done by CPH in conjunction with the KPB. Local planning is conducted via evidence based planning and is focused on service delivery. The most recent community health needs assessment was conducted in 2016.

The proposed project was spawned from a comprehensive process which included community health needs assessments, strategic planning, an open community process, and master site planning. State plans reviewed include Health Alaskans 2020 and reports and recommendations produced from the Alaska Health Care Commission. CPH is active at the federal level and is current on the Patient Protection and Affordable Care Act and proposed changes currently under consideration for the American Health Care Act.

The proposed project is certainly consistent with and augments plans at all levels. Common issues discussed in multiple forums include dialogue related to payment reform, rising costs, quality/value, evidenced based medicine, patient centered care, access to services, and population health. The proposed project is intended to promote access, create efficiencies for patients and most importantly – provide lifesaving diagnostics and treatment for our target population. CPH has an outstanding record for patient satisfaction and quality of service. Costs are also closely monitored, as this is another area of concern for residents of the Kenai Peninsula. Recent (2014 is latest data set available) data released from Medicare indicated that CPH charges were considerably below many Alaskan providers and even below national averages in some cases.

General Review Standard #3 – Stakeholder Participation:

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

The stakeholder participation for the proposed project included the CPH Administration, Hospital Nonprofit Operating Board (CPGH, Inc. public meetings), members of the medical staff, KPB Mayor, Capital Works and Finance staff, and public hearings and final unanimous approval by the KPB Assembly following public hearings.

The process undertaken for planning of the proposed project is explained in detail in Section IV.A.

General Review Standard #4 – Alternatives Considered:

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.

CPH has considered and assessed alternative methods for the proposed services. Doing nothing for all three is an option but it came with consequences. Leaving the current OB department in its current location also leaves CPH vulnerable to regulatory violation that will require costs to come into compliance. Those costs will be spent on the oldest portion of the hospital which eventually needs to be replaced due to code and structure issues. It also leaves CPH with a hospital that at a minimum is cut in half access-wise due to having a secured section in the middle where patients cannot pass through to other services without exiting and walking over 200 feet to a different exterior entrance. This is difficult for patients who suffer from mobility issues, respiratory problems, and cardiac issues (cardiology is one service that indoor access is barred due to infant security). These issues are often exacerbated in times of severe weather.

In addition, another option of remodeling and upgrading a 24/7 department in place and keeping it functional is not only more expensive but operationally prohibitive. This option was considered and ruled out as a suitable approach. The most suitable approach determined was to build a new department and collocate it next to med/surg to gain operational efficiencies, save money that would be poured into a more than 40 year old structure and open access to the entire hospital back up to all patients via removal of the secured corridor.

With regard to ICU beds. There are only two options as there are no alternative methods for providing intensive care services. Do nothing or add capacity. Doing nothing leaves our patient population vulnerable as our ICU runs at over 62% capacity on average. More importantly, it runs at 100% capacity frequently (163 days this fiscal year), high acuity patients will need to be transported at significant cost under the do nothing scenario. Adding capacity was deemed the most suitable as it will provide the capacity needed to take care of our most critically ill patients at home while saving the cost of expensive medevac transports.

For cardiac catheterization lab services, the options were do nothing and continue to transport cardiac patients or provide the lifesaving service locally. Doing nothing has been the correct option for many years as CPH was not able to provide cardiology services due to lower volumes and a younger population. CPH can no longer do nothing as the population in the KPB has changed dramatically demographically. We are significantly older than with a median age that is eight (8) years older than the Alaska median age and even surpasses the US median age by four (4) years. The 65+ age cohort of the Kenai Peninsula population makes up more of the total population (14.9%) than any other major population center of Alaska and surpasses the same age cohort of the total US population beyond 2040 (see chart in section IV. B). Doing nothing is no longer an option for our population in the KPB. The residents have told us through multiple community health needs assessments they want these services, the volume is able to support it, we meet the specific needs criteria, and most importantly, it will save lives when patients arrive at the hospital and receive a procedure as opposed to the current model in place which is to stabilize, load them on a helicopter and tell the family we hope they will make it to Anchorage in time. Unfortunately, not all make it in time. Providing this new service is the suitable option after considering the alternative.

General Review Standard #5 – Impact on the Existing System:

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.

There will be an effect on volumes for cath lab and intensive care services in Anchorage and some out of state locations for elective cardiology services. While reducing volume to other providers is always a concern, the most important factor is that providing these services locally will not only benefit patients in many ways – it will save lives. Not all services should not be limited to the Anchorage bowl area when they can be performed safely in other locations at lower cost to the healthcare system. Denying rural hospitals the ability to provide lifesaving procedures to their patients for the sake of concentration of a single service to one urban location would be poor public policy in our view. Currently Anchorage has no less than eight cath labs serving a population of 300,000. That equates to one lab for every 37,500 residents. Central Peninsula Hospital maintains that approving a cath lab in the KPB with a population of approximately 60,000 people to save lives would therefore is prudent public policy and puts patients' lives ahead of provider impact.

There will also be an impact on air ambulance and hospitalist services in Anchorage. However, both of these groups support the construction of a cath lab at Central Peninsula Hospital. The hospitalist group contracted to provide services at CPH is the same group that provides services at both Anchorage hospitals and their inpatient revenue should remain steady as a result. There are no existing facilities locally and therefore there is no impact. Positive impacts are expected for the recently opened full-time cardiology provider as well as local internal medicine practices who also manage care for patients with heart disease.

The new OB department will not have any anticipated impacts on local or other providers outside of the community as this service remains the same as it is today and is being relocated to a new location in the hospital.

General Review Standard #6 – Access:

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.

CPH is open twenty-four hours a day - every day of the year. Immediate and extended family have twenty-four hour visiting access to their loved ones who are patients at CPH. Family pets are even allowed to visit patients following approval of the physician. Community members frequent CPH daily for multiple reasons aside from patient care. These include educational events, training, patient visiting, community meetings related to health care and just to have lunch at our popular cafeteria. Overall, access for all patients will be improved due to improved access to the entire hospital when OB is relocated and more importantly – Peninsula residents will have access to catheterization lab and interventional radiology services will be available for the first time locally to all borough residents.

The proposed project is located on the hospital campus located in the heart of Soldotna which is accessible by road to the majority of KPB residents. Some primary and secondary service area residents are off the road system which is accessible by regularly scheduled air service into Kenai. The services in the application are all located in the hospital

All facilities at CPH are compliant with the American's with Disabilities Act of 1990 as amended. The proposed project will achieve and in some cases surpass statutory and regulatory requirements. Special attention to the physical needs of patients who will utilize the services in this application is extremely important. Examples of addressing these issues include easier physical access via heated ice-free parking spaces located at sidewalks edge, heated ice-free sidewalks, power assisted entrance doors, wheel chair availability at the entry, and elevators near the entrance to assist patients who will utilize the OB department.

Specific Review Standards for Obstetrical (Acute Care Beds)

SPECIFIC REVIEW STANDARDS	Comments
1. Beds for acute care hospital services for the state or service area will be within the limits calculated using the methodology below. An application will not be approved if bed need standards are exceeded.	Met – CPH is not requesting authorization for new beds. We are reducing the number of OB beds from 9 to 4 and are requesting to replace the department in a new structure.
2. An applicant serving patients from a community with a population of 10,000 or less demonstrates that the transport of patients to or from those areas for medical care or services will be facilitated, directly or through coordinated efforts with other organizations.	N/A – The service area and target population far exceed the 10,000 population limit.

Acute Care Bed Need Calculations

Based on State Dept of Labor Population Estimates

Obstetrical BEDS (SERVICE SPECIFIC)

ALL INPATIENT BEDS

$$C = (Ps * URs) * SAS$$

Step One: Determine the projected inpatient caseload for the population to be served using the formula:

Ps	40781.00	2025 CPH PSA Pop Estimate
Ur	0.03	1048 Avg Pat Days OB 3yrs/Current Pop
SAS	1	Percent of PSA to be served
C	1142	$C = (Ps * URs) * SAS$

Ps	40781.0	2025 CPH PSA Pop Estimate
Ur	0.2	8967 Avg Pat Bed Days 3yrs/Current Pop
SAS	1	Percent of PSA to be served
C	9774	$C = (Ps * URs) * SAS$

$$ADC = C / SA$$

Step Two: Determine the projected average daily inpatient census for the service using the formula:

C	1142	From Step 1
SA	365	Days in year
ADC	3	$ADC = C / SA$

C	9774	From Step 1
SA	365	Days in year
ADC	27	$ADC = C / SA$

$$PBN = ADC / TO$$

Step Three: Determine the projected number of hospital beds needed for the service by using the formula:

ADC	3	From Step 2
TO	0.5	Target Occupancy 50%
PBN	6.3	$PBN = ADC / TO$

ADC	27	From Step 2
TO	0.5	Target Occupancy 50%
PBN	54	$PBN = ADC / TO$

$$UBN = PBN - IHB$$

Step Four: Subtract existing beds from total hospital bed need (PBN)

PBN	6.3	From Step 3
IHB	9	Current OB Beds
UBN	-2.7	$UBN = PBN - IHB$

Reduction of 2.7 OB Beds under formula (Reducing by 5 under this application)

PBN	54	From Step 3
IHB	49	Current Acute Beds
UBN	5	$UBN = PBN - IHB$

5 New Acute care beds allowed under formula

Data

2016 CPH Service Area Population	37,414
2025 Est CPH Service Area Population*	40,781

**State projects .09% growth rate over 10 years*

Total Inpatient Bed Days

	2017*	2016	2015	AVG
Total Patient Days	8918	9345	8638	8967

**Data extrapolated from half year of data*

OB Bed Days

	2017*	2016	2015	AVG
Total OB Patient Days	1056	1104	984	1048

**Data extrapolated from half year of data*

Specific Review Standards for ICU (Acute Care Beds)

SPECIFIC REVIEW STANDARDS	Comments
1. Beds for acute care hospital services for the state or service area will be within the limits calculated using the methodology below. An application will not be approved if bed need standards are exceeded.	Met – CPH has met the limits of the calculations and methodology to be approved.
2. An applicant serving patients from a community with a population of 10,000 or less demonstrates that the transport of patients to or from those areas for medical care or services will be facilitated, directly or through coordinated efforts with other organizations.	N/A – The service area and target population far exceed the 10,000 population limit.

