Complete Certificate of Need (CON) Application

Petersburg Medical Center (PMC)

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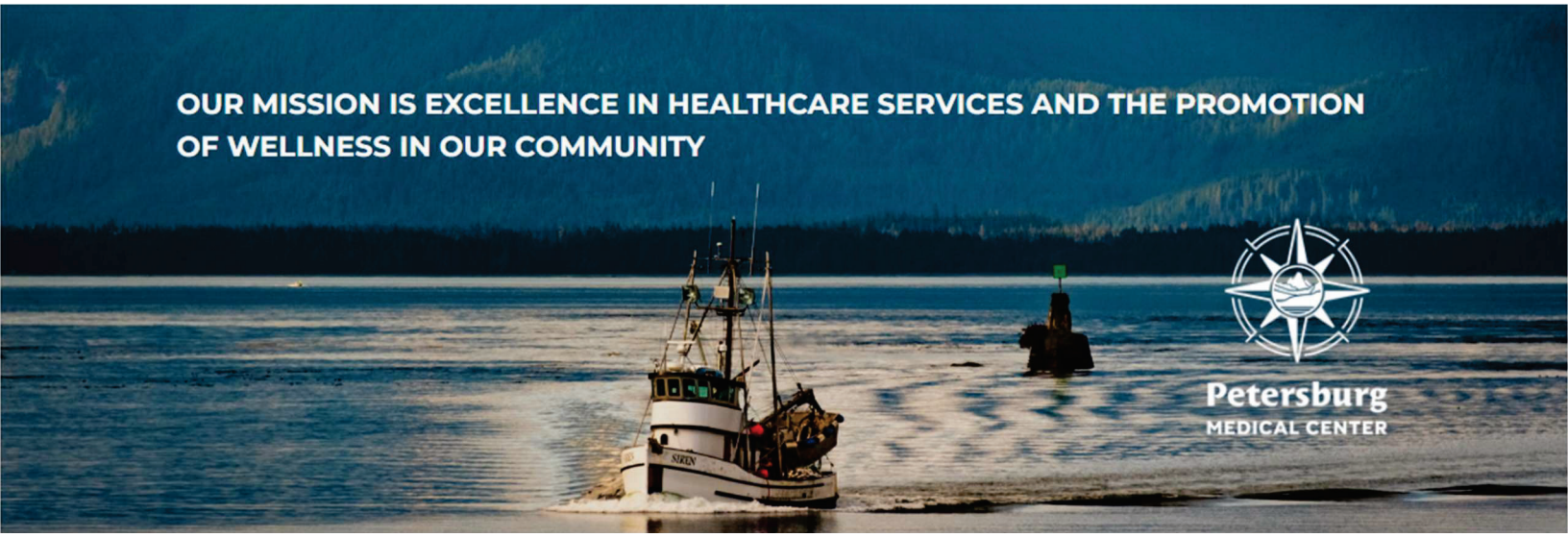


Certificate of Need Application Proposing the Construction of a New Medical Office Building and Acquisition of an MRI

July 22, 2025

CERTIFICATE OF NEED APPLICATION

APPLICANT IDENTIFICATION AND CERTIFICATION OF ACCURACY

1. Applicant Identification

Facility Name Petersburg Medical Center	**Medicaid Provider Number** 1005609(HSO9IP)
Facility Address (*Street/City/State/Zip Code*) PO Box 589, 103 Fram St, Petersburg, AK 99833	**Medicare Provider Number** 02-1304
Name and mailing address of organization that operates the facility (if different from above) Petersburg Borough 12 South Nordic Drive, PO Box 329, Petersburg, AK 99833	
Facility Administrator (*Name, title, mailing address, including City/State/Zip Code*) Philip Hofstetter, CEO PO Box 589, 103 Fram St, Petersburg, AK 99833	**Telephone:** (907) 304-1243 **E-mail:** phofstetter@pmc-health.org
Applicant (*Name, title, mailing address, including City/State/Zip Code*) Petersburg Medical Center Philip Hofstetter, CEO PO Box 589, 103 Fram St, Petersburg, AK 99833	**Telephone:** (907) 772-4291 **E-mail:** phofstetter@pmc-health.org
Principal Contact Person (*Name, title, physical address, mailing address, including City/State/Zip Code*) Jason McCormick, CFO, PO Box 589, 103 Fram St, Petersburg, AK 99833	**Telephone:** (970) 549-6031 **E-mail:** jmccormick@mccmgroup.pro

2. Ownership Information

A. Type of Ownership (*check applicable category*)

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

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

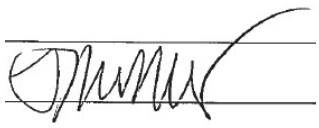
C. Accreditation Information *(Page 2 of application*)

3. Agreement to participate in the Uniform Statewide Reporting System

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

4. Certification of Accuracy by Certifying Officer of the Organization

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

Name Philip Hofstetter	**Title** CEO
Signature 	**Date** July 22, 2025

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:

(1) For individual owners and partnerships, list the names, titles, organizational name, mailing and street addresses, and telephone and facsimile numbers of the owner or partners.

Not applicable.

(2) For corporations, list the names, titles, and addresses of the corporate officers and Board of Directors. If the facility is a subsidiary of another company or has multiple owners, provide the names and addresses of the all of companies that have ownership in the facility.

Not applicable,

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

The members of the locally elected PMC board are as follows:

Name	Title	Address
Jerod Cook	President	103 Fram St, Petersburg, AK 99833
Cindi Lagoudakis	Vice President	103 Fram St, Petersburg, AK 99833
Marlene Cushing	Secretary	103 Fram St, Petersburg, AK 99833
Joe Stratman	Member	103 Fram St, Petersburg, AK 99833
Heather Conn	Member	103 Fram St, Petersburg, AK 99833
James Roberts	Member	103 Fram St, Petersburg, AK 99833
Kimberly Simbahon	Member	103 Fram St, Petersburg, AK 99833

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

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

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

We are not accredited by an accrediting organization. PMC is licensed by the State of Alaska and certified by the federal Centers for Medicare & Medicaid Services as a Critical Access Hospital. PMC is also licensed and certified for Home Health and Long-Term Care.

Section II. Summary Project Description

(1) A brief description of each proposed service, including whether equipment will be purchased or replaced and a list of that equipment.

PMC has plans to eventually relocate the entire hospital to a new location. The project will be undertaken in phases. In Phase 1, which is detailed in this application, we are proposing to construct a new office building, known as the Wellness, Education, & Resource Center (WERC) which will house a number of PMC services and staff including PMC's Community Wellness and Youth programs, public internet access and education spaces, information technology, materials management, and administrative offices. It will also include a Magnetic Resonance Imaging (MRI) suite, which establishes the first local access to this critical healthcare service. PMC is a Critical Access Hospital with a Long-Term Care facility, serving Petersburg Borough and surrounding remote Census Area communities in Southeast Alaska. Petersburg's nearest neighbor is the smaller town of Wrangell, 50 miles away, while Juneau lies about 200 miles north. Subsidized by the US DOT's Essential Air Service program for small, rural communities, a single-runway airport provides year-round, weather-dependent service to our community, which is accessible only by air or water.

PMC provides the only primary care, acute care, 24-7 emergency, Home Health, Long-Term Care, and other healthcare services in our Borough. The people we serve do not currently have access to MRI services unless they can afford the time and expense of travelling several hundreds of miles away from their jobs and families. This travel also involves at least one overnight stay in a region with significant seasonal cost and availability fluctuations. This has inevitably led to some patients delaying or foregoing this diagnostic technology entirely. The disproportionate burdens and diminished health outcomes this lack of local access poses – particularly for older adults, disabled individuals, caregivers, low-income Alaskans, and parents of young children – should not be underestimated. PMC's project will establish MRI access for the population living in and around Petersburg Borough, one in ten of whom are Veterans and one in four of whom are over age 65.

As noted above, the addition of MRI services is a key component of the first Phase of PMC's plan to replace an outdated hospital and Long-Term Care facility.

Through grants and donations, PMC has secured 100% of the funding required for this project as follows:

- Health Resources and Services Administration Community Project Grant ($8 million)
- United States Department of Treasury Coronavirus Capital Projects Fund Grant ($20 million)
- Land donated by the Petersburg Borough (approximately $2 million)

(2) The number of square feet of construction/renovation.

Total square footage of the WERC building is 18,980 sq. ft. The MRI space is 1,329 sq. ft. of that total.

(3) The number and type of beds/surgery suites/specialty rooms.

Not applicable. This project does not propose any new or additional hospital beds or surgery specialty rooms.

(4) Services to be expanded, added, replaced, or reduced.

This project proposes the addition of MRI diagnostic equipment and services.

(5) The total cost of the project.

The total cost of the WERC Building project is $24,425,422, inclusive of the cost of the MRI diagnostic machinery, as outlined below.

Project Element	Cost
WERC building construction and other project costs	$20,918,102
WERC Building FFE	$780,000
MRI diagnostic machinery	$970,520
Site Acquisition (donation)	$1,756,800
TOTAL COST	**$24,425,422**

(6) How the project will be financed.

Grants and contributions have been secured from the U.S. Health Resources and Services Administration, U.S. Treasury Department, and Petersburg Borough as outlined below.

Sources	Financing
HRSA Community Project Grant	$8,000,000[1]
Dept. of Treasury Coronavirus Capital Projects Fund Grant	$20,000,000
Petersburg Borough Land Contribution	$1,756,800

(7) Estimated completion date.

Construction of the WERC will be completed in the summer of 2025.

[1] $2,668,622 of the $8,000,000 grant is allocated to Phase 1:WERC Building, while the remaining funds support other project Phases.

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	Not Applicable.		
1-bed room/unit			
2-bed room/unit			
Other (list)			
ICU Beds			
Obstetrics Beds			
Pediatric Beds			
Acute Rehab Beds			
Obstetrics Beds			
Pediatric Beds			
Ancillary Services (list)			
BEHAVIORAL HEALTH CARE			
In-patient Acute Psychiatric Beds	Not Applicable.		
RPTC Beds			
In-patient Substance Abuse Beds			
LONG-TERM CARE			
Acute Beds	Not Applicable.		
1-bed room/unit			
2-bed room/unit			
Other (list)			
Nursing Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
DIAGNOSTIC AND DIAGNOSTIC IMAGING SERVICES			
CT Scanner			
MRI	**0**	**1**	**1**
PET or PET/CT			
Cardiac Catherization			
Emerging Med. Tech. (list)			
SURGICAL CARE			
Ambulatory Surgery or Dedicated OP Suites	Not Applicable.		
Suites for IP & OP			
Endoscopy Suites			
Open-Heart Surgery			
Organ Transplantation			
Other Services (list)			
THERAPEUTIC CARE			
Radiation Therapy	Not Applicable.		
Lithotrypsy			
Renal Dialysis			
Other (List)			
Total Capacity	**0**	**1**	**1**

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.

PMC is proposing the addition of magnetic resonance imaging (MRI) services within the new WERC Building. The MRI suite is 1,329 sq. ft. of the total 18,980 sq. ft. of the WERC Building and includes the purchase of $970,520 in MRI diagnostic equipment and machinery. In addition, PMC's Community Wellness and Youth programs, public internet access and education spaces, information technology, maintenance, and administrative offices will be located in WERC. The Borough's Public Health and morgue will also be based in the WERC.

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

Equipment to be Purchased			
Equipment Description	**Make**	**Model**	**Cost**
MRI Unit	Siemens	14471000	$970,520

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

Not applicable. The proposed project is for a new MRI service. No equipment will be replaced or retired.

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

Not applicable. The project is new construction.

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

Grade Beams, Thickened Concrete Slab, 2 floor Addition.

G. Total square footage in current facility/project.

Not applicable. There is no WERC or MRI in the current hospital location. The project is for new construction.

H. Total square footage of proposed facility/project.

18,980 sq. ft.

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

Not applicable. There are no beds or surgery proposed for WERC. .

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

The following table depicts each area and the associated square footage:

Direct Service Activity	Square Footage	Percentage of Total
MRI Services	1,329	7%
Public Health Nursing	1,388	7.3%
Morgue	278	1.5%
Community IRC (Wellness, Internet)	1,647	8.7%
Administration	1,604	8.5%
Materials Management	3,843	20%
Information Technology	993	5.2%
Public/Common Spaces	3,298	17.4%
Building Support and Maintenance	4,600	24%
Total	**18, 980**	**100.0%**

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

As outlined in detail in Section IV. Narrative Review Questions, PMC is proposing the establishment of MRI services. In the first three years of operation, 16 MRIs per month have been projected.

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.

PMC revised its master plan in January of 2021 to assure it can remain a viable partner and provide the best possible community healthcare well into the future. The master planning process identified the need for a new facility to replace the original hospital built in 1955. Even with significant remodels in 1969 and 1984, the bulk of the hospital is at least 40 years old and at the end of its useful life. Many building systems do not meet current codes, are no longer manufactured or supported, and require constant maintenance, which is made difficult when parts and expertise are no longer available for an increasing number of components, and must be shipped by air or water. The building cannot support increased technological demands, essential

for the delivery of modern healthcare. Critically, assessments since 2015 have documented necessary functional improvements to comply with current guidelines on infection control, patient safety, patient privacy, food service, and sanitation. As noted above, PMC is engaged in a multi-phase plan to replace the Critical Access Hospital and Long-Term Care facility.

In PMC's 2024-2028 strategic plan, our locally elected Board identified the following five key priorities for the community-owned non-profit hospital: Financial Wellness, New Facility (e.g., PMC plans to construct a new building that meets regulatory standards and incorporates state-of-the-art technology with community needs considered), Community Engagement, Patient-Centered Care, and Workforce Wellness. By implementing these strategies – and specifically the elements listed below – PMC will continue to ensure excellence in community-driven healthcare services and promoting wellness within the community and drive long-term success in the years to come. Over the past five years, while engaged in long-range planning, PMC has focused on enhancing service capabilities through strategic expansions and renovations:

- **New Equipment and Services.** Construction of the WERC building responds to needs repeatedly expressed by the population we serve in Community Health Needs Assessments, specifically by including expanded local imaging services. This project establishes our area's first MRI services, significantly expanding healthcare access and eliminating the need for costly travel – a primary cause for delayed or sacrificed care.
- **Facility Enhancements**. The WERC building will not only house the MRI but also includes additional programmatic, administrative, and community spaces, improving overall patient and staff experience and public access to free internet and other resources.
- **Current Status**. The construction of the WERC building is now complete and nearing opening, marking a significant step in PMC's long-range plans, outlined below.

The proposed project is integrated with PMC's long-range plans:

- **Current Projects.** The addition of MRI services and facilities is a critical part of PMC's strategy to ensure the healthcare we are able to deliver to rural Alaskans reflects and complies with modern standards of care.
- **Future Plans and Development.** Within the next five years, our long-range plan involves a comprehensive redevelopment of our healthcare infrastructure as the functional lifespan of both hospital and Long-Term Care facilities are at an end. We plan to construct a new hospital and nursing home, focusing on sustainability, efficiency, and patient comfort. This aligns with our commitment to be a leading healthcare provider serving the Southeast region through the integration of advanced medical technologies and improved access to care.

As noted previously, across a 4,000-square mile service area accessible only by boat or plane, Borough residents, visitors, the U.S. Coast Guard, and a significant seasonal workforce population depend on PMC's Primary Care Clinic, 24-hour Emergency Room, and Pharmacy, as well as Acute and Long-Term Care and Home Health services. Being able to provide local MRI appointments immediately when needed will transform access to care for those we serve, and for our providers who strive to deliver the health information and lifelong outcomes our communities deserve.

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.)

See also General Review Standard #1 and #2 in a later section.

As noted in Section III, the proposed project is fully integrated with, and integral to, PMCs strategic plan. The replacement of an aging and obsolescent hospital building has been in planning for more than six years. Related to this application, the introduction of MRI services in Phase I of the master plan, is part of a five-year strategic enhancement of the hospital's service capabilities through expansions and renovations. Phase I, targeted at improvement in access and patient experience, includes the construction of the WERC building, inclusive of expanded imaging services, additional administrative and community spaces, and improved patient and staff experience. Phase II, once funding is fully in place, includes the construction of a replacement hospital and Long-Term Care facility, with sustainability, efficiency, and quality of patient experience at the forefront. The two phased project nicely aligns with our commitment to becoming a leading healthcare provider in the region through the integration of advanced medical technologies and enhanced patient access to care.

This expansion and associated planned projects underscore our dedication to elevating the standard of healthcare in and around Petersburg Borough, ensuring that those we serve have access to comprehensive, high-quality medical services without having to fly hundreds of miles away. Nationally, the value of decentralizing high-tech medical services from urban centers to smaller communities has been recognized as significantly improving access to care. Establishing MRI services in Petersburg Borough aligns with this best practice and reduces dependency – and pressure – on distant hospitals for specialized diagnostics. National trends research between 2000 through 2016 demonstrated that that MRI use rates increased rapidly between 2000 and 2006 and continued to rise, though at at a slower pace through 2016.[2] MRI scans in the U.S. are expected to grow by 18.3% between 2023 and 2030, according to Grand View Research's U.S. Magnetic Resonance Imaging Market Size Report, 2030.

[2] Smith-Bindman R, Kwan ML, Marlow EC, Theis MK, Bolch W, Cheng SY, Bowles EJA, Duncan JR, Greenlee RT, Kushi LH, Pole JD, Rahm AK, Stout NK, Weinmann S, Miglioretti DL. Trends in Use of Medical Imaging in US Health Care Systems and in Ontario, Canada, 2000-2016. JAMA. 2019 Sep 3;322(9):843-856. doi: 10.1001/jama.2019.11456. PMID: 31479136; PMCID: PMC6724186.

The Association of State & Territorial Health Officials[3] have identified local access to MRI as a recruitment issue, as physicians and other health care providers seek workplaces that will support their ability to provide the highest quality, most responsive care – relevant for PMC as we seek continuously to recruit and retain an expert workforce in a HRSA-designated Health Professional Shortage Area. This expansion and the planned replacement project are designed not only to maintain but to elevate the standard of healthcare in Petersburg; ensuring that those we serve have access to the comprehensive, high-quality medical services they need, where they live.

The addition of MRI services in our rural service area also supports the Healthy Alaskans 2023 health improvement plan strategy for *Healthcare Access: Reduce the rate of preventable hospitalizations per 1,000 adults*. In addition to being a diagnostic tool for a wide range of conditions affecting soft tissues, organs, and the skeletal system, they have immense value in assessing tumors, brain/spinal cord injuries, and joint issues, and can be used to diagnose conditions such as multiple sclerosis, strokes, and heart abnormalities. Establishing this service recognizes and rises to meet long-documented national trends in MRI usage for high quality preventative and diagnostic care.

The *Alaska Certificate of Need Review Standards and Methodologies* for Magnetic Resonance Imaging, last updated in 2005-06, outline that applicants wishing to establish an MRI service in a community with a population of less than 10,000 demonstrate the ability to provide at least 1,000 MRI scans by the end of the third year of operation. Per the standards and methodologies, this expectation is based on an estimate of 2,500 scans for a population of 70,000 (this translates into a use rate of use rate of 35.7 MRIs per 1,000 Population).

PMC recognizes that it will not meet this standard as its population is not large enough. Applying the translated use rate from the Standards and Methodologies to the estimated population of the Petersburg Borough results in a range of 115-120 MRIs annually. However, a review of recent studies and data, detailed in Section IV.B: Demonstration of Need, found use rates higher than the current methodology, but remain well below 1,000. Recent guidance suggests that volumes below 1,000 do not have an adverse outcome on care, and that staff training is paramount. We have addressed staff training and competency.

As outlined elsewhere in the application, PMC has incurred no debt service for the construction or equipment related to this project. Other benefits of this project, applicable to the Standards and Methodology review, include:

- Our federal legislature has provided the necessary funding to the Petersburg Borough to have this critical community service and technology
- We have an aging community with increased use and demand for MRI services
- Staffing plans are in place that assures the highest quality and patient care
- The diagnostic and quality of care advantages of MRI are clear
- The cost and time of travel for Petersburg Borough residents is prohibitive and negatively impacts access to care.

We are confident that the Department will weigh the above in approval of this application.

[3] The Association of State and Territorial Health Officials was incorporated on March 23, 1942. For 80 years, ASTHO has continued to support its members and other public health officers in improving the collection and utilization of public health data, expanding access to care and treatment, and creating new preparedness frameworks to respond to crises.

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.

See also General Review Standard #1 and #4 in a later section.

The project proposes the addition of a new service addressing several issues including the following:

- **Aging infrastructure and service accessibility**: The original hospital facility was built in 1955; with the last significant remodels being at least 40 years ago. The hospital is at the end of its useful life, making modernization, improvement, or addition of new services like MRI impossible in the current space.
- **Community Need**: The absence of local MRI services forces all patients, including those on Medicare and Medicaid, to travel to Juneau, incurring significant costs for travel, lodging, and the MRI procedure itself – or to make the difficult decision to delay or forego care based on cost and other barriers.
- **Cost Savings**: By providing MRI services locally, we will reduce the financial burden on patients and payers, at minimum, with the avoidance of travel expenses; and the burden on families and employers of travel absences. Patients who would otherwise delay or forego MRI related to the demands of travel will instead have access to timely diagnoses, increasing the capacity for less costly early intervention and prevention rather than need for more expensive emergency healthcare. This initiative will save time and money, enhancing efficiency.
- **Enhanced Diagnostic Capabilities**: Introducing an MRI will allow for more immediate and comprehensive diagnostic care within our service area. PMC also expects that it will reduce the number of patients who forego the benefit of MRI-informed diagnostic services due to the travel burden.

