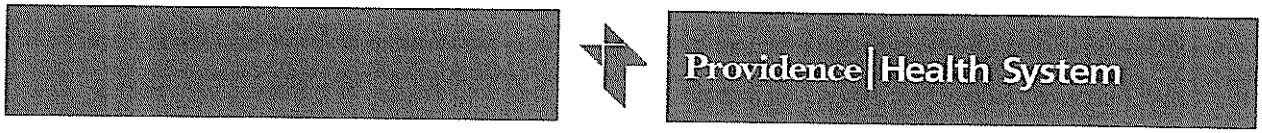

Certificate of Need Application

Expansion
of
Neonatal Intensive Care Unit

Providence Alaska Medical Center
Anchorage Alaska

June 2007

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Section I. General Applicant Information

CERTIFICATE OF NEED APPLICATION

APPLICANT IDENTIFICATION AND CERTIFICATION OF ACCURACY

1. Applicant Identification

Facility Name Providence Alaska Medical Center	**Medicaid Provider Number** HS11IP; HS11OP
Facility Address (*Street/City/State/Zip Code*) 3200 Providence Drive, Anchorage, AK 99508	**Medicare Provider Number** 020001
Name and mailing address of organization that operates the facility (if different from above) P.O. Box 196604, Anchorage, AK 99519-6604	
Facility Administrator (*Name. title, mailing address, including City/State/Zip Code*) Bruce Lamoureux; Administrator, Providence Alaska Medical Center P.O. Box 196604, Anchorage, AK 99519-6604	**Telephone** 907-261-3675 **Facsimile** 907-261-3041 **E-mail** blamoure@provak.org
Applicant (*Name, title, mailing address, including City/State/Zip Code*) Bruce Lamoureux; Administrator, Providence Alaska Medical Center P.O. Box 196604, Anchorage, AK 99519-6604	**Telephone** 907-261-3675 **Facsimile** 907-261-3041 **E-mail** blamoure@provak.org
Principal Contact Person (*Name, title, physical address, mailing address, including City/State/Zip Code*) Lisa Wolf, Director of Planning, Providence Health System in Alaska P.O. Box 196604, Anchorage, AK 99519-6604	**Telephone** 907-261-3037 **Facsimile** 907-261-2884 **E-mail** lwolf@provak.org

2. Ownership Information

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

- ☐ For profit: individual
- ☐ For profit: partnership
- ☐ For profit: corporation
- ☐ Not for profit: government
- X 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 Bruce Lamoureux	**Title** Administrator, Providence Alaska Medical Center
Signature Bruce Lamoureux	**Date** 6-21-2007

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

Providence Health & Services
Board of Directors
January 1, 2007

Director	Title	Locale
Jeffrey B. Clode, MD	Physician	Spokane, WA
M. Adrian Davis, LCM	Trustee / woman religious	Jasper, IN
Lucille M. Dean, SP	Retired high school principal / woman religious	Burbank, CA
Orcilia Z. Forbes	Retired University Vice President	Portland, OR
Mary Corita Heid, RSM	Trustee / woman religious	Mason City, IA
Gerald P. Leahy	Retired health care executive	Spokane, WA
Dana Rasmussen	Consultant	Seattle, WA
Paul A. Redmond	Retired	Spokane, WA
James S. Roberts, MD	Retired	Sequim, WA
Owen Robinson	Private sector – Executive	Great Falls, MT
Peter J. Snow	Health Care Executive	Albuquerque, NM
E. Kay Stepp	Retired	Manzanita, OR
Philip J. Thompson	Retired Judge	Spokane, WA
Robert E. Wilson	Retired	Scottsdale, AZ
Ellen L. Wolf	Retired school superintendent	Walla Walla, WA

PROVIDENCE HEALTH AND SERVICES
OFFICERS, 2007

John F. Koster, MD
President/CEO

Jeffrey W. Rogers
Corporate Secretary

Roger Chase
Assistant Corporate Secretary

Mike Butler
Vice President/Finance, & Treasurer

Tammy Teodosio
Assistant Corporate Secretary

Providence Health System
ALASKA REGION BOARD MEMBERSHIP

2007

John, (Chris) Swalling
Certified Public Accountant
Anchorage, Alaska 99503

Charles Ryan, MD, Chair
Chair, Health Alaska Network
Anchorage, Alaska 99508

Kris Erchinger, Secretary
Finance Director, City of Seward
Seward, Alaska 99664

Al Parrish – Ex officio member
Vice President, Chief Executive
Providence Health System in Alaska

Ronald Christensen, M.D. – Ex officio member
Chief, PAMC Medical Staff
Anchorage, Alaska 99507

Eleanor Andrews
Andrews Group, Owner
Anchorage, Alaska 99515

Stephanie Birch, RNC, MPH
Women's Children's and Family Health Unit
Dept. of Health & Social Services
Anchorage, Alaska 99503

Pat Branson
Chair, PKIMC Advisory Board
Kodiak, Alaska 99615

Pam Shirrell
Vice Chair/Valdez Regional Health Authority Board
Valdez, Alaska 99686

Vince Curry
CEO/Mat-Su Health Foundation
Wasilla, AK 99654

Jeffrey (Jeff) Cook
VP External Affairs – Flint Hill Resources
North Pole, Alaska 99705

Maurice (Maury) Coyle, M.D.
Anchorage, Alaska 99508

Dave Dengel
Valdez, Alaska 99686

John E. Hall, M.D.
PAMC Emergency Department

Karen Perdue
University of Alaska – Associate VP/Health
Fairbanks, Alaska 99775-5010

Christopher Dyke, M.D.
Private Practice Physician
Anchorage, Alaska 99508

Archbishop Roger L. Schwietz, OMI
Anchorage, Alaska 99501

Debby Sedwick
Anchorage Alaska 99501

Steven Smith, M.D.
Chief, Medical Staff
Providence Kodiak Island Medical Center

David G. Wight
Anchorage, Alaska

James B. Blasingame
Alaska Railroad
Anchorage, AK 99510-7500

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

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

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

Providence Alaska Medical Center (PAMC) is accredited by the Joint Commission of Accreditation of Hospitals. PAMC was surveyed in October of 2005 and received accreditation through October 2008. A copy of the accreditation letter is located in the appendices.

Section II. Summary Project Description

Provide a one-page summary of the proposed project including:

(1) A brief description of each proposed service, including whether equipment will be purchased or replaced and a list of that equipment.
This project is to expand the Neonatal Intensive Care Unit (NICU) by 6 beds.

(2) The number of square feet of construction/renovation.
The expansion is a renovation of 952 square feet of adjacent space that is currently being used for conference room and staff lockers. To facilitate this expansion, the staff lockers will be moved to another location within the department which is currently being used for conference room, restrooms and office space. This space is approximately 1,456 square feet. The overall total renovation for this project is 2,408 square feet.

(3) The number and type of beds/surgery suites/specialty rooms.
There will be 6 additional NICU bassinettes.

(4) Services to be expanded, added, replaced, or reduced.
Additional NICU beds will be added. Staff lockers will be relocated. Two conference rooms and some office space will be reduced. No other services will be affected.

(5) The total cost of the project.
This project will cost $1,717,448.

(6) How the project will be financed.
The project will be paid through accumulated revenues.

(7) Estimated completion date.
The new beds should be operational February 2008.