Review Standards

- 1. Beds for acute care hospital services for the state or service area will be within the limits calculated using the methodology below. An application will not be approved if bed need standards are exceeded.***

Acute Care Bed Need

Review standards for acute care hospital beds require a calculation for both service specific beds (in this case ICU) as well as a calculation based on all inpatient bed caseload. These calculations follow on the next page:

Figure 28: ICU Bed Calculations

Acute Care Bed Need Calculations

Based on State Dept of Labor Population Estimates

ICU BEDS (SERVICE SPECIFIC)

ALL INPATIENT BEDS

$$C = (Ps * URs) * SAS$$

Step One: Determine the projected inpatient caseload for the population to be served using the formula:

Ps	40781.00	2025 CPH PSA Pop Estimate
Ur	0.04	1379 Avg Pat Days ICU 3yrs/Current Pop
SAS	1	Percent of PSA to be served
C	1503	$C = (Ps * URs) * SAS$

Ps	40781.0	2025 CPH PSA Pop Estimate
Ur	0.2	8967 Avg Pat Bed Days 3yrs/Current Pop
SAS	1	Percent of PSA to be served
C	9774	$C = (Ps * URs) * SAS$

$$ADC = C / SA$$

Step Two: Determine the projected average daily inpatient census for the service using the formula:

C	1503	From Step 1
SA	365	Days in year
ADC	4	$ADC = C / SA$

C	9774	From Step 1
SA	365	Days in year
ADC	27	$ADC = C / SA$

$$PBN = ADC / TO$$

Step Three: Determine the projected number of hospital beds needed for the service by using the formula:

ADC	4	From Step 2
TO	0.5	Target Occupancy 50%
PBN	8.2	$PBN = ADC / TO$

ADC	27	From Step 2
TO	0.5	Target Occupancy 50%
PBN	54	$PBN = ADC / TO$

$$UBN = PBN - IHB$$

Step Four: Subtract existing beds from total hospital bed need (PBN)

PBN	8.2	From Step 3
OJB	6	Current ICU Beds
UBN	2.2	$UBN = PBN - IHB$

2.2 New ICU Beds allowed under formula

PBN	54	From Step 3
OJB	49	Current ICU Beds
UBN	5	$UBN = PBN - IHB$

5 New Acute care beds allowed under formula

Data

2016 CPH Service Area Population	37,414
2025 Est CPH Service Area Population*	40,781

*State projects .09% growth rate over 10 years

Total Inpatient Bed Days				
2017*	2016	2015	AVG	
Total Patie	8918	9345	8638	8967

*Data extrapolated from half year of data

ICU Bed Days				
2017*	2016	2015	AVG	
Total ICU F	1356	1501	1280	1379

MODIFICATION TO METHODOLOGY:

Per the instructions and allowance for Acute Care Hospital Service review standards and methodology, CPH is making additional projections for consideration as allowed based on the following:

If there is public information about service area population changes expected over the planning horizon, such as a military base closing, or a major economic project such as a new mine, the service area share estimate may be modified with explanation to reflect the expected change.³²

The Kenai Peninsula, in spite of a receding economy is well positioned for growth. There are large active projects that are not just on the drawing board but actually in the permitting phase at various levels of the state and federal government.

It is well documented in the public domain that Alaska is seeking to construct a world class LNG project in Alaska. Public information can be found on the Governor's webpage.³³ This project consists of a large gas treatment plant on the North Slope that would clean, dehydrate, chill and compress natural gas that would be transported through an 800 mile pipeline terminating in Nikiski which is inside the CPH primary service area. The project requires a mega 6 train liquefaction facility to be constructed in Nikiski to create, store and load up to 20 million tons of LNG per year.

Construction estimates for this large liquefaction plant include the labor of up to 6,000 employees over four to five years with construction beginning in in the fourth quarter of 2019.³⁴ This is a substantial increase in the population of the PSA over several years. This increase in population does not include indirect jobs that will also increase the population and need for services.

One of many indirect results include the reopening of the Agrium Kenai Nitrogen Plant. This facility will add approximately 935 direct and indirect jobs to the primary service area.³⁵ While this is a 2013 study of potential benefits, the Alaska State Legislature passed House Bill 100 in 2015 (Short Title: UREA/AMMONIA/GAS-LIQ FACILITY; TAX CREDIT) granting Agrium (among others) tax credits for in-state processing. Agrium followed up in October 2016 by filing for a wastewater discharge permit with the State of Alaska. The public comment phase just recently closed and a decision is forthcoming from the state of Alaska.³⁶

CPH has conservatively modified the State of Alaska population projections by 6,000 based on publicly available information of major economic projects. As a result the following is submitted for determining need for additional acute care (ICU) beds:

³² Alaska Certificate of Need Review Standards and Methodologies, December 9, 2009, page 4

³³ <http://gov.alaska.gov/administration-focus/alaskas-gasline/>

³⁴ Alaska LNG Project Draft Resource Report to Federal Energy Regulatory Commission, Page 1-109

http://www.kpb.us/images/KPB/MYR/LNG_Project/Resource_Report_No._1_General_Project_Description-op.pdf

³⁵ Economic Benefits of Reopening the Agrium Kenai Nitrogen Plant, McDowell Group Study 2013

http://www.akleg.gov/basis/get_documents.asp?session=29&docid=2758, page 7

³⁶ http://dec.alaska.gov/water/wwdp/pdfs/publicnoticedocs/ak0000507_public_notice.pdf

Figure 29: Modified Methodology ICU Bed Calculations

Acute Care Bed Need Calculations

*Modified for Pipeline Population Expansion

ICU BEDS (SERVICE SPECIFIC)

ALL INPATIENT BEDS

Step One:

C = (Ps * URs) *SAS

Ps	46781.00	*2025 CPH PSA Pop Estimate Adj for economic projects
Ur	0.04	1379 Avg Pat Days ICU 3yrs/Current Pop
SAS	1	Percent of PSA to be served
C	1724.2476	C = (Ps * URs) *SAS

Ps	46781.0	*2025 CPH PSA Pop Estimate Adj for economic projects
Ur	0.2	8967 Avg Pat Bed Days 3yrs/Current Pop
SAS	1	Percent of PSA to be served
C	11211.99	C = (Ps * URs) *SAS

ADC = C / SA

Step Two:

C	1724.2476	From Step 1
SA	365	Days in year
ADC	5	ADC = C / SA

C	11212	From Step 1
SA	365	Days in year
ADC	31	ADC = C / SA

PBN = ADC / TO

Step Three:

ADC	5	From Step 2
TO	0.5	Target Occupancy 50%
PBN	9.447932	PBN = ADC / TO

ADC	31	From Step 2
TO	0.5	Target Occupancy 50%
PBN	61	PBN = ADC / TO

UBN = PBN - IHB

Step Four:

PBN	9.447932	From Step 3
OJB	6	Current ICU Beds
UBN	3.4	UBN = PBN - IHB

3.4 New ICU Beds allowed under formula

New ICU Beds Allowed

PBN	61	From Step 3
OJB	49	Current ICU Beds
UBN	12	UBN = PBN - IHB

12 New Acute care beds allowed under formula

Data

2016 CPH Service Area Population	37,414
2025 State Est CPH Service Area Population	40,781
2025 Est CPH Service Area Population*	46,781

*State projects .09% growth rate over 10 years (CPH added 6000 for economic projects)

Total Inpatient Bed Days

2017**	2016	2015	AVG
Total Patie	8918	9345	8638
			8967

**Data extrapolated from half year of data

ICU Bed Days

2017***	2016	2015	AVG
Total ICU F	1356	1501	1280
			1379

***Data extrapolated from half year of data

Based on CPH's Modification of Methodology, the Projected Bed Need (PBN) is for 3.4 new ICU beds or 12 new acute care beds. Without modification, the calculations allow for 2.2 ICU beds or 5 acute care beds. Neither of these calculations include the anticipated increase in volume associated with the approval of the catheterization lab that is requested for approval in this Certificate of Need request. The catheterization lab will increase ICU utilization which already exceeds the target occupancy of the formula.

- 2. *An applicant serving patients from a community with a population of 10,000 or less demonstrates that the transport of patients to or from those areas for medical care or services will be facilitated, directly or through coordinated efforts with other organizations.***

N/A - This standard is not applicable as the CPH primary service area population exceeds 10,000.

Specific Review Standards for Cardiac Catheterization Lab

SPECIFIC REVIEW STANDARDS	Comments
1. No new cardiac catheterization laboratories will be approved in a community with existing cardiac catheterization services unless all existing adult laboratories are operating at an average of at least 75% of capacity or an average of at least 750 procedures per year.	Not applicable. There are no cardiac catheterization laboratories in the community. The only laboratories in the State are located in Anchorage, Wasilla and Fairbanks.
2. The applicant for a facility that will offer pediatric cardiac catheterization demonstrates that at least 250 procedures per year will be performed.	Not applicable. Pediatric catheterizations will not be offered.
3. The applicant for a facility that will offer primary angioplasty without onsite cardiac surgery capability must have a proven and tested plan for rapid access (within 90 minutes from declaration of emergency to the patient being in a cardiac surgical operating room). Appropriate hemodynamic support capability for such a transfer must exist as well as a team of appropriately trained individuals. The ability to place an intra-aortic balloon pump (IABP) and temporary transvenous pacemaker for stabilization before transport must also exist.	Met - Transport is possible in as few as 60 minutes. Transport times have averaged 85 minutes this year according to the Statewide STEMI Data where we report data for transfer of heart attack patients from CPH to Anchorage hospitals. See APPENDIX A Appropriate hemodynamic support capability for transfer currently exists. A team of appropriately trained individuals with the ability to place an intra-aortic balloon pump (IABP) and temporary transvenous pacemaker for stabilization before transport will be trained and implemented upon approval of this project. The current transport teams are comprised of critical care nurses and paramedics. All are certified in ACLS, PALS, and currently transport cardiac patients throughout the state.
4. A facility requesting authorization to perform elective coronary interventions must be located	The Department's conditions for authorization to perform elective coronary interventions in a

<p>within a hospital or in a laboratory attached to a hospital with onsite cardiac surgery capability. The department may approve a laboratory that is not located within a hospital or not attached to a hospital with onsite cardiac surgery capability, if the following conditions are met:</p> <p>4a. Patients with acute coronary syndromes, severe congestive heart failure, pulmonary edema due to acute ischemia, severe multi-vessel or left main disease, and severe left ventricular dysfunction associated with valvular disease are excluded.</p>	<p>laboratory not attached to a hospital with onsite cardiac surgery capability will be met.</p> <p>Patients with acute coronary syndromes, severe congestive heart failure, pulmonary edema due to acute ischemia, severe multi-vessel or left main disease, and severe left ventricular dysfunction associated with valvular disease will be excluded.</p>
<p>4b. Patients with complex (Type IIb and III) coronary lesions and other high-risk anatomic situations (only remaining coronary artery, vessel to be treated supplies more than 40% of remaining viable myocardium, etc.) are excluded. Facilities requesting approval for percutaneous coronary intervention (PCI) services in the absence of onsite cardiac surgery must develop criteria to screen for the types of clinical and anatomic situations appropriate and inappropriate for their facility based on published criteria in the literature.</p>	<p>Potential elective candidates will be rigorously screened for the types of clinical and anatomic situations appropriate and inappropriate for their facility based on published criteria in the literature. The screening protocol is attached in APPENDIX A.</p>
<p>4c. A plan for proper oversight must be approved by the department before approval of a certificate of need. The plan must include</p> <ul style="list-style-type: none"> • accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); • membership in the American College of Cardiology – National Cardiovascular Data Registry (for benchmarking outcomes); • an independent peer review of the program by the, to be conducted once in the first six months and then annually thereafter for the first three years, to ensure that all issues related to quality assurance are monitored and addressed; and • supplying the department with all reports and data developed within 10 working days after each is developed. 	<ul style="list-style-type: none"> • CPH is accredited by the JCAHO (see APPENDIX A). • CPH will become a member of the American College of Cardiology — National Cardiovascular Data Registry for the purpose of benchmarking outcomes. • Upon approval of this project, CPH will make arrangements for the program to be reviewed by the Society for Cardiovascular Angiography and Interventions to ensure that all issues related to quality assurance are monitored and addressed within the first six months and then annually for the first three years as requested. • National standards and benchmarks would apply to all aspects of the program. • Reports will be provided to the Department within 10 days of receipt.

4d. The laboratory director must have extensive experience performing coronary interventions (more than 500 procedures performed during their career and more than 75 procedures annually during the past two years), and must have and maintain a certificate of “Added Qualifications” in Interventional Cardiology from the American Board of Internal Medicine.	A laboratory director has been selected with extensive experience and qualified as noted. Our cardiologist will have the ability to travel on an annual or as needed basis in order to maintain competency and obtain education from colleagues in the specialty of Cardiology.
4e. The laboratory must maintain a quality standard for diagnostic catheterization mortality of less than 3 per 1000 procedures and for PCI of less than 1 per 100 procedures.	CPH will provide mortality experience that falls within the required standards of less than 3 per 1000 procedures and less than 1 per 100 for PCI procedures.
5. An applicant who seeks to establish new cardiac catheterization services in a community without existing services demonstrates that the facility is likely to perform a minimum of 500 cardiac catheterizations per year by the third year after program implementation	Met - CPH projections indicate that utilization meets the requirement of 500 cardiac catheterizations per year by the third year of the program. Please see narrative below.
6. The applicant demonstrates that the facility has the capability of providing immediate transvenous pacemakers in case of cardiac arrest	Met - CPH has demonstrated the capability of providing transvenous pacemakers in the case of cardiac arrest.