The proposed project will significantly improve healthcare delivery through the addition of a vital new service and align with our long-term vision to better serve the community living in and around Petersburg Borough through meaningful improvements in local healthcare access.

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.
See also General Review Standard #1, #2 and #5 in a later section.

The proposed addition of MRI services:

- **Addresses an Unmet Community Need** as there are currently no MRI services available to those we serve without multi-day and costly travel. Establishing MRI services fills a significant gap in local healthcare access. This technology is essential for diagnosing a wide range of conditions, from orthopedic issues to neurological disorders, which are currently managed with less diagnostic precision due to the absence of local MRI capabilities.

- **Follows a National Trend in Providing This Type of Service**: Nationally, the value of decentralizing high-tech medical services from urban centers to smaller communities is well documented as improving access to care. Installing an MRI in Petersburg aligns with this best practice, reducing the dependency and pressure on distant hospitals to meet the needs of rural patients forced to travel for specialized diagnostics.
- **Meets a Higher Quality or Efficiency Standard** in terms of:
    - **Quality**: On-site MRI services will enhance the quality of local care by ensuring all patients have meaningful and timely access to modern diagnostic care. This is expected to enhance diagnosis and allow for more tailored treatment plans based on immediate and detailed imaging results, without the delay and cost of travel and disruption (at minimum) of sharing results between multiple separate providers.
    - **Efficiency**: The local availability of MRI services would drastically reduce the logistical and financial burdens associated with patient travel for diagnostics at both the individual and payer levels; leading to lower costs by eliminating travel expenses, reduced turnaround time (wait times are expected to be reduced due to ease of local scheduling), and lower health risks for patients, particularly those with mobility issues or chronic conditions, with reduction in travel.

Overall, this project not only resolves an existing community need and gap in healthcare access but also positions PMC to meet future healthcare demands more efficiently and at a higher standard of care.

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 project is the construction of a new building and the addition of a new service (MRI). While this project stands alone in the context of this application, it is noteworthy that it is Phase I of a larger strategic project to replace and modernize the hospital's facilities. The current hospital is at the end of life, does not meet modern building codes – including those for Americans with Disabilities Act (ADA), life safety, and fire safety standards – and has outdated mechanical, plumbing, and electrical systems that are failing. These deficiencies in the existing hospital preclude the addition of the proposed service, requiring construction of a new facility.

Phase II will include building a new (replacement) hospital facility that will be fully compliant with all current building codes, particularly ADA, life safety, and fire safety codes and replace all mechanical, plumbing, and electrical systems with modern, efficient, and safe installations.

4. Identify the target population to be served by this project. The "target population" is the population that is or may reasonably be expected to be served by a specific service at a particular site. Explain whether this is a local program, or a program that serves a population outside of the proposed service area. Use the most recent Alaska Department of Labor and Workforce Development statistics for population data and projections. Explain

and document any variances from those projections. The population may be defined in one or more ways:

a. Document the service area by means of a patient origin analysis.
b. Justify the customary geographical area served by the facility using trade and travel pattern information. Indicate the number and location of individuals using services who live out of the primary service area.
c. Use Alaska Department of Labor and Workforce Development information, including current census data on cities, municipalities, census areas, or census sub-areas, to describe trends, age/sex breakdowns, and other characteristics pertinent to the determination of need.
d. The population to be served can be defined according to the unique needs of patients requiring specialized or tertiary care (e.g. heart, cancer, kidney, alcoholism, etc.) or the needs of under-served groups.

See also General Review Standard #1 in a later section.

PMC's target population for this project primarily includes the residents of Petersburg Borough and surrounding remote Southeast Alaska communities. As one of only three community-owned Critical Access Hospitals in Alaska unaffiliated with larger health care systems, PMC represents a unique and vital resource to the generations of Alaskan families we serve. The reach of PMC's services outstrips our service region population numbers: while the Alaska Department of Labor most recently lists the population of Petersburg Borough as 3,436, over the most recent three-year period PMC served 4,798 unduplicated individuals, including 3,698 people whose physical address was located in Petersburg Borough. Rural and remote healthcare providers like PMC serve significantly undercounted populations from seasonal workforce and visitors, as well as the US Coast Guard, each of which relies on us for quality care when they need it, whether they live in, work in, or just visit Alaska's remote communities. According to 2023 and 2024 data provided by the Alaska Department of Labor and Workforce Development, the target population includes but is not limited to:

- **Local Residents:** There are approximately 3,436 total residents of Petersburg Borough, with population estimates showing little or no growth by 2030 – a rate of growth which is nonetheless higher than the average for the Southeast Region, where population loss is projected overall.
- **65+ Population:** According to 2025 estimates, a quarter (25%) of the Petersburg Borough is aged 65+, with the relative population of 65+ projected to remain 25% through 2035. This is one of the highest populations of older adults nationwide (and has been among the fastest growing in the country for the past decade), and higher relative to the state as a whole, which is currently 16% 65+, projected to grow only to 18% by 2035.
- **Alaska Native**: According to the most recent Alaska Department of Labor and Workforce Development analysis, 15% of Petersburg Borough residents are Alaska Native or American Indian alone or in combination with other racial identities. PMC is the primary local healthcare provider for this population through longstanding service agreements with the regional Tribal Health consortium.
- **Surrounding Communities:** Residents from nearby islands and coastal communities like Wrangell (2,030 residents), or Kake and Klawock (5,740 residents), generally find it more convenient and less costly to travel to Petersburg Borough for specialized services not available in their local areas than to fly to Juneau or other urban areas. Some portion

of these populations are anticipated to benefit from establishing MRI services in Petersburg as well.
- **Transient Populations:** Additionally, seasonal workers, such as those in the fishing and tourism industries, can increase our local population by up to 20%+ during peak seasons.

The geographical isolation of Southeast Alaska means that travel for medical imaging like MRI is both time-consuming and expensive. Ferry travel (when available) to the nearest MRI facility in Juneau is a 10-hour trip one way; and like air travel is restricted in scheduling, necessitating multiple days of travel even without accounting for potential appointment delays or follow-ups. MRI access in Petersburg Borough significantly reduces travel and associated costs for residents in and around our service area.

The addition of MRI services will dramatically improve our diagnostic capabilities in:

- **Neurology:** Providing detailed images of the brain and spinal cord to detect strokes, tumors, aneurysms, or degenerative diseases like multiple sclerosis.
- **Cardiology:** Allowing for non-invasive cardiac MRI to assess heart function, detect cardiomyopathies, and guide the management of congenital heart diseases.
- **Orthopedics:** Enhancing our ability to diagnose bone and joint conditions, including sports injuries, arthritis, and spinal issues, with exceptional clarity to guide treatment plans.

These conditions are currently undiagnosed or require patients to travel for imaging. Given the occupational hazards of the fishing and logging industries, there is need for timely local imaging services to assess injuries. Those with mobility issues, older adults, disabled individuals, and caregivers whose responsibilities for young children or dependent adults, as well as low-income Alaskans, are all uniquely impacted by the lack of access to local MRI services. Local access to these services will eliminate the disproportionate logistical and cost burdens of travel.

By bringing MRI services to PMC, we aim to reduce barriers to needed healthcare, lower costs for patients and payers, and improve timeliness, efficiency, and quality of care for all those living in Petersburg Borough and surrounding areas.

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

While not currently performing any MRIs locally, PMC refers about 190 people annually for a scan. We are not certain as to the number that actually travel and have the scan performed. We also have no data on persons that live locally, but do not use our primary care and ED, and are referred to an MRI by an out-of-area provider.

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.

As noted in response to earlier sections, this project proposes a new service. For purposes of this CN, we have conservatively estimated that the number we know our referred from our providers locally is the year 1 estimate (192 MRIs). While no formal study has been undertaken, PMC has recognized the growing need for this service and has reviewed the literature to develop its utilization projections.

In 2018, the Kaiser Family Foundation conducted an analysis using the Organization of Economic Co-operation and Development (OECD) data on MRI use rates globally, finding that the U.S. use rate for MRI scans was 118 per 1,000 population.

A 2019 study *Trends in Use of Medical Imaging in U.S. Health Care Systems and in Ontario, Canada, 2000-2019* in the Journal of the American Medical Association, found use rates in the U.S. for all imaging (CT, MRI, ultrasound, nuclear medicine) have risen between 2000-2016.[4] The study examined 135 million imaging examinations conducted across 7 U.S. integrated healthcare systems. The findings are reported in annual rates per 1000 person-year, which is similar to rates per 1000 persons except that individuals contributed less than a full year during years they were born or died. The study found MRI rates in the U.S. in 2016 were:

- **64 per 1,000 person-years**
- 21 per 1,000 person-years for children under 18
- 139 per 1,000 person-years for adults

Finally, PMC also utilized outpatient MRI data available to us for rural communities in Washington State, which estimate a contemporary use rate of 87 per 1,000 population.

Applying these use rates to the Petersburg Borough population results in the following estimates, each of which is below the 1,000 minimum volume referenced in Section VI:

Use Rate	2024 Population	Estimated MRIs
64/1,000 population	3,436	220
87/1,000 population	3,436	300
118/1,000 population	3,436	405

[4] Smith-Bindman R, Kwan ML, Marlow EC, et al. Trends in Use of Medical Imaging in US Health Care Systems and in Ontario, Canada, 2000-2016. *JAMA.* 2019;322(9):843–856. doi:10.1001/jama.2019.11456

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.

As noted earlier, there is no access to MRI services within 200 miles of PMC's service area. The nearest services are in Juneau, accessible only by air or ferry travel potentially requiring multiple days away from home for a single appointment. However, based on the data calculated in response to the item c. above, PMC conservatively projected utilization of 16 scans per month for each of the first three years of operation. This is the same volume we currently refer through primary care and ED for an MRI.

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

This application proposes the acquisition of a new service, the establishment of locally based MRI services. The estimated utilization by PMC has conservatively been assumed to be 192 scans per year for the first three years of operation. PMC has based this on a number of factors including the number of patient referrals outside of the service area.

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:

While there may be incremental affects to utilization of inpatient, outpatient, or other diagnostic services we do not assume that the addition of MRI services will affect utilization of other services. The number of MRI scans will go from 0 (none) to 192 per year. MRI scan projections are provided in the table below.

	2026	2027	2028
Projected MRI Scans	192	192	192

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

Not applicable. No services will be reduced.

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

Please accept all of the information presented in this application as being pertinent to establish the need for PMC's proposed addition of MRI services.

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

All letters of support from local and regional agencies, other health care facilities, individuals, or government bodies will be provided in the upcoming public comment process.

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.

PMC reviewed the specific methodology for projecting MRI need outlined in the *Alaska Certificate of Need Review Standards and Methodologies* and calculated an annual use rate based on the requirement of providing 2,500 scans per 70,000 population. This equates to a use rate of 35.7 MRIs per 1,000 population. Applying this use rate to the latest state population estimates and projections of the Petersburg Borough results in a range of 115-120 MRIs annually, which is below the minimum threshold of 1,000 outlined in the Standards and less than the 192 per year that PMC already refers.

Year	MRI Use Rate per 1,000	Population Estimate (Petersburg Borough)*	MRI Need
2025	35.7	3,367	120
2030	35.7	3,297	118
2035	35.7	3,225	115
**Source: Alaska Department of Labor and Workforce Development*			

PMC believes that while this use rate is low, it does recognize that our population is not large enough to generate 1,000 scans. That said, a review of recent studies and data found use rates higher than the current methodology and sufficient to demonstrate that PMC's projected utilization of 192 annual scans is likely conservative. As outlined above in 5.d., these three use rates estimate a range of 220-405 scans for the 2025 projected population of the Petersburg Borough.

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.

See also General Review Standard #4 in a later section.

PMC considered the following alternatives:

1. Maintain status quo (do nothing). The impact of continuing without an MRI would mean:
    - Increased Costs: Medicare and Medicaid, and the patient and their family, would continue to experience the high costs associated with patients traveling to Juneau for MRI scans, including travel, lodging, and the MRI procedure itself.
        - **Patient Burden**: Patients would face prolonged wait times, travel-related stress, potential loss of income due to time away from work, and delayed treatment due to slower diagnostic processes.
        - **Health Risks**: The physical strain of travel might exacerbate conditions, especially for those with chronic illnesses or mobility issues, with potentially disproportionate impact on those who face barriers related to their age, disability status, caregiving responsibilities, or access to financial resources.

2. Utilizing a periodic mobile MRI unit. This alternative was rejected due to:
        - **Logistical Challenges**: Given Petersburg's location on an island, the logistics of transporting and operating a mobile MRI unit would be extremely difficult, involving significant challenges with transportation, setup, and maintenance.
        - **Consistency and Availability**: Even if feasible, MRI services would not be continuously available, leading to delays in patient diagnosis and treatment.
        - **Operational Costs**: The cost of logistics, maintenance, and operation in such an isolated location could be prohibitively high, with less control over scheduling.

PMC ultimately selected an on-site permanent MRI installation based on the following factors:

- **Community Health Needs**: An MRI is state of art, and essential for diagnosing a broad spectrum of conditions, offering unparalleled detail and versatility. There is no effective alternative technology that provides the same diagnostic capabilities. Each of PMC's Community Health Needs Assessments (required for non-profit hospitals every three years) over the past decade has identified local access to services including MRI as a primary community concern.
- **Cost Efficiency**: Installing an on-site MRI reduces long-term costs for both the patients and payers including Medicare and Medicaid by eliminating travel expenses and reducing diagnostic turnaround time. As Alaskans know well, there are times of year when travel and lodging costs in Juneau rise significantly in cost and may not be available at all due to fluctuating seasonal demands. There are also many days in the year where travel into Juneau is compromised by weather.
- **Improved Care Quality**: Immediate access to MRI services would enhance the speed and accuracy of diagnoses, leading to better treatment plans and outcomes.

- **Long-term Investment**: This option addresses both current needs and positions the facility to manage future healthcare demands efficiently, particularly given the geographical challenges of Petersburg.

In summary, the decision to establish local MRI services was based on the need to provide high-quality, accessible healthcare services directly to the population living in and around Petersburg Borough while considering the unique logistical challenges of being on an island. This approach ensures that Petersburg can offer comprehensive are while managing costs effectively for all involved.

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.

See also General Review Standard #1 in a later section.

Throughout the application PMC has demonstrated the unique needs of our isolated population and the impact on access to care and costs. The closest existing MRI services are 10 hours away by ferry, or require roundtrip airfare, increasing barriers and costs, risking delays in necessary care, and generating a lack of access for Alaskans living in our service area. The addition of the proposed services will mitigate or eliminate these factors and improve both the quality and standard of care locally and regionally. Our commitment to this expansion project is evidence of our commitment to adapting our services to meet the unique needs of each patient, ensuring that regardless of complexity, every individual receives the care, respect, and support they deserve.

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.

Our hospital serves a diverse population, including a significant number of older adults, many of whom are Medicare and/or Medicaid beneficiaries. PMC is the sole healthcare provider for a broad spectrum of rural and remote residents, including Veterans, Alaska Native patients, and patients who require diagnostic imaging but find it challenging or prohibitive to travel due to age, health conditions, or financial constraints.

There are no MRI facilities available in our service area, and no road access to MRI services for our population. The nearest service for MRI scans is in Juneau, which is not immediately accessible for those we serve due to geographical constraints. Without local MRI services, patients must travel by air or sea to Juneau for MRI scans. This is prohibitive for:

- **Travel:** Patients needing MRI services must arrange travel (either via ferry or flight) to Juneau, which can be logistically challenging, especially for more urgent cases or those with mobility limitations.
- **Cost:** High travel expenses (airfare averaging $500+ per round trip or ferry travel which can take upwards of 10 hours, one way) and accommodation costs affect patients' out-of-pocket expenses and increases the financial burden on Medicare and Medicaid, which fund these trips.
- **Accessibility:** Physical distance, coupled with Alaska's unique climate challenges, makes access to MRI services in Juneau less feasible for timely medical care. Travel is a significant barrier, especially during harsh weather, delaying or preventing needed procedures and leading to less optimal outcomes due to delayed diagnosis or treatment.
- **Acceptability:** Leaving one's home community for access to medical care presents cost and logistical barriers, as well as acceptability related to family support needs, assistive services, and the general comfort of being in a familiar environment. Many patients are unable or prefer not to leave their community for treatment, particularly if they are seriously ill or elderly.
- **Financial Assistance:** Medicare and Medicaid currently cover the cost of travel for necessary medical procedures, but this is still an inefficient use of resources.
- **Delayed Care:** The necessity of travel often results in delayed care, as patients might postpone the procedure due to the inconvenience or wait for weather conditions to improve.

By establishing an MRI service at our hospital, we would address these unmet needs by providing immediate, cost-effective, and culturally acceptable diagnostic services, thereby improving health outcomes, patient satisfaction, and financial efficiency for both the hospital and government-funded health programs.

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

See also General Review Standard #5 in a later section.

Since no local facilities currently offer MRI scans, there will be no direct competition with existing services in our immediate community. For facilities in Juneau or other cities where patients currently travel for MRI services, there might be a slight decrease in patient volume from our region. However, this impact would be minimal as these facilities would continue to serve their local populations and those from other parts of the state.

The MRI service will integrate seamlessly with our existing diagnostic and treatment services, enhancing the capabilities of our radiology department. It will allow for comprehensive care pathways that do not require patient travel for imaging, thus improving the flow of patient treatment within our hospital.

By offering MRI services locally, we provide an alternative to the current system where patients must leave their community for such services. This unique service will cater to the needs of those who cannot easily travel, offering a service not previously available in our area.

This service will particularly benefit rural Alaskans, including populations who face significant barriers in accessing healthcare. It will directly address the needs of older and disabled Medicare and Medicaid beneficiaries and caregivers who are disproportionately affected by travel costs and inconvenience.

In summary, introducing an MRI to our hospital will primarily improve local healthcare access without directly competing with existing facilities due to the absence of such services in our area.

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.

As the primary healthcare provider on the island, PMC enjoys strong working relationships with local providers (though we provide the predominance of services). For specialized care beyond our capabilities, we have:

- **Patient Transfer Agreements:** Formal agreements with Bartlett Regional Hospital in Juneau for emergency and specialized care transfers, including critical cases or when specialized surgery is required. These agreements ensure smooth, coordinated patient transfers with pre-arranged transport logistics.
- **Community Health Planning:** We participate in local health planning meetings with other community leaders and organizations to assess and address health needs, including disaster preparedness and public health campaigns.
- **Shared Services:**
    - **Emergency Services:** While we manage emergency care, we have informal agreements with local law enforcement and the Coast Guard for support in mass casualty events or natural disasters.
    - **Obstetrics:** Although limited by our isolation, we have arrangements for telehealth consultations with specialists in larger medical centers for complex obstetrics cases.

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.

For specific projections of Financial Feasibility, please see Schedule IV of Section IX.

With the congressional and HRSA grants covering 100% of the cost of WERC and the MRI, the financial burden of capital outlay is eliminated. This provides a solid foundation for financial viability from the outset and removes the need for loans or local fundraising, thus no interest costs or repayment obligations.

While operational costs remain, the costs for training or hiring staff can now be managed within the hospital's operational budget without the pressure of equipment financing. Utilities and consumables expenses will still be necessary but can be directly factored into the cost of each MRI scan, ensuring operational costs are covered by service fees.

With no debt service from equipment or construction costs, we can use the savings to subsidize other healthcare services or enhance our community service offerings. Cost savings can lead to better negotiation for reimbursement rates or provide a buffer to accept lower reimbursements if needed, making services more accessible to all patients, including those on Medicare or Medicaid.

Long-term Viability:

- **Demand:** The demand for MRI services remains constant, and is actually increasing slowly, ensuring a steady revenue stream without the initial investment cost impacting the hospital's financial health.
- **Reduction in Outflow:** We will keep volume local by reducing the need for patients to travel off-island.
- **Preventive and Early Detection:** The same benefits apply here, potentially reducing future healthcare costs for the community and state.

Financial Effect on Consumers:

- **Cost Savings:** Consumers directly benefit from potentially lower or more stable MRI costs due to the absence of equipment-related debt. There is also a significant reduction in personal/out-of-pocket expenses related to travel for MRI scans.
- **Increased Access:** The affordability and availability of local MRI services are enhanced, reducing the likelihood of patients foregoing MRI services and supporting timely diagnosis and earlier initiation of treatment.

Financial Effect on the State, Region, or Community Served:

- **State:** The state sees immediate benefits in terms of reduced healthcare costs for its Medicare and Medicaid patients, as no funds are required for equipment acquisition, and fewer travel expenses are incurred.
- **Region:** The region benefits from a model example of how federal grants can be utilized to improve rural healthcare, potentially encouraging similar investments elsewhere.
- **Community:** The community sees a direct economic benefit from retaining all healthcare expenditures within the local economy, job creation, and an elevation in the standard of healthcare without the community or hospital having to bear the financial burden of the equipment.