Section III. Description of Facilities and Capacity Indicators

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

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	TOTAL PROPOSED CAPACITY
IN-PATIENT ACUTE CARE HOSPITALS			
Med/Surg Beds			
1-bed room/unit	152	0	152
2-bed room/unit	16	0	16
Other (list) NICU	**38**	6	**44**
ICU Beds	37	0	37
Obstetrics Beds	36	0	36
Pediatric Beds	32	0	32
Acute Rehab Beds	10	0	10
Ancillary Services (list)	0	0	0
BEHAVIORAL HEALTH CARE			
In-patient Acute Psychiatric Beds	27	0	27
RPTC Beds	0	0	0
In-patient Substance Abuse Beds	0	0	0
LONG-TERM CARE			
Acute Beds	0	0	0
Nursing Beds	0	0	0
DIAGNOSTIC AND DIAGNOSTIC IMAGING SERVICES			
CT Scanner	2	0	2
MRI	1	0	1
PET or PET/CT	0	0	0
Cardiac Catherization	4	0	4
SURGICAL CARE			
Ambulatory Surgery or Dedicated OP Suites	0	0	0
Suites for IP & OP	14	0	14
Endoscopy Suites	4	0	4
Open-Heart Surgery	1	0	1
Organ Transplantation	0	0	0
Other Services (list) o Cysto OR o PACU beds	 1 14	0	 1 14
THERAPEUTIC CARE			
Radiation Therapy	2	0	2
Lithotrypsy	0	0	0
Renal Dialysis	6	0	6
Other (List)			
Total Capacity	326 licensed beds		326 licensed beds

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.

The NICU at Providence is a 38 bed Level III Neonatal Intensive Care Unit (NICU); the only one in Alaska. Level III designation provides for all critical medical and surgical care and is comprehensive except for some cardiac surgical care or Extra-Corporeal Membrane Oxygenation (ECMO). As the only Level III in Alaska, the Providence NICU serves a diverse population of newborn patients from all over Alaska, including Alaskan Natives and the military community.

The major conditions or most frequent diagnosis in the NICU include the following:

- Prematurity of the Newborn, with its many co-morbidities: Chronic Lung Disease, Rentinopathy of Prematurity, Pneumothorax, Necrotizing Enterocolitis, Intraventricular Hemorrhage, Sepsis, Anemia, nutritional deficits and growth restrictions;
- Congenital anomalies, such as Gastroschesis, and other conditions requiring surgical interventions;
- Term or near term newborns with transitional distress, transient respiratory concerns, hypoglycemia, birth trauma, other symptomatic conditions or conditions that put them at medical risk;
- Infants with major congenital anomalies or metabolic conditions requiring acute care.

Common treatment modalities in the NICU include a variety of respiratory support therapies such as conventional ventilation, high frequency ventilation, jet ventilation, nitric oxide administration, continuous positive airway pressure, hood oxygenation, and nasal cannula use. Other treatments and therapies include hemodynamic and oxygen saturation monitoring, IV therapy, blood administration, pre and post op surgical care. Caregivers in the NICU provide age appropriate developmental supportive care, including but not limited to the following: light, sound, handling, long periods of uninterrupted sleep, positions of flexion, and physical and emotional contact with their family. Stressors from the environment and care-giving are eliminated or reduced whenever possible.

Two facilities in Alaska operate Level II NICUs: Alaska Regional Hospital with eight beds and Alaska Native Medical Center with six beds. The highest designation for an NICU, Level IV, offers cardiac surgery and ECMO in addition to the Level III care and is not available in Alaska. A description of the type of care delivered at each service level is located in the appendix.

Providence is asking to add six Level III NICU beds to serve the increasing number of newborns needing these services.

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

Equipment to be Purchased				
Description	**Make**	**Model**	**Quantity**	**Cost**
Radiant warmer	Ohmeda	Giraffe Omni-bed	6	$216,000.00
Open cribs	Hard, Inc	Medium size	2	$ 3,000.00
Monitors	Phillips	Viridia	6	$150,000.00
Infusion pumps	Aleris	3 channel	6	$ 15,000.00
Med infusion pumps	Medex	3500	6	$ 18,000.00
Supply carts	Hill-rom	L carts	6	$ 6,000.00
Suction heads and cannisters	Ohmeda	Suction regulator	6	$ 6,000.00
Biliblanket	Ohmeda	portable	3	$ 7,500.00
Bili-lights	Natus	Generation 2 - neoblue	2	$ 7,000.00
Bili-meter	Ohmeda	Bili light meter	2	$ 5,000.00
Portable bedside warmer	Fischer-Payxel	Baby control	2	$ 2,000.00
O2 blenders/flowmeters	Ohmeda	Regular & Low-flow	6	$ 8,000.00
Baby scale - breastfeeding	Medela	Baby weigh	1	$ 1,000.00
Baby scale and cart	Olympic	Warm Scale	1	$ 2,500.00
Breast pump	Medela	Symphany	1	$ 3,000.00
Privacy screens	Hill-rom	Large	3	$ 6,000.00
Recliner chairs	Hill-rom	Procedural Recliner	3	$ 7,500.00
Vapoltherm	Vapotherm	2000i	1	$ 2,000.00
IV poles	IV League Med	Single pole w/4 hooks	6	$ 6,000.00
Staff chairs	Fixture furniture/ Jami, Inc.	Straight chairs/vinyl seat	6	$ 3,600.00

TOTAL $475,100.00

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

NA

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

Electrical Service and Distribution

At each patient location, emergency power outlets will be installed to support all necessary equipment. The existing 2E panels in the area have sufficient spare circuits to support the project.

Interior lighting
The lighting controls in the patient area have capacity to support the new space. Existing lighting circuits will be reused when possible, a new lighting feed from the adjacent elec closet will be installed as necessary. Fixtures that match existing lights will be installed.

Communications Systems
Additional data connections will be installed to accommodate bedside computers, phones and equipment. As no additional entrances are being installed in the area, no modifications to the security system are necessary.

Fire Alarm System
Fire alarms are existing and will be relocated and devices added as necessary to comply with building codes for the new layout.

Heating System
Forced air is heated via the ventilation system, see below.

Ventilation System
A supply fan located in the basement mechanical room serves the project. This variable pitch fan is running at near capacity. An engineering study has determined that the fan pitch can be adjusted and the discharge lines reconfigured to maximize airflow to the area. The bulk of this work will take place in the basement mechanical room, the work in the patient area will include replacement of pneumatic controlled boxes with DDC VAV boxes.

F. Describe the structural framing, floor system, and number of floors (including the basement).
No structural changes are required for this project. The renovations are to take place in the first floor, which is concrete on metal deck over the basement level. Below the NICU space in the basement level are administrative offices, the second floor above NICU houses the Anchorage Fracture and Orthopedic Clinic.

G. Total square footage in current facility/project.
The current NICU is 13,676 square feet.

H. Total square footage of proposed facility/project.
The proposed NICU will be 13,676 square feet. The proposed remodel is 2,408 square feet from within the existing space. For the six bed expansion, 952 feet will be remodeled. In addition, 1,456 square feet will be remodeled for the displaced support space.

I. Area per bed, service unit, or surgery suite (if applicable).
The 952 square feet for the six beds equals 159 square feet per bed.

J. Percentage of total floor area used for direct service (non-bed activity).
Of the total area to be remodeled, 40 percent is for direct patient care and 60 percent is for support space.

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

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.