Review Standards

- 1. No new cardiac catheterization laboratories will be approved in a community with existing cardiac catheterization services unless all existing adult laboratories are operating at an average of at least 75% of capacity or an average of at least 750 procedures per year.***

N/A. There are no existing cardiac catheterizations services on the Kenai Peninsula.

- 2. The applicant for a facility that will offer pediatric cardiac catheterization demonstrates that at least 250 procedures per year will be performed.***

N/A CPH will not be offering pediatric cardiac catheterization services.

- 3. The applicant for a facility that will offer primary angioplasty without onsite cardiac surgery capability must have a proven and tested plan for rapid access (within 90 minutes from declaration of emergency to the patient being in a cardiac surgical operating room). Appropriate hemodynamic support capability for such a transfer must exist as well as a***

team of appropriately trained individuals. The ability to place an intraaortic balloon pump (IABP) and temporary transvenous pacemaker for stabilization before transport must also exist.

SEE APPENDIX A

4. A facility requesting authorization to perform elective coronary interventions must be located within a hospital or in a laboratory attached to a hospital with onsite cardiac surgery capability. The department may approve a laboratory that is not located within a hospital or not attached to a hospital with onsite cardiac surgery capability, if the following conditions are met:

a. Patients with acute coronary syndromes, severe congestive heart failure, pulmonary edema due to acute ischemia, severe multi-vessel or left main disease, and severe left ventricular dysfunction associated with valvular disease are excluded.

CPH will meet this standard as these patients will be screened and excluded from the services being requested in this application.

b. Patients with complex (Type IIb and III) coronary lesions and other high-risk anatomic situations (only remaining coronary artery, vessel to be treated supplies more than 40% of remaining viable myocardium, etc.) are excluded. Facilities requesting approval for percutaneous coronary intervention (PCI) services in the absence of onsite cardiac surgery must develop criteria to screen for the types of clinical and anatomic situations appropriate and inappropriate for their facility based on published criteria in the literature.

CPH will meet this standard as these patients will be screened and excluded from the services being requested in this application. See APPENDIX A

c. A plan for proper oversight must be approved by the department before approval of a certificate of need. The plan must include

- accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);**

Central Peninsula Hospital is accredited by The Joint Commission (see APPENDIX A)

- membership in the American College of Cardiology – National Cardiovascular Data Registry (for benchmarking outcomes);**

CPH will become a member of ACC National Cardiovascular Data Registry upon approval of the CON. There are high annual fees associated with membership that would accrue prior to actual approval and opening of the facility.

- ***an independent peer review of the program by the Society for Cardiovascular Angiography and Interventions or the American Medical Foundation for Peer Review, to be conducted once in the first six months and then annually thereafter for the first three years, to ensure that all issues related to quality assurance are monitored and addressed; and***

Upon approval of this project, CPH will make arrangements for the program to be reviewed by the Society for Cardiovascular Angiography and Interventions to ensure that all issues related to quality assurance are monitored and addressed within the first six months and then annually for the first three years as requested.

- ***supplying the department with all reports and data developed within 10 working days after each is developed.***

CPH will satisfy this requirement and provide all reports and data within the timeframes required.

- d. The laboratory director must have extensive experience performing coronary interventions (more than 500 procedures performed during their career and more than 75 procedures annually during the past two years), and must have and maintain a certificate of “Added Qualifications” in Interventional Cardiology from the American Board of Internal Medicine.***

A laboratory director has been selected (AHI who perform over 95% of all cardiology procedures in Alaska) with extensive experience and qualified as required. They will provide a cardiologist(s) annually or as needed to maintain competency and obtain education from colleagues in the specialty of Cardiology.

- e. The laboratory must maintain a quality standard for diagnostic catheterization mortality of less than 3 per 1000 procedures and for PCI of less than 1 per 100 procedures.***

CPH will provide mortality experience that falls within the required standards of less than 3 per 1000 procedures and less than 1 per 100 for PCI procedures.

- 5. An applicant who seeks to establish new cardiac catheterization services in a community without existing services demonstrates that the facility is likely to perform a minimum of 500 cardiac catheterizations per year by the third year after program implementation.***

Determining future volumes of a cardiac catheterization service is not an exact science. It requires the development of accurate numerical assumptions based upon the best available data. This task is more daunting than it sounds, as there is considerable conflicting data and a lack of agreed upon numerical assumptions for making predictions. Nevertheless, we attempt to predict

future volumes as rigorously as possible by examining all assumptions in detail and basing our final calculations on a multi-modal perspective.

In order to provide a comprehensive analysis of expected volumes, we review the following areas:

- 1) why CPH began seriously considering a cardiac catheterization service;
- 2) why sustainability of this service today is different than in past CON applications;
- 3) how we established numerical assumptions;
- 4) identification of other factors that may influence our numerical estimate of volumes; and
- 5) our final, multi-modal assessment of predicted volumes.

Why CPH Began Seriously Considering a Cardiac Catheterization Service

For over ten years, CPH has evaluated the merit of establishing a cardiac catheterization service. We initially approached this concept cautiously, due largely to uncertainty regarding whether sufficient volumes existed, whether non-interventional approaches or other technologies would eventually reduce the need for cardiac catheterizations, uncertainty about health care reform, and the high capital/operational costs involved in establishing this service.

Our tentativeness toward this service line changed markedly in 2016 when AHI began providing cardiology services in space leased from CPH. Their service quickly grew, and within six months AHI had already requested significantly more lease space and added a second provider. It was soon clear that a surprising number of cardiac catheterizations were being referred outside of our service area. These observations led to a more focused assessment of the viability of this service, culminating in this CON.

Why Sustainability Issues Are Different Today

Previous CON applications for a cardiac catheterization services in Alaska have always assumed the service would remain a strong profit center. Looking forward, this assumption can no longer be trusted. Ongoing shifts in payers from commercial insurance to increasing percentages of Medicaid and Medicare patients and the possibility of an eventual single, governmental payer system raises question regarding whether cardiac catheterization services will remain profit centers for lower volume locations. This places increased pressure on arriving at accurate conclusions regarding expected volumes and revenues.

Establishing Numerical Assumptions For Use Rate

Given the importance of accurately assessing expected volumes, we approached this question from multiple perspectives. Here we include analysis from an external consultant and review of the multitude of assumptions from the most recent CON for a new cardiac catheterization service. Rigorous examination of all of these data provided us with increased confidence in setting our expected use rate.

Expected Volumes Based on External Consultant. Prior to considering a cardiac catheterization service, we obtained cursory data from a full service consultant with a background in rural

cardiology markets. Their initial analysis suggested that between our primary and secondary service areas, we would likely do 401 diagnostic catheterizations and 134 cardiac interventions, for a total of 535 cases annually. This volume, combined with the expected interventional radiology procedures, represents a viable service line, prompting us to initiate our own in-depth analysis.

Expected Volumes Based on State of Alaska Review of Previous CONs. Our next step involved reviewing the data analysis from the last CON application for development of a new cardiac catheterization service submitted to the State of Alaska. Unfortunately, this evaluation is over 10 years old (February 2007), so some assumptions have likely changed. Nevertheless, this document contains a number of interesting statements/assumptions worthy of close evaluation. These statements/assumptions included:

1. *the national use rate for cardiac catheterization is 11.25 per 1,000 population;*
2. *it is unlikely that Alaska rates will match the national rates anytime soon, if ever;*
3. *the State estimate of 4.7 was lower than the applicant's rate of 5.7 per 1,000 population;*
4. *that new technologies could slow the growth of cardiac catheterizations, but the aging of Alaskan's in this region would likely offset new technologies, leading to stable projections; and*
5. *a total population of about 100,000 is the number generally served by a cath lab, and therefore Alaska's need is for seven cath labs.*

National use rate. After extensive research, we concluded there is no universally accepted national use rate for cardiac catheterizations. This is not surprising given the tremendous variation in access to care³⁷ significant demographic variability across regions, and challenges associated with obtaining proprietary information.

Acknowledging the lack of a universally accepted standard, we still sought the most empirically defensible data for establishing our national use rate for cardiac catheterizations. We chose the *2014 Cardiac Cath Lab Benchmark Report* (IMV, 2014), which is a proprietary data set based on survey information from May 2013 through April 2014 for both hospital and non-hospital sites with cath labs. To be included in this survey, the cath lab site had to be either a dedicated cardiac catheterization lab or an angiography suite whose cardiac cath volume was more than 50% of the total volume. If the cardiac cath volume was below 50%, that lab was considered an angio lab, and those volumes were included in a different benchmark report. This data set was based on 319 interviews and extrapolated to an estimated 2,120 sites offering cardiac cath services. Their results estimated that nationally there were 4,057,578 cardiac catheterization cases in 2013, with a **national use rate of 12.7 per 1,000 population.**

The national use rate identified by **the State of Alaska in their most recent CON response (2007) was 11.25.** Although lower than the IMV 2014 *Benchmark Report*, this figure is relatively close, and only 11% lower. Given our desire to remain conservative in our analysis,

³⁷ c.f., Langabeer et al., 2013

we adopted the lower 11.25 figure, even though we suspect the IMV data is closer to the national use rate, especially since the data is more recent.

Will Alaska ever reach the national use rate? The State's 2007 prediction that Alaska's rates are unlikely to match the national rate any time soon has held true. Ten years later, all data sources consistently reveal that Alaska's rate falls well below the national use rate. Unfortunately, this is not due to Alaskans' superior health, as there is little evidence that Alaskans are healthier than the rest of the nation.³⁸ We therefore believe that Alaska's lagging use rate is due primarily to two factors: 1) long distances to tertiary facilities and very poor access in some parts of Alaska; and 2) the population age. Each issue is worthy of consideration.

Poor access to specialty health care services is an undisputable reality for many Alaskans. Approximately one quarter of Alaskans in the 2016 population live in census areas that are either completely off the road system or are effectively so far from the nearest cardiac catheterization service that access is significantly challenged. Especially in cases involving potential percutaneous coronary interventions (PCI), the targeted 90 minute door-to-balloon time of under 90 minutes will continue to remain elusive, if not impossible, in many regions of Alaska. Given Alaska's unique size and geographic challenges, it is unreasonable to expect Alaska to rival the national use rate into the foreseeable future for the entire state. However, it would be equally unreasonable to apply an overall state average rate to our region, were access to a cardiac catheterization service would be far better.

A second reason Alaska's rate may remain lower than the national rate is differences in population age. Since statehood, Alaska has always been a young state. In 2020, the median age for Alaska is projected to be 35.2, compared to 38.1 nationally, a difference of nearly three years. Similarly, the Alaskan population 65+ is expected to be 13% compared to 17% nationally. This younger age discrepancy was even more pronounced in the region of the 2007 CON applicant, where although their population is getting older, it is still projected for 2020 to be 34.2 and 12% for median age and 65+, respectively, making it even younger than the rest of Alaska. Younger people would be expected to have less need for cardiac catheterization services.

Figure 30: Median Age

Geography Name	Median Age & Projections			
	2010	2020	2030	2040
*United States	37.2	38.1	38.9	39.0
**Alaska	33.8	35.2	36.6	36.3
**Previous CON Applicant	33	34.2	36.4	36.5
**KPB	41.1	41.2	41.8	41.3

Data Sources: *University of Virginia Demographics Research Group and **Alaska Dept. of Labor

The trend of Alaska being younger than the national average is sharply reversed for the KPB. With a reputation for diverse recreational/retirement opportunities, a modest cost of living, and

³⁸ c.f., *Healthy Alaskans 2020*

favorable tax structure for retirees, the KPB is much older than the Alaskan average. We see no evidence that this trend will change. Even if a gas pipeline brings a large influx of younger, working age people, it is not likely to reduce this population of older adults. Instead, this would merely increase the overall population. Current projections indicate that the median age in 2020 for the KPB is expected to be 41.2 and the 65+ at 19%, making the KPB is not only significantly older than the Alaska average, but even older than the national average. Perhaps just importantly, we are dramatically older than the previous CON applicant (34.2 versus 41.2, or a seven year difference, and 12% versus 19%, respectively for median age and 65+ in 2020).