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 entire cost of the MRI machine and its associated building is covered by Congressional Community Project and HRSA grants, providing the necessary capital for:

- **Construction of the WERC,** which includes the suite that houses the MRI, including any architectural or engineering costs.
- **Acquisition of the MRI Equipment**
- **Installation** of the MRI, which includes specialized lead shielding and magnetic safety.

Once operational, the MRI will generate income through:

- **Service Fees:** We will charge for each MRI scan at rates that cover operational costs, including maintenance, staff salaries, and consumables.
- **Insurance Reimbursements:** Medicare, Medicaid, and private insurance payments for services rendered will form a significant part of the operational revenue.

The hospital's operational budget will absorb the additional staff costs for radiology technicians or training. These costs are manageable within our current financial framework, as they do not involve the capital expenses now covered by the grant.

PMC's long-term financial stability is evidenced through:

- **Hospital Financial Health**: PMC has a history of balanced budgets, with an established revenue stream from the assorted services it provides. Despite being in a remote location, PMC has managed its finances well, with reserves that can cover unexpected costs or operational shortfalls.
- **Revenue Projections**: Preliminary financial projections based on current healthcare utilization patterns in Petersburg suggest that the MRI will be financially self-sustaining within the first year of operation. We anticipate a demand that matches or exceeds the current need for off-island MRI services, ensuring revenue.
- **Backup Plans**: In case of unforeseen financial challenges, we have contingency plans, including:
    - Utilizing Hospital Reserves: If needed, we can dip into our financial reserves to maintain operations.
    - Cost Management: We can adjust operational costs by optimizing staff schedules, managing consumables more efficiently, or negotiating better supplier deals.
- **Community Support**: There's strong community support for this project, which could be leveraged for additional fundraising, if necessary, although this scenario is unlikely given the grant's scope.
- **State and Federal Support**: Being on an island in Alaska, there is a likelihood of continued support from state and federal programs for rural healthcare initiatives, ensuring long-term sustainability, including the recently budgeted Rural Transformation Initiative.

With the HRSA grant covering the capital costs, and our hospital's operational revenues expected to cover the ongoing operating costs of the MRI service, we demonstrate not only sufficient financial resources but also the stability to construct and operate this project. The financial model is designed to ensure that this service will be a long-term, sustainable asset to the community of Petersburg, Alaska.

3. Provide a description and estimate of:

a. Probable Impact of the Proposal on the Annual Increase in Health Service Costs:

This will reduce, not increase, costs associated with delayed diagnosis and treatment and costs for travel.

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: PMC is not applying to build a residential psychiatric treatment center, nursing home, or nursing home beds.

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

- **Immediate Feasibility:**
  - **Zero Capital Outlay:** With the HRSA grant, there is no immediate need for any capital investment or debt from PMC, ensuring financial stability from day one.
  - **Operational Costs:** Covered by revenue from services. The hospital's existing budget can comfortably accommodate the initial operational costs like staff training and consumables.
- **Long-term Financial Feasibility:**
  - **Revenue Stream:** MRI services are expected to become a steady revenue source due to consistent local demand. The absence of equipment debt service makes this project financially attractive long-term.
  - **Cost Management:** Operational costs will be managed through efficient service delivery, negotiated supply contracts, and potential bulk purchasing agreements for consumables.
  - **Market Demand:** The isolated nature of Petersburg ensures a captive market with limited competition, making long-term operations financially viable.
  - **Community and Health Impact:** Reducing travel for diagnostics can lead to cost savings for the state and better health outcomes, indirectly supporting the hospital's operational sustainability by reducing the need for emergency or out-of-state care.
  - **Risk Mitigation:** The hospital can leverage its financial reserves and community support for any unforeseen operational issues, ensuring continuity.

In summary, the proposal not only promises to reduce healthcare costs for the target population but also ensures immediate and long-term financial feasibility for the hospital, thanks to the strategic use of grant funding and anticipated operational revenues.

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.

PMC is committed to providing services based upon clinical need. Services are provided to all patients regardless of income, race, creed, gender, national origin, or disability. Included in **Exhibit 1** are copies of PMC's non-discrimination statement, financial assistance policy, and charity care policy demonstrating this commitment.

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.

Table 1 provides the requested information for the last four years and current year projected.

Table 1
Petersburg Medical Center
Charity Care, Revenue Deductions and Contractual Allowances, 2021-2025

Year	Charity Care	Revenue Deductions	Contractual Allowances
2021	$0	$3,039,754	$2,567,057
2022	$0	$4,501,821	$4,325,934
2023	$166,093	$5,658,039	$5,040,547
2024	$153,955	$4,814,102	$4,362,222
2025 proj.	$218,561	$5,852,264	$5,620,148

Source: Applicant

Table 2 provides pro forma information for PMC beginning in 2026.

Table 2
Petersburg Medical Center
Charity Care, Revenue Deductions and Contractual Allowances, 2026-2028

Year	Charity Care	Revenue Deductions	Contractual Allowances
2026	$343,369	$7,042,142	$6,012,035
2027	$360,537	$7,391,015	$6,309,403
2028	$378,564	$7,760,566	$6,624,873

Source: Applicant

3. Address the following access issues:

a. transportation and travel time to the facility;

Petersburg is a small community geographically and it is possible to traverse the whole city relatively easily. There is a public bus system, taxi, and ride shares. From the furthest part of the town, travel time to PMC is about 10 minutes.

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

PMC has ensured that the proposed building exceeds ADA standards, with ramps, automatic doors, and an elevator for easy access to all floors. There are wide corridors, accessible bathrooms, and plenty of seating areas. Non-slip flooring is used throughout, and there is clear, large-font signage with braille. For those with visual or hearing impairments, the building also has visual alarms, tactile wayfinding, and TTY phones available. PMC will arrange for interpreters if needed via video conference. Mobility aids such as wheelchairs are available at the entrance for anyone who might need them during their visit.

c. hours of operation;

PMC has extended our hours to include evening clinics from 6 PM to 8 PM on weekdays and half-day services on Saturdays. This accommodates those who cannot make it during traditional hours due to work or other commitments.

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

PMC’s nondiscrimination policy is clearly posted in our waiting areas, on our website, and included in our patient information packets. We do not discriminate based on any protected characteristics like race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Staff training on cultural sensitivity and inclusivity is mandatory and occurs annually. We ensure all employees understand how to provide care without bias. We offer translation and interpretation services for non-English speaking patients and ensure all medical equipment and facilities are accessible to everyone, including those with disabilities. We have a transparent reporting system for any discrimination concerns, with a dedicated compliance officer to investigate and resolve issues swiftly. This aligns with legal requirements like those set forth by the ACA.

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.

PMC currently holds an active hospital license from the State of Alaska, renewed annually, with the last renewal on January 1, 2024. PMC is certified for both Medicare and Medicaid services, ensuring compliance with federal health standards. Our CMS Certification Numbers (CCN) for these programs are updated and active.

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

To ensure high-quality service, PMC employs a comprehensive Quality Management Program that includes:

- Regular peer reviews and audits.
- Continuous staff training and certification updates.
- Patient satisfaction surveys with actionable feedback loops.
- Implementation of evidence-based practices.
- A dedicated quality improvement team that conducts monthly reviews of clinical outcomes and patient care processes.

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

Our staffing plan includes physicians, nurses, and allied health professionals at ratios that comply with industry standards (e.g., 1:5 nurse-to-patient in acute care, adjusted for acuity). Technicians and support staff are scheduled based on workload analysis to ensure efficiency without compromising care. We employ administrative and support roles like housekeeping and dietary services with a focus on flexibility to meet peak demand times.

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

As part of its two phased modernization project, PMC is exploring:

- Expansion of outpatient services to reduce hospital admissions for non-acute conditions,
- Assisted living in partnership with local providers,
- Increased focus on home health services to reduce unnecessary hospital stays, and
- Preventive health care through programs like community health screenings and wellness education to minimize emergency visits.

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.

This CN proposes the modernization of diagnostic services and treatment at PMC. We will operate a state-of-the-art MRI machine equipped with the latest imaging technology that will dramatically improve our diagnostic capabilities in:

- **Neurology:** Providing detailed images of the brain and spinal cord to detect strokes, tumors, aneurysms, or degenerative diseases like multiple sclerosis.
- **Cardiology:** Allowing for non-invasive cardiac MRI to assess heart function, detect cardiomyopathies, and guide the management of congenital heart diseases.
- **Orthopedics:** Enhancing ability to diagnose bone and joint conditions, including sports injuries, arthritis, and spinal issues, with exceptional clarity to guide treatment plans.
- **Oncology:** Facilitating early detection and precise staging of cancers, which is crucial for effective treatment planning.

The benefits of the new, modern MRI services include a reduction in the need for exploratory surgeries, greater diagnostic certainty, and earlier intervention, improving patient outcomes. It will also eliminate the current necessity for our patients to travel for such services, significantly reducing costs and inconvenience.

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

PMC will implement:

- **Automated Medication Dispensing Systems:** To reduce errors and staff time spent on medication management.
- **Electronic Health Records (EHR):** To streamline information management and care coordination.
- **Robotic Cleaning Systems:** For improved hygiene with less labor.

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

Future evaluations will include:

- **Outcome Studies:** To measure the effectiveness and quality enhancements of new services like MRI against expectations.
- **Cost-Benefit Analysis:** Regular review of financial and health outcomes to adjust service delivery.
- **Patient and Provider Feedback:** Integrated into our ongoing quality assurance process.

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

PMC's organizational chart is included as **Exhibit 2.**

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.

Descriptions of Major Position Requirements (hospital wide):

- Registered Nurses (RNs):
  - Must hold a valid RN license in Alaska, with a Bachelor's degree in Nursing preferred. Experience in acute care, especially in specialties like geriatrics or emergency care, is critical. RNs need to be adept at patient assessment, medication administration, IV therapy, and patient education.
  - Medical-Surgical: 1 RN to 5 patients, based on the American Nurses Association (ANA) guidelines for maintaining patient safety and quality care.
  - Critical Care: 1 RN to 2 patients, reflecting the higher acuity of care required.
  - Nursing: To maintain proficiency, RNs should have a minimum of 20 hours per week in direct patient care, ensuring they engage with a variety of clinical scenarios. This is based on the principle of maintaining clinical competence through regular practice.

- Physicians:
  - Board-certified, or eligible, in their specialty, with a valid medical license to practice in Alaska. Must demonstrate proficiency in diagnosis, treatment planning, emergency management, and ongoing Continuing Medical Education (CME).
  - Physicians: Specialists should see a minimum number of patients or perform procedures aligned with their specialty's average caseload to maintain and refine their skills. For example, a radiologist should interpret at least 50 MRI scans per month to stay proficient, based on informal standards within the field.

- Radiologic Technologists:
  - Must possess an Associate's degree from an accredited program, be certified by the American Registry of Radiologic Technologists (ARRT) and hold a license from the Alaska Board of Medical Imaging and Radiation Therapy. Need expertise in operating imaging equipment, including the MRI.
  - Imaging (Post-MRI Installation): one radiologic technologist for MRI unit during operational hours, with support for scheduling and patient management to ensure efficient throughput.
  - Radiologic Technologists: For MRI technologists, PMC will ensure that they are well-trained and experienced in proper patient positioning, image acquisition, and adherence to protocols.

- Physical Therapists:
    - A Doctorate in Physical Therapy (DPT) is required, along with licensure by the Alaska Physical Therapy Board. Skills include patient rehabilitation planning, manual therapy, and therapeutic exercise prescription.
    - One physical therapist or therapist assistant to 3-4 patients in outpatient settings, depending on the complexity of cases.
    - Physical Therapists: They must engage in continuous therapy sessions, averaging at least 20 patient interactions per week to maintain clinical skills, as recommended by the American Physical Therapy Association.

- Support Staff (e.g., Medical Assistants, CNAs):
    - Certified Medical Assistants (CMAs) need certification from the American Association of Medical Assistants or a similar body, while Certified Nursing Assistants (CNAs) must be certified in Alaska. These roles involve direct patient care support, from vital signs to basic patient mobility assistance.
    - CNAs or Medical Assistants should be available in ratios that support nursing staff, typically one per 10-15 patients on general wards, adjusted for patient dependency.

PMC's staffing standards are guided by:

- American Nurses Association (ANA) for nursing ratios and competencies.
- The Joint Commission for overall staffing adequacy in healthcare settings.
- Specialty-specific organizations like the American College of Radiology for imaging staff and the American Physical Therapy Association for physical therapy staffing.

These standards help ensure that our staff at Petersburg Medical Center not only meet but exceed the expectations for quality care delivery, maintaining both patient safety and staff proficiency in their respective fields.

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.

While our volumes will be low, PMC is confident that it can offer a high-quality service. PMC has determined, for all of the reasons outlined in this CN application, that a permanent fixed MRI is the best option, based on:

- **Local Demand and Access Limitations:** Considering the population size of Petersburg and surrounding areas, and the current necessity for residents to travel for MRI scans, a single unit can meet demand; well into the future.
- **Cost-Benefit Analysis**: The high cost of travel for residents to access MRI services in other cities justifies this investment even on a smaller scale. PMC believes, from a continuity of care perspective, that a locally based service will increase continuity of care as well as reduce travel expenses for patients. PMC's grant funds allow it to establish this new service without significant capital expenditure.

PMC proposes to install one fixed unit MRI unit based on:

- **Financial Sustainability:** Given the size of the service area, and its remoteness necessitated the installation of one MRI as opposed to a moveable machine. As noted earlier, with the grant funding, PMC will be able to operationalize the MRI service without any capital investment beginning in year 1.
- **Utilization Rates:** PMC has conservatively assumed that the volumes will be low in that we assumed no growth over patients currently referred by PMC. Data included in an earlier section of this application details that the CN MRI methodology likely understates, significantly, demand.
- **Impact on Travel Costs:** By having an MRI in Petersburg, we directly address the high cost and inconvenience of travel for residents. The savings in travel and lodging costs for each MRI scan significantly reduce the overall cost of care for the community, making healthcare more accessible and affordable.
- **Staffing:** As noted earlier, PMC is only proposing to add one fixed location MRI. We have no plans to add a 2nd one. PMC is confident that it will have the staff needed to operate a high quality, albeit small volume service.
- **Space and Infrastructure:** The WERC will include space for one MRI unit which should be sufficient for the foreseeable future.
- **Growth Potential:** At this point in time, PMC's single MRI will be able to accommodate significant growth well into the future.
- **Community Benefit:** A single MRI unit is transformative for healthcare access for residents, directly tackling the issue of high travel costs for diagnostic imaging.

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.***

According to the last update of the Alaska Certificate of Need Review Standards and Methodologies (December 9, 2005), the Department will apply general review standards, the applicable service-specific review standards, the standards set out in AS 18.07.043, and the requirements of 7 AAC 07 in its evaluation of CN applications. The six *General Standards* applicable to all CN applications are restated below.

General Review Standards

1. **The applicant demonstrates 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.**

Like many SE Alaska communities, Petersburg is located on an island, and it is accessible only by water or air, the Alaska Marine Highway System (ferry), or local boat charters/operators. The need for an MRI in Petersburg is justified by the fact that 100% of those in need have to travel out of area, most commonly to Juneau for services. This incurs significant costs, lost time, and inconvenience. Our demographic analysis shows an aging population with increased health needs (data demonstrates that the 65+ use health care services at 3 to 5 times the rate of the under 65). This increased utilization is for a variety of services including diagnostic imaging, which supports the necessity of this project. The project targets both local residents and those from surrounding communities, eliminating the need for travel, and delay in diagnosis or treatment, thus directly addressing an unmet need in our service area.

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

The proposed project is fully integrated into PMCs strategic planning, including a 5-year strategic enhancement of the hospital's service capabilities through expansions and renovations. The proposed expansion underscores our dedication to elevating the standard of healthcare in Petersburg, ensuring that our community has access to comprehensive, high-quality medical services locally. Nationally, there is a trend towards decentralizing high-tech medical services from urban centers to smaller communities, improving access to care. Installing an MRI in

Petersburg aligns with this trend, reducing the dependency on larger, more distant hospitals for specialized diagnostics.

The addition of MRI services in our rural service area supports the Healthy Alaskans 2023 health improvement strategy of *Healthcare Access: Reduce the rate of preventable hospitalizations per 1,000 adults,* rising to meet long-documented national trends in MRI usage for high quality preventative and diagnostic care.

PMC will implement quality control measures tailored for MRI services, including peer reviews and maintenance of equipment. All staff involved in MRI operations will undergo specialized training and certification, ensuring that the care provided is of the highest quality.

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

PMC has actively engaged stakeholders in a Community Health Needs Assessment Process. The last CHNA (2022) showed high community need and interest in the expansion of technology, facilities, and services. Diagnostic technologies and expansion of services locally were specifically identified as needed and community input supported locally based hospital services.

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

As noted in an earlier section of this application, PMC considered the project alternatives including maintaining status quo (do nothing), outsourcing services by partnering with, or contracting out, to another facility, or utilizing an intermittent mobile MRI unit. PMC ultimately selected an on-site MRI installation based on the following factors:

- Community Health Needs: An MRI is essential for diagnosing a broad spectrum of conditions, offering unparalleled detail and versatility. There is no effective alternative technology that provides the same diagnostic capabilities.
- Cost Efficiency: Installing an on-site MRI reduces long-term costs for both the patients and payers by eliminating travel expenses and reducing diagnostic turnaround time.
- Improved Care Quality: Immediate access to MRI services would enhance the speed and accuracy of diagnoses, leading to better treatment plans and outcomes.
- Long-term Investment: This option addresses both current needs and positions and the facility to handle future healthcare demands efficiently, particularly given the geographical challenges of Petersburg.

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

Since no local MRI is in place, PMC's project will have a positive impact on the existing local health care service area by filling a diagnostic service gap. The MRI service will integrate seamlessly with our existing diagnostic and treatment services, enhancing the capabilities of our radiology department. It will allow for comprehensive care pathways that do not require patient travel for imaging, thus improving the flow of patient treatment within our hospital.

The proposed service will particularly benefit rural Alaskans, including the populations described above, who face disproportionate barriers in accessing healthcare. Specifically, it will directly address the needs of Medicare and Medicaid beneficiaries who are disproportionately affected by travel costs and inconvenience.

We do not anticipate any negative impact on the statewide delivery system as moving services from more urban (Juneau) to rural will reduce costs. There are a number of providers in Juneau with MRI capabilities including the local hospital, SEARHC, and several specialty clinics. We understand that several have relatively long wait times; this fact coupled with our low volume, suggests no negative financial impact.

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

The proposed project enhances healthcare access by providing services locally, reducing travel time and cost for patients from Petersburg and nearby areas. The new facility will be ADA compliant, offering accommodations for the elderly and disabled, thus improving service availability for all community members.

Service-Specific Review: MRI Services Review Standards

After determining whether an applicant has met the general review standards in Section I of this document, the department will apply the following service-specific review standards, as applicable, in its evaluation of an application for a certificate of need for Magnetic Resonance Imaging:

1. Except as provided in Review Standard 2, an applicant who seeks to establish an MRI service demonstrates the ability to provide a minimum of 3,000 MRI scans per year by the end of the third operational year, dating from the initiation of the service.

PMC does not propose that it provide 3,000 MRI scans per year and has provided additional documentation and support for its project in response to Review Standard 2 below.

2. An applicant who seeks to establish an MRI service in a community with a population of 10,000 or less demonstrates the ability to provide a minimum of 1,000 MRI scans per year by the end of the third year, dating from the initiation of the service. (Based on the estimate of a minimum of 2,500 scans/70,000 people, it is estimated that the minimum service area population for an MRI service to provide a minimum of 1,000 MRI scans per year would be 28,000 people.)

PMC is located in a service area with a population of less than 4,000 people. Using the data in the CN guidelines, a "use rate" can be calculated (1,000 scans per year for 28,000 people = 35.7 scans per 1,000 population, or an estimated 115-120 scans annually in the Petersburg Borough).

As discussed in earlier sections, this use rate is significantly lower than use rates found in recent data and literature. Specifically, more recent use rates ranged from 64/1,000 population to a high of 118/1,000 population. All of these use rates would support PMC's proposed project.

Use Rate	2024 Population	Estimated MRIs
64/1,000 population	3,379	216
87/1,000 population	3,379	295
118/1,000 population	3,379	399

Nonetheless, PMC does not anticipate performing 1,000 scans per year. This application demonstrates our quality, accessibility, distance to an MRI and reduced total cost of care. This project should be approved based on those criteria.

3. No MRI service will be approved at a location that is less than 30 minutes access time of an existing MRI service performing fewer than 3,000 scans per year, or of a CON-approved, but not yet operational, MRI service.

PMC is located on an island accessible only by water or air. Travel to the nearest MRI service requires significant travel in terms of both time and cost; well in excess of the 30 minutes access time in this standard. As such, this standard is not applicable.

Section VII. Construction Data

A. Please check appropriate boxes:

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

B. Project Development Schedule

1. Estimated completion of final drawings and specifications
2. Estimated construction begun by
3. Estimated construction complete by
4. Estimated opening of proposed services Summer 2025

As noted in earlier sections of this application, the building has been completed.

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 site is owned, and the title for the land is held by Petersburg Borough. PMC is a Borough-owned non-profit Critical Access Hospital with all the buildings and land owned by the Borough and designated for use by the PMC.

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

The requested information is included as an attachment in **Exhibit 3**.