Over the last five years, PAMC has completed the following upgrades:

- Upgraded radiology services (2000)
- Upgraded NICU (2001)
- Upgraded Pharmacy (2005)
- Replacement of Linear Accelerator (2005)
- Replacement of a Cath Lab (2005)

Through the Certificate of Need process, PAMC has completed the following:

- Expansion of the First Floor of the North Tower (2000)
- Relocation of the Laboratory (2000)
- Addition of 19 Acute Care beds (2002)
- Magnetic Resonance Imaging System (2004)
- Long Term Acute Care Hospital as a Joint Venture (2005)
- Relocation and Expansion of Cancer Services - Approved 2006
- Expansion of Post Anesthesia Care Unit – Approved 2006
- Expansion of the Cardiovascular Observation – Approved 2007

Providence Health System in Alaska has a three year Strategic Plan that is updated each year. The current plan acknowledges the population growth of Anchorage and Alaska, especially in the age cohorts of 45-64 and 65 plus. These populations are large users of health care services, especially of heart, cancer and surgery programs. All three of these areas will need to expand their capacity to continue meeting demands. In addition, there have been steady increases in volumes in the Women's and Children's Service line affecting capacity in obstetrics and NICU. An evaluation to update and expand this area is part of the strategic planning process.

Alaska has also had a short supply of physicians. In order to serve the growing population, efforts to recruit additional physicians to our State will continue to be a priority. Additional medical office space is being constructed to support these new physicians. Additional physicians require additional capacity to serve their patients both in diagnostic areas as well as beds.

In response to this growth and in alignment with our strategic plan, the following Certificates of Need have been submitted:

- Ambulatory Surgery Center – Pending
- Addition of One Catheterization Laboratory – Pending
- Expansion and Relocation of Sports Medicine/Rehabilitation Therapy - Pending

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.)

There are no local, regional or state government plans that address the increase of critically ill and low birth weight babies and the need for facilities to care for them. This increase has been a nationwide event and many NICUs throughout the country are struggling to provide appropriate space for the increase in babies. Volumes have been increasing steadily for the last two years and have yet to level off. An magazine article which addresses this nationwide issue and its impact is in the appendix.

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.

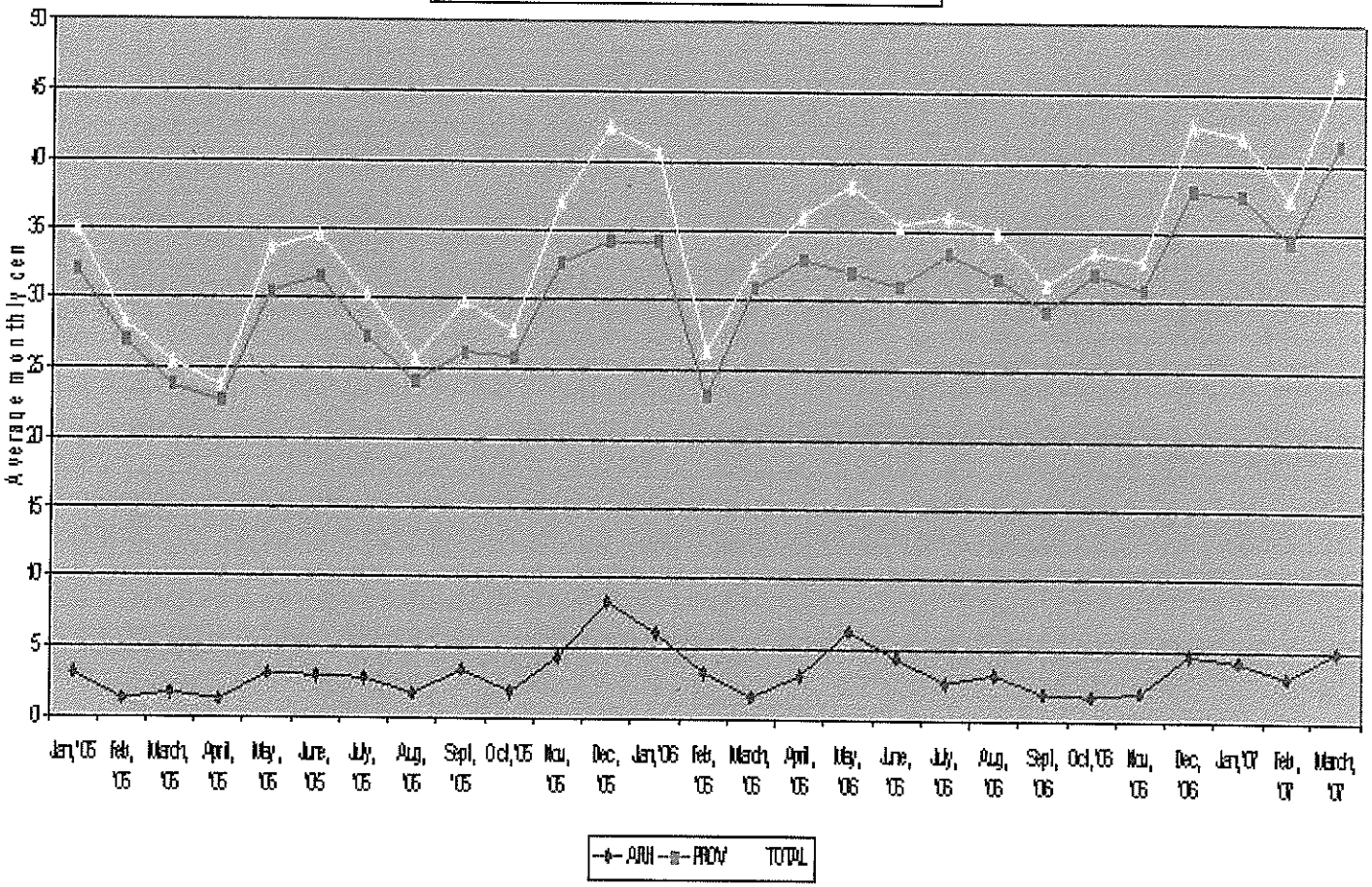
The NICU is experiencing an extremely high census with occupancies of over 100%. The unit is sized for 38 bassinettes. The average daily census for January – May 2007 was 38. The high volumes have been accommodated by using a temporary annex for six additional beds and the allowable doubling of twins. Even with the temporary spaces, the census continued to increase. Peak census was as high as 47 babies. The average occupancy in the first five months of 2007 was 100 percent with 55 days being over 100%. Because of the long lengths of stay for NICU babies which average about a month, these high occupancies are continuous and are not just infrequent spikes in census. Target occupancy for an intensive care unit is 65 percent.

The following charts illustrate the high volumes:

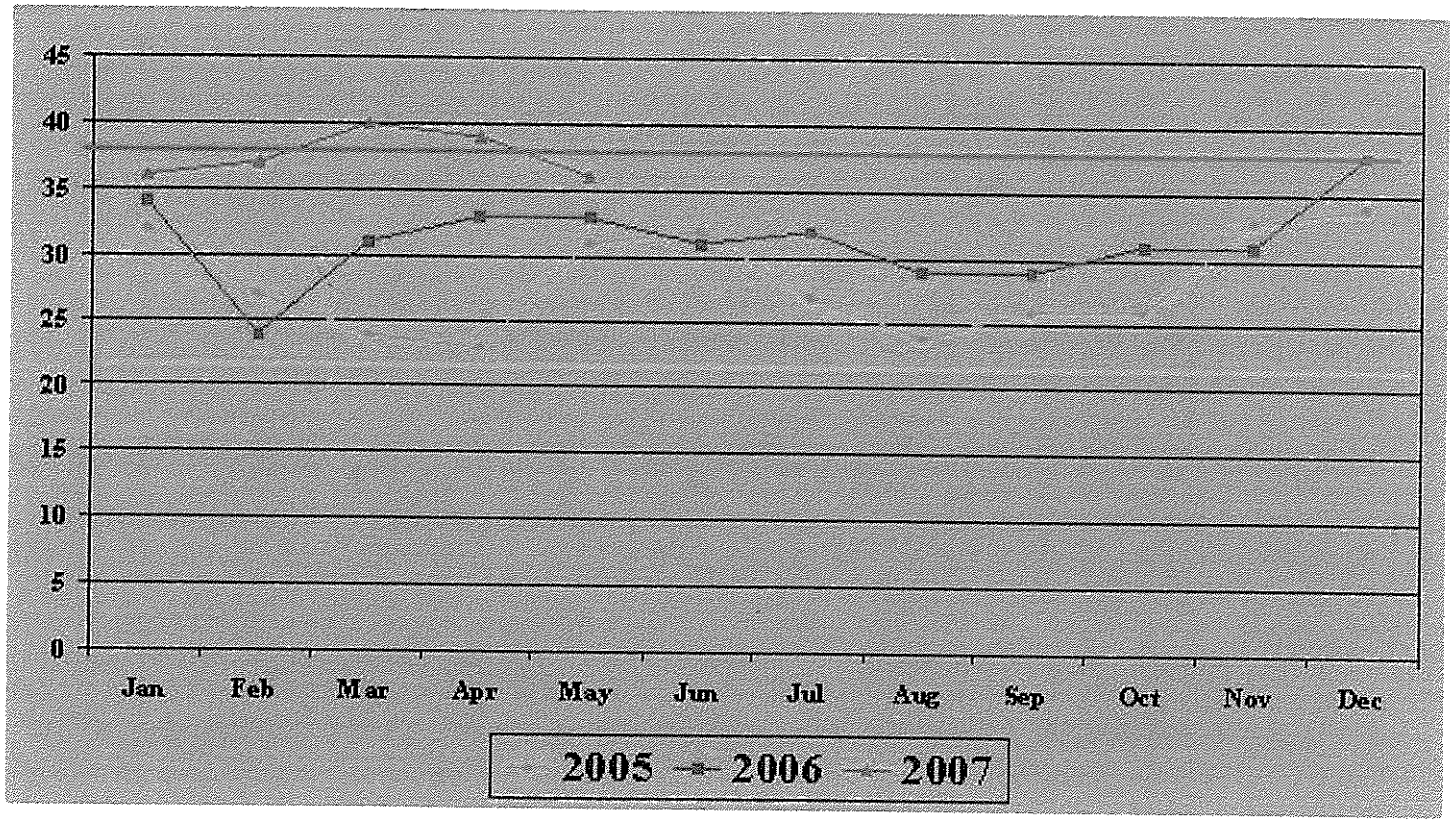
- Graph I shows the average monthly census of the Providence NICU and the Alaska Regional NICU for 2005, 2006 and January-March 2007. The Providence unit has seen a steady increase with large increase in the last several months.
- Graph II shows the monthly occupancy percentages of the Providence NICU. The unit has been over the target 65% occupancy for the last two and a half years. The extremely high occupancy over 100% or higher has been over the last six months.
- Graph III shows the steady increase in patient days of the babies who weigh < 1500 grams from 2006 through March 2007. It also shows the jump in patient days in 2006 for those infants who weigh less than 1000 grams. This is in part from the improved viability and survivability of these very low birth weight babies.

Graph I
Average Monthly Census
Combined, PAMC, & ARH Census
2005-1Q 2007

PEDIATRIX MEDICAL GROUP, INC.



Graph II
Providence Neonatal Intensive Care Unit
Occupancy 2005-May 2007



100% occupancy

65% occupancy

Graph III

PEDIATRIX MEDICAL GROUP, INC.

Patient Days by Quarter, PAMC, 2003-Q1, 2007

Table A
Providence Neonatal Intensive Care Unit
Average Daily Census
January – May 2007

Day of the Month	Jan	Feb	Mar	Apr	May
1	39	38	40	43	38
2	36	38	41	44	37
3	36	39	41	45	38
4	40	39	41	41	36
5	41	37	41	44	35
6	42	41	42	40	35
7	42	40	43	40	37
8	40	42	43	41	37
9	36	40	41	39	35
10	37	39	38	39	40
11	35	36	37	37	39
12	36	36	39	39	36
13	35	36	40	40	35
14	37	34	39	37	34
15	36	34	38	38	33
16	37	36	38	38	32
17	36	36	36	36	32
18	35	33	35	39	35
19	33	37	34	41	36
20	34	37	34	40	36
21	34	36	36	38	35
22	33	35	37	37	37
23	33	34	38	38	37
24	33	35	38	37	37
25	35	35	41	38	38
26	37	34	43	38	39
27	35	36	43	39	36
28	35	38	47	40	37
29	35		41	37	39
30	36		43	39	39
31	34		41		33
Total Days	1123	1031	1229	1182	1123
Monthly Average Daily Census	36	37	40	39	36
Occupancy based on 38 beds	95%	97%	105%	102%	95%

Key: Over 38 or over 100% occupancy
38 or 100% occupancy

Table A shows the daily census of the Providence NICU with those days at 100 percent occupancy highlighted in green and those days over 100 percent occupancy highlighted in yellow.

Providence has taken two measures in an effort to keep all level III babies in Alaska and not have to transfer them to a hospital in the lower 48.

- Transfer lower level care babies to other local hospitals that have a Level II NICU to make room for new Level III admissions.
- Expand the NICU temporarily into two postpartum rooms, creating 6 additional beds for babies for a total of 44 bassinettes. The postpartum beds were replaced by converting beds on a medical/surgical floor to care for postpartum patients.

Even with these measures in place, the occupancy in 2007 remains at 100% capacity. Further expansion is needed.

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.

The high demand for NICU services is a nationwide trend. Some of the trends include the following:

- The number of women who are childbearing age is increasing;
- The number of births is increasing;
- More older women are choosing to have babies, increasing the number of high risk deliveries;
- The number of c-sections is increasing;
- The number of low weight babies is increasing;
- There is an increase in the number of multiple births (twins, triplets, etc.); and,
- Longer lengths of stay due to the increased survive-ability of low weight babies made possible by better technology and treatment.

All of these trends have been experienced at the Providence. In addition, there are several other issues that are unique to Alaska and lead to higher numbers of babies needing critical care.

- High rate of smoking.
- High rates of substance abuse.
- High rates of physical abuse.

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.

Although there are no regulatory deficiencies, there are several internal problems that will be addressed in the expansion. The current temporary space in two postpartum rooms does not meet all the national standards as a permanent solution would achieve.

- Crowding - With the current use of two postpartum rooms, up to three babies are cared for in a room. This space does not meet the national recommendations for spacing of bassinettes in nurseries. The crowding can increase risks for infection.
- Lack of Privacy - With the crowding comes the lack of privacy for families. The lack of privacy discourages families from discussing their baby's care. Many mothers feel uncomfortable nursing their babies in a room with other families present. This interferes with progress in successful breastfeeding and with bonding with their babies.
- Air handling - The air supply to the area to be remodeled is not currently adequate for a patient care area and will be upgraded to meet regulatory requirements.

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:

PAMC Neonatal Intensive Care Unit is the only Level III unit in Alaska. The majority of moms with high risk pregnancies deliver at Providence and thus the majority of babies needing intensive care are delivered at Providence. Approximately 40% of NICU babies or high risk mothers who deliver at Providence are transferred here from other hospitals.

a. Document the service area by means of a patient origin analysis.