With an older population than Alaska, the nation, and especially the most recent CON applicant for a new cardiac catheterization service, we are very confident that applying the Alaska average cardiac catheterization rate would grossly underestimate projected volumes. **Indeed, based on the variables of access and age only, we would expect the projected volumes for the proposed cath lab to at least reach the national use rate.**

State estimate of 4.7 was lower than the applicant's rate of 5.7 per 1,000. In the previous CON application, the applicant set their use rate at 5.7 for total population. The State review challenged this estimate, stating that "Alaska's cardiac catheterization rate is 4.7 per 1,000 for all ages, which means using the latest Department of Labor population projection for the service area....[it] would expect to generate about 506 cardiac catheterizations." Although the State ultimately supported the application, the reviewer predicted that "With the range of volume for the [x] facility being between 300 and 500 based on application of state and national norms, and potentially being in the range of 700 per year as anticipated by the applicant, the proposed cath lab can be considered appropriate for meeting a regional population need."

Fortunately, today we have the benefit of hindsight. The previous applicant has graciously shared this proprietary information, so we now know they are currently exceeding the 500 threshold by a considerable margin. Assuming that cardiac catheterizations and PCI's make up 95% of their cardiac volumes, their use rate has exceeded 6.0 per total population, and 9.0 for the adult-only population. This is occurring despite relatively stable population statistics. This finding adds to our confidence that applying the State's 4.7 ratio, or even the applicant's 5.7 ratio, would result in a significant underrepresentation of projected volumes. This is particularly obvious in light of our population having a projected median age seven years older than the previous applicant in 2020.

New technologies could slow the growth of diagnostic catheterizations; however, the aging of the population in [this applicant's] region would likely offset new technologies, leading to stable projections. This statement is interesting on multiple levels. First, our region is already much older. While it is getting even older, we do not want to rely on aging to "make up" for any miscalculations we make in our projection. In other words, we have less room for error. Second, the changing science issue is always a concern when making large capital/operational

investments. We evaluated this issue closely, especially in light of the landmark study³⁹ that raised questions about the efficacy of cardiac catheterizations above and beyond optimal medical therapy. Ten years ago, this study challenged any potentially low volume facility that might be considering a catheterization lab. However, that seminal study is now over seven years old, and given the improving technologies available in cath labs nationwide, it is clear mechanical catheterizations remain a vital part of diagnostic workups. Finally, the statement is interesting on its own merit, since it reveals the subjectivity of making projections. Our goal is to eliminate the subjectivity of this process as much as possible by scrutinizing data sources closely and from as many perspectives as possible.

A total population of about 100,000 is the number generally served by a cath lab, and therefore Alaska's need is for seven cath labs. We reached out to the State of Alaska, Department of Health & Social Services, Division of Health Care Services to identify how many cardiac cath labs currently exist in Alaska.⁴⁰ The list we were provided was overly inclusive, and included equipment/locations that were not solely cath labs. We subsequently sought information from the AHI, who currently report owning or providing physician services in eight cath labs. We then juxtaposed this data with the three major vendors who supply cardiac cath equipment. This allowed us to see exactly what type of equipment and labs are operating in Alaska. With this information, we determined that there are currently at least nine primary cardiac cath labs in Alaska, although there are likely other locations that are serving “hybrid” roles for additional volume.

The notion that a population of 100,000 is needed for a catheterization lab in Alaska is clearly no longer true. With a State population estimate of just under 740,000 for 2016, there are approximately currently 82,000 people per cath lab. However, including the entire state artificially inflates this statistic, since many residents of Southeast Alaska are referred to Seattle, which is closer than other cath labs, less expensive, and where strong referral affiliations already exist. Taking the southeast region out of the Alaska data would push the current ratio down to 74,000 people per catheterization lab. Given the access issues already noted, this is still likely an overestimation of the people needed per lab, since obtaining these services is so difficult for many Alaskans.

Divided by regions, the Anchorage Municipality currently has approximately 43,000 people per lab, whereas the Mat-Su and Interior region have 102,500 and 113,000 per lab, respectively. Given the volumes and equipment in both the Mat-Su and Interior regions, we strongly suspect both will need additional labs in the relatively near future.

Identification of Other Factors That Could Influence Our Numerical Estimate of Volumes

There are at least three additional factors that could significantly influence our estimated volumes. The first, and perhaps the most critical, is market share. It is well known within the

³⁹ *c.f., Boden et al., 2007*

⁴⁰ *Email to Alexandria Hicks, May 30, 2017*

healthcare industry that the confidence patients have with a facility exhibits a profound impact on volumes. Fortunately for CPH, we enjoy a robust market share. We have every reason to expect that if we initiate a cardiac catheterization service, it will be strongly supported by patients and provider referrals.

A second factor is our experience with other new service lines. For example, in 2011 we initiated a spine center service line. The questions at that time were extremely similar; namely, we vacillated over whether we would have sufficient volumes to support the service and the costly infrastructure required to maintain a quality program. Six years later, we enjoy a robust spine service at CPH. There are now two full-time spine surgeons and two physician extenders providing services at CPH. Furthermore, in our secondary service area, we now have providers from two other service lines (urology and surgical podiatry) that routinely commute to provide services to the Southern Peninsula. In all three of these service lines, CPH has witnessed surprising growth that exceeded our initial projections.

Finally, one of the most overlooked elements of developing a new service line involves the relationship between providers. While these relationship dynamics are often subtle and even hidden, they can have profound effects on whether a local service line is successful. Many rural hospitals have learned through failures that providers will often verbally support a new service line, yet continue to refer their specialty patients to larger tertiary centers. This occurs because these providers have done so for years and enjoy a close relationship with the provider at that distant facility, who has come to rely on these referrals.

In our case, we are extremely fortunate to have a co-cardiac medical directorship relationship with two AHI physicians, Dr. Chambers and Dr. McDonagh. Dr. Chambers already provides outpatient cardiology services solely at CPH, along with a physician extender. Dr. McDonagh is an interventional cardiologist currently based out of Anchorage, but was a previous internal medicine physician and Chief of Staff at CPH prior to completing a fellowship and becoming an interventional cardiologist. He enjoys a close relationship with his previous internal medicine, family medicine, and emergency room physician colleagues, many of whom consult with him and refer to him within the Anchorage market. In many respects, establishment of a cardiac catheterization service at CPH is essentially moving the physician closer to the patients, rather than requiring hundreds of patients to leave their service area for specialty care. Unlike previous new service lines we have developed, here we have the luxury of having established medical providers with very strong and tested affiliations with our medical staff. While these subtle factors often are excluded from CON applications, they are important factors regarding whether a service is ultimately successful. In this respect, we believe we are poised for success.

Our Final, Multi-Modal Assessment of Predicted Volumes

Below is a summary of our final set of assumptions.

Figure 31: Catheterization Rate

Variable	Rate	Comments
Total Adult Population in 2020	46,000 ⁴¹	Alaska Dept. of Labor Projections ⁴²
Use rate per 1,000 (adults $\geq 18+$)	11.25	Set slightly above previous CON applicant to account for significantly older population demographics; still below national rate, which is for a younger population
Primary Service Area Market Share	75%	Based on Alaska State Hospital and Nursing Home Association dataset extrapolated from 2012
Secondary Service Area Market Share	55%	Estimate based on existing referral patterns and proximity
In-Migration	8%	Based on 2016 data obtained from the Kenai Peninsula Tourism Marketing Council. These data include out of state visitors to the Kenai Peninsula (565,169) and in-state visitors (214,764), for a total of 779,933 annual visitors.
Final Expected Cardiac Catheterization Volumes ⁴³	512	Based on extensive analysis of all known relevant factors; very close but slightly below the number proposed by an external consulting firm

While we meet the requirement for a cardiac catheterization service based on cardiac volumes, our larger concern is whether this service is viable five, 10, and 15 years from now in an ever changing payer environment. Although not part of the CON process, we also closely analyzed the expected non-cardiac procedures we could be expected to perform. Our detailed analysis of the interventional radiology volumes, combined with the cardiac procedures, leaves us confident that this service line will remain both viable and clinically necessary for years to come.

6. The applicant demonstrates that the facility has the capability of providing immediate transvenous pacemakers in case of cardiac arrest.

CPH will have the capability to provide immediate transvenous pacemakers in the event of cardiac arrest upon commencing to provide cath lab services.

⁴¹ In an effort to remain conservative, this estimate does not include population growth due to a major economic project as described previously under specific review standards for ICU beds

⁴² <http://live.laborstats.alaska.gov/pop/projections/data/BCAProjections.xls> Visited 6.1.17

⁴³ Includes expected diagnostic catheterizations and PCI's plus and estimated two (2) percent additional volumes in conduction and vascular cases; see Figure 21

Section VII.

Construction Data

A. Please check appropriate boxes:

1. *Construction type* ☒ New ☐ Expansion ☐ Renovation
2. *Basement* ☐ Full ☒ Partial ☐ None

B. Project Development Schedule

Date

1. *Estimated completion of final drawings and specifications* September 2017
2. *Estimated construction begun by* November 2017
3. *Estimated construction complete by* December 2019
4. *Estimated opening of proposed services* January 2020

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?*

The legal description of the proposed site identified on the KPB Parcel Viewer found at <http://mapserver.borough.kenai.ak.us/kpbmapviewer/> is listed as:

- Parcel ID 0510068
- Physical Address 250 Hospital Place
- Legal Description: T5N R 10 W Sec 29 Seward Meridian KN 2005052 Central Peninsula General Hospital Sub Lot 1
- Acreage = 15.05
- Owner: Kenai Peninsula Borough

2. *Diagrammatic plan showing:*

- a. *dimensions and location of structures, easements, rights-of-way or encroachments;*

SEE APPENDIX A (Master Site Plan)

- b. *location of all utility services available to the site; and*

SEE APPENDIX A (Utility Diagram)

- c. *location of service roads, parking facilities, and walkways within site boundaries.*

SEE APPENDIX A (Fire Lane Diagram)

The service roads providing access to the proposed Phase V – Specialty Clinics Building can be found coming from the North, East and West. On the West side of the structure, Fireweed Street will be accessible through two entry points. Additionally, to the North, staff, patients and patient family members will be able to access the location from W. Marydale Drive. There will also be access through a service road leading from N. Binkley Street on the East side of the proposed construction.

Parking and walkway access will also be provided through the proposed construction. Parking facilities will be provided on the South, West and North side of the building. This parking will be in addition to that found currently at CPH, and will meet City requirements. Walkways for patients will be provided on the North and East side of the construction, as well as that coming from the corridor access to the main hospital building.

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).

SEE APPENDIX A (Fire and Utility Diagrams)

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

SEE APPENDIX A

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

SEE APPENDIX A

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

Because the new construction will replace part of the existing 1985 single story wood frame building, and be joined on three sides by existing buildings, some departments will be displaced and/or impacted during construction that will require work. These include the permanent relocation of the Administrative offices, cardiac rehab gym, physical therapists offices, medical staff services, sleep lab, and some ancillary space. These areas are intended to be permanently relocated to other space in the hospital, or off site. The outpatient lab, Cardio-Pulmonary clinic, and materials management/loading dock, will need to have temporary locations to accommodate their services during construction as their departments will be adjacent to construction areas and renovated as part of the project.

Section VIII.A.