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).

As noted in earlier sections of this application, the building has been completed, and all appropriate approvals have been acquired.

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

The information requested in #4 is included as an attachment in **Exhibit 4**.

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

The information requested in #5 is included as an attachment in **Exhibit 4**.

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

As noted in response to earlier questions, the building has been completed. Because it was a greenfield site, it had no impact on existing services. .

Section VIIIA. Financial Data - Acquisitions

1. Acquisition type: (Please check applicable boxes)

☐ Lease ☐ Rent ☒ Donation ☐ Purchase ☐ Stock Transaction

2. Cost data (Omit cents)

a. Total acquisition cost*	$1,756,800
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.)	Donation: $1,756,800
d. Anticipated interest rate ___% , term ___ years.	
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.

The financing for the project is secured through a combination of contributions and grants. The Petersburg Borough has generously donated the land for the new facilities. Additionally, funding has been obtained through grants from the U.S. Department of the Treasury and the Health Resources and Services Administration (HRSA).

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 VIIIB. 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)	$1,756,800
b. Estimated general construction**	$19.442,911[5]
c. Fixed equipment, not included in a**	$0
d. Total construction costs (sum of items a, b, and c)**	$21,199,711
e. Major movable equipment**	$970,520
f. Other cost:**	
(1) Administration expense	$297,458
(2) Site survey, soils investigation, and materials testing	$0
(3) Architects and engineering fees	$1,319,451
(4) Other consultation fees (preparation of application included)	$394,600
(5) Legal fees	$47,822
(6) Land development and landscaping	$0
(7) Building permits and utility assessments (including water, sewer, electrical, phones, etc.)	$145,960
(8) Additional inspection fees (clerk of the works)	$50,000
(9) Insurance (required during construction period)	$0
g. Total project cost (sum of items d, e, f)	$24,425,522
h. Amount to be financed	$0
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.)	$24,425,522
j. Anticipated long-term interest rate 0%	
k. Anticipated interim (construction) interest rate 0%	
l. Anticipated long-term interest amount	$0
m. Anticipated interim interest amount	$0
n. Total items g, l, and m	$0
o. Estimated annual debt service requirement	$0
p. Construction cost per sq. ft.	$1,067
q. Construction cost per bed	N/A
r. Project cost per sq. ft.	$1,287
s. Project cost per bed (if applicable)	$0

SQ ft = 18,980
*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.

[5] The general construction costs include $780,000 in FFE.

Section IX. Financial Data – All Proposed Activities

Provide an accompanying narrative explanation for each of the schedules below if there are any significant trends or significant changes in any item or group of items from year to year.
Note: Indicate whether you are using a calendar year or other fiscal year period.

A. Attach Schedule I - Facility Income Statement

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

B. Attach Schedule II - Facility Balance Sheet

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

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

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

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

D. Attach Schedule IV – Operating Budget

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

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

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

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.

G. Attach Schedule VII – Depreciation Schedule

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

Schedules I – VII above are all reported in Fiscal Year and attached as **Exhibit 5 .**

APPLICATION FEE – DETERMINATION AND CERTIFICATION OF AMOUNT

Determination of Application Fee Using 7 AAC 07.079

7 AAC 07.079 Specifies: An applicant for a certificate of need must include with the application a nonrefundable application fee as follows:

(1) for an activity valued at $2,500,000 or less, $2,500 or

(2) for an activity valued at more than $2,500,000, a fee equal to .1 percent of the estimated cost, up to a maximum fee of $75,000.

Estimated Cost of the Project (i.e., activity value): $24,425,522

Amount of Application Fee Submitted with this application: $24,425.52

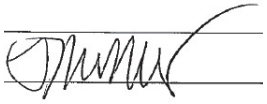
Certification of Individual Determining Application Fee

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: July 22, 2025

Facility Name and Address:
Petersburg Medical Center,
103 Fram Street
Petersburg, AK 99833

Name and Title of Person Determining Application Fee:
Philip Hofstetter, CEO



_____
Signature of Certifying Officer of the Organization

PMC CON Exhibit List

Exhibit 1 – Hospital Policies (Non-Discrimination, Financial Assistance, and Charity)

Exhibit 2 – PMC Organizational Chart

Exhibit 3 – Section VII. C. Facility Site Data – Diagrammatic Site Plan

Exhibit 4 – Section VII. C. Facility Site Data – Architectural and Schematic Floor Plan

Exhibit 5 – Section IX. Financial Data – Schedules:

A. **Schedule I - Facility Income Statement**
B. **Schedule II - Facility Balance Sheet**
C. **Schedule III - Average Patient Cost Per Day (Per Diem Rate if applicable) and Revenue Amounts**
D. **Schedule IV – Operating Budget**
E. **Schedule V – A. Debt Service Summary, and B. New Project Debt Service Summary**
F. **Schedule VI - Reimbursement Sources**
G. **Schedule VII – Depreciation Schedule**

Exhibit 1 – Hospital Policies (Non-Discrimination, Financial Assistance, and Charity)

Discrimination is Against the Law

Petersburg Medical Center complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. Petersburg Medical Center provides reasonable modifications and free auxiliary aids/services such as access to qualified language interpreters via the Languageline app, written information in other formats (large print, audio, and translated documents). If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, please request assistance at reception.

If you believe that Petersburg Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sheena Canton, Compliance Officer/Section 1557 Coordinator,
PO Box 589 Petersburg, AK 99833
907-772-5724, fax: 907-531-5924, scanton@pmc-health.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Sheena Canton/ Compliance Officer/ Section 1557 Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Status **Active** PolicyStat ID **9614416**

Origination	07/2016	Owner	Cynthia Brandt: Chief Financial Officer
Last Approved	04/2021	Policy Area	Fiscal Services
Last Revised	04/2021		
Next Review	04/2022		

Financial Assistance Policy

PURPOSE/SCOPE

The Financial Assistance Policy is designed to provide a consistent and uniform evaluation of the patient/guarantor's ability to pay self pay balances owed to Petersburg Medical Center (PMC). The overall expectation of Petersburg Medical Center is that those persons who have the ability or resources to pay amounts due to PMC should be required to do so. However, those persons who cannot pay amounts owed, or who face extenuating circumstances, may receive corresponding accommodation by PMC in the form of a Financial Assistance write off.

POLICY

Petersburg Medical Center is committed to the provision of health care services to all persons in need of medical attention regardless of the ability to pay. Petersburg Medical Center does not discriminate in the provision of services to an individual based on: the individual's inability to pay; whether payment for those services would be made under Medicare, Medicaid, or CHIP; the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. This Financial Assistance Policy establishes criteria for discounts from billed charges to those persons whose income or resources are insufficient to pay for services provided to them.

All services billed by the Petersburg Medical Center, including but not limited to inpatient, outpatient, emergency, physician and clinic services are covered by the hospital's Financial Assistance Policy. Asset testing and other items not related to income or family size will not be applied.

DEFINITIONS

Patient/guarantor: These terms are used interchangeably in the Policy to refer to the person or persons responsible for payment of the services provided.

Alaska Poverty Level: The schedule of annual and monthly poverty guidelines issued for the State of Alaska by the U.S. Department of Health and Human Services.
Medicaid and Medicare: Government programs which provide payment for medical services to individuals under certain circumstances.
Self Pay Balance: The balance of a patient account owed by the patient/guarantor, either after a third party such as an insurance company or Medicare has paid on the account, or because the responsible party has no insurance or other coverage.
Third Party: Companies, programs or individuals, other than the patient/guarantor , who have legal obligations to pay on a patient account. Examples of third parties are insurance companies, Medicare, Medicaid, Worker's Compensation programs, the Veteran's Administration, or individuals (in the case of automobile accidents).

PROCEDURE

1. The Financial Assistance policy applies to self-pay balances after all third party and personal resources have been exhausted. Financial assistance is secondary to all other resources. Financial assistance may be applied for prior to services being received if the guarantor expects there may be a cost to the services over and above his or her ability to pay for such services. Financial assistance may not be applied to an account that has been turned over to a collection agency for collection.
2. Complete application may be submitted as follows:
    a. Delivered in person to the PMC Business Office
    b. Faxed to the PMC Business Office (907)772-3085
    c. Emailed to financialservices@pmc-health.org
    d. Mail to: Petersburg Medical Center, PO Box 589, Petersburg, AK 99833
3. To qualify for financial assistance, the patient, guardian, guarantor, relative, or patient representative must complete the Financial Assistance Application and provide the required supporting documentation.
4. All patients/guarantors who receive a Financial Assistance Application must complete and return the application within 10 business days (unless the patient calls with a legitimate reason to extend the deadline), along with the required documentation listed in the application that serves as the minimum information necessary to process an application for financial assistance.
5. A Medicaid application is required to be concurrently completed with most Financial Assistance Applications. PMC may dispense with the Medicaid application requirement if the guarantor's circumstances indicate that the Medicaid application will be denied. If guarantors are required to complete a Medicaid application, the Medicaid application must be submitted within two weeks of the Financial Assistance Application. It is the patient's responsibility to notify PMC if their financial situation changes. PMC reserves the right to reevaluate a patient's financial assistance based off any changes in patient's financial situation.
6. A copy of the completed Medicaid application must be supplied to Petersburg Medical Center. Failure to provide evidence that Medicaid has been applied for when required may result in the account being turned over to a collection agency immediately.

7. Medicaid applications generally take about 30 days to process. The response from Medicaid, either approval or denial, must be submitted to the Business Office immediately upon receipt by the guarantor or applicant.
8. Patients already receiving Medicaid and unable to make their Medicaid co-payments may qualify for financial assistance. Co-payments of $50 or less will automatically qualify for write off. Medicaid patients with Co-payments of $50 or more will need to apply for financial assistance.
9. There are instances where a patient may appear eligible for Financial Assistance care, but supporting documentation is lacking or unavailable. In such event, Petersburg Medical Center will use other appropriate 3rd party resources to estimate an individual's income. A patient meeting the criteria for presumptive financial assistance will have all charges waived. Presumptive eligibility may be determined on the basis of an applicant's circumstances that may include:
    a. Enrolled in a state-funded prescription programs
    b. Being homeless or receiving care from a homeless clinic
    c. Participating in a WIC program
    d. Being eligible for food stamps
    e. Being eligible for other state or local assistance programs such us Medicaid and out-of-state Medicaid
    f. Residing in low income/subsidized housing, providing the address supplied by the patient is a valid address
    g. Patient is deceased with no known estate
10. Financial assistance eligibility depends on annual income and family size. All circumstances are considered in the determination of eligibility for a financial assistance write off, including income other than wages, employment status, and the ability to earn income in the immediate future and in the long term.
11. Financial assistance applications are processed by the Petersburg Medical Center Chief Financial Officer, Controller, or designee. Notifications of either approval or denial are made in writing to the address on the application. Determinations on financial assistance applications are normally made within 10 business days of submission.
12. Financial assistance write offs are based on the percentage of gross monthly income compared to the current monthly Alaska Poverty Level. The Alaska Poverty Level is revised annually by the U.S. Department of Health and Human Services. The write off percentages are outlined in attached file.
13. Appeals of financial assistance denials may be made in writing to the PMC Chief Executive Officer or designee within 10 business days of receipt of the denial. The appeal request must be in writing. Determinations by the Chief Executive Officer or designee are final.
14. A request may be made for a catastrophic circumstance adjustment, even if the guarantor's income exceeds the current Alaska Poverty Level. Typical catastrophic circumstances are cases where major medical issues, or extensive long term medical problems, have placed the guarantor in severe economic jeopardy. The catastrophic adjustment request must be in writing with adequate supporting documentation. Catastrophic adjustment decisions are

documented in writing by the Chief Financial Officer or Controller.

OTHER CONSIDERATIONS

Determining Amounts Generally Billed

Following a determination of financial-assistance eligibility, an individual will not be charged more than the amounts generally billed (AGB) for emergency or other medically necessary care provided to individuals with insurance covering that same care.

At Petersburg Medical Center the AGB is determined through the "Look-back method" which is calculated as follows:

1. The AGB is calculated by reviewing all past claims that have been paid in full to the hospital facility for medically necessary care by Medicare with all private health insurers paying claims to the hospital in a prior 12-month period. This amount can include co-insurance; copayments and deductibles.
2. The AGB for emergency or medically necessary care provided to a financial assistance-eligible individual is determined by multiplying gross charges for that care by one or more percentages of gross charges (called "AGB percentages").
    a. The percentages are calculated at least annually by dividing the sum of certain claims paid to the hospital facility by the sum of the associated gross charges for those claims.
    b. Multiple AGB percentages may be calculated for separate categories of care (for example, in-patient versus out-patient care; or care provided by different departments) or for separate items or services.
3. The percentages are applied by the 45th day after the end of the 12-month period the hospital facility used in calculating the AGB percentage(s).

Criteria for Referral to Third Party Collection

Petersburg Medical Center will make all reasonable efforts to determine eligibility under its financial assistance policy prior to sending any account to a third party for collection.

Guarantors for self-pay accounts have 120 days from the date of the first statement to apply for financial assistance or to pay the balance in full. Within the 120 days, guarantors will receive three statements, a courtesy phone call, and a final demand letter. Any outstanding balance due after 120 days from the first statement date will be referred to a third party collection agency.

Payment Plan

Petersburg Medical Center offers an affordable payment plan to assist patients in meeting their financial needs and obligations.

The following schedule will be used by the Business Office in establishing a reasonable payment schedule by guarantors. This schedule is modifiable with approval of the Chief Executive Officer and Controller, or designees.

Balance:	Payment Term
$125- $749.99	6 months
$750 –$1,499.99	12 months
$1,500-$2,499.99	18 months
$2,500 – $2,999.99	24 months
$3,000 +	36 months

Any patient may apply for financial assistance up to 240 days after the first billing date and no extraordinary collection activity (credit reporting and/or legal action) will take place before the 240 days.

CROSS REFERENCE

Credit and Collection Policy

REFERENCE

Alaska Poverty Guidelines

Financial Assistance application

AFFECTED DEPARTMENTS

Facility wide

END OF POLICY

All Revision Dates

04/2021, 03/2021, 03/2021, 01/2021, 01/2021, 03/2019, 06/2017, 07/2016

Attachments

2021 Sliding fee matrix

Approval Signatures

Step Description	Approver	Date

	Philip Hofstetter: CEO	04/2021
Policy Committee	Belinda Chase: Policy coordinator	04/2021
	Rocio Tejera: Controller	04/2021

Origination:	*07/2016*
Last Approved:	*01/2021*
Last Revised:	*01/2021*
Next Review:	*01/2022*
Owner:	*Rocio Tejera: Controller*
Policy Area:	*Financial Services*
Affected Areas:	

Charity Policy

PURPOSE/SCOPE

The Charity Policy is designed to provide a consistent and uniform evaluation of the patient/guarantor's ability to pay self pay balances owed to Petersburg Medical Center (PMC). The overall expectation of Petersburg Medical Center is that those persons who have the ability or resources to pay amounts due to PMC should be required to do so. However, those persons who cannot pay amounts owed, or who face extenuating circumstances, may receive corresponding accommodation by PMC in the form of a charity write off.

POLICY

Petersburg Medical Center is committed to the provision of health care services to all persons in need of medical attention regardless of the ability to pay. Petersburg Medical Center does not discriminate in the provision of services to an individual based on: the individual's inability to pay; whether payment for those services would be made under Medicare, Medicaid, or CHIP; the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.This Charity Policy establishes criteria for discounts from billed charges to those persons whose income or resources are insufficient to pay for services provided to them. All services billed by the Petersburg Medical Center including but not limited to inpatient, outpatient, emergency, physician and clinic services are covered by the hospital's Financial Assistance Policy.

DEFINITIONS

Patient/guarantor: These terms are used interchangeably in the Policy to refer to the person or persons responsible for payment of the services provided.
Alaska Poverty Level: The schedule of annual and monthly poverty guidelines issued for the State of Alaska by the U.S. Department of Health and Human Services.
Medicaid and Medicare: Government programs which provide payment for medical services to individuals under certain circumstances.
Self Pay Balance: The balance of a patient account owed by the patient/guarantor, either after a third party such as an insurance company or Medicare has paid on the account, or because the responsible party has no insurance or other coverage.
Third Party: Companies, programs or individuals, other than the patient/guarantor , who have legal obligations to pay on a patient account. Examples of third parties are insurance companies, Medicare, Medicaid, Worker's Compensation programs, the Veteran's Administration, or individuals (in the case of automobile accidents).

PROCEDURE

1. The Charity Policy applies to self pay balances after all third party and personal resources have been exhausted. Charity is secondary to all other resources. Charity may be applied for prior to services being received if the guarantor expects there may be a cost to the services over and above his or her ability to pay for such services. Charity may not be applied for after an account has been turned over to a collection agency for collection.
2. A Medicaid application is required to be concurrently completed with most charity applications. The PMC Business Office may dispense with the Medicaid application requirement if the guarantor's circumstances indicate the Medicaid application will be denied. If guarantors are required to complete a Medicaid application they may wait for a response from Medicaid before completing the charity application.
3. Medicaid applications must be submitted to the State of Alaska Medicaid office within 14 days of the guarantor's first contact with the Business Office regarding charity. A copy of the completed Medicaid application must be supplied to Petersburg Medical Center. Failure to provide evidence that Medicaid has been applied for when required may result in the account being turned over to a collection agency immediately.
4. Medicaid applications generally take about 30 days to process. The response from Medicaid, either approval or denial, must be turned in to the Business Office immediately upon receipt by the guarantor.
5. Criteria on the charity application include annual income, household/family size, assets, amounts owed, and income tax returns for two years. All circumstances are considered in the determination of eligibility for a charity write off including, but not limited to, disposable assets, income other than wages, , and the ability to earn income in the immediate future and in the long term. A credit report on the guarantor, or any member of the household, may be generated at the option of Petersburg Medical Center. A deliberate omission or misstatement on the charity application will result in a denial when identified.
6. The charity application must be returned within 14 days of when the application form is given to the account guarantor. Failure to return the charity form, with all attachments, within 14 days may result in the account, or accounts, being immediately turned over to a collection agency.
7. Charity applications are processed by the Petersburg Medical Center Chief Financial Officer, controller or designee. Notifications of either approval or denial are made in writing to the address on the application. Determinations on charity applications are normally made within 14 days of submission.
8. Amounts written off for approved charity applications are based upon the percentage of gross monthly income compared to the current monthly Alaska Poverty Level. The Alaska Poverty Level is revised annually by the U.S. Department of Health and Human Services. The write off percentages are outlined in Exhibit A.
9. Appeals of charity denials may be made in writing to the Administrator of Petersburg Medical Center within 14 days of receipt of the denial. The appeal request must be in writing. Determinations by the Administrator are final.
10. In circumstances where major economic distress will result as a consequence of the guarantor's medical liabilities, a request may be made for a catastrophic circumstance adjustment even if the guarantor's income exceeds the current Alaska Poverty Level. Typical catastrophic circumstances are cases where major medical issues, or extensive long term medical problems, have placed the guarantor in severe economic jeopardy. The catastrophic adjustment request must be in writing with adequate supporting documentation. Catastrophic adjustment decisions are documented in writing by the Chief Financial Officer. To maintain a consistent application of the adjustments, an annual review each January of all

catastrophic adjustments for the previous 12 months is made by the Administrator or designee.

OTHER CONSIDERATIONS

Determining Amounts Generally Billed

Following a determination of financial-assistance eligibility, an individual will not be charged more than the amounts generally billed (AGB) for emergency or other medically necessary care provided to individuals with insurance covering that same care.

At Petersburg Medical Center the AGB is determined through the "Look-back method" which is calculated as follows:

1. The AGB is calculated by reviewing all past claims that have been paid in full to the hospital facility for medically necessary care by Medicare with all private health insurers paying claims to the hospital in a prior 12-month period. This amount can include co-insurance; copayments and deductibles.
2. The AGB for emergency or medically necessary care provided to a financial assistance-eligible individual is determined by multiplying gross charges for that care by one or more percentages of gross charges (called "AGB percentages").
    a. The percentages are calculated at least annually by dividing the sum of certain claims paid to the hospital facility by the sum of the associated gross charges for those claims.
    b. Multiple AGB percentages may be calculated for separate categories of care (for example, in-patient verses out-patient care; or care provided by different departments) or for separate items or services.
3. The percentages are applied by the 45th day after the end of the 12-month period the hospital facility used in calculating the AGB percentage(s).

Criteria for Referral to Third Party Collection

Petersburg Medical Center will make all reasonable efforts to determine eligibility under its financial assistance policy prior to sending any account to a third party for collection.

As a self pay account the guarantor will be sent two monthly statements by Petersburg Medical Center. The second statement will prominently display a notice to the effect that the balance is past due. Self pay accounts not paid or agreeing to a payment schedule will be sent a demand letter after the second patient responsibility statements, and business office staff will make a final notification phone call approximately 2-3 weeks after the demand letter. If payment in full or a reasonable payment schedule is not agreed to by the account guarantor within 90 days of the account being classified as a self pay account, the account will be transferred to a collection agency for follow up collection.