At Providence Alaska Medical Center, 74 percent of the patients come from the Anchorage area and 26 percent come from the rest of the state. However, because the NICU is a tertiary service and serves the entire state of Alaska, only 51 percent of its patients are from Anchorage and 49 percent are from the rest of the state. This is closer to the state's population distribution. The NICU sees a higher percentage of Native patients than the rest of the hospital with 22 percent vs. four percent, and a higher percentage than the State's distribution of 16 percent. See tables B-E.

Table B
Providence Alaska Medical Center
Total Patients and NICU Patients vs. 2005 Statewide Population Distribution
Patient Origin, 2006

Service Area	Total PAMC	NICU Patients	Statewide 2005
Anchorage	74%	51%	42%
Gulf Coast & Mat-Su Region	15%	24%	22%
Other Alaska	8%	24%	36%
Outside Alaska	3%	1%	0%
Total	100%	100%	100%

Table C
Providence Alaska Medical Center
Total Patients and NICU Patients vs. 2005 Statewide Population Distribution
Race by Percentage, 2006

Race	Total PAMC	NICU Patients	Statewide 2005
Caucasian	73%	58%	70%
Native	4%	22%	16%
Black	6%	4%	4%
Pacific/Asian Islander	9%	8%	5%
Hispanic	4%	4%	5%
Unknown	4%	4%	0%
Total	100%	100%	100%

Table D
Providence Alaska Medical Center
Total Patients and NICU Patients vs. 2005 Statewide Population Distribution
Gender by Percentage, 2006

Gender	Total PAMC	NICU Patients	Statewide 2005
Female	59%	45%	48%
Male	41%	55%	52%
Total	100%	100%	100%

Table E
Providence Alaska Medical Center
Total Patients vs. NICU Patients vs. Statewide Population Distribution
Age by Percentage, 2006

Age	PAMC	NICU Patients	Statewide 2005
0-14	22%	100%	24%
15-44	33%	0%	44%
45-64	25%	0%	25%
65+	20%	0%	7%
Total	100%	100%	100%

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.

The NICU sees patients from throughout Alaska, with 49 percent coming from outside of Anchorage.

Table F
Providence Alaska Medical Center
2006 NICU Patients vs. 2005 State Population Distribution
By Area of Residence

Alaska Boroughs	NICU Patients Percentage	State Population Distribution
Anchorage	51%	42%
Gulf Coast & Mat-Su	24%	22%
Other Alaska Boroughs	24%	36%
Unknown	1%	0%
Total	100%	100%

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.

Tables B-E show how the NICU patient population compares to the Alaska statewide population in terms of patient origin, race, gender, and age. The NICU patients are a close representation of the state's population with slightly more Native patients and slightly less patients from outside of Southcentral Alaska.

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.

The Providence NICU is a level III NICU which provides critical care for newborns. Babies with higher care needs such as cardiac surgery and ECMO are sent to Level IV NICU's in other states. In 2006, 19 babies were transferred to a Level IV NICU.

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.

The State's Review Methodology was used to calculate projected utilization. Utilization is based on statewide births and Providence NICU patient days. Birth data from Vital Statistics was used for births from 2004 and 2005. Official birth numbers for 2006 are not yet available from Vital Statistics. The State of Alaska Department of Labor has projected births in three growth scenarios f(low, medium, and high) for years 2004-05 to 2028-29. The medium scenario is about three percent lower than actual births for 2004 and 2005. The high scenario is too high, about four percent higher in 2004 and seven percent higher in 2005. The medium scenario for projected births was used with a three percent increase for each year for years 2006 -2013.

Step 1

	Year	Statewide Births	PAMC NICU Patient Days	PAMC NICU Use Rate
Actual	2004	10,336	10,410	1.00715944
Actual	2005	10,451	9,984	0.95531528
Estimated*	2006	10,617	11,286	1.06301215
	3 year avg	10,468	10,560	1.00878869

* 2006 births are based on the DOL medium growth scenario plus three percent

Births divided by patient days equals a use rate. The three year historic average use rate was used for projections.

Step 2

	Year	Projected Statewide Births	PAMC NICU Use Rate	Projected PAMC NICU Patient Days
Projected**	2008	10,877	1.00878869	10,972
Projected**	2009	11,002	1.00878869	11,099
Projected**	2010	11,145	1.00878869	11,243
Projected**	2011	11,288	1.00878869	11,387
Projected**	2012	11,391	1.00878869	11,491
Projected**	2013	11,466	1.00878869	11,567

** Projected births are based on the DOL medium growth scenario plus three percent

Projected births times the three year historic average use rate gives projected patient days.

Step 3

	Year	Projected PAMC NICU Patient Days	Days per Year	PAMC NICU Average Daily Census
Projected	2008	10,972	365	30
Projected	2009	11,099	365	30
Projected	2010	11,243	365	31
Projected	2011	11,387	365	31
Projected	2012	11,491	365	31
Projected	2013	11,567	365	32

Projected patient days divided by 365 equals the average daily census.
(Note that Jan – May 2007 average daily census was 38 as compared to this forecast)

Step 4

	Year	PAMC NICU Average Daily Census	Target Occupancy	PAMC NICU Projected Bed Need
Projected	2008	30	0.65	46
Projected	2009	30	0.65	47
Projected	2010	31	0.65	47
Projected	2011	31	0.65	48
Projected	2012	31	0.65	48
Projected	2013	32	0.65	49

The average daily census divided by the target occupancy equals the projected bed need.

Step 5

	Year	PAMC NICU Projected Bed Need	PAMC Current Bed Inventory	Additional PAMC NICU Beds Needed
Projected	2008	46	38	8
Projected	2009	47	38	9
Projected	2010	47	38	9
Projected	2011	48	38	10
Projected	2012	48	38	10
Projected	2013	49	38	11

The projected bed need minus the current bed inventory equals the number of additional beds needed

Providence is asking for 6 new beds. There is not additional space available in the NICU or adjacent to the NICU for more beds at this time.

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;

The NICU sees over 500 patients per year. In addition, 84% of all babies are admitted for critical care, 11% are admitted at the intermediate care stage, and 5% need routine NICU care. Approximately 20% of babies are low birth weight babies, a weight of less than 1500 grams and 80% of babies are greater than 1500 grams.

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.

NA

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.

See Tables G and H.

Table G

Providence Alaska Medical Center
Neonatal Intensive Care Unit
Historic Patient Volume, 2002-2006

	2002	2003	2004	2005	2006
Patients	421	490	495	492	556
Patient Days	8860	9911	10,336	10,451	10,617
Avg Daily Census	24.27	27.15	28.32	28.63	29.09
Occupancy @ 38 beds	63.87%	71.45%	74.52%	75.34%	77.00%

Table H

Providence Alaska Medical Center
Neonatal Intensive Care Unit
Patient Volume, January – May 2007

	Jan 07*	Feb 07	Mar 07	Apr 07	May 07
Patients	46	42	54	na	na
Patient Days	1172	1071	1282	1182	1128
Avg Daily Census	37.8	34.5	41.4	39.4	36.2
Occupancy @ 38 beds	99.47%	90.79%	108.95%	103.68%	95.26%
Occupancy @ 44 beds	85.91%	78.41%	94.09%	89.55%	82.27%

* Six overflow beds were added in January 2007 to handle the high census

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.

The State Review Methodology was used to project future volumes. However, using a three year historic use rate put the projected average daily census significantly below volumes experienced in 2007. The average daily census for the first five months of 2007 was 38, which is 35% above the State Review Methodology outcome of 30 in 2008. The math for the State methodology is located on pages 19-21.