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* | \$ 0 |
| 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.) | |
| | \$ 0 |
| d. Anticipated interest rate ___% , term ___ years. | N/A |
| e. Total anticipated interest amount | \$ 0 |
| f. Total of (a) and (e) | \$ 0 |
| g. Estimated annual debt service requirements | \$ 0 |

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.

Section VIIB.

Financial Data – Construction Only

1. Construction Method (Please check)

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

2. Construction Cost (New Activity)

(Omit cents)

- | | |
|---|---------------------|
| a. Site acquisition (Section VIIIA.2.f) | \$N/A |
| b. Estimated general construction** | \$19,133,349 |
| c. Fixed equipment, not included in a** | \$1,335,590 |
| d. Total construction costs (sum of items a, b, and c)** | \$20,468,939 |
| e. Major movable equipment** | \$1,265,872 |
| f. Other cost:** | |
| (1) Administration expense | \$281,407 |
| (2) Site survey, soils investigation, and materials testing | \$35,140 |
| (3) Architects and engineering fees | \$2,424,625 |
| (4) Other consultation fees (preparation of application included) | \$0 |
| (5) Legal fees | \$0 |
| (6) Land development and landscaping | \$1,751,562 |
| (7) Building permits and utility assessments (including water, sewer, electrical, phones, etc.) | \$128,574 |
| (8) Additional inspection fees (clerk of the works) | \$562,814 |
| (9) Insurance (required during construction period) | \$0 |
| g. Total project cost (sum of items d, e, f) | \$26,918,933 |
| h. Amount to be financed | \$26,918,933 |
| 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.) | \$0 |
| j. Anticipated long-term interest rate | 3.5% |
| k. Anticipated interim (construction) interest rate | 3.5% |
| l. Anticipated long-term interest amount | \$10,961,969 |
| m. Anticipated interim interest amount | \$1,851,000 |
| n. Total items g, l, and m | \$39,731,902 |
| o. Estimated annual debt service requirement | \$1,894,045 |
| p. Construction cost per sq. ft. | \$446.50 |
| q. Construction cost per bed | \$0 |
| r. Project cost per sq. ft. | \$0 |
| s. Project cost per bed (if applicable) | \$0 |

*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.

Section IX.

Financial Data – All Proposed Activities

A. Attach Schedule I – Facility Income Statement

1. For the most recent five prior full fiscal or calendar years

The following spreadsheet, in the format provided in the application, identifies the most recent five prior full fiscal years of Income Statements for Central Peninsula Hospital (CPH) from the Fiscal Year (FY) 2012 through FY 2016. As indicated in the spreadsheet and accompanying narrative, CPH has experienced stable growth over the past five fiscal years.

Schedule I. Facility Income Statement					
Provide Last Five Years Actual					
Gross Patient Revenue:	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Inpatient Routine	18,412,997	19,420,199	24,315,301	26,273,547	30,384,327
Inpatient Ancillary	44,129,303	54,406,135	61,486,777	67,430,459	78,422,224
Outpatient	92,587,195	98,967,691	100,809,515	125,490,059	143,794,550
Long-Term Care	11,456,332	11,529,883	12,446,951	12,545,465	12,336,318
Swing Beds	791,230	869,906	1,396,213	995,627	1,685,899
Other	27,273,454	30,120,519	30,139,945	36,478,142	38,845,253
Total Patient Revenue	194,650,511	215,314,333	230,594,702	269,213,299	305,468,571
Less Deductions					
Charity Care	7,050,090	9,031,980	8,880,963	6,296,353	5,924,412
Contractual Allowances	65,854,267	76,190,663	87,732,089	111,607,451	134,902,863
Bad Debts	9,094,261	9,941,178	11,597,401	12,811,570	9,937,048
Total Deductions	81,998,618	95,163,821	108,210,453	130,715,374	150,764,323
Net Operating Revenues	112,651,893	120,150,512	122,384,249	138,497,925	154,704,248
All Other Revenues	4,608,518	5,944,945	4,697,065	5,815,799	6,426,580
EXPENSES:					
Salaries	47,194,158	49,283,257	51,562,119	56,727,459	59,586,770
Benefits	18,462,074	16,791,568	15,614,051	17,890,326	19,494,509
Supplies	17,688,267	19,996,729	20,460,103	23,515,731	26,082,151
Utilities	2,577,498	2,534,082	2,650,983	3,112,916	3,330,434
Property Tax	-	-	-	-	-
Rent	719,127	784,911	709,756	775,652	756,132
Lease					
Other Expenses	12,677,272	13,318,556	13,828,820	15,673,535	16,498,261
Depreciation	8,004,562	7,959,305	8,066,688	8,471,959	10,152,657
Interest	1,103,590	1,218,937	961,727	969,176	1,194,176
Total Expenses	108,426,548	111,887,345	113,854,247	127,136,754	137,095,090
Excess (Shortage) of Revenue Over Expenditures	8,833,863	14,208,112	13,227,067	17,176,970	24,035,738
Note: FY is for the Fiscal Year from July 1 - June 30 Revenue and Expenses are total organizational revenues and expenses					

Over the past five completed fiscal years, CPH has seen Total Patient Revenues increase from \$194,650,511 in FY 2012 to \$305,468,571 in FY 2016. This increase demonstrates steady growth in patient revenues year over year showing an increase of 11% from FY 2012 to FY 2013, 7% from FY 2013 to FY 2014, 17% from FY 2014 to FY 2015, and 13% from FY 2015 to FY 2016.

Net Operating Revenue calculated as the Gross Patient Revenues less Deductions defined as Charity Care, Contractual Allowances, and Bad Debt, has shown steady growth as well with Net Operating Revenue increasing from \$112,651,893 in FY 2012 to \$154,704,248 in FY 2016. Year over year growth showing an increase of 7% from FY 2012 to FY 2013, 2% from FY 2013 to FY 2014, 13% from FY 2014 to FY 2015, and 12% from FY 2015 to FY 2016.

Total Revenue consisting of all Net Operating Revenue plus All Other Revenue produced at CPH shows a similar growth pattern increasing from \$117,260,411 in FY 2012 to \$161,130,828 in FY 2016. Year over year growth showing an increase of 8% from FY 2012 to FY 2013, 1% from FY 2013 to FY 2014, 14% from FY 2014 to FY 2015, and 12% from FY 2015 to FY 2016.

Total Expense shows a controlled growth less than that of Total Revenues, indicating the impact of effective expense management measures from \$108,426,548 in FY 2012 to \$137,095,090 in FY 2016. Year over year growth showing an increase of 3% from FY 2012 to FY 2013, 2% from FY 2013 to FY 2014, 12% from FY 2014 to FY 2015, and 8% from FY 2015 to FY 2016.

As the result of consistent revenue growth paired with responsible expense management, the overall Excess (Shortage) of Revenue Over Expenditures shows growth from \$8,833,863 in FY 2012 to \$24,035,738 in FY 2016. Year over year growth showing an increase of 61% from FY 2012 to FY 2013, -7% from FY 2013 to FY 2014, 30% from FY 2014 to FY 2015, and 40% from FY 2015 to FY 2016.

Earnings before Interest, Taxes, Depreciation, and Amortization (EDITDA) has grown from \$17,942,015 in FY 2012 to \$35,382,571 in FY 2016. Year over year growth showing an increase of 30% from FY 2012 to FY 2013, -5% from FY 2013 to FY 2014, 20% from FY 2014 to FY 2015, and 33% from FY 2015 to FY 2016.

2. Projections during construction or implementation period (if applicable)

The following spreadsheet, in the format included in the application, provides total CPH organization estimates for Fiscal Years 2017 through 2020.

Schedule I. Facility Income Statement				
Projections During Construction Period				
Gross Patient Revenue:	FY 2017	FY 2018	FY 2019	FY 2020
Inpatient Routine	19,420,199	19,420,199	43,684,825	47,705,679
Inpatient Ancillary	80,196,792	91,042,547	81,990,478	90,503,822
Outpatient	150,958,121	172,285,674	189,514,241	208,465,666
Long-Term Care	12,561,852	13,117,599	13,773,479	14,462,153
Swing Beds	2,059,091	2,264,999	2,491,499	2,740,649
Other	38,646,840	43,393,850	45,563,542	47,841,719
Total Patient Revenue	303,842,895	341,524,868	377,018,064	411,719,687
Less Deductions			-	-
Charity Care	3,617,283	4,145,195	5,655,271	6,175,795
Contractual Allowances	151,877,018	177,670,208	203,589,755	230,563,025
Bad Debts	6,072,302	7,881,204	9,425,452	10,292,992
Total Deductions	161,566,603	189,696,607	218,670,477	247,031,812
Net Operating Revenues	142,276,292	151,828,261	158,347,587	164,687,875
All Other Revenues	4,713,240	5,306,835	5,837,519	6,421,270
EXPENSES:			-	-
Salaries	64,046,934	67,137,236	70,494,098	74,378,109
Benefits	20,429,815	20,915,131	22,558,111	23,800,995
Supplies	24,943,979	26,795,450	27,599,314	29,042,305
Utilities	3,434,056	3,660,000	3,769,800	3,882,894
Property Tax	-	-	-	-
Rent	780,241	814,779	839,222	864,399
Lease			-	-
Other Expenses	17,878,497	16,378,116	16,893,190	17,737,393
Depreciation	13,577,515	13,889,757	14,000,000	16,137,841
Interest	1,867,733	1,678,973	1,974,167	1,795,212
Total Expenses	146,958,770	151,269,442	158,127,902	167,639,147
Excess (Shortage) of Revenue Over Expenditures	30,762	5,865,654	6,057,203	3,469,998
Note: FY is for the Fiscal Year from July 1 - June 30 Revenue and Expenses are total organizational revenues and expenses				

During the construction period running from FY 2017 through FY 2020, it is projected that CPH will experience continued growth. Total Patient Revenues are projected to increase from \$303,842,895 in FY 2017 to \$411,719,687 in FY 2020. This shows growth in patient revenues over the period of 36%.

Net Operating Revenue calculated as the Gross Patient Revenues less Deductions defined as Charity Care, Contractual Allowances, and Bad Debt, is projected to experience growth as well with Net Operating Revenue increasing from \$142,276,292 in FY 2017 to \$164,687,875 in FY 2020. This shows growth in net operating revenues over the period of 16%.

Total Revenue consisting of all Net Operating Revenue plus All Other Revenue produced at CPH is projected to show a similar growth pattern increasing from \$146,989,532 in FY 2017 to \$171,109,145 in FY 2020. This shows growth in total revenue over the period of 16%.

Total Expense is projected to show a controlled growth less than that of Total Revenues, indicating the impact of effective expense management measures from \$146,958,770 in FY 2017 to \$167,639,147 in FY 2020. This shows growth in total expenses over the period of 14%.

As the result of consistent revenue growth paired with responsible expense management, the overall Excess (Shortage) of Revenue Over Expenditures is projected to show growth from \$30,762 in FY 2017 to \$3,469,998 in FY 2020.

Earnings before Interest, Taxes, Depreciation, and Amortization (EDITDA) is projected to increase from \$15,476,010 in FY 2017 to \$21,403,051 in FY 2020. This shows growth in total revenue over the period of 38%.