The following schedule will be used by the Business Office in establishing a reasonable payment schedule by guarantors. This schedule is modifiable with approval of the Chief Executive Officer:

Payment Schedule

Balance Due:	Maximum Payment Term
Under $500	Six months
$501-$1,200	12 months
$1,201-$2,400	24 months
$2,401-$3,600	36 months
$3,601-$4,800	48 months
$4,801+	60 months

Any patient may apply for financial assistance up to 240 days after the first billing date and no extraordinary collection activity (credit reporting and/or legal action) will take place before the 240 days.

CROSS REFERENCE

Credit and Collection Policy

RELEVANT FORMS

Alaska Poverty Guidelines

Charity application

AFFECTED DEPARTMENTS

Business Office
Finance
Clinic

END OF POLICY

All revision dates: 01/2021, 03/2019, 06/2017, 07/2016

Attachments

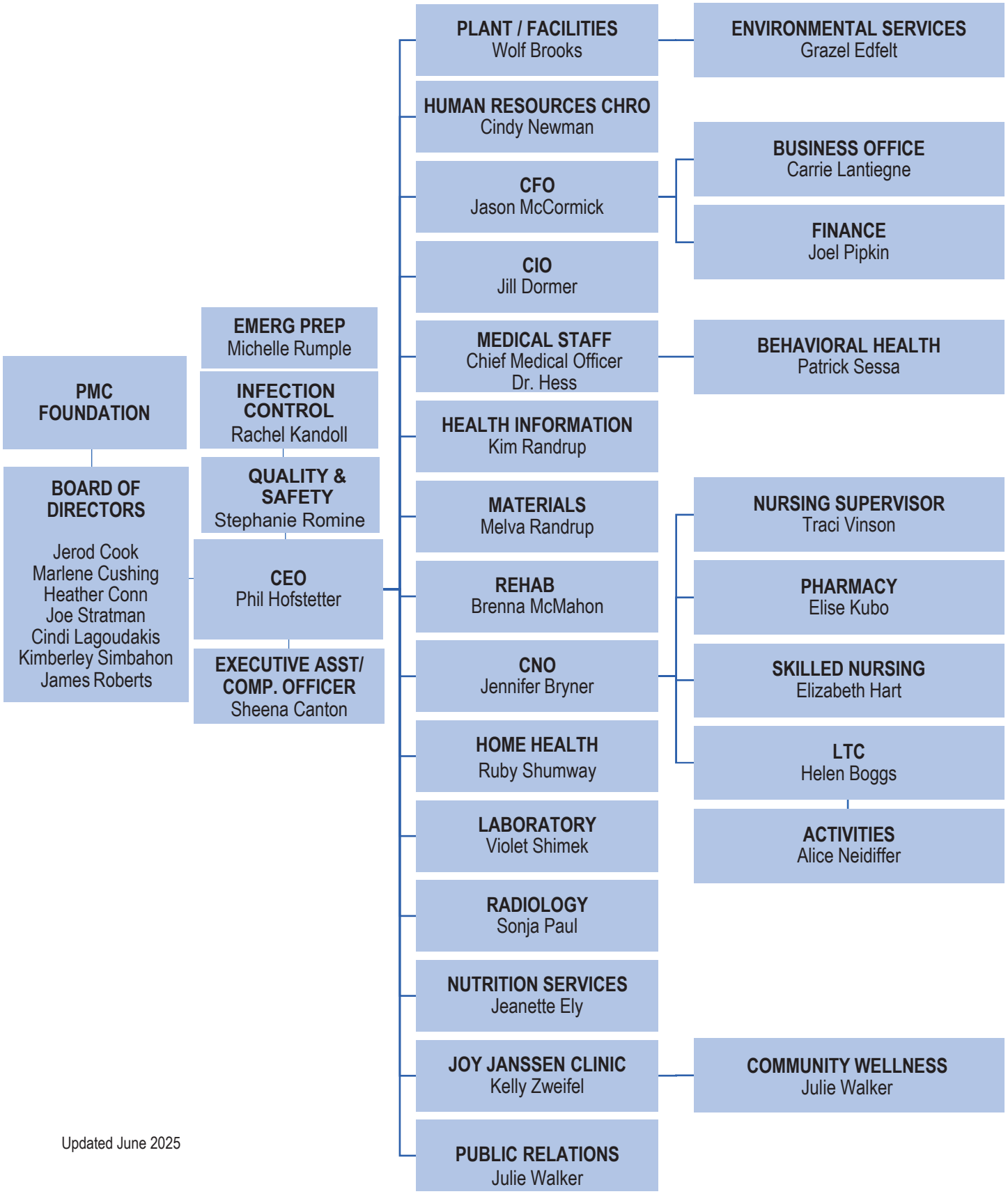
No Attachments

Approval Signatures

Step Description	Approver	Date
	Philip Hofstetter: CEO	01/2021
Policy Committee	Belinda Chase: Policy coordinator	01/2021
	Rocio Tejera: Controller	01/2021

Exhibit 2 – PMC Organizational Chart

Petersburg □edical Center



Updated June 2025

Exhibit 3 – Section VII. C. Facility Site Data – Diagrammatic Plan

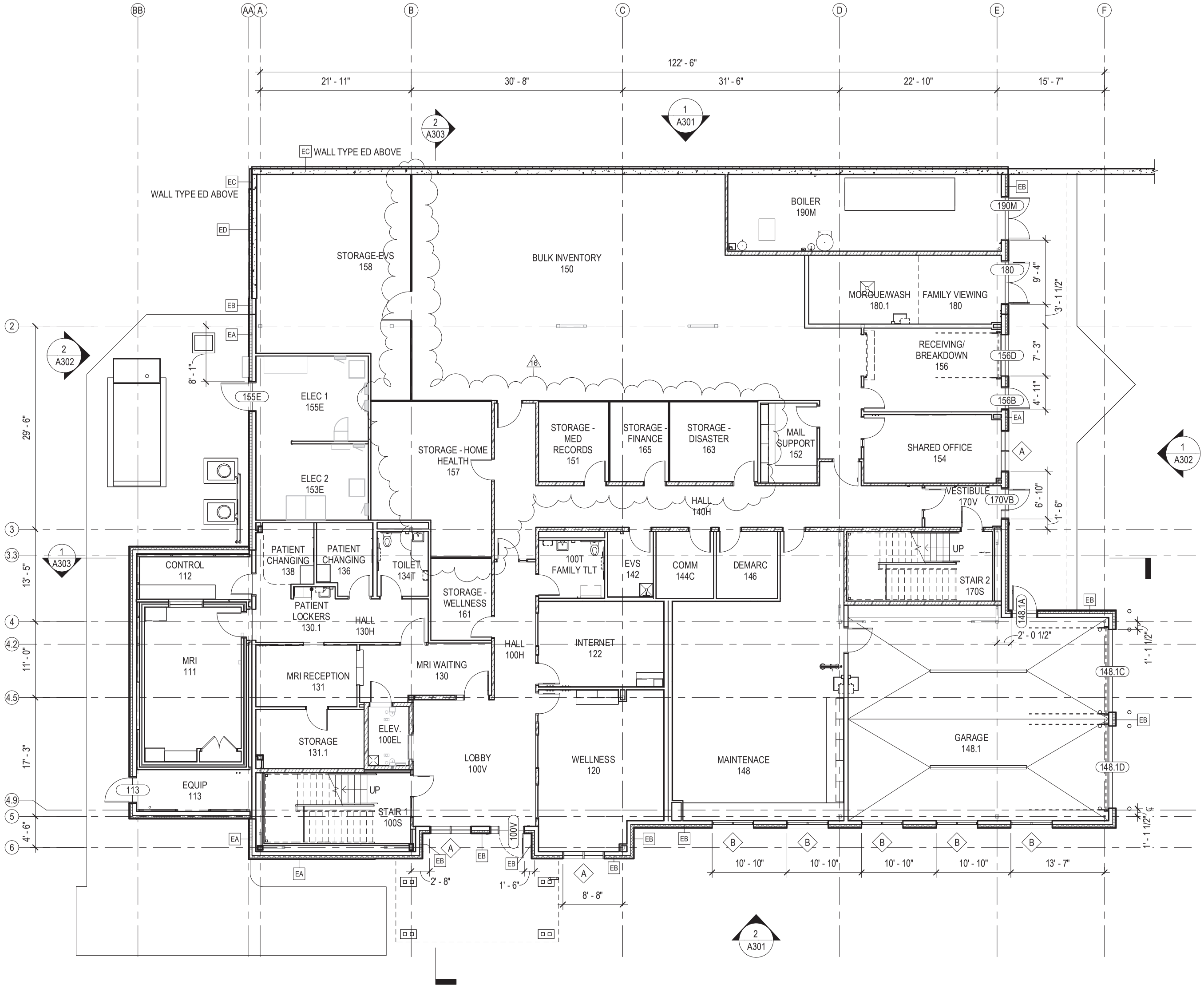
Site Plan

PETERSBURG MEDICAL CENTER - Petersburg, AK

October 16, 2023

BETTISWORTH NORTH

Exhibit 4 – Section VII. C. Facility Site Data – Architectural & Schematic Floor Plan



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FIRST FLOOR PLAN - OVERALL
1/8" = 1'-0"

GENERAL FLOOR PLAN NOTES

FIELD VERIFICATION: THE CONTRACTOR SHALL FIELD-VERIFY ALL DIMENSIONS PRIOR TO WORK. PROMPTLY NOTIFY THE ARCHITECT, OWNER'S REPRESENTATIVE, AND/OR THE CONTRACTING OFFICER IN WRITING OF ALL DISCREPANCIES IN NEW OR EXISTING CONDITIONS.

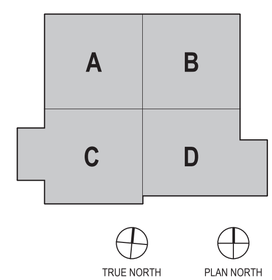
DIMENSIONING GUIDE: ALL DIMENSIONS ARE TAKEN FROM GRIDS, FACE OF METAL STUD PARTITION, OR FACE OF CONCRETE UNLESS OTHERWISE NOTED. DIMENSIONS BETWEEN SURFACES WILL BE NOTED WHERE APPLICABLE FROM MATERIAL FINISHES. UNLESS OTHERWISE NOTED ALL DIMENSIONS REFERENCED HEREIN ARE IMPERIAL STANDARDS AND SHALL BE TREATED WITHOUT ANY HIERARCHY OR ORDER OF PRECEDENCE.

REFERENCE ELEVATION: ALL ELEVATIONS NOTED ON THIS PLAN CORRESPOND TO REFERENCE ELEVATION 0'-0" FOR THIS FLOOR LEVEL. VARIANCES IN THIS ELEVATION MAY EXIST, AS INDICATED. UPPER FLOOR ELEVATIONS TO BE NOTED ACCORDINGLY.

REFLECTED CEILING PLANS: REFER TO A200 SERIES SHEETS FOR CORRESPONDING RCP'S.

PARTITION/WALL RATINGS: UNLESS OTHERWISE NOTED PARTITION/WALL FIRE/SMOKE RATINGS ARE DESIGNATED ON SHEETS G101.

DOOR OPENINGS: ALL DOOR OPENINGS ARE TAGGED IN CORRESPONDENCE WITH THE DOOR TYPE SCHEDULE ON SHEET A901 . THIS MAY INCLUDE MISCELLANEOUS OPENINGS SUCH AS OVERHEAD SECTIONAL OR COILING, SLIDING, AND OPERABLE PANEL ASSEMBLIES. TYPICAL DOOR JAMBS ARE LOCATED 6" FROM FACE OF STUD AT ADJACENT WALL TO JAMB ROUGH OPENING UNO.



BETTISWORTH NORTH ZGF ARCHITECTS INC

CORPORATE NO. AECC219 BETTISWORTHNORTH.COM

STATE OF ALASKA 49TH L. Ralston No. A-8298 Feb. 20, 2025 REGISTERED PROFESSIONAL ARCHITECT

PETERSBURG MEDICAL CENTER
WELLNESS, EDUCATION, AND RESOURCE CENTER
PETERSBURG, ALASKA

100% CONSTRUCTION DOCUMENTS

CONSULTANT:

PROJECT NO:	23-186
DATE:	2024-06-14
DRAWN BY:	DCH
CHECKED BY:	RR

REVISION	DESCRIPTION	DATE
16	SI-20	2025-04-01

FIRST FLOOR PLAN - OVERALL

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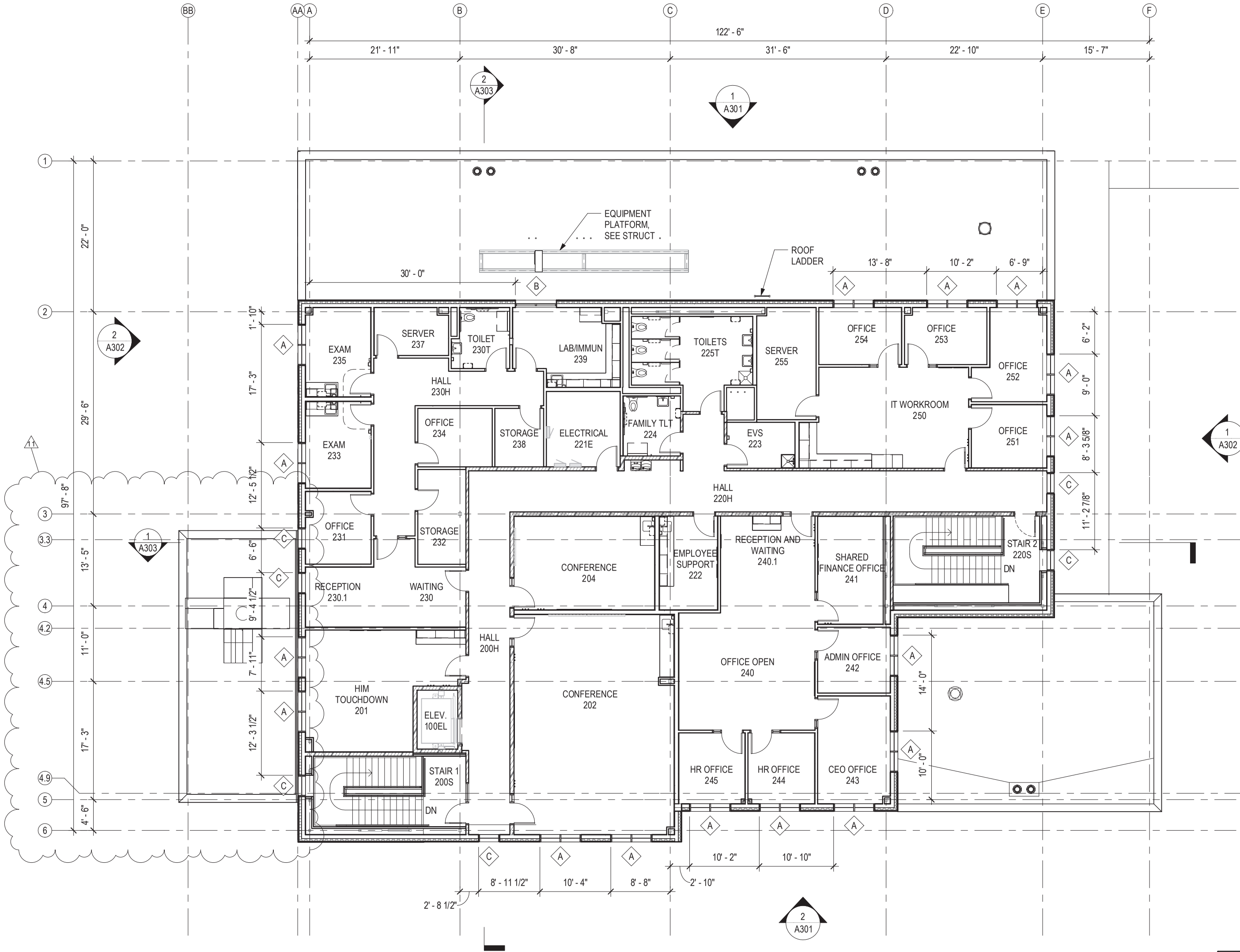

1 A120 SECOND FLOOR PLAN - OVERALL

1/8" = 1'-0"

GENERAL FLOOR PLAN NOTES

FIELD VERIFICATION: THE CONTRACTOR SHALL FIELD-VERIFY ALL DIMENSIONS PRIOR TO WORK. PROMPTLY NOTIFY THE ARCHITECT, OWNER'S REPRESENTATIVE, AND/OR THE CONTRACTING OFFICER IN WRITING OF ALL DISCREPANCIES IN NEW OR EXISTING CONDITIONS.

DIMENSIONING GUIDE: ALL DIMENSIONS ARE TAKEN FROM GRIDS, FACE OF METAL STUD PARTITION, OR FACE OF CONCRETE UNLESS OTHERWISE NOTED. DIMENSIONS BETWEEN SURFACES WILL BE NOTED WHERE APPLICABLE FROM MATERIAL FINISHES. UNLESS OTHERWISE NOTED ALL DIMENSIONS REFERENCED HEREIN ARE IMPERIAL STANDARDS AND SHALL BE TREATED WITHOUT ANY HIERARCHY OR ORDER OF PRECEDENCE.

REFERENCE ELEVATION: ALL ELEVATIONS NOTED ON THIS PLAN CORRESPOND TO REFERENCE ELEVATION 0'-0" FOR THIS FLOOR LEVEL. VARIANCES IN THIS ELEVATION MAY EXIST, AS INDICATED. UPPER FLOOR ELEVATIONS TO BE NOTED ACCORDINGLY.

REFLECTED CEILING PLANS: REFER TO A200 SERIES SHEETS FOR CORRESPONDING RCP'S.

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BETTISWORTH NORTH ZGF ARCHITECTS INC

CORPORATE NO. AECC219 BETTISWORTHNORTH.COM

STATE OF ALASKA 49TH L. Rountree No. A-8288 Feb. 20, 2025 REGISTERED PROFESSIONAL ARCHITECT

PETERSBURG MEDICAL CENTER

WELLNESS, EDUCATION, AND RESOURCE CENTER

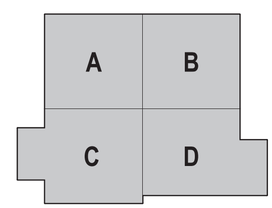
PETERSBURG, ALASKA

100% CONSTRUCTION DOCUMENTS

CONSULTANT:

PROJECT NO:	23-186
DATE:	2024-06-14
DRAWN BY:	DCH
CHECKED BY:	RR

REVISION	DESCRIPTION	DATE
11	SI-14	2025-02-19



TRUE NORTH PLAN NORTH

SECOND FLOOR PLAN - OVERALL

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Exhibit 5 – Section IX. A. Financial Data Schedules

A. Schedule I - Facility Income Statement

Schedule 1.b, PMC Income Statement year of project

Fiscal year July 1 to June 30	FY25 Projected	
OPERATING REVENUE		
Clinic	5,371,588	
Outpatient	7,110,071	
Emergency	2,932,691	
Observation	653,658	
Inpatient	4,562,864	
Swing Bed	2,716,799	
Home Health	539,444	
Nursing Home	7,335,928	
Gross Patient Revenue	**31,223,044**	
Contractual Adjustments	5,620,148	
Prior Year Settlement	(454,791)	
Chairty	218,561	
Bad Debt	468,346	
Deductions From Revenue	**5,852,264**	
Net Patient Revenue	**25,370,780**	
Other Operating Revenue	**4,581,525**	
TOTAL REVENUE	**29,952,304**	
OPERATING EXPENSES		
Salaries & Wages	12,430,634	
Taxes & Benefits, Total	4,748,502	
Salaries Taxes & Benefits	**17,179,137**	
Contract Labor	1,981,999	
Purchased Services	2,273,741	
Supplies	1,831,531	
Minor Equipment	407,486	
Insurance	213,512	
Other Operating Expenses	474,517	
Utilities	1,033,150	
Repairs & Maintenance	602,358	
Rentals & Leases	370,975	
Depreciation Expense	1,089,742	
TOTAL EXPENSES	**27,458,148**	
Operating Profit / (Loss)	**2,494,156**	
Non Operating Rev & (Exp)		
Interest Expense	(131,656)	
Investment (Gain) / Loss	194,159	
Building Grants	13,687,349	
Total Non-Operating	**13,749,852**	
Net Income	**16,244,008**	
Net Position Beginning of Year	14,268,774	
Net Position End of Year	30,512,782	

*** Other Operating Revenue for FY 25 includes $3 M from the Employee Retention Tax Credit and the commencement of the 340B program.**