Table I
Providence Alaska Medical Center
Projected NICU Patient Days
Based on State Review Methodology, 2008-2013

		2008	2009	2010	2011	2012	2013
Providence	Patient Days	10,972	11,099	11,243	11,387	11,491	11,567
	Percentage growth		1.16%	1.30%	1.28%	0.91%	0.66%
	Average Daily Census	30	30.4	30.8	31.2	31.5	31.7
	Occupancy of 44 beds	68%	69%	70%	71%	72%	72%

However, based on actual experience in 2006 and 2007, volumes will be higher than the formula predicts. Providence's projected volumes for the unit are based on a three year average of use rates using 2005, 2006 and 2007 annualized. The math for this calculation is shown on pages 24-25. Table J below shows the expected volumes 2008 – 2013.

Table J
Providence Alaska Medical Center
Projected NICU Patient Days for 2008-2013
Based on Growth from 2005-2007

		2008	2009	2010	2011	2012	2013
Providence	Patient Days	11,928	12,065	12,222	12,378	12,491	12,574
	Percentage growth		1.15%	1.30%	1.28%	0.91%	0.06%
	Average Daily Census	32.6	33.1	33.5	33.9	34.2	34.4
	Occupancy of 44 beds	74%	75%	76%	77%	78%	78%

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.
NA

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).
There are many factor that are influencing the continued increase of critically ill babies:

- Growth in female population age cohort of 15-44 years
- Growth in the birth rate
- Growth in the number of low weight babies
- Growth in multiple births
- Growth in the number of older women giving birth
- Growth in c-sections
- High incidence of smoking
- High incidence of substance abuse
- High incidence of physical abuse

All of these combined have lead to an continued increase in the number of babies requiring Level III NICU care. Graph I, page 12 illustrates the increases in Anchorage by quarter, 2005- March 2007.

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

g. Provide any other information that may be pertinent to establishing the need for this project.
The high census in the Providence's NICU has caused them to create a temporary overflow area of six beds in order to accommodate newborns and not force them to be transferred to another facility outside of Alaska due to capacity constraints. Even with this increase in capacity, the census has continued to climb in 2007 and kept the average daily census at 38 for the first five months of the year. This high growth is illustrated in Graph I, page 12.

In addition there have been many days that the census has been at this expanded capacity over these last several months. Table A, page 15 shows the number of days per month that the Providence NICU has been at or over its capacity of 38 beds.

h. Attach letters of support from local and regional agencies, other health care facilities, individuals, governmental bodies, etc.
Letters of support will be sent directly to the CON Coordinator under separate cover.

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.
The State's Review methodology projects an average daily census that is lower than those experienced in 2007. Graphs I, II, and Table A, pages 12-14 show the high volumes in 2007. applying annualized 2007 volumes as part of the State Review Methodology calculation would raise the average use rate to 1.09666666 and the average daily census to 34 patients in 2013. This use rate shows that the beds needed in 2013 are increased to 52 which is an additional 14 beds.

Step 1

	Year	Statewide Births	PAMC NICU Patient Days	PAMC NICU Use Rate
Actual	2005	10,451	9,984	0.95531528
Estimated*	2006	10,617	11,286	1.06301215
Estimated*	2007	10,747	13,651**	1.27021494
	3 year avg	10,605	11,640	1.09666666

Births divided by patient days equals a use rate. The three year historic average use rate is what is used for projections.

* 2006 and 2007 births are based on the DOL medium growth scenario plus 3%
** 2007 patient days annualized based on Jan-May actual

Step 2

	Year	Projected Statewide Births	PAMC NICU Use Rate	Projected PAMC NICU Patient Days
Projected**	2008	10,877	1.09666666	11,928
Projected**	2009	11,002	1.09666666	12,065
Projected**	2010	11,145	1.09666666	12,222
Projected**	2011	11,288	1.09666666	12,378
Projected**	2012	11,391	1.09666666	12,491
Projected**	2013	11,466	1.09666666	12,574

Projected births times the three year historic average use rate gives projected patient days.

** Projected births are based on the DOL medium growth scenario plus 3%

Step 3

	Year	Projected PAMC NICU Patient Days	Days per Year	PAMC NICU Average Daily Census
Projected	2008	11,928	365	33
Projected	2009	12,065	365	33
Projected	2010	12,222	365	33
Projected	2011	12,378	365	34
Projected	2012	12,491	365	34
Projected	2013	12,574	365	34

Projected patient days divided by 365 equals the average daily census.

Step 4

	Year	PAMC NICU Average Daily Census	Target Occupancy	PAMC NICU Projected Bed Need
Projected	2008	33	0.65	51
Projected	2009	33	0.65	51
Projected	2010	33	0.65	51
Projected	2011	34	0.65	52
Projected	2012	34	0.65	52
Projected	2013	34	0.65	52

The average daily census divided by the target occupancy equals the projected bed need.

Step 5

	Year	PAMC NICU Projected Bed Need	PAMC Current Bed Inventory	Additional PAMC NICU Beds Needed
Projected	2008	51	38	13
Projected	2009	51	38	13
Projected	2010	51	38	13
Projected	2011	52	38	14
Projected	2012	52	38	14
Projected	2013	52	38	14

The projected bed need minus the current bed inventory equals the number of additional beds needed

Providence is asking to add 6 beds. There is not additional space available at this time for more beds.

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.

There were six different alternatives considered for this project:

- Do nothing – This alternative will continue to stress the nursery with extremely high occupancies and will lead to babies being sent to hospitals in other states. Transporting Level III babies increases risk and is very disruptive for families. Babies stay an average of two months. **NOT CHOSEN**

- Transfer Level II babies to other local Level II nurseries in order to accommodate Level IIIs –This is currently being done as needed. The other nurseries are small, with a capacity of eight and six bassinettes each and can easily then reach maximum occupancy as well. Transfers are not ideal for the babies. Families grow comfortable with the NICU care providers and develop trust in the care processes. Changing facilities requires a family to begin new care processes and time is needed to develop trust in the new providers as they learn about the baby's care needs. However, transfers do occur to meet various demands. Providence transferred 30 babies to Alaska Native Medical Center and 46 babies to Alaska Regional Hospital in 2006. **CURRENTLY BEING DONE**

- Convert postpartum rooms to accommodate three NICU bassinets each – As a temporary fix, the NICU expanded into two postpartum rooms, however, the high census has continued. This temporary solution has added additional strain on the postpartum unit. Many of the same trends causing the NICU to have high census also cause high census in maternity. The lost maternity beds were regained by converting medical/surgical beds to postpartum beds to accommodate additional moms and the conversion to NICU beds. The two postpartum rooms can handle six babies but they do not meet all the specific national standards. Thus a more permanent solution with remodeling of space to meet standards is needed. **ALSO CURRENTLY BEING DONE**

- Expand into Cancer Therapy Center vacated space – The Cancer Therapy Center will be moving into new space by January 2008. Although the square footage of space to be vacated would be adequate for an expansion of NICU, the infrastructure is not suited for clinical intensive care space. This space would need proper medical gases, airflow and other environmental controls which are cost prohibitive. Also, the expanded section of the NICU would be separated from the main NICU by a main public corridor and fire path creating safety concerns. **NOT CHOSEN**

- Add six permanent NICU bassinets by converting conference room and office space into patient care area – The NICU is landlocked and does not have adequate adjoining space in which to expand. Internal NICU space that adjoins the current main NICU is a conference room and staff locker space of 952 square feet. This space could accommodate 6 NICU bassinets. The displaced locker space needs to be replaced.