3. Projection for three years following completion of construction, or implementation of the proposed activity.

Schedule I. Facility Income Statement			
Projections for three Years Following Completion of Construction			
Gross Patient Revenue:	FY 2021	FY 2022	FY 2023
Inpatient Routine	53,017,892	60,824,894	70,449,547
Inpatient Ancillary	106,802,378	139,869,376	184,318,983
Outpatient	229,312,232	252,243,455	277,467,801
Long-Term Care	15,185,261	15,944,524	16,741,750
Swing Beds	3,014,714	3,316,186	3,647,804
Other	50,233,805	52,745,495	55,382,770
Total Patient Revenue	457,566,282	524,943,930	608,008,654
Less Deductions	-	-	-
Charity Care	6,863,494	7,874,159	9,120,130
Contractual Allowances	265,388,443	314,966,358	376,965,366
Bad Debts	11,439,157	13,123,598	15,200,216
Total Deductions	283,691,095	335,964,115	401,285,712
Net Operating Revenues	173,875,187	188,979,815	206,722,942
All Other Revenues	7,063,397	7,769,737	8,546,711
EXPENSES:	-	-	-
Salaries	78,575,100	83,223,855	88,177,048
Benefits	25,144,032	26,631,634	28,216,655
Supplies	30,731,897	32,886,254	35,228,482
Utilities	3,999,381	4,119,362	4,242,943
Property Tax	-	-	-
Rent	890,331	917,041	944,552
Lease	-	-	-
Other Expenses	18,389,607	19,166,686	19,814,366
Depreciation	16,137,841	16,137,841	16,137,841
Interest	2,537,190	2,269,049	1,958,764
Total Expenses	176,405,379	185,351,722	194,720,651
Excess (Shortage) of Revenue Over Expenditures	4,533,205	11,397,830	20,549,002
Note: FY is for the Fiscal Year from July 1 - June 30 Revenue and Expenses are total organizational revenues and expenses			

Construction completion is expected to occur during FY 2020 and the projected income statement figures demonstrate financial stability. Total Patient Revenues are projected to increase from \$457,566,282 in FY 2021 to \$608,008,654 in FY 2023. This increase demonstrates steady growth in patient revenues year over year showing an increase of 15% from FY 2021 to FY 2022 and 16% from FY 2022 to FY 2023.

Net Operating Revenue calculated as the Gross Patient Revenues less Deductions defined as Charity Care, Contractual Allowances, and Bad Debt, is projected to experience growth as well with Net Operating Revenue increasing from \$173,875,187 in FY 2021 to \$206,722,942 in FY 2023. This increase demonstrates steady growth in net operating revenues year over year showing an increase of 9% from FY 2021 to FY 2022 and 9% from FY 2022 to FY 2023.

Total Revenue consisting of all Net Operating Revenue plus All Other Revenue produced at CPH is projected to show a similar growth pattern increasing from \$180,938,584 in FY 2021 to \$215,269,653 in FY 2023. This increase demonstrates steady growth in total revenues year over year showing an increase of 9% from FY 2021 to FY 2022 and 9% from FY 2022 to FY 2023.

Total Expense is projected to show a controlled growth less than that of Total Revenues, indicating the impact of effective expense management measures from \$176,405,379 in FY 2021 to \$194,720,651 in FY 2023. This increase demonstrates steady growth in total expenses year over year showing an increase of 5% from FY 2021 to FY 2022 and 5% from FY 2022 to FY 2023.

As the result of consistent revenue growth paired with responsible expense management, the overall Excess (Shortage) of Revenue Over Expenditures is projected to show growth from \$4,533,205 in FY 2021 to \$20,549,002 in FY 2023. This increase demonstrates steady growth year over year showing an increase of 151% from FY 2021 to FY 2022 and 80% from FY 2022 to FY 2023.

Earnings before Interest, Taxes, Depreciation, and Amortization (EDITDA) is projected to increase from \$23,208,236 in FY 2021 to \$38,645,607 in FY 2023. This increase demonstrates steady growth year over year showing an increase of 28% from FY 2021 to FY 2022 and 30% from FY 2022 to FY 2023.

B. Attach Schedule II – Facility Balance Sheet

1. For the most recent five prior fiscal or calendar years

The following attached schedule II provides Balance Sheet information for Central Peninsula Hospital covering the previous five completed fiscal years.

Schedule I. Facility Balance Sheet					
Provide Last Five Years Actual					
CURRENT ASSETS	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Cash & Cash Equivalent	27,803,487	35,197,813	35,508,443	37,638,411	37,048,762
Net Patient Accounts Rceivable	18,913,586	21,376,530	23,521,293	28,180,281	29,632,663
Other Accounts Receivable	908,594	831,128	1,237,463	807,261	845,621
Inventories	3,539,385	4,247,583	4,488,685	5,169,890	5,837,172
Prepaid Expenses	1,341,753	1,219,529	1,555,004	1,409,211	1,967,254
Other	-	-			
Total Current Assets	52,506,805	62,872,583	66,310,888	73,205,054	75,331,472
Property and Equipment					
Land & Improvements	3,511,739	3,749,952	4,242,497	4,654,429	4,975,346
Building/Fixed Equipment	88,480,878	96,366,504	96,803,392	99,988,259	136,039,459
Leasehold Improvements	625,797	551,163	545,822	567,520	562,002
Construction in Progress	893,763	2,033,428	5,544,999	27,190,019	6,207,528
Major Movable Equipment	19,608,965	19,212,319	18,680,170	20,816,850	27,741,737
Accumulated Depreciation	(48,267,250)	(52,483,407)	(54,428,890)	(60,066,030)	(66,272,903)
Net Property & Equipment	64,853,892	69,429,959	71,387,990	93,151,047	109,253,169
Other Assets	16,735,210	14,010,965	54,267,199	45,752,720	45,792,420
TOTAL ASSETS	134,095,907	146,313,507	191,966,077	212,108,821	230,377,061
LIABILITIES/FUND BALANCE					
Current Liabilities					
Accounts Payable	2,753,112	3,822,693	4,620,209	8,209,222	3,966,082
Current Portion of Long-Term Debt	2,125,000	2,225,000	4,035,000	4,575,000	5,023,000
Due To Third Party Payors	2,408,723	1,824,649	791,371	852,751	150,000
Claims Payable	2,955,265	2,807,624	2,552,277	2,615,806	3,513,562
Accrued Bond Interest	535,263	491,617	852,990	792,737	766,343
Accrued Expenses (total for lines in red above)	8,024,251	7,348,890	8,231,638	8,836,294	9,452,905
Accrued Compensation	4,634,420	4,925,214	5,228,649	5,992,403	6,440,168
Other Accruals	125,917	125,833	110,907	115,482	92,883
Total Current Liabilities	15,537,700	16,222,630	18,191,403	23,153,401	19,952,038
Long Term Liabilities					
Long Term Debt	30,341,745	28,058,953	56,454,449	55,018,180	53,012,000
Other (Premium on Bonds Payable)	4,417,326	4,024,675	6,085,909	5,525,954	4,965,998
Total Long Term Liabilities	34,759,071	32,083,628	62,540,358	60,544,134	57,977,998
Fund Balance	83,799,136	98,007,249	111,234,316	128,411,286	152,447,025
Total Liabilities & Fund Balance	134,095,907	146,313,507	191,966,077	212,108,821	230,377,061
Note: Fiscal Year is from July 1 - June 30					

2. Current fiscal of calendar year to date

The following attached schedule II provides Balance Sheet information for Central Peninsula Hospital covering the current fiscal year as of April 30, 2017.

Schedule II. Facility Balance Sheet	
Provide Current Fiscal Year (as of Apr 30, 2017)	
CURRENT ASSETS	FY 2017
Cash & Cash Equivalent	34,167,269
Net Patient Accounts Rceivable	27,980,713
Other Accounts Receivable	684,907
Inventories	6,080,155
Prepaid Expenses	2,158,867
Other	-
Total Current Assets	71,071,911
Property and Equipment	
Land & Improvements	5,323,620
Building/Fixed Equipment	136,106,328
Leasehold Improvements	562,002
Construction in Progress	1,516,834
Major Movable Equipment	38,554,821
Accumulated Depreciation	(71,066,086)
Net Property & Equipment	110,997,519
Other Assets	38,507,758
TOTAL ASSETS	220,577,188
LIABILITIES/FUND BALANCE	
Current Liabilities	
Accounts Payable	5,803,983
Current Portion of Long-Term Debt	6,162,460
Due To Third Party Payors	250,000
Claims Payable	3,038,350
Accrued Bond Interest	727,320
Accrued Expenses (total for lines in red above)	10,178,130
Accrued Compensation	7,270,126
Other Accruals	100,000
Total Current Liabilities	23,352,239
Long Term Liabilities	-
Long Term Debt	84,119,331
Other (Premium on Bonds Payable)	4,406,043
Total Long Term Liabilities	88,525,374
Fund Balance	108,699,575
Total Liabilities & Fund Balance	220,577,188
Note: Fiscal Year is from July 1 - June 30	

B. 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)*

Schedule III. Average Patient Cost Per Day (Per Diem Rate if applicable) and Revenue Amounts					
Provide Last Five Years Actual					
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Revenues	194,650,511	215,314,333	230,594,702	269,213,299	305,468,571
Expenses	108,426,548	111,887,345	113,854,247	127,136,754	137,095,090
Patient Days	7,019	6,894	8,420	8,641	9,304
Revenue Per Patient Day	\$ 27,731.94	\$ 31,232.13	\$ 27,386.54	\$ 31,155.34	\$ 32,831.96
Operating & Capital Budget Summary:					
Gross Revenues	194,650,511	215,314,333	230,594,702	269,213,299	305,468,571
Deductions from Revenue	81,998,618	95,163,821	108,210,453	130,715,374	150,764,323
Net Revenue	112,651,893	120,150,512	122,384,249	138,497,925	154,704,248
Direct Expense	83,344,499	86,071,554	87,636,273	98,133,516	105,163,430
Indirect Expense	20,473,531	19,870,846	21,520,909	23,187,439	25,505,080
Net Income Projected	8,833,863	14,208,112	13,227,067	17,176,970	24,035,738
Rate Computation					
Medicaid Acute Rate	\$ 3,272.53	\$ 3,609.19	\$ 3,678.34	\$ 3,762.01	\$ 3,762.01
Medicaid Swing Bed Rate	\$ 493.67	\$ 536.60	\$ 584.29	\$ 618.12	\$ 638.76
Medicaid Long Term Care Rate	\$ 406.99	\$ 445.88	\$ 455.96	\$ 466.76	\$ 466.76
Outpatient Medicaid Rate	54.48%	48.98%	48.98%	48.98%	48.98%
Cost Basis for Rate					
Base Year Patient Days					
Cost per Patient Day					

2. *Current fiscal or calendar year to date*

Schedule III. Average Patient Cost Per Day	
Current Fiscal Year to Date (April 30, 2017)	
	FY 2017
Revenues	303,842,895
Expenses	146,958,770
Patient Days	7,314
Revenue Per Patient Day	\$ 41,542.64
Operating & Capital Budget Summary:	
Gross Revenues	303,842,895
Deductions from Revenue	161,566,603
Net Revenue	142,276,292
Direct Expense	109,420,728
Indirect Expense	32,824,802
Net Income Projected	30,762
Rate Computation	
Medicaid Acute Rate	\$ 4,013.21
Medicaid Swing Bed Rate	\$ 730.06
Medicaid Long Term Care Rate	\$ 468.24
Outpatient Medicaid Rate	32.25%
Cost Basis for Rate	
Base Year Patient Days	
Cost per Patient Day	

3. Projection for five years following completion of construction or implementation

Schedule III. Average Patient Cost Per Day and Revenue Amounts			
Projections For Three Years Beyond Project Completion			
	FY 2021	FY 2022	FY 2023
Revenues	457,566,282	524,943,930	608,008,654
Expenses	176,405,379	185,351,722	194,720,651
Patient Days	9,497	10,052	10,983
Revenue Per Patient Day	\$ 48,178.96	\$ 52,221.97	\$ 55,358.01
Operating & Capital Budget Summary:			
Gross Revenues	457,566,282	524,943,930	608,008,654
Deductions from Revenue	283,691,095	335,964,115	401,285,712
Net Revenue	173,875,187	188,979,815	206,722,942
Direct Expense	134,451,029	142,741,743	151,622,185
Indirect Expense	34,890,953	34,840,242	34,551,755
Net Income Projected	4,533,205	11,397,830	20,549,002
Rate Computation			
Annual Medicaid Rate			
Base Year Cost			
Less Ancillary			
Plus Admin. Overhead			
Cost Basis for Rate			
Base Year Patient Days			
Cost per Patient Day			

D. Attach Schedule IV – Operating Budget*Current and projected line item capital and operating budgets for the proposed activity.**Describe what alternate plans have been made if deficits occur.*

The schedule below presents the Line Item Operating Budget for CPH from the current year, through the period of construction, and for three years after completion of the project. These projections show a stable and increasing Net Income over the period of construction and following the completion of the project. Following this operating is the line item capital budget in fulfillment of this requirement.