Schedule 1.c PMC Income Statement Projected 5 years

Fiscal year July 1 to June 30	WERC bldg. Projected	FY 26 Total	FY 27 Proj	FY 28 Proj	FY 29 Proj	FY 30 Proj
OPERATING REVENUE						
Clinic		5,801,315	6,091,380	6,395,949	6,715,747	7,051,534
Outpatient	616,000	8,294,877	8,709,621	9,145,102	9,602,357	10,082,475
Emergency		3,167,306	3,325,672	3,491,955	3,666,553	3,849,881
Observation		705,951	741,248	778,311	817,226	858,088
Inpatient		4,927,893	5,174,288	5,433,002	5,704,652	5,989,885
Swing Bed		2,934,143	3,080,851	3,234,893	3,396,638	3,566,470
Home Health		582,600	611,730	642,316	674,432	708,154
Nursing Home		7,922,802	8,318,942	8,734,889	9,171,633	9,630,215
Gross Patient Revenue	**616,000**	**34,336,887**	**36,053,731**	**37,856,418**	**39,749,239**	**41,736,701**
Contractual Adjustmer	110,880	6,012,035	6,309,403	6,624,873	6,956,117	7,303,923
Prior Yr MCR Settlement						
Chairity	6,160	343,369	360,537	378,564	397,492	417,367
Bad Debt	12,320	686,738	721,075	757,128	794,985	834,734
Deductions From Revenu	**129,360**	**7,042,142**	**7,391,015**	**7,760,566**	**8,148,594**	**8,556,024**
Net Patient Revenue	**486,640**	**27,294,745**	**28,662,716**	**30,095,852**	**31,600,645**	**33,180,677**
340B Rev		732,000	883,890	928,085	974,489	1,023,213
Other Operating Revenue	**123,339**	**3,544,910**	**3,900,924**	**4,050,192**	**4,190,259**	**4,335,457**
TOTAL REVENUE	**609,979**	**30,839,655**	**32,563,641**	**34,146,044**	**35,790,904**	**37,516,134**
Salaries & Wages	68,960	13,083,562	13,737,740	14,424,627	15,145,858	15,903,151
Taxes & Benefits	51,170	4,978,628	5,629,650	5,911,133	6,206,690	6,517,024
Total Personnel	**120,130**	**18,062,190**	**19,367,391**	**20,335,760**	**21,352,548**	**22,420,176**
Contract Labor	-	1,404,504	1,516,079	1,591,883	1,671,477	1,755,051
Purchased Services		2,341,953	2,412,212	2,484,578	2,559,115	2,635,889
Medical Supplies	28,120	2,323,228	2,392,925	2,464,712	2,538,654	2,614,813
Minor Equipment	5,000	424,711	437,452	450,576	464,093	478,016
Insurance	43,000	262,918	270,805	278,929	287,297	295,916
Other Operating Expense	-	588,456	606,110	624,293	643,022	662,313
Utilities	341,258	1,473,713	1,517,924	1,563,462	1,610,365	1,658,676
Repairs & Maintenance	120,000	740,429	762,642	785,521	809,086	833,359
Rentals & Leases	-	389,524	401,210	413,246	425,643	438,413
Depreciation Expense	1,396,009	2,643,751	2,723,063	2,804,755	2,888,898	2,975,565
TOTAL EXPENSES	**2,053,517**	**30,655,376**	**32,407,812**	**33,797,716**	**35,250,200**	**36,768,187**
Operating Profit / (Loss)	**(1,443,537)**	**184,279**	**155,828**	**348,328**	**540,704**	**747,947**
	7%					
Non Operating Rev & (Exp)						
Interest Expense		(138,238)	(142,386)	(146,657)	(151,057)	(155,589)
Investment (Gain) / Loss		250,000	250,000	250,000	250,000	250,000
Building Grants		700,000	100,000	100,000	100,000	100,000
Total Non-Operating	**-**	**811,762**	**207,614**	**203,343**	**198,943**	**194,411**
Net Income	**(1,443,537)**	**996,040**	**363,443**	**551,671**	**739,647**	**942,358**
Net Position Beginning of Year	32,952,360	31,508,823	32,504,863	32,868,306	33,419,977	34,159,624
Net Position End of Year	31,508,823	32,504,863	32,868,306	33,419,977	34,159,624	35,101,982

Schedule 2.a, PMC Balance Sheet, 5 years prior					
Fiscal Year July 1 to June 30	**FY20 Audited**	**FY21 Audited**	**FY22 Audited**	**FY23 Audited**	**FY24 Audited**
ASSETS					
Current Assets					
Cash & Equivalents- Unrest.	$ 10,626,321	$ 4,412,839	$ 1,700,244	$ 470,126	$ 1,414,123
Investments	2,597,057	2,600,105	2,597,751	300,541	333,812
Patient Receivables	4,054,559	5,259,277	5,443,468	4,556,591	5,155,281
Allowance	(2,710,964)	(2,857,200)	(2,546,336)	(1,051,420)	(1,125,844)
Net Pat accounts receivable	1,343,595	2,402,077	2,897,132	3,505,171	4,029,437
Receivables, Grants				884,502	2,247,762
Receivables, Other	69,849	141,339	90,696	45,047	118,615
Supplies in inventory	287,035	320,886	356,624	304,713	303,569
Prepaid Expenses	95,727	1,488,446	111,147	113,382	155,699
Total Current Assets	**15,019,584**	**11,365,692**	**7,753,594**	**5,623,482**	**8,603,017**
Capital Assets, Net	**4,256,174**	**4,439,359**	**8,237,794**	**8,090,938**	**15,730,313**
Assets Limited as to use by board					
Investments	3,020,937	3,819,014	3,362,424	3,657,305	4,062,070
Net OPED Asset		1,054,533	8,781,677	6,685,608	7,338,848
Restricted Assets - Foundation Purposes					
Cash	153,702	157,721	164,244	203,771	208,129
Investments	247,046	313,399	276,165		
Total ASSETS	**22,697,443**	**21,149,718**	**28,575,898**	**24,261,104**	**35,942,377**
Deferred Outflows of Resources	2,524,894	2,894,105	2,756,254	2,554,803	2,428,790
Total Assets & Deferred Outflows of Resources	**25,222,337**	**24,043,823**	**31,332,152**	**26,815,907**	**38,371,167**
LIABILITIES					
Current Liabilities					
Accounts Payable	732,502	878,886	1,286,753	1,858,275	1,330,773
Capital Accounts Payable					2,011,634
Accrued Payroll & Related Liabilities	573,514	644,480	314,809	424,171	477,532
Accrued Vacation	880,051	1,012,792	994,450	1,079,210	1,018,401
Deferred Revenue	2,654,847	98,690	402,639	147,862	120,527
Due to Third Party Payers	4,404,094	2,572,701	2,544,436	121,627	301,048
Paycheck Protection Program Advance	1,800,000				
Other			3,515		
Current Portion of Obligations Capital Leases	85,962	86,973	333,818	347,641	618,245
Total Current Liabilities	11,130,970	5,294,522	5,880,420	3,978,786	5,878,160
Long Term Capital Leases, net of current portion	69,412	172,395	2,734,424	2,435,762	2,283,595
Net Pension Liability	11,270,762	12,894,055	12,053,763	16,521,607	15,526,950
Net OPEB Liability	323,644				
Total LIABILITIES	**22,794,788**	**18,360,972**	**20,668,607**	**22,936,155**	**23,688,705**
Deferred Inflows of Resources	1,148,977	903,147	9,613,036	623,594	413,688
Total Liabilities & Deferred Inflows of resources	**23,943,765**	**19,264,119**	**30,281,643**	**23,559,749**	**24,102,393**
Net Position					
Invested in Capital Assets, Net of related debt	4,100,800	4,179,991	5,169,552	5,307,535	10,816,839
Restricted for					
Foundation	400,748	471,120	440,409	504,312	541,941
Unrestricted deficit	(3,222,976)	128,593	(4,559,452)	(2,555,689)	2,909,994
Total Net Position	**$ 1,278,572**	**$ 4,779,704**	**$ 1,050,509**	**$ 3,256,158**	**$ 14,268,774**
Total Liabilities, Deferred Inflows & Net Position	**25,222,337**	**24,043,823**	**31,332,152**	**26,815,907**	**38,371,167**

B. Schedule II - Facility Balance Sheet

Schedule 2.a, PMC Balance Sheet, 5 years prior					
Fiscal Year July 1 to June 30	**FY20 Audited**	**FY21 Audited**	**FY22 Audited**	**FY23 Audited**	**FY24 Audited**
ASSETS					
Current Assets					
Cash & Equivalents- Unrest.	$ 10,626,321	$ 4,412,839	$ 1,700,244	$ 470,126	$ 1,414,123
Investments	2,597,057	2,600,105	2,597,751	300,541	333,812
Patient Receivables	4,054,559	5,259,277	5,443,468	4,556,591	5,155,281
Allowance	(2,710,964)	(2,857,200)	(2,546,336)	(1,051,420)	(1,125,844)
Net Pat accounts receivable	1,343,595	2,402,077	2,897,132	3,505,171	4,029,437
Receivables, Grants				884,502	2,247,762
Receivables, Other	69,849	141,339	90,696	45,047	118,615
Supplies in inventory	287,035	320,886	356,624	304,713	303,569
Prepaid Expenses	95,727	1,488,446	111,147	113,382	155,699
Total Current Assets	**15,019,584**	**11,365,692**	**7,753,594**	**5,623,482**	**8,603,017**
Capital Assets, Net	**4,256,174**	**4,439,359**	**8,237,794**	**8,090,938**	**15,730,313**
Assets Limited as to use by board					
Investments	3,020,937	3,819,014	3,362,424	3,657,305	4,062,070
Net OPED Asset		1,054,533	8,781,677	6,685,608	7,338,848
Restricted Assets - Foundation Purposes					
Cash	153,702	157,721	164,244	203,771	208,129
Investments	247,046	313,399	276,165		
Total ASSETS	**22,697,443**	**21,149,718**	**28,575,898**	**24,261,104**	**35,942,377**
Deferred Outflows of Resources	2,524,894	2,894,105	2,756,254	2,554,803	2,428,790
Total Assets & Deferred Outflows of Resources	**25,222,337**	**24,043,823**	**31,332,152**	**26,815,907**	**38,371,167**
LIABILITIES					
Current Liabilities					
Accounts Payable	732,502	878,886	1,286,753	1,858,275	1,330,773
Capital Accounts Payable					2,011,634
Accrued Payroll & Related Liabilities	573,514	644,480	314,809	424,171	477,532
Accrued Vacation	880,051	1,012,792	994,450	1,079,210	1,018,401
Deferred Revenue	2,654,847	98,690	402,639	147,862	120,527
Due to Third Party Payers	4,404,094	2,572,701	2,544,436	121,627	301,048
Paycheck Protection Program Advance	1,800,000				
Other			3,515		
Current Portion of Obligations Capital Leases	85,962	86,973	333,818	347,641	618,245
Total Current Liabilities	11,130,970	5,294,522	5,880,420	3,978,786	5,878,160
Long Term Capital Leases, net of current portion	69,412	172,395	2,734,424	2,435,762	2,283,595
Net Pension Liability	11,270,762	12,894,055	12,053,763	16,521,607	15,526,950
Net OPEB Liability	323,644				
Total LIABILITIES	**22,794,788**	**18,360,972**	**20,668,607**	**22,936,155**	**23,688,705**
Deferred Inflows of Resources	1,148,977	903,147	9,613,036	623,594	413,688
Total Liabilities & Deferred Inflows of resources	**23,943,765**	**19,264,119**	**30,281,643**	**23,559,749**	**24,102,393**
Net Position					
Invested in Capital Assets, Net of related debt	4,100,800	4,179,991	5,169,552	5,307,535	10,816,839
Restricted for					
Foundation	400,748	471,120	440,409	504,312	541,941
Unrestricted deficit	(3,222,976)	128,593	(4,559,452)	(2,555,689)	2,909,994
Total Net Position	**$ 1,278,572**	**$ 4,779,704**	**$ 1,050,509**	**$ 3,256,158**	**$ 14,268,774**
Total Liabilities, Deferred Inflows & Net Position	**25,222,337**	**24,043,823**	**31,332,152**	**26,815,907**	**38,371,167**

Schedule 2.b, PMC Balance Sheet, year of project

Fiscal Year	July 1 to June 30	FY25 Projected
ASSETS		
Current Assets		
Cash & Equivalents- Unrest.		$ 1,687,631
Investments		2,089,395
Patient Receivables		7,603,537
Allowance		(2,727,047)
Net Pat accounts receivable		4,876,490
Receivables, Grants		
Receivables, Other		3,374,146
Supplies in inventory		362,586
Prepaid Expenses		207,462
Total Current Assets		**12,597,710**
Capital Assets, Net		**27,569,310**
Assets Limited as to use by board		
Investments		4,217,224
Net OPEB Asset		7,338,848
Restricted Assets - Foundation Purposes		
Cash		
Investments		
Total ASSETS		**51,723,092**
Deferred Outflows of Resources		2,428,790
Total Assets & Deferred Outflows of Resources		**54,151,882**
LIABILITIES		
Current Liabilities		
Accounts Payable		1,089,874
Accounts Payable, new facility		1,156,101
Accrued Payroll & Related Liabilities		829,402
Accrued Vacation		1,167,446
Deferred Revenue		166,312
Due to Third Party Payers		1,466,833
Other		3,203
Current Portion of Obligations Capital Leases		457,424
Total Current Liabilities		6,336,595
Long Term Capital Leases, net of current portion		1,903,811
Net Pension Liability		15,526,950
Net OPEB Liability		
Total LIABILITIES		**23,767,356**
Deferred Inflows of Resources		413,688
Total Liabilities & Deferred Inflows of resources		**24,181,044**
Net Position		
Unrestricted		9,534,931
Restricted		4,191,899
Current year net income (Loss)		16,244,008
Total Net Position		**$ 29,970,838**
Total Liabilities, Deferred Inflows & Net Position		**54,151,882**

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

Schedule 3 a PMC Avg Patient Cost & Revenue Amounts Prior					
Fiscal Year July 1 to June 30	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Revenues, Operating Total	18,600,878	18,516,402	21,205,733	25,839,628	26,807,630
Expenses, Operating Total	17,243,857	21,720,141	23,340,388	22,125,966	22,081,212
Patient Days, Acute	324	282	309	329	353
Patient Days, Swing SNF	865	734	552	461	441
Patient Days, Swing ICF	303	93	55	79	11
Patient Days, LTC	4,140	2,940	3,174	4,506	4,774
Patient Days, Total	**5,632**	**4,049**	**4,090**	**5,375**	**5,579**
Revenues per patient day Acute & Swing					
Revenues per patient day LTC	$ 906	$ 955	$ 1,054	$ 1,218	$ 1,336
Delete, Growth		5%	10%	16%	10%
Oper. & Cap. Budg Sum					
Gross Revenue	18,600,878	18,516,402	21,205,733	25,839,628	26,807,630
Deductions from Revenue	3,656,108	3,039,754	4,501,821	5,658,039	4,814,102
Net Patient Revenue	14,944,770	15,476,648	16,703,912	20,181,589	21,993,528
Direct Expense	$ 8,007,066	$7,869,141	$8,740,216	$9,402,161	$9,249,165
Indirect Expense	8,480,890	$12,062,080	$13,312,250	$11,658,161	$13,080,669
Net Income Projected	$ 978,401	$3,430,759	($3,729,195)	$2,205,649	$11,012,616
Rate Computation					
Annual MCD Rate, Acute	7,413	7,635	7,858	8,088	10,658
Annual MCD, Outpatient	73.2	73.2	73.2	73.2	93.5
Annual MCD Rate, LCT	798	847	872	897	1,114
Base Year Cost - MCD Acute (inflated)	460,694	442,508	212,378	648,425	1,055,529
Ancillary - Acute - MCD	100,199	147,471	87,032	166,194	263,609
Plus Admin Overhead					
Cost Basis for Rate - MCD Acute -	442,027	589,979	299,410	814,619	1,319,138
Base yr pat. days - MCD Acute	63	43	20	68	114
Cost per pat. day - MCD Acute	7,016	13,720	14,970	11,980	11,571
Base Year Cost - MCD LTC (inflated)	3,623,184	3,994,917	4,569,542	4,490,179	4,140,185
Ancillary - LTC - MCD	2,971	793	2,795	-	2,649
Plus Admin Overhead					
Cost Basis for Rate - LTC	3,726,622	3,994,917	4,569,542	4,490,179	4,140,185
Base yr pat. days - LTC - total	4,802	2,932	3,171	4,506	4,774
Base yr pat. days - MCD LTC	4,406	2,912	2,959	4,024	4,078
Cost per pat. day LTC - total	775	1,372	1,543	1,116	1,015
Cost per pat. day LTC MCD ancillary	0.64	0.27	0.94	-	0.65
Cost per pat. day LTC - totals	776	1,372	1,544	1,116	1,015

Schedule 3 b PMC Avg Patient Cost & Revenue Amounts Current

Fiscal Year July 1 to June 30	Y 2025
Revenues, Operating Total	29,952,304
Expenses, Operating Total	27,458,148
Patient Days, Acute	364
Patient Days, Swing SNF	883
Patient Days, Swing ICF	312
Patient Days, LTC	4,932
Patient Days, Total	**6,491**
Revenues per patient day Acute & Swing	
Revenues per patient day LTC	$ 1,487
Delete, Growth	11%
Oper. & Cap. Budg Sum	
Gross Revenue	31,223,044
Deductions from Revenue	5,852,264
Net Patient Revenue	25,370,780
Direct Expense	11,532,422
Indirect Expense	15,925,726
Net Income Projected	16,244,008
Rate Computation	
Annual MCD Rate, Acute	10,976
Annual MCD, Outpatient	93.5
Annual MCD Rate, LCT	1,148
Base Year Cost - MCD Acute (inflated)	1,087,225
Ancillary - Acute - MCD	271,525
Plus Admin Overhead	
Cost Basis for Rate - MCD Acute -	1,358,750
Base yr pat. days - MCD Acute	117
Cost per pat. day - MCD Acute	11,571
Base Year Cost - MCD LTC (inflated)	4,277,208
Ancillary - LTC - MCD	2,737
Plus Admin Overhead	
Cost Basis for Rate - LTC	4,277,208
Base yr pat. days - LTC - total	4,932
Base yr pat. days - MCD LTC	4,213
Cost per pat. day LTC - total	1,048
Cost per pat. day LTC MCD ancillary	0.65
Cost per pat. day LTC - totals	1,049

Schedule 3 c PMC Avg Patient Cost & Revenue Amounts Pro

Fiscal Year July 1 to June 30	Y 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
Revenues, Operating Total	29,952,304	30,839,655	32,563,641	34,146,044	35,790,904	37,516,134
Expenses, Operating Total	27,458,148	30,655,376	32,407,812	33,797,716	35,250,200	36,768,187
Patient Days, Acute	364	350	355	361	366	371
Patient Days, Swing SNF	883	827	840	852	865	878
Patient Days, Swing ICF	312	328	344	361	379	398
Patient Days, LTC	4,932	5,006	5,081	5,110	5,110	5,110
Patient Days, Total	**6,491**	**6,511**	**6,620**	**6,684**	**6,720**	**6,758**
Revenues per patient day Acute & Swing						
Revenues per patient day LTC	$ 1,487	$ 1,583	$ 1,637	$ 1,709	$ 1,795	$ 1,885
Delete, Growth	11%	6%	3%	4%	5%	5%
Oper. & Cap. Budg Sum						
Gross Revenue	31,223,044	34,336,887	36,053,731	37,856,418	39,749,239	41,736,701
Deductions from Revenue	5,852,264	7,042,142	7,391,015	7,760,566	8,148,594	8,556,024
Net Patient Revenue	25,370,780	27,294,745	28,662,716	30,095,852	31,600,645	33,180,677
Direct Expense	11,532,422	12,875,258	13,611,281	14,195,041	14,805,084	15,442,638
Indirect Expense	15,925,726	17,780,118	18,796,531	19,602,675	20,445,116	21,325,548
Net Income Projected	16,244,008	996,040	363,443	551,671	739,647	942,358
Rate Computation						
Annual MCD Rate, Acute	$ 10,975.79	12,447	12,820	13,205	13,601	14,009
Annual MCD, Outpatient	93.53	102.9	102.9	102.9	102.9	102.9
Annual MCD Rate, LCT	$ 1,148.28	1,303	1,342	1,383	1,424	1,467
Base Year Cost - MCD Acute (inflated)	$1,087,225	1,046,559	1,062,257	1,078,191	1,094,364	1,110,779
Ancillary - Acute - MCD	$271,525	261,369	265,289	269,269	273,308	277,407
Plus Admin Overhead						
Cost Basis for Rate - MCD Acute -	$1,358,750	1,307,928	1,327,546	1,347,460	1,367,672	1,388,187
Base yr pat. days - MCD Acute	117	113	115	116	118	120
Cost per pat. day - MCD Acute	$11,571.39	11,571	11,571	11,571	11,571	11,571
Base Year Cost - MCD LTC (inflated)	$4,277,208	4,341,366	4,406,487	4,431,576	4,431,576	4,431,576
Ancillary - LTC - MCD	$2,737	2,778	2,819	2,835	2,835	2,835
Plus Admin Overhead						
Cost Basis for Rate - LTC	$4,277,208	4,341,366	4,406,487	4,431,576	4,431,576	4,431,576
Base yr pat. days - LTC - total	4,932	5,006	5,081	5,110	5,110	5,110
Base yr pat. days - MCD LTC	4,213	4,276	4,340	4,365	4,365	4,365
Cost per pat. day LTC - total	$1,048.18	1,064	1,080	1,086	1,086	1,086
Cost per pat. day LTC MCD ancillary	$0.65	0.65	0.65	0.65	0.65	0.65
Cost per pat. day LTC - totals	$1,048.83	1,065	1,081	1,087	1,087	1,087