Further away is another conference room, office space and restrooms that will be converted into replacement staff locker space. **CHOSEN**

- Construction of a new NICU sized for the current and future demand – Construction of a new mother baby tower is under consideration as there are growing demands for both maternity and NICU services. A new tower requires several years to design and construct, it would not address the critical need of space for Level III babies today. This alternative is under consideration as a long term solution to the increase in this population. **NOT CHOSEN**

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.
If additional beds are not made available, critically ill newborns will need to be sent to hospitals in other states not because of medical needs, but due to capacity constraints in Alaska. Being sent to a facility in another state creates transport risks, and causes hardship on families by forcing them to be away from home for several months while the baby recovers and matures.

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.
Providence NICU is the only Level III NICU in Alaska. Two other facilities offer Level II NICUs – Alaska Regional Hospital with eight beds and Alaska Native Medical Center with six beds. Level II babies are less critical and more stable, requiring less specialized services.

Both of the Level II NICU's in Anchorage are experiencing high census and at times are not able to take transfers when the Providence NICU has reached capacity. ANMC is planning to expand their Level II unit from six beds to 10 due to the continued high census.

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
This proposed increase in beds will add to the capacity of the current Level III NICU.

b. provide an alternative or unique service
This Level III NICU is the only program in Alaska and is available to all Alaskans including Alaska Natives and the military community.

c. provide a service for a specific target population
Providence's Level III NICU serves the most critically ill babies in Alaska.

d. provide needed competition
NA – There is no other Level III NICU in Alaska.

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.
Babies can be transferred from the Providence Level III NICU to a Level II NICU at one of the other hospitals. In 2006, 30 babies were transferred to Alaska Regional Hospital and 46 were transferred to Alaska Native Medical Center. These transfers were done to make room for Level III babies at Providence. In addition, some transfers happen the other way with some babies being transferred from ARH and ANMC that need additional services and are transferred to the Level III care of Providence's NICU. In 2006, 40% of the NICU babies or high risk mothers who deliver at Providence were transferred from other facilities.

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.
The addition of 6 beds to the NICU will provide additional capacity to serve newborns needing critical care services. This expansion will not increase charges to patients beyond normal inflation adjustments. Based on the payor mix, 55% of the Providence NICU patients are paid for through Medicaid. The additional volume would create additional Medicaid expenses of $750,753 in 2012.

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.
Providence Alaska Medical Center will finance the NICU expansion with internal capital funds. No borrowing of funds will be required.

3. Provide a description and estimate of:
a. the probable impact of the proposal on the annual increase on the overall costs of the health services to the target population to be served;
There is no anticipated increase on the pricing of services to our patients, community, or the state as a result of this project.

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);

NA

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

This project will not have any negative impact on the overall financial condition of Providence Alaska Medical Center nor its ability to continue operations.

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.

Providence Alaska Medical Center maintains an open door philosophy consistent with the values of the Sisters of Providence and their mission to provide quality health care to all individuals regardless of their race, creed or ability to pay.

PAMC utilizes interpreters via a telephone service, which is available 24 hours a day. The interpreter is connected via speakerphone so the patient, family and staff can all hear each other.

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

Over the last five years, Providence has provided over $119 million in charity care, an average of $23 million a year. A projected detail budget for total deductions is difficult to predict. A conservative estimate for total deductions from revenue has been used of about five percent increase per year in the table below. No data is available for the breakdown within that amount.

Table K
Providence Alaska Medical Center
Total Deductions from Revenue (in thousands)
Actual 2002-2006, Projected 2007-2009

	Year	Charity Care	Contractual Allowances	Other	Total Deductions from Revenue
Actual	2002	$20,411	$54,206	$157,763	$232,380
	2003	$21,308	$61,516	$198,448	$281,272
	2004	$23,214	$76,115	$242,612	$341,941
	2005	$27,874	$85,660	$264,292	$377,826
	2006	$26,776	$100,274	$305,583	$432,633
Projected					
	2007	na	na	na	$421,226
	2008	na	na	na	$438,435
	2009	na	na	na	$460,357

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

   a. **transportation and travel time to the facility;**
   PAMC is located in Anchorage, Alaska's largest city with 42 percent of the state's population. Being in the center of Anchorage, Providence is easily within a half hour's drive for most residents and from the International Airport. PAMC is served by the city transit system. Providence provides care 24 hours a day/ seven days a week.

   b. **special architectural provisions for the aged and persons with a disability;**
   PAMC complies with the Rules and Regulations of the Federal Register Nondiscrimination on the basis of Disability by Public Accommodations and in Commercial Facilities; the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and Alaska State Department of Health and Social Services, which oversees hospital licensing.

   c. **hours of operation; and**
   The hospital services are available 24 hours a day, seven days a week.

   d. **the institution's policies for nondiscrimination in patient services.**
   Providence Alaska Medical Center maintains an open door philosophy consistent with the values of the Sisters of Providence and their mission to provide quality health care to all individuals regardless of their race, creed or ability to pay.

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.

PAMC is licensed as an acute care hospital with 326 beds by the State of Alaska. It is certified by Medicare and Medicaid. PAMC's Medicaid ID numbers are HP11IP and HP11OP. The hospital's Medicare number is 02-0001. A copy of the license is located in the appendices. PAMC is accredited by the Joint Commission on Accreditation of Hospitals Organization (JCAHO). The hospital was surveyed in October 2005. A copy of a letter from JCAHO acknowledging the survey is located in the appendices.

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

The quality control program at Providence is outlined below;

a. Equipment – all equipment meets quality and safety standards required of all manufactures by the federal government. Preventative maintenance is performed on equipment, and consists of a thorough inspection for any defects that may affect patient care or safety.
b. Physicians – Physician's education, training and skills are evaluated through a credentialing process, and only qualified physicians are recommended for privileges. Members of the medical staff, through training and continuing education, stay current with new developments in their respective specialties.
c. Clinical and Non-Clinical Personnel – All personnel must meet professionally accepted job requirements.
d. Continuing Education – The hospital provides continuing education training and ensures that all personnel receive training provided by equipment vendors, professional societies and attend selected special educational meetings both in and out of state.
e. The objectives of the Quality Improvement Program include the following:
   - Provide optimal patient care within available resources;
   - Manage resources in the most appropriate manner;
   - Minimize risk and injury;
   - Identify and act upon opportunities to improve patient care; and
   - Trend, benchmark and maximize patient outcomes with advanced databases.
f. The Providence Health System Alaska Region board provides oversight of the Quality Improvement program.

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

The intradisciplinary team from the NICU works collaboratively to provide both critical care and on-going convalescent care for newborns. Members of the team include health unit coordinators, equipment technicians, social workers, family care coordinators, dieticians, pharmacists, respiratory therapists, occupational and physical therapists, registered nurses, neonatal nurse practioners, neonatologists, NICU navigator, and pediatric surgeons. Consultants from various

pediatric subspecialties are also available. Team members round daily to evaluate and modify the plan of care of each patient. Parents of infants are also considered to be care partners and are encouraged to participate in planning and giving care to their infants.

Core nursing staff is planned based on the overall expected volume of patients, the average daily census, the acuity of patients and activity level of the unit (consideration of known admissions, discharges, surgeries, off-unit procedures, consultations to other units to evaluate newborns in Maternity or ER).

The general ratio of nurse to patients is: 1:2.5
Acuity impacts on this ratio and nurse staffing are as follows:

- Level III Unstable patients are staffed at 1:1 or 1:2
- Level III Stable patients are staffed at 1:2 or 1:2.5
- Level II Intermediate or complex patients are staffed 1:3 or 1:3.5
- Level II Stable patients are staffed 1:3.5 or 1:4

All staffing levels remain the same for all shifts and are modified if re-evaluation of a patient changes the level of care category.