Schedule IV. Operating Budget								
Current Actual and Projections For Three Years Beyond Project Completion								
Description:	FY17 (10 mo)	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Number of Beds	49	49	49	49	49	49	49	49
Days in a year	304	365	365	365	366	365	365	365
Available bed days	14,896	17,885	17,885	17,885	17,934	17,885	17,885	17,885
Resident bed days	15,833	19,000	19,163	19,163	19,215	19,163	19,163	19,163
Percent growth		#REF!	2%	2%	4%	6%	9%	10%
Occupancy	49%	49%	50%	51%	53%	56%	61%	68%
Average length of stay	3.58	3.58	3.60	3.60	3.60	3.60	3.60	3.60
Patient Bed Days	7,314	8,777	8,953	9,132	9,497	10,052	10,983	12,115
Number of Residents	52.08	52.05	52.50	52.50	52.50	52.50	52.50	52.50
Daily Room and Board Rate*	\$ 3,953.75	\$ 3,953.66	\$ 4,349.02	\$ 4,783.92	\$ 5,023.12	\$ 5,274.27	\$ 5,537.99	\$ 5,814.89
Nursing Revenue	28,917,693	34,701,232	38,934,782	43,684,825	47,705,679	53,017,892	60,824,894	70,449,547
Nursing Services								
Payer Mix:								
Medicaid	24.1%	24.1%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
Medicare	36.3%	36.3%	36.5%	36.7%	36.9%	37.1%	37.3%	37.5%
Other	39.6%	39.6%	39.5%	39.3%	39.1%	38.9%	38.7%	38.5%
Ancillary Revenue	219,754,979	269,141,663	302,590,086	333,333,239	364,014,009	404,548,389	464,119,036	537,559,107
Total Revenue	248,672,672	303,842,895	341,524,868	377,018,064	411,719,687	457,566,282	524,943,930	608,008,654
Rate Computation								
Annual Medicaid Rate								
Base Year Cost								
Less Ancillary								
Plus Admin. Overhead								
Cost Basis for Rate								
Base Year Patient Days								
Cost per Patient Day								

Schedule IV. Capital Budget	
Equipment Description	Cost
Analyzer, Coagulation	\$4,200
Barrier, Radiation, Mobile	\$5,820
Co-Oximeter, Whole Blood	\$6,950
Defibrillator	\$24,080
Dispenser, Medication - 2 Dwr Main	\$32,280
Dispenser, Medication - 6 Dwr Main	\$53,160
Hemodynamic Monitoring System	\$146,000
Icemaker, Countertop, 10 Lb	\$3,560
Injector, Contrast- Pedestal	\$30,800
Interventional/Cardiac Cath Lab, Single Plane	\$1,122,000
Lock, Remote Medication Management	\$3,490
Monitor, Central Station, 8 bed	\$21,039
Monitor, Patient - 8 Waveforms - Wall	\$164,563
Pump, Intra-Aortic Balloon	\$58,090
Scrub Sink w/Infrared, 1 Bay	\$6,690
Stretcher, Procedural	\$19,840
Table, Cardiac Tilt	\$12,000
Warming Cabinet, 1 Comp, Countertop, 3.5 CUFT	\$5,500
Bed, ICU	\$117,780
Headwall, Horizontal	\$25,470
Monitor, Patient - 8 Waveforms - Wall	\$98,738
Ventilator, Adult	\$27,250
Dispenser, Medication - 2 Dwr Main	\$32,280
Electrosurgical Unit	\$29,870
Light, Birthing - Recessed	\$94,860
Light, Surgical, Dual LED	\$25,960
Scrub Sink w/Infrared, 2 Bay	\$9,130
Table, Surgical	\$45,650
Warming Cabinet, 1 Comp, Countertop, 3.5 CUFT	\$5,500
Freezer, Medication, U/C, -20C, 3.9 CUFT, 31.25" H	\$3,720
Hood, Biosafety- 4Ft Exhaust Class II Type B2	\$9,750
Refrigerator, Pharmacy - 1 Door	\$4,510
Scrub Sink w/Infrared, 1 Bay	\$6,690
EKG	\$17,120
Dispenser, Supply, Auxiliary, 2 Column	\$48,820

Dispenser, Supply, Main, 2 Column	\$45,600
Multiple Equipment Group Purchases	\$232,702
Fixtures, Furniture and Equipment	\$2,006,600
Construction Contingency	\$3,132,737
Professional Design Fees	\$2,424,625
Soils Investigation, Materials Testing	\$35,140
Permitting	\$128,574
Administrative Fees	\$844,221
011 - Selective Building Demolition	\$146,806
012 - Site Preparation and Earthwork	\$319,046
013 - Site Improvements	\$181,809
014 - Site Mechanical	\$139,229
015 - Site Electrical	\$964,672
021 - Standard Foundations	\$104,787
022 - Slab on Grade	\$119,877
023 - Basement	\$361,448
031 - Floor Construction	\$834,165
032 - Roof Construction	\$662,765
033 - Stair Construction	\$113,436
041 - Exterior Walls	\$477,041
042 - Exterior Doors and Windows	\$345,907
051 - Roofing	\$286,277
061 - Partitions and Doors	\$1,073,933
062 - Interior Finishes	\$917,545
063 - Specialties	\$259,035
007 - Conveying Systems	\$428,845
081 - Plumbing	\$531,113
082 - HVAC	\$2,411,707
083 - Fire Protection	\$327,642
084 - Special Mechanical Systems	\$124,049
091 - Service and Distribution	\$305,918
092 - Lighting and Power	\$718,320
093 - Special Electrical Systems	\$1,189,099
101 - Fixed and Movable Equipment	\$82,387
102 - Furnishings	\$58,594
011 - Pharmacy Renovations	\$276,064
012 - General Requirements	\$4,913,312
122 - Home Office/Bonds/Insurances	\$828,093
123 - Profit	\$1,381,990
	\$32,058,270

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

Schedule V-A. Debt Service Summary							
Provide Current Debt Data and Projections For the Next Three Years							
Existing Debt:	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
2011 Refunding Bonds (2003 Hospital Expansion Bonds re-funded)							
Principal	2,445,000	2,570,000	2,700,000	2,825,000	2,960,000	3,115,000	3,280,000
Interest	1,077,125	951,750	820,000	696,000	565,500	413,625	253,750
2014 Specialty Clinic Building Revenue Bonds							
Principal	2,956,280	2,956,670	2,960,067	2,960,062	2,959,103	2,955,849	2,957,500
Interest	1,106,280	1,086,670	1,055,067	1,015,062	964,103	905,849	817,500
2015 Specialty Clinic Building Revenue Bonds							
Principal	383,000	387,000	392,000	398,000	406,000	414,000	425,000
Interest	52,389	48,988	44,023	37,555	30,061	21,129	11,122
2016 Specialty Clinic Building Revenue Bonds							
Principal	345,000	430,000	435,000	445,000	455,000	465,000	475,000
Interest	54,207	62,173	55,078	46,595	37,028	26,335	14,013
Johnson & Johnson - Ortho Clinical Vitros 350 & ECI							
Principal	12,945						
Interest	165						
Johnson & Johnson - Ortho Clinical Vitros 5600 & Peripherals							
Principal	20,235						
Interest	145						
Total Existing Debt							
Principal	6,162,460	6,343,670	6,487,067	6,628,062	6,780,103	6,949,849	7,137,500
Interest	2,290,311	2,149,581	1,974,167	1,795,212	1,596,691	1,366,938	1,096,385
Estimated Debt –							
2019 Cath Lab/OB Revenue Bonds							
Principal			1,023,880	1,059,716	1,096,806	1,135,194	1,174,926
Interest			1,013,425	977,589	940,499	902,111	862,379

The issuance of Revenue Bonds to fund this project was approved by the Kenai Peninsula Borough as ordinance 2016-19-12 on October 25, 2016. The ordinance authorizes the issuance of up to \$28,955,000 in revenue bonds with maturity in 20 years. It is estimated that the interest rate will be 3.5% which results in annual debt service payments of \$2,037,305 to satisfy both the repayment of principle as well as the payment of interest. The balance of funding necessary for this project will be appropriated from the hospital's Plant Replacement and Equipment Fund (PREF) which stands in excess of \$31,000,000 as of April 30, 2017.

Schedule V-B. New Project Debt Service Summary					
Attach a debt service cash flow schedule over the life of the debt for the new project.					
Break out principal, interest, and other.					
Year	Item	Principal	Interest	Other	Total
2019	Revenue Bonds on OB/Cath Lab Project	1,023,880	1,013,425		2,037,305
2020	Revenue Bonds on OB/Cath Lab Project	1,059,716	977,589		2,037,305
2021	Revenue Bonds on OB/Cath Lab Project	1,096,806	940,499		2,037,305
2022	Revenue Bonds on OB/Cath Lab Project	1,135,194	902,111		2,037,305
2023	Revenue Bonds on OB/Cath Lab Project	1,174,926	862,379		2,037,305
2024	Revenue Bonds on OB/Cath Lab Project	1,216,048	821,257		2,037,305
2025	Revenue Bonds on OB/Cath Lab Project	1,258,610	778,695		2,037,305
2026	Revenue Bonds on OB/Cath Lab Project	1,302,661	734,644		2,037,305
2027	Revenue Bonds on OB/Cath Lab Project	1,348,254	689,051		2,037,305
2028	Revenue Bonds on OB/Cath Lab Project	1,395,443	641,862		2,037,305
2029	Revenue Bonds on OB/Cath Lab Project	1,444,284	593,021		2,037,305
2030	Revenue Bonds on OB/Cath Lab Project	1,494,834	542,471		2,037,305
2031	Revenue Bonds on OB/Cath Lab Project	1,547,153	490,152		2,037,305
2032	Revenue Bonds on OB/Cath Lab Project	1,601,303	436,002		2,037,305
2033	Revenue Bonds on OB/Cath Lab Project	1,657,349	379,956		2,037,305
2034	Revenue Bonds on OB/Cath Lab Project	1,715,356	321,949		2,037,305
2035	Revenue Bonds on OB/Cath Lab Project	1,775,394	261,911		2,037,305
2036	Revenue Bonds on OB/Cath Lab Project	1,837,532	199,773		2,037,305
2037	Revenue Bonds on OB/Cath Lab Project	1,901,846	135,459		2,037,305
2038	Revenue Bonds on OB/Cath Lab Project	1,968,411	68,894		2,037,305
2039	Revenue Bonds on OB/Cath Lab Project				
Total	Revenue Bonds on OB/Cath Lab Project	28,955,000	11,791,100	-	40,746,100

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.