D. Schedule IV – Operating Budget

Schedule 4 PMC Operating Budget prior 5 years					
Fiscal Year July 1 to June 30	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Days in a year	366	365	365	365	366
Acute, OBS & Swing					
Number of Beds, Acute & Swing	12	12	12	12	12
Available bed days Acute & Swing	4,392	4,380	4,380	4,380	4,392
Actual Bed Days, Acute& OBS	324	282	309	329	353
Actual Bed Days Swing & ICF	1,168	827	607	540	452
Actual Bed Days Total	1,492	1,109	916	869	805
Occupancy, Acute & Swing	34%	25%	21%	20%	18%
Growth, Acute & Swing		-13%	10%	6%	7%
Number of Acute & OBS patients	101	94	116	106	125
Average Length of Stay, Acute	3.2	3.0	2.7	3.1	2.8
Number of Swing Bed & ICF Pat	19	14	18	10	16
Average length of stay, Swing	62.5	60.6	32.9	53.9	28.0
LTC					
Number of Beds, LTC	15	15	15	15	15
Available Bed Days, LTC	5,490	5,475	5,475	5,475	5,490
Actual Bed Days, LTC	4,140	2,940	3,174	4,506	4,774
Occupancy	75%	54%	58%	82%	87%
Percent Growth		-29%	8%	42%	6%
Number of LTC Residents	24	16	27	22	16
Average Length of Stay	173	184	118	205	298
Daily Room & RN Revenue					
Nursing Services					
Payer Mix, total	$587,688	$563,069	$724,515	$1,429,763	$1,974,600
Medicaid	$119,470	$86,571	$144,826	$175,875	$377,391
Medicare	$412,467	$386,248	$380,017	$457,032	$534,346
Other	$55,751	$90,250	$199,672	$796,856	$1,062,863
Ancillary Revenue	12,328,241	$13,055,542	$15,469,501	$16,980,095	$16,971,210
Total Revenue	$ 18,600,878	18,516,403	$21,205,732	$25,839,628	$26,807,727
Rate Computation					
Annual MCD Rate, Acute	7,413	7,635	7,858	8,088	10,658
Annual MCD, Outpatient	73.2	73.2	73.2	73.2	93.5
Annual MCD Rate, LCT	798	847	872	897	1,114
Base Year Cost - MCD Acute (inflated)	460,694	442,508	212,378	648,425	1,055,529
Ancillary - Acute - MCD	100,199	147,471	87,032	166,194	263,609
Plus Admin Overhead	-	-	-	-	-
Cost Basis for Rate - MCD Acute -	442,027	589,979	299,410	814,619	1,319,138
Base yr pat. days - MCD Acute	63	43	20	68	114
Cost per pat. day - MCD Acute	7,016	13,720	14,970	11,980	11,571
Base Year Cost - MCD LTC (inflated)	3,623,184	3,994,917	4,569,542	4,490,179	4,140,185
Ancillary - LTC - MCD	2,971	793	2,795	-	2,649
Plus Admin Overhead	-	-	-	-	-
Cost Basis for Rate - LTC	3,726,622	3,994,917	4,569,542	4,490,179	4,140,185
Base yr pat. days - LTC - total	4,802	2,932	3,171	4,506	4,774
Base yr pat. days - MCD LTC	4,406	2,912	2,959	4,024	4,078
Cost per pat. day LTC - total	775	1,372	1,543	1,116	1,015
Cost per pat. day LTC MCD ancillary	0.64	0.27	0.94	-	0.65
Cost per pat. day LTC - totals	776	1,372	1,544	1,116	1,015

Schedule 4 PMC Operating Budget Year of Project

Fiscal Year July 1 to June 30	Y 2025
Days in a year	365
Acute, OBS & Swing	
Number of Beds, Acute & Swing	12
Available bed days Acute & Swing	4,380
Actual Bed Days, Acute& OBS	364
Actual Bed Days Swing & ICF	1,155
Actual Bed Days Total	1,519
Occupancy, Acute & Swing	35%
Growth, Acute & Swing	3%
Number of Acute & OBS patients	121
Average Length of Stay, Acute	3.0
Number of Swing Bed & ICF Pat	25
Average length of stay, Swing	47.0
LTC	
Number of Beds, LTC	15
Available Bed Days, LTC	5,475
Actual Bed Days, LTC	4,932
Occupancy	90%
Percent Growth	3%
Number of LTC Residents	25
Average Length of Stay	195
Daily Room & RN Revenue	
Nursing Services	
Payer Mix, total	$2,033,894
Medicaid	$388,723
Medicare	$535,864
Other	$1,109,306
Ancillary Revenue	$19,766,421
Total Revenue	$31,223,044
Rate Computation	
Annual MCD Rate, Acute	10,976
Annual MCD, Outpatient	93.5
Annual MCD Rate, LCT	1,148
Base Year Cost - MCD Acute (inflated)	1,087,225
Ancillary - Acute - MCD	271,525
Plus Admin Overhead	-
Cost Basis for Rate - MCD Acute -	1,358,750
Base yr pat. days - MCD Acute	117
Cost per pat. day - MCD Acute	11,571
Base Year Cost - MCD LTC (inflated)	4,277,208
Ancillary - LTC - MCD	2,737
Plus Admin Overhead	-
Cost Basis for Rate - LTC	4,277,208
Base yr pat. days - LTC - total	4,932
Base yr pat. days - MCD LTC	4,213
Cost per pat. day LTC - total	1,048
Cost per pat. day LTC MCD ancillary	0.65
Cost per pat. day LTC - totals	1,049

Schedule 4 PMC Operating Budget Projected

Fiscal Year July 1 to June 30	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
Days in a year	365	365	366	365	365
Acute, OBS & Swing					
Number of Beds, Acute & Swing	12	12	12	12	12
Available bed days Acute & Swing	4,380	4,380	4,392	4,380	4,380
Actual Bed Days, Acute& OBS	350	355	361	366	371
Actual Bed Days Swing & ICF	1,184	1,214	1,244	1,276	0
Actual Bed Days Total	1,534	1,569	1,605	1,642	371
Occupancy, Acute & Swing	35%	36%	37%	37%	8%
Growth, Acute & Swing	-4%	1%	1%	1%	1%
Number of Acute & OBS patients	117	118	120	122	124
Average Length of Stay, Acute	3.0	3.0	3.0	3.0	3.0
Number of Swing Bed & ICF Pat	25	26	26	27	0
Average length of stay, Swing	47.0	47.0	47.0	47.0	47.0
LTC					
Number of Beds, LTC	15	15	15	15	15
Available Bed Days, LTC	5,475	5,475	5,490	5,475	5,475
Actual Bed Days, LTC	5,006	5,081	5,110	5,110	5,110
Occupancy	91%	93%	93%	93%	93%
Percent Growth	1%	1%	1%	0%	0%
Number of LTC Residents	26	26	26	26	26
Average Length of Stay	195	195	195	195	195
Daily Room & RN Revenue					
Nursing Services					
Payer Mix, total	$1,957,819	$1,987,186	$2,016,994	$2,047,249	$2,077,957
Medicaid	$374,184	$379,796	$385,493	$391,276	$397,145
Medicare	$553,523	$550,378	$555,460	$568,997	$591,607
Other	$1,030,112	$1,057,011	$1,076,041	$1,086,976	$1,089,205
Ancillary Revenue	$21,737,707	$22,824,593	$23,965,822	$25,164,113	$26,422,319
Total Revenue	$34,336,887	$36,053,731	$37,856,418	$39,749,239	$41,736,701
Rate Computation					
Annual MCD Rate, Acute	12,447	12,820	13,205	13,601	14,009
Annual MCD, Outpatient	102.9	102.9	102.9	102.9	102.9
Annual MCD Rate, LCT	1,303	1,342	1,383	1,424	1,467
Base Year Cost - MCD Acute (inflate	1,046,559	1,062,257	1,078,191	1,094,364	1,110,779
Ancillary - Acute - MCD	261,369	265,289	269,269	273,308	277,407
Plus Admin Overhead	-	-	-	-	-
Cost Basis for Rate - MCD Acute -	1,307,928	1,327,546	1,347,460	1,367,672	1,388,187
Base yr pat. days - MCD Acute	113	115	116	118	120
Cost per pat. day - MCD Acute	11,571	11,571	11,571	11,571	11,571
Base Year Cost - MCD LTC (inflated)	4,341,366	4,406,487	4,431,576	4,431,576	4,431,576
Ancillary - LTC - MCD	2,778	2,819	2,835	2,835	2,835
Plus Admin Overhead	-	-	-	-	-
Cost Basis for Rate - LTC	4,341,366	4,406,487	4,431,576	4,431,576	4,431,576
Base yr pat. days - LTC - total	5,006	5,081	5,110	5,110	5,110
Base yr pat. days - MCD LTC	4,276	4,340	4,365	4,365	4,365
Cost per pat. day LTC - total	1,064	1,080	1,086	1,086	1,086
Cost per pat. day LTC MCD ancillary	0.65	0.65	0.65	0.65	0.65
Cost per pat. day LTC - totals	1,065	1,081	1,087	1,087	1,087

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

Schedule 5 Debt Service Summary

As of Fiscal 2025

There will be no new debt from the WERC building or MRI

Total

Fiscal Year	Principal	Interest	Principal + Interest
2025	435,201.70	127,693.71	562,895.41
2026	463,883.86	105,349.75	569,233.61
2027	395,400.57	82,987.91	478,388.48
2028	401,710.35	63,019.89	464,730.24
2029	422,614.89	42,115.35	464,730.24
2030	209,624.54	3,028.98	212,653.52

Delage (Mammo)

Fiscal Year	Principal	Interest	Principal + Interest
2025	32518.28	9863.62	42381.9
2026	37496.68	8738.12	46234.8
2027	39731.88	6502.92	46234.8
2028	42093.95	4140.85	46234.8
2029	44599.83	1634.97	46234.8
2030	3834.38	18.52	3852.9

Cerner

Fiscal Year	Principal	Interest	Principal + Interest
2025	309,621.18	108,874.26	418,495.44
2026	325,461.99	93,033.45	418,495.44
2027	342,113.24	76,382.20	418,495.44
2028	359,616.40	58,879.04	418,495.44
2029	378,015.06	40,480.38	418,495.44
2030	205,790.16	3,010.46	208,800.62

Olympus

Fiscal Year	Principal	Interest	Principal + Interest
2025	36853.93	3731.71	40585.64
2026	38894.9	1690.74	40585.64
2027	10055.74	90.67	10146.41
2028			
2029			
2030			

Schedule 5 Debt Service Summary

As of Fiscal 2025

GreateAmerican

Fiscal Year	Principal	Interest	Principal + Interest
2025	16811.77	2478.7	19290.47
2026	16871.56	811.37	17682.93
2027	0		
2028	0		
2029	0		
2030	0		

Philips

Fiscal Year	Principal	Interest	Principal + Interest
2025	39396.54	2745.42	42141.96
2026	45158.73	1076.07	46234.8
2027	3499.71	12.12	3511.83
2028	0		
2029	0		
2030	0		

F. Schedule VI - Reimbursement Sources

Schedule 6 Reimbursement Sources

Fiscal Year 2019				
Reimbursement Source	# of Pat Svc	Gross Revenue	Deductions	Net Revenue
Medicaid	3,496	7,984,358	(239,985)	7,744,372
Medicare	5,932	5,036,670	(1,239,771)	3,796,899
Private Insurance	8,441	6,192,260	(663,953)	5,528,307
Self-Pay	1,865	707,173	(100,793)	606,380
Charity	398		(54,006)	(54,006)
Workmans Compensation	116	98,012	(15,622)	82,391
Other	2	2,016	0	2,016
Total	19,852	20,020,488	(2,314,129)	17,706,358

Fiscal Year 2020				
Reimbursement Source	# of Pat Svc	Gross Revenue	Deductions	Net Revenue
Medicaid	3,600	8,643,755	(1,131,253)	7,512,502
Medicare	6,077	5,595,336	(897,848)	4,697,488
Private Insurance	8,671	5,571,016	(809,826)	4,761,190
Self-Pay	2,105	626,695	(201,200)	425,495
Charity	712		(149,782)	(149,782)
Workmans Compensation	59	52,186	(5,208)	46,978
Other	138	29,122	(46)	29,076
Total	20,650	20,518,110	(3,195,163)	17,322,947

Fiscal Year 2021				
Reimbursement Source	# of Pat Svc	Gross Revenue	Deductions	Net Revenue
Medicaid	4,213	7,788,129	(1,102,244)	6,685,885
Medicare	5,826	5,569,589	(1,081,692)	4,487,896
Private Insurance	9,892	5,775,383	(763,697)	5,011,686
Self-Pay	10,023	654,748	(218,980)	435,767
Charity	831		(147,099)	(147,099)
Workmans Compensation	101	105,717	(5,940)	99,777
Other	257	65,235	(22,555)	42,680
Total	30,312	19,958,799	(3,342,209)	16,616,591

Schedule 6 Reimbursement Sources

Fiscal Year 2022				
Reimbursement Source	# of Pat Svc	Gross Revenue	Deductions	Net Revenue
Medicaid	3,767	6,461,368	(1,193,979)	5,267,388
Medicare	6,585	8,235,040	(184,016)	8,051,024
Private Insurance	8,457	5,780,027	(1,280,226)	4,499,802
Self-Pay	4,325	1,074,879	(131,963)	942,916
Charity	995		(191,771)	(191,771)
Workmans Compensation	154	149,040	(19,377)	129,664
Other	89	46,374	(13,910)	32,464
Total	23,377	21,746,729	(3,015,242)	18,731,487

Fiscal Year 2023				
Reimbursement Source	# of Pat Svc	Gross Revenue	Deductions	Net Revenue
Medicaid	3,446	7,041,341	(1,871,553)	5,169,789
Medicare	6,337	10,637,945	(1,975,234)	8,662,711
Private Insurance	8,809	6,830,809	(1,918,469)	4,912,339
Self-Pay	835	509,113	(768,357)	(259,244)
Charity	1,134		(808,088)	(808,088)
Workmans Compensation	272	218,045	(53,939)	164,106
Other	0		(16,530)	(16,530)
Total	20,560	25,237,253	(7,412,170)	17,825,084

Fiscal Year 2024				
Reimbursement Source	# of Pat Svc	Gross Revenue	Deductions	Net Revenue
Medicaid	3,920	8,843,629	(1,257,020)	7,586,609
Medicare	6,401	10,302,287	(1,543,032)	8,759,255
Private Insurance	7,173	6,381,008	(1,287,701)	5,093,307
Self-Pay	894	505,839	(281,086)	224,754
Charity	1,007		(280,501)	(280,501)
Workmans Compensation	301	317,357	(92,041)	225,315
Other	0	0	0	0
Total	19,595	26,350,121	(4,741,381)	21,608,740

G. Schedule VII – Depreciation Schedule

Schedule 7, Depreciation Schedule WERC

Description	Cost	AHA Years	Dep per Year
Property	1,756,800.00	0	
WERC building excluding property	20,918,102	20	1,045,905
WERC FFE	780,000	5	156,000
MRI	970,520	5	194,104
Project Total	24,425,422.00		1,396,009

CON Program's Request for Information

August 8, 2025

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health
OFFICE OF RATE REVIEW
Anchorage
3601 C Street, Suite 902
Anchorage, Alaska 99503-5923
Main: 907.269.7800
Fax: 907.269.0060

August 8, 2025

Jason McCormick, CFO
Petersburg Medical Center
PO Box 589
103 Fram St
Petersburg, Alaska 99833
VIA: jmccormick@mccmgroup.pro

RE: PMC –CON Application FINAL 7.22.25 received 7/22/2025

Dear Mr. McCormick

Under 7 AAC 07.050, a completeness review of the Certificate of Need (CON) application recently submitted by Petersburg Medical Center (PMC) has identified items requiring clarification for the Office of Rate Review CON team to proceed with its Staff Analysis and Recommendation for the Commissioner.

1. Clarification: CON Project Focus
There is conflicting information that should be clarified.

The application is titled *Certificate of need Application Proposing the Construction of a New Medical Office Building and Acquisition of an MRI.* Both the title and application reflect the whole medical office building as part of the CON program, though the CON program does not consider outpatient medical offices as a defined health care facility.

> As per **AS 18.07.111(8)(B)(8)** "health care facility" means a private, municipal, state, or federal hospital, psychiatric hospital, independent diagnostic testing facility, residential psychiatric treatment center, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, and ambulatory surgical facility; the term excludes (A) the Alaska Pioneers' Home and the Alaska Veterans' Home administered by the Department of Health and Social Services under AS 47.55; and (B) the offices of private physicians or dentists whether in individual or group practice;"

Conversely, the application, on **page 4** under **Section II. Summary Project Description (4)** Services to be expanded, added, replaced, or reduced, states clearly "*This project proposes the addition of MRI diagnostic equipment and services."*

Please acknowledge that the Certificate of Need (CON) application submitted on July 7, 2025, pertains specifically to the addition of MRI services and the building space dedicated to those services.

To that end, please also provide the costs specifically attributable to the portion of the building allocated for the MRI, the net present value of a lease for that portion of the space, and/or the fair market value of the donated land as per **7AAC 07.010**[1].

2. Clarification: Project Timing

The project as presented is an initial step in a multi-step plan ultimately relocating the entire hospital. This phase of the project, as indicated in the "*Current Status"* section on **page 8** states, *"the construction of the WERC building is now complete."*

Please provide a statement regarding when the WERC building construction began and the expected date of the MRI suite completion. Further, to the extent possible, please share known plans about how any/all services moved into this building fit into the larger overall plan. Specifically, are any services placed in this building that are meant to be moved once the next phase is complete and the hospital will be relocated?

As specified in 7 AAC 07.050 (c), please submit the required documentation and clarifications within sixty (60) days of the date of this letter. Once the requested clarifications and supporting documentation have been received, the CON team will proceed with the completeness review.

Should you have any questions or require further assistance, please do not hesitate to contact me.

Sincerely,

Heidi M Barnes

Heidi Barnes
Medicaid Program Specialist IV | Office of Rate Review

Cc:
Jody Carona, Health Facilities Planning & Development, HealthFac@healthfacilitiesplanning.com
Nicole Lebo | Interim Executive Director | Office of Rate Review

1. https://www.akleg.gov/basis/aac.asp#7.07.010

PMC Response to CON Program's Request for Information

September 9, 2025

Petersburg
MEDICAL CENTER

PO Box 589
103 Fram Street
Petersburg, AK 99833

907-772-4291
www.pmcak.org

September 9, 2025

Heidi Barnes, Medicaid Program Specialist IV
Office of Rate Review
Department of Health
3601 C Street, Suite 902
Anchorage, AK 99503

RE: Petersburg Medical Center Application 7-22-2025

Dear Ms. Barnes,

Thank you for your letter of August 8, 2025, requesting clarification of Petersburg Medical Center's (PMC) Certificate of Need (CON) application. We appreciate the opportunity to clarify the scope of this project and provide additional information to assist the Office of Rate Review in its Staff Analysis and Recommendation.

Clarification: CON Project Focus

We respectfully request that the record reflect that the facility at issue is not a "medical office building," as referenced in the application title, but rather a hospital administrative, support, and outpatient services building that directly supports PMC's ongoing hospital operations. In addition, this building will house a new MRI suite, which represents the introduction of a new diagnostic service requiring CON approval under AS 18.07.031.

Alaska's CON statute (AS 18.07.111(8)(B)) defines "health care facility" to include hospitals and their associated services, while specifically excluding only private physician and dental offices. The WERC building does not contain private offices; it houses hospital-owned and operated administrative, support, and outpatient functions, including

Administration, Materials Management, Information Technology, Facilities/Maintenance, the morgue, and a Public Health clinic (Table 1). These functions are integral to hospital operations and are appropriately considered within the scope of a hospital facility under the CON program.

Table 1
Identification of Services in WERC

Direct Service Activity	Square Footage	Percentage of Total	MRI or Provide Direct Administrative Support to Current PMC operation
MRI Services	1,329	7%	X
Public Health Nursing	1,388	7.3%	
Morgue	278	1.5%	
Community IRC (Wellness, Internet)	1,647	8.7%	
Administration	1,604	8.5%	X
Materials Management	3,843	20%	X
Information Technology	993	5.2%	X
Public/Common Spaces	3,298	17.4%	
Building Support and Maintenance	4,600	24%	X
Total	18, 980	100.0%	

Additionally, the implementing regulation at 7 AAC 07.010 addresses which construction costs, land, and equipment expenditures must be considered in determining CON applicability. Subsection (e) explains that expenditures for nonclinical purposes, such as administrative or physician office space, land acquired for nonclinical use, or nonmedical equipment, may in some circumstances be excluded. Specifically, nonclinical expenditures must be *included* when the applicant is a Medicaid provider and the expenditures are included in the Medicaid prospective payment rate methodology under 7 AAC 150. Allowable costs for the Medicaid prospective rate methodology are the costs as reported

on the Medicare cost report (in accordance with Medicare requirements) except as provided in the Alaska Administrative Code. 7 AAC 150.170(a). The Medicare regulations at 413.9 clarify that nonclinical or administrative expenses are appropriate to include on the cost report. See also, Medicare Provider Reimbursement Manual, Part II, Section 4013. Further, the Alaska Administrative Code states that home office costs (which cover the types of nonclinical expenditures at issue here) are appropriately includable in the the Medicaid prospective rate methodology. 7 AAC 150.170(b)(12).

Here, the conditions are satisfied for inclusion of the nonclinical expenditures. The applicant is an enrolled Medicaid provider and the administrative, support, and outpatient services components of the WERC building are covered by the Medicaid prospective payment rate methodology because they are the types of costs that are appropriately included on PMC's Medicare cost report.