Fiscal Year 2012				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	16,995	38,475,346	17,842,691	20,632,655
Medicare	22,717	61,705,068	34,948,132	26,756,936
Private Insurance	30,341	65,598,706	6,080,287	59,518,419
Self Pay	9,646	16,901,458	1,688,595	15,212,863
Charity			7,050,090	(7,050,090)
Bad Debt			9,094,261	(9,094,261)
Other	5,536	11,969,933	5,294,562	6,675,371
Total	85,235	194,650,511	81,998,618	112,651,893
Fiscal Year 2013				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	14,426	36,905,721	16,522,877	20,382,844
Medicare	26,233	69,486,978	42,557,717	26,929,261
Private Insurance	36,317	71,461,176	6,970,643	64,490,533
Self Pay	6,466	20,002,371	1,871,613	18,130,758
Charity			9,031,980	(9,031,980)
Bad Debt			9,941,178	(9,941,178)
Other	6,514	17,458,087	8,267,813	9,190,274
Total	89,956	215,314,333	95,163,821	120,150,512
Fiscal Year 2014				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	12,552	38,429,231	18,684,098	19,745,133
Medicare	27,993	82,129,061	50,779,904	31,349,157
Private Insurance	36,092	73,111,245	8,054,697	65,056,548
Self Pay	5,455	19,578,488	1,822,829	17,755,659
Charity			8,880,963	(8,880,963)
Bad Debt			11,597,401	(11,597,401)
Other	4,924	17,346,677	8,390,561	8,956,116
Total	87,016	230,594,702	108,210,453	122,384,249

Fiscal Year 2015				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	13,276	40,646,022	21,162,889	19,483,133
Medicare	32,744	96,068,785	63,075,360	32,993,425
Private Insurance	43,698	88,518,049	10,954,200	77,563,849
Self Pay	5,316	19,080,013	1,809,732	17,270,281
Charity			6,296,353	(6,296,353)
Bad Debt			12,811,570	(12,811,570)
Other	7,068	24,900,430	14,605,270	10,295,160
Total	102,102	269,213,299	130,715,374	138,497,925
Fiscal Year 2016				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	19,103	56,144,452	32,174,022	23,970,430
Medicare	35,707	110,079,335	74,032,765	36,046,570
Private Insurance	43,164	93,492,366	12,148,595	81,343,771
Self Pay	6,388	19,090,880	2,168,008	16,922,872
Charity			5,924,412	(5,924,412)
Bad Debt			9,937,048	(9,937,048)
Other	6,724	26,661,538	14,379,473	12,282,065
Total	111,086	305,468,571	150,764,323	154,704,248
Fiscal Year 2017				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	34,327	73,226,138	46,864,728	26,361,410
Medicare	22,316	110,294,971	75,000,580	35,294,391
Private Insurance	39,500	82,455,289	11,543,740	70,911,548
Self Pay	4,952	10,938,344	1,203,218	9,735,126
Charity			3,617,283	(3,617,283)
Bad Debt			6,072,302	(6,072,302)
Other	8,476	26,928,153	17,264,751	9,663,402
Total	109,571	303,842,895	161,566,603	142,276,292

Fiscal Year 2018				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	35,014	81,965,968	55,736,858	26,229,110
Medicare	22,762	124,656,577	87,259,604	37,396,973
Private Insurance	40,290	95,409,993	14,311,499	81,098,494
Self Pay	5,051	12,294,895	1,352,438	10,942,457
Charity			4,145,195	(4,145,195)
Bad Debt			7,881,204	(7,881,204)
Other	8,646	27,197,435	19,009,808	8,187,627
Total	111,763	341,524,868	189,696,607	151,828,261
Fiscal Year 2019				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	35,539	90,484,335	65,148,721	25,335,614
Medicare	23,103	138,365,630	99,623,253	38,742,376
Private Insurance	40,894	107,126,040	17,140,166	89,985,873
Self Pay	5,127	13,572,650	1,492,992	12,079,659
Charity			5,655,271	(5,655,271)
Bad Debt			9,425,452	(9,425,452)
Other	8,776	27,469,409	20,184,622	7,284,787
Total	113,439	377,018,064	218,670,477	158,347,587
Fiscal Year 2020				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	36,250	98,812,725	74,109,544	24,703,181
Medicare	23,565	151,924,565	113,943,423	37,981,141
Private Insurance	41,712	118,416,386	20,130,786	98,285,600
Self Pay	5,230	14,821,909	1,630,410	13,191,499
Charity			6,175,795	(6,175,795)
Bad Debt			10,292,992	(10,292,992)
Other	8,952	27,744,103	20,748,862	6,995,241
Total	115,709	411,719,687	247,031,812	164,687,875

Fiscal Year 2021				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	37,700	109,815,908	85,656,408	24,159,500
Medicare	24,508	169,757,090	130,712,960	39,044,131
Private Insurance	43,380	133,499,353	25,364,877	108,134,476
Self Pay	5,439	16,472,386	1,811,962	14,660,424
Charity			6,863,494	(6,863,494)
Bad Debt			11,439,157	(11,439,157)
Other	9,310	28,021,544	21,842,236	6,179,308
Total	120,337	457,566,282	283,691,095	173,875,187
Fiscal Year 2022				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	39,208	125,986,543	102,049,100	23,937,443
Medicare	25,488	195,804,086	156,643,269	39,160,817
Private Insurance	45,115	155,953,560	31,190,712	124,762,848
Self Pay	5,657	18,897,981	2,078,778	16,819,204
Charity			7,874,159	(7,874,159)
Bad Debt			13,123,598	(13,123,598)
Other	9,682	28,301,760	23,004,499	5,297,260
Total	125,150	524,943,930	335,964,115	188,979,815
Fiscal Year 2023				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid	40,776	145,922,077	122,574,545	23,347,532
Medicare	26,508	228,003,245	188,102,677	39,900,568
Private Insurance	46,920	183,610,243	40,394,253	143,215,989
Self Pay	5,883	21,888,312	2,407,714	19,480,597
Charity			9,120,130	(9,120,130)
Bad Debt			15,200,216	(15,200,216)
Other	10,069	28,584,777	23,486,176	5,098,602
Total	130,156	608,008,654	401,285,712	206,722,942

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.

Schedule VII. Depreciation Schedule			
Use the straight-line method.			
Provide a separate schedule for any pieces of major moveable equipment.			
Equipment Description	Cost	AHA Life	Depreciation Per Year
Analyzer, Coagulation	\$4,200	5	\$840
Barrier, Radiation, Mobile	\$5,820	7	\$831
Co-Oximeter, Whole Blood	\$6,950	10	\$695
Defibrillator	\$24,080	5	\$4,816
Dispenser, Medication - 2 Dwr Main	\$32,280	10	\$3,228
Dispenser, Medication - 6 Dwr Main	\$53,160	10	\$5,316
Hemodynamic Monitoring System	\$146,000	7	\$20,857
Icemaker, Countertop, 10 Lb	\$3,560	10	\$356
Injector, Contrast- Pedestal	\$30,800	10	\$3,080
Interventional/Cardiac Cath Lab, Single Plane	\$1,122,000	5	\$224,400
Lock, Remote Medication Management	\$3,490	10	\$349
Monitor, Central Station, 8 bed	\$21,039	5	\$4,208
Monitor, Patient - 8 Waveforms - Wall	\$164,563	5	\$32,913
Pump, Intra-Aortic Balloon	\$58,090	7	\$8,299
Scrub Sink w/Infrared, 1 Bay	\$6,690	20	\$335
Stretcher, Procedural	\$19,840	10	\$1,984
Table, Cardiac Tilt	\$12,000	10	\$1,200
Warming Cabinet, 1 Comp, Countertop, 3.5 CU	\$5,500	15	\$367
Bed, ICU	\$117,780	15	\$7,852
Headwall, Horizontal	\$25,470	10	\$2,547
Monitor, Patient - 8 Waveforms - Wall	\$98,738	5	\$19,748
Ventilator, Adult	\$27,250	10	\$2,725
Dispenser, Medication - 2 Dwr Main	\$32,280	10	\$3,228

Electrosurgical Unit	\$29,870	7	\$4,267
Light, Birthing - Recessed	\$94,860	20	\$4,743
Light, Surgical, Dual LED	\$25,960	15	\$1,731
Scrub Sink w/Infrared, 2 Bay	\$9,130	15	\$609
Table, Surgical	\$45,650	10	\$4,565
Warming Cabinet, 1 Comp, Countertop, 3.5 CU	\$5,500	15	\$367
Freezer, Medication, U/C, -20C, 3.9 CUFT, 31.25	\$3,720	10	\$372
Hood, Biosafety- 4Ft Exhaust Class II Type B2	\$9,750	10	\$975
Refrigerator, Pharmacy - 1 Door	\$4,510	10	\$451
Scrub Sink w/Infrared, 1 Bay	\$6,690	15	\$446
EKG	\$17,120	7	\$2,446
Dispenser, Supply, Auxiliary, 2 Column	\$48,820	10	\$4,882
Dispenser, Supply, Main, 2 Column	\$45,600	10	\$4,560
Multiple Equipment Group Purchases	\$232,702	5	\$46,540
Fixtures, Furniture and Equipment	\$2,006,600	10	\$200,660
Construction Contingency	\$3,132,737	20	\$156,637
Professional Design Fees	\$2,424,625	20	\$121,231
Soils Investigation, Materials Testing	\$35,140	20	\$1,757
Permitting	\$128,574	20	\$6,429
Administrative Fees	\$844,221	20	\$42,211
011 - Selective Building Demolition	\$146,806	20	\$7,340
012 - Site Preparation and Earthwork	\$319,046	20	\$15,952
013 - Site Improvements	\$181,809	20	\$9,090
014 - Site Mechanical	\$139,229	20	\$6,961
015 - Site Electrical	\$964,672	20	\$48,234
021 - Standard Foundations	\$104,787	20	\$5,239
022 - Slab on Grade	\$119,877	20	\$5,994
023 - Basement	\$361,448	20	\$18,072
031 - Floor Construction	\$834,165	20	\$41,708
032 - Roof Construction	\$662,765	20	\$33,138

033 - Stair Construction	\$113,436	20	\$5,672
041 - Exterior Walls	\$477,041	20	\$23,852
042 - Exterior Doors and Windows	\$345,907	20	\$17,295
051 - Roofing	\$286,277	20	\$14,314
061 - Partitions and Doors	\$1,073,933	20	\$53,697
062 - Interior Finishes	\$917,545	20	\$45,877
063 - Specialties	\$259,035	20	\$12,952
007 - Conveying Systems	\$428,845	20	\$21,442
081 - Plumbing	\$531,113	20	\$26,556
082 - HVAC	\$2,411,707	20	\$120,585
083 - Fire Protection	\$327,642	20	\$16,382
084 - Special Mechanical Systems	\$124,049	20	\$6,202
091 - Service and Distribution	\$305,918	20	\$15,296
092 - Lighting and Power	\$718,320	20	\$35,916
093 - Special Electrical Systems	\$1,189,099	20	\$59,455
101 - Fixed and Movable Equipment	\$82,387	20	\$4,119
102 - Furnishings	\$58,594	20	\$2,930
011 - Pharmacy Renovations	\$276,064	20	\$13,803
012 - General Requirements	\$4,913,312	20	\$245,666
122 - Home Office/Bonds/Insurances	\$828,093	20	\$41,405
123 - Profit	\$1,381,990	20	\$69,100
	\$32,058,270	Total	\$2,000,296
Capitalizable Interest (estimated)	\$2,204,402	16.027	137,545
		(Avg Life_yrs)	
Annual Depreciation Estimate			<u>\$2,137,841</u>

Fair Market Value – How to Calculate

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.

N/A - This is not applicable for this application.

FAIR MARKET VALUE – HOW TO CALCULATE

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.

Not applicable to this 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): \$0

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): \$26,918,933

Estimated Value of the Activity for (1)
(sum of A & B above) \$26,918,933

(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): \$_____N/A_____

Estimated Value for (1) from above: \$_____N/A_____

Total Estimated Value of the Activity
(sum of (1) and (2): \$_____N/A_____

Amount of Application Fee submitted with this application
(see 7 AAC 07.079 to calculate amount due): \$26,919.00

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 certificate of need activity are accurate.

Date: June 28, 2013

Facility Name and Address: Central Peninsula Hospital
250 Hospital Place
Soldotna, Alaska 99669

Name and Title of Person Determining Application Fee:
Richard L. Davis, CEO Central Peninsula Hospital

Signature of Certifying Officer of the Organization

APPENDIX A