For this reason, prior staff in the CN Program advised and required, and PMC concurs, that it is both appropriate and necessary to include the full scope of the WERC building—not only the MRI suite—in the CON review.

To ensure clarity going forward, we have revised the project title to: *"Certificate of Need Application proposing the construction of a hospital administrative, support and outpatient services building, including the acquisition and installation of an MRI."*

Clarification: Project Timeline

- Construction site work began in November 2023; vertical construction commenced February 2024.
- Substantial completion of the building in July 2025.
- MRI suite: Construction and installation currently in progress, with completion and anticipated service start in November 2025.

Project Costs

As noted in PMC's original application and July 2025 submission, the square footage and capital cost allocations for both the MRI suite and

the associated hospital administrative/support functions were clearly identified. Because PMC is not paring down the scope of the project, those original figures remain accurate and applicable to the present clarification request. For ease of reference, we confirm that the MRI suite comprises approximately 7% of the building's square footage, with the remainder dedicated to hospital administrative, support, and outpatient service functions.

We hope this clarification resolves the questions raised. PMC respectfully maintains that the full scope of the WERC building is properly subject to CON review as an extension of hospital facilities, in addition to the new MRI service. We appreciate the Department's consideration and look forward to your confirmation that the revised project title and scope will guide the completeness review.

Please let me know if any further clarification or documentation is required.

Sincerely,

Philip Hofstetter
Chief Executive Officer
Petersburg Medical Center

CON Program's 2nd Request for

Information

October 23, 2025

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health
OFFICE OF RATE REVIEW
3601 C Street, Suite 978
Anchorage, Alaska 99503-5932
Main: 907.334-2464

October 23, 2025

Philip Hofstetter, CEO | Petersburg Medical Center
PO Box 589
103 Fram St
Petersburg, Alaska 99833
Sent via email: Phofstetter@pmc-health.org

RE: Completeness Review: 2nd request for information Petersburg Medical Center

Dear Mr. Hofstetter,

Under 7 AAC 07.050, the Certificate of Need (CON) program conducts a completeness review of all applications. Petersburg Medical Center (PMC) submitted a CON application for Construction of a New Medical Office Building and Acquisition of an MRI on July 22, 2025. The CON program sent a request for additional information on August 8, 2025, and in response PMC submitted an addendum on October 3, 2025 (the letter is dated September 9, 2025). The CON program identified further items requiring additional information and/or clarification to proceed with the staff analysis and recommendation for the Commissioner. We discussed several of these items during our October 21 meeting, which focused on reviewing the information needed to determine the completeness of your application. The items requiring further information and/or clarification are as follows:

1. MRI-Specific Cost Allocation

As requested in the CON team's letter dated August 8, 2025, please provide additional details on the capital costs specifically attributable to the MRI portion of the project. Please include:

- The construction costs associated with the 1,329 square feet dedicated to the MRI suite, separate from the remainder of the WERC building;
- Equipment costs for the MRI suite;
- The fair-market value of the land attributable solely to the MRI suite, consistent with 7 AAC 07.010[1]; and
- Any other expenditures described in 7 AAC 07.010 that are attributable specifically to the MRI suite and separate from the rest of the WERC building.

[1] https://www.akleg.gov/basis/aac.asp#7.07.010

2. Project Clarification and Relocation Plan

Throughout the application, the project is described as a two-phase construction plan. Phase I being completion of the WERC building, and Phase II being the relocation of the hospital.

However, an article published by the *Petersburg Pilot*[2] indicates that PMC is reconsidering the Phase II approach and may instead pursue a standalone long-term care (LTC) facility. The article additionally references the WERC building as a 15,000-square-foot facility, while the application identifies a total of 18,980 square feet.

Please provide a statement regarding these discrepancies.

Also, please address the following:

- If there are two or three phases to the project, and what will happen in each phase;
- The anticipated start date for construction of the proposed next facility;
- Regarding the administrative and support services that are moving to the WERC, what is happening with the space those services are vacating in the old building;
- Whether any services housed within the WERC building, aside from the MRI suite, will be an addition of a category of health services provided by PMC; and
- Whether PMC intends to relocate any services currently housed within the WERC building again once the new facility/facilities have been completed.

As specified in 7 AAC 07.050 (c)[3], please submit the required documentation and clarifications within sixty days of the date of this letter. Once the requested clarifications and supporting documentation have been received, the CON team will proceed with the completeness review.

Should you have any questions or require further assistance, please do not hesitate to contact me.

Sincerely,

Mattie Dawson

Mattie Dawson
Program Manager, Certificate of Need Program | Office of Rate Review

Cc:
Jason McCormick, CFO | Petersburg Medical Center | jmccormick@pmc-health.org
Jody Carona, Health Facilities Planning & Development | HealthFac@healthfacilitiesplanning.com
Nicole Lebo, Interim Executive Director | Office of Rate Review

[2] https://www.petersburgpilot.com/story/2025/08/21/news/new-werc-building-opens-completing-first-phase-of-petersburg-hospital-project/15162.html
[3] https://www.akleg.gov/basis/aac.asp#7.07.050

PMC Response to CON Program's 2nd Request for Information

December 19, 2025

Petersburg
MEDICAL CENTER

PO Box 589
103 Fram Street
Petersburg, AK
99833

907-772-4291

December 19, 2025

Mattie Dawson, Program Manager
Certificate of Need Program
Office of Rate Review
3601 C Street, Suite 978
Anchorage, Alaska 99503-5932

RE: Petersburg Completeness Review: 2nd Request

Dear Ms. Dawson:

Per your letter of October 23, 2025, and as noted during our October 21, 2025, meeting, the Certificate of Need (CON) Program raised two additional questions after reviewing Petersburg Medical Center's (PMC) October 3, 2025, Screening #1 response. We have prepared the following additional details per your request.

1. **MRI-Specific Cost Allocation:**

As requested in the CON team's letter dated August 8, 2025, please provide additional details on the capital costs specifically attributable to the MRI portion of the project. Please include:

- **The construction costs associated with the 1,329 square feet dedicated to the MRI suite, separate from the remainder of the WERC building;**
- **Equipment costs for the MRI suite;**
- **The fair-market value of the land attributable solely to the MRI suite, consistent with 7 AAC 07.010; and**
- **Any other expenditures described in 7 AAC 07.010 that are attributable specifically to the MRI suite and separate from the rest of the WERC building.**

Page 5 of our CON submittal included a summary of costs. That table is restated below with a new column added for the MRI-specific portion of the project, including the equipment and the value of land attributable to the MRI operations. Attachment 1 to this letter provides line-item detail.

Project Element	Total WERC Costs restated from Page 5 of CN Application	MRI-Only Costs
WERC building construction and other project costs	$20,918,102	$1,966,302
WERC Building FFE	$780,000	$73,320
MRI diagnostic machinery	$970,520	$970,520
Site Acquisition (donation)	$1,756,800	$49,542
TOTAL COST	**$24,425,422**	**$3,059,684**

The methodology for determining the pro rata share of the land's cost attributable to the MRI operations first involved dividing the value reported for the property in its entirety (*Applicant Market Assessment*) by three (since the project will ultimately be three phases). The MRI operations accounts for 9.4% of the value of the Phase 1 WERC project, and that percentage was multiplied by the cost of Phase 1 for land, as well as building construction and non-MRI fixtures, furniture, and equipment costs.

PMC has not identified any other expenditures described in 7 AAC 07.010 attributable specifically to the MRI suite.

2. <u>Project Clarification and Relocation Plan:</u>
Throughout the application, the project is described as a two-phase construction plan. Phase I being completion of the WERC building, and Phase II being the relocation of the hospital.

However, an article published by the *Petersburg Pilot*[2] indicates that PMC is reconsidering the Phase II approach and may instead pursue a standalone long-term care (LTC) facility. The article additionally references the WERC building as a 15,000-square-foot facility, while the application identifies a total of 18,980 square feet.

Please provide a statement regarding these discrepancies. Also, please address
the following:

- **If there are two or three phases to the project, and what will happen in each phase.**

PMC's response is below, but we first note that we are not aware of where the 15,000 sq. ft. referenced in the article is from. As noted in our CON application, the WERC was designed and built as an 18,890 square foot building.

PMC initially structured the broader project as a two-phase effort, based on the funding assumptions and project priorities at that time. As funding availability and project needs evolved, we reassessed the sequencing and have refined the plan into a three-phase approach, as outlined below:

Phase 1:
Scope: WERC and MRI
Status: completed

Phase 2:
Scope: LTC & Support Services
Status: Our phasing strategy is to continue building and assembling a capital funding stack from state and federal appropriations, competitive grants, and capital campaign for each phase. The full campus site is now shovel-ready, and we have remaining HRSA appropriations funding to carry the next phases through estimated schematic design and into early design development (~35%) over the next six months. This will allow us to be construction-ready once capital funding is committed.

Phase 3:
Scope: Hospital Core (Primary are, ED, Inpatient, Diagnostics, Outpatient)
Status: see Phase 2 Status above

- **Regarding the administrative and support services that are moving to the WERC, what is happening with the space those services are vacating in the old building;**

The space vacated in the old building has already been reassigned to programs and services that previously lacked sufficient room. These areas were undersized for their operational needs, so the newly available space is being used to better accommodate their staff, activities, and service delivery

- **Whether any services housed within the WERC building, aside from the MRI suite, will be an addition of a category of health services provided by PMC**

Aside from the MRI Suite, none of the other services in the WERC building represent a new category of health services

- **Whether PMC intends to relocate any services currently housed within the WERC building again once the new facility/facilities have been completed.**

As discussed during our October call, no services currently housed within WERC are expected to relocate once the replacement hospital is completed. Further, none of the services in the WERC building, aside from the MRI, are health services per AS 18.07.031(a).

The State has long been an advocate of rural health care access and has a history and commitment of support rural CAHs. An essential provider, and rural Alaskan CAH, such as PMC, the State knows that phased campus approach—starting with WERC in order to deliver the lowest total cost over the building life, assure patient and resident safety during construction and activation, increase resilience, and measurably reduce operating expenses is necessary. It is ***the*** prudent, sustainable alternative to a single disruptive megaproject and aligns with PMC's mission to provide safe, reliable care to Petersburg and the surrounding communities.

The State understands that there is no categorically dedicated funding for hospital capital at either the federal or state level. Based on this reality, the needed PMC replacement project is phased to allow for funding to be confirmed and made available. The phases must have a logical end point that allows for completion, staffing, training, and opening of a new facility and the provision of services, which in turn supports building the next capital funding sequence. Separating phases provides the opportunity to build to the best code for the services being provided in that phase (i.e.: i occupancy vs b occupancy); this in turn reduces costs per square foot.

A three phased campus (WERC first) provides the lowest total-cost, safest, and most sustainable pathway. PMC is an essential provider Critical Access Hospital, and the sole provider of integrated services (Emergency, Primary Care/Outpatient, Inpatient/Swing Bed, Home Health, and Long-Term Care) on an isolated island serving the Borough of Petersburg; population 3,200.

The 2020 Petersburg Medical Center Master Plan evaluated replacing the aging facility by comparing renovation in place to constructing a new greenfield

replacement. Renovation in place not only carried the highest cost estimates, it also would have exposed LTC residents and patients to avoidable disruption and safety risks. Using Borough-designated greenfield land allowed a phased approach that maximizes funding efficiency, reduces costs by staying within local construction capacity, and avoids concentrating capital and operational risk into a single "all-or-nothing" activation. A phased greenfield campus—beginning with the Wellness Education Resource Center (WERC)—delivers the needed capacity while maintaining continuous operations and regulatory compliance as outlined below.

In addition to the clear, bounded phasing noted above that will serve to reduce later costs, the phasing of this project accomplishes the following:

1) Patient and resident safety during construction and activation.
   Long-Term Care (LTC) residents are not "short stay" patients; they are permanent residents whose home is within our facility. Renovation of occupied space creates sustained noise, vibration, dust, and infection-control risk, and repeatedly alters egress and clinical workflows—each a known contributor to medical error. Phasing construction in separate, code-compliant buildings allows PMC to decant services section by section, complete staff training and equipment commissioning in smaller, controlled blocks, and avoid the high-risk "big-bang" cutover where phones, IT, MEP systems, and clinical equipment all transition at once. This materially reduces activation risk for Emergency, Primary Care, Inpatient/Swing Bed, and LTC particularly in rural Alaska where over staffing is costly and not as accessible in a large cutover.

2) Lower total cost of ownership (TCO) versus a single mega build.
   - Right-sized systems: Building the WERC first removes administrative and selected outpatient loads from the future clinical buildings, allowing smaller, correctly sized mechanical/electrical systems in later phases. Avoiding oversizing reduces both capital and lifecycle costs (equipment cost, electrical service size, maintenance, and energy).
   - Distributed utilities: Equates to less single-point-of-failure. Multiple smaller air-handling, heat-pump, and domestic hot-water plants create redundancy a single large plant cannot. When one unit is down, only a portion of the campus is affected, reducing revenue loss and emergency rentals.
   - Staged replacements: Distributed systems come due on staggered cycles, smoothing capital spikes and allowing competitive procurement, gross maximum price as opposed to low bid process to stay within budget as evidenced by the WERC building project.
   - Reduced specialty infrastructure run-lengths. Shorter medical-gas and hot-water distribution in smaller buildings lowers high dollar costs such as

copper/piping quantities, balancing, and stagnation risk, and simplifies future tie-ins.

3) Proven operational savings and energy performance.
   Early operating data show materially lower electricity use per square foot in the new WERC building compared with the legacy hospital. Based on September 2025 bills, WERC's kWh/ft^2-month was ~40–50% lower than the main campus. While a full 12-month measurement and verification (M&V) is underway, this aligns with the WERC envelope/heat-pump design intent and supports lower operating expense per square foot going forward.

4) Rural Alaska constructability and community capacity.
   A single, large mobilization would overwhelm local housing, materials handling, and seasonal coordination, driving up costs and risk. Phasing spreads contractor headcount, housing demand, barge deliveries, and specialty commissioning over multiple seasons, which: reduces price escalation tied to peak labor/housing shortages, allows "lessons learned" from Phase 1 to improve Phase 2/3, and keeps critical PMC staff focused on safe care rather than repeated, facility-wide moves.

5) Regulatory clarity and the right setting of care.
   Separating buildings by function improves compliance and patient experience. LTC can be planned to meet residential standards appropriate for elders, without back-of-house hospital traffic. Emergency/Diagnostic/Primary Care can be ventilated and sized to contemporary guidelines (e.g., ASHRAE 170/FGI) without carrying loads unrelated to those services. Administrative/education/telehealth/MRI (WERC) is sited out of acute care to relieve congestion and permit flexible hours and community education.

6) Resilience and emergency preparedness.
   A campus with physically separated utility-redundant buildings is inherently more resilient to regional power events, seismic activity, and localized failures. The campus can operate in "islanded" fashion: if one building is impaired, others can continue caring for patients or serving as temporary clinics, preserving community access to care.

7) Measurable commitments to the State of Alaska: PMC will- maintain uninterrupted LTC, Inpatient, Outpatient, Emergency and Primary care services through decanting plans; Implement M&V for each phase (12-month kWh and, if applicable, fuels) and publish site EUI and O&M cost/ft^2 to verify savings; Preserve redundancy by keeping at least two independent HVAC/heating plants

campus-wide at all times during phasing; Use standardized equipment across phases to simplify parts, training, and service contracts; Provide an updated life-cycle cost analysis at each schematic milestone, demonstrating that phasing continues to minimize total cost of ownership.

In closing, we would like to respectfully note that we engaged in discussions with the CON Program nearly a year prior to our initial submission. At that time, the Program Manager consistently advised that the CON application must include the entirety of the Phase 1 project. In Attachment 2, we have included supporting documentation, including email and meeting notes—most recently from a May 16, 2025, conference call—that confirm the guidance provided regarding resubmission requirements.

Receiving full and accurate Medicaid payment is essential to our continued viability. While we understand that the CON Program's current focus is limited to the MRI, we respectfully reiterate our request to include the full WERC project in the review.

Should you have any questions or require further assistance, please do not hesitate to contact me.

Sincerely,

Philip Hofstetter, CEO

cc:
Jason McCormick, CFO, Petersburg Medical Center, jmccormick@pmc-health.org
Jody Carona, Health Facilities Planning & Development, HealthFac@healthfacilitiesplanning.com
Nicole Lebo, Interim Executive Director. Office of Rate Review

Attachment 1

Section VIIIA. Financial Data – LAND

1. Acquisition type: (Please check applicable boxes)

☐ Lease ☐ Rent ☒ Donation ☐ Purchase ☐ Stock Transaction

2. Cost data

Cost Data	WERC	MRI FMV Portion of WERC
a. Total acquisition cost*	$1,756,800	$49,542
b. Amount to be financed	NA	NA
c. Difference between items (a) and (b) (list available resources to be used, e.g., available cash, investments, grants, etc.)	Donation - $1,756,800	Donation - $49,542
d. Anticipated interest rate	NA	NA
e. Total anticipated interest amount	NA	NA
f. Total of (a) and (e)	$1,756,800	$49,542
g. Estimated Annual debt service requirements	NA	NA

*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 VIIIB. 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)

Construction Cost (new Activity)	WERC	MRI Portion Only
a. Site acquisition (Section VIIIA.2.f)	$1,756,800	$49,542
b. Estimated general construction**	$19,442,911[1]	$2,039,622
c. Fixed equipment, not included in a**	$	$970,520
d. Total construction costs (sum of items a, b, and c)**	$21,199,711	$3,059,684
e. Major movable equipment**	$70,520	$ -
f. Other cost:**	$ -	$ -
(1) Administration expense	$297,458	$ -
(2) Site survey, soils investigation, and materials testing	$ -	$ -
(3) Architects and engineering fees	$1,913,451	$ -
(4) Other consultation fees (preparation of application included)	$ 394,600	$ -
(5) Legal fees	$ 47,822	$ -
(6) Land development and landscaping	$ -	$ -
(7) Building permits and utility assessments (including water, sewer, electrical, phones, etc.)	$145,960	$ -
(8) Additional inspection fees (clerk of the works)	$50,000	$ -
(9) Insurance (required during construction period)	$ -	$ -
g. Total project cost (sum of items d, e, f)	$24,425,522	$3,059,684
h. Amount to be financed	$ -	$ -
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.)	$24,425,522	$3,059,684
j. Anticipated long-term interest rate	0%	NA
k. Anticipated interim (construction) interest rate	0%	NA
l. Anticipated long-term interest amount	$ -	NA
m. Anticipated interim interest amount	$ -	NA
n. Total items g, l, and m	$ -	NA
o. Estimated annual debt service requirement	$ -	NA
p. Construction cost per sq. ft.	$1,067	$1,715
q. Construction cost per bed	N/A	NA
r. Project cost per sq. ft.	$1,287	$2,302
s. Project cost per bed (if applicable)	$ -	$ -

SQ ft = 18,980

[1] The general construction costs include $780,000 in FFE.

*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.

Attachment 2 –

- **Email Between Jody Carona (for Petersburg Medical Center) and Alexandria Hicks (Alaska Office of Rate Review) - May 16, 2025**
- **Contemporaneous Notes From Conference Call Between Petersburg Medical Center and Alexandra Hicks - May 16, 2025**

From: HealthFac
To: Hicks, Alexandria M (DOH)
Cc: Barnes, Heidi M (DOH)
Subject: RE: Request for conference call
Date: Friday, May 16, 2025 4:57:00 AM
Attachments: image003.png
image005.png

Good morning, they have updated the pro foma for the MRI and MRI space., but have not done it for the rest of the new building (referred to as the WERC). They are still asking whether they are submitting for WERC and MRI or just MRI. Based on our conversations, I keep telling them that it is both. I think they want to hear it directly from the Program.

I will send the invite shortly.

Happy Friday!

Jody

Jody Carona
Health Facilities Planning & Development
120 1st Avenue West, Suite 100
Seattle, WA 98119
Phone: (206) 441-0971 | Fax: (206) 441-4823
E-mail: healthfac@healthfacilitiesplanning.com

From: Hicks, Alexandria M (DOH) <alexandria.hicks@alaska.gov>
Sent: Thursday, May 15, 2025 4:37 PM
To: HealthFac <HealthFac@healthfacilitiesplanning.com> **Cc:** Barnes, Heidi M (DOH) <heidi.barnes@alaska.gov>
Subject: Re: Request for conference call

Yes, please!

Again, what specifically do they want to speak about re: their financials? It'd be helpful to know going in - the general "jist" if you will.

Thank you,
Alex

Contemporaneous Notes From Conference Call Between Petersburg Medical Center and Alexandra Hicks (Alaska Office of Rate Review) - May 16, 2025, 12:00 PM PST.

Attendees: Heidi Barnes and Alex Hicks from the CN Program, along with Jason McCormick, Daniel McCormick, Phil Hofstetter, and Jody Carona for Petersburg Medical Center.

Notes:

- *The WERC + MRI is the project which should be defined as Phase 1 of the replacement hospital.*
- *WERC + MRI is under the hospital's financial responsibility*
- *The building will fall under the hospital and being built now, in part, to support the MRI. As such, even though it includes non-clinical space the entire cost must be included in the application.*