Other disciplines staffing levels are as follows:

- A neonatologist is generally available 24 hours a day;
- A neonatal nurse practioner is staffed in the unit and is available for LifeGuard call 24 hours a day. They may be called out of the unit anytime a neonatal transport isneeded;
- Two respiratory therapists are staffed 24 hours a day;
- One health unit coordinator is staffed at the entry of the NICU 24 hours a day;
- Equipment technicians and nurse externs are staffed each shift to provide essential support services to the NICU nursing staff;
- Occupational and physical therapy developmental support services are available 5-7 days a week; and
- The NICU navigator works 20 hours per week.

The registered nurse to patient ratios for care are in compliance with the American Academy of Pediatrics and the American College of OB and GYN. Documentation is included in the appendices.

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

The NICU utilizes both social workers and case managers to assist with discharge planning and community placement, if necessary.

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

The six new beds will be equipped with new equipment including ventilators and a blood gas machine.

6. LABOR SAVING DEVICES AND EFFICIENCY: The employment of labor-saving equipment and programs to provide operating economies.
Placing the six new beds adjacent to the main NICU will allow sharing of equipment and staff to maintain efficiencies within the NICU.

7. PROGRAM EVALUATION: Future plans for evaluation of the proposed activity to ensure that it fulfills present expectations and benefits.
The NICU reviews its budget, volumes, staffing, productivity, quality indicators monthly as well as through an annual review process. Both the clinical manager and medical director are responsible for developing plans for corrective action when indicators are not met.

8. ORGANIZATIONAL STRUCTURE: Include an organizational chart, descriptions of major position requirements and board representation; show representation from community economic and ethnic groups.
The NICU is part of The Children's Hospital at Providence. The NICU clinical manager reports to the Assistant Chief Nurse of the Children's Hospital at Providence. The Assistant Chief Nurse reports to the Chief Nurse Executive who reports to the Providence Alaska Medical Center Administrator. An organizational chart of the Children's Hospital at Providence and Providence Alaska Medical Center is located in the appendices.

Rosters of the Providence Health and Services (PHS) Board of Directors, PHS Officers and the Alaska Region Board are located in Section I of this document.

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.
Copies of the following resumes and job descriptions are located in the appendix:
- Assistant Chief Nurse, The Children's Hospital at Providence
- Clinical Manager, Neonatal Intensive Care Unit

A copy of the job description for a Registered Nurse and a copy of the resume of the Medical Director of the Providence NICU is also located in the appendix.

The general ratio of nurse to patients in the NICU is: 1:2.5
Acuity impacts on this ratio and nurse staffing are as follows:
- Level III Unstable patients are staffed at 1:1 or 1:2
- Level III Stable patients are staffed at 1:2 or 1:2.5
- Level II Intermediate or complex patients are staffed 1:3 or 1:3.5
- Level II Stable patients are staffed 1:3.5 or 1:4

All staffing levels remain the same for all shifts and are modified if re-evaluation of a patient changes the level of care category.

The nurse to patient ratios for care are in compliance with the American Academy of Pediatrics and the American College of OB and GYN. Documentation is included in the Appendices.

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

The size of this expansion is limited by the space that is available adjacent to the NICU. Thus services are being moved within the NICU to make the best use of all spaces and meet the growing needs of the nursery. Because staffing levels are about 1 nurse to 2 patients, expansions are usually done in twos to order to keep staffing efficient.

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

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

General Review Standards

1. **The applicant documents need for the project by the population served, or to be served, including, but not limited to, the needs of rural populations in areas having distinct or unique geographic, socioeconomic, cultural, transportation and other barriers to care.**
   The PAMC NICU provides services to babies from throughout Alaska. About 51 percent of the infants are from Anchorage and 49 percent are from other areas of Alaska. See Table B. About 40% of the NICU babies or high risk mothers who deliver at Providence are transferred to Providence from other hospitals due to the special services provided at this NICU.

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.**
   There are no current community, regional, state or federal health plans that have forecasted the high increase in volume, the impact of such a high census on access to care or that address the need for expansion of the NICU

3. **The applicant demonstrates evidence of stakeholder participation in planning for the project and in the design and execution of services.**
   Stakeholder involvement is accomplished in many ways in the NICU:
   - Staff involvement is through self-governance committees that meet regularly on the unit;
   - Monthly meeting with physicians
   - Monthly physician and nursing meetings
   - Monthly meeting with Family Action Council which involves interested families
   - Quarterly meetings with community partners which is the Children's Hospital Advisory Committee
   - Quarterly Children's Hospital open public forums

   The expansion project of NICU has been a topic of discussion with these groups.

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.**

Providence considered six different alternatives to addressing the high census in the NICU:

- Do nothing – This alternative will continue to stress the nursery with extremely high occupancies and will lead to babies being sent to hospitals in other states. Transporting Level III babies increases risk and is very disruptive for families. Babies stay an average of two months. **NOT CHOSEN**

- Transfer Level II babies to other local Level II nurseries in order to accommodate Level IIIs –This is currently being done as needed. The other nurseries are small sized with eight and six bassinettes each and can easily then reach maximum occupancy as well. This is not ideal for the babies. Families grow comfortable with the NICU care providers and develop trust in the care processes. Changing facilities requires a family to begin new care processes and time is needed to develop trust in the new providers as they learn about the baby's care needs. However, transfers do occur to meet the various demands. Providence transferred 30 babies to Alaska Native Medical Center and 46 babies to Alaska Regional Hospital in 2006. **CURRENTLY BEING DONE**

- Convert postpartum rooms to accommodate three NICU bassinets each – As a temporary fix, the NICU expanded into two postpartum rooms, however, the high census has continued. This temporary solution has added additional strain on the postpartum unit. Many of the same trends causing the NICU to have high census also cause high census in maternity. The lost maternity beds were regained by converting medical/surgical beds to postpartum beds to accommodate additional moms and the conversion to NICU beds. The two postpartum rooms can accommodate six babies but they do not meet all the specific national standards. Thus a more permanent solution with remodeling of space to meet standards is needed. **ALSO CURRENTLY BEING DONE**

- Expand into Cancer Therapy Center vacated space – The Cancer Therapy Center will be moving into new space by January 2008. Although the square footage of space to be vacated would be adequate for an expansion of NICU, the infrastructure is not suited for clinical intensive care space. This space would need proper medical gases, airflow and other environmental controls which are cost prohibitive. Also, the expanded section of the NICU would be separated from the main NICU by a main public corridor and fire path creating safety concerns. **NOT CHOSEN**

- Add six permanent NICU bassinets by converting conference room and office space into patient care area – The NICU is landlocked and does not have adequate adjoining space in which to expand. Internal NICU space that adjoins the current main NICU is a conference room and staff locker space of 952 square feet. This space could accommodate 6 NICU bassinets. The displaced locker space needs to be replaced. Further away is another conference room, office space and restrooms that will be converted into replacement staff locker space. **CHOSEN**

- Construction of a new NICU sized for the current and future demand – Construction of a new mother baby tower is under consideration as there are growing demands for both maternity and NICU services. A new tower requires several years to design and construct, it would not address the critical need of space for Level III babies today. This alternative is under consideration as a long term solution to the increase in this population. **NOT CHOSEN**

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.**
PAMC's NICU is the only Level III NICU in Alaska. If this unit is at capacity, babies must be transported to another Level III NICU in another state. The two Level II nurseries in Alaska care for less critically ill babies and can not care for babies requiring Level II care. Babies are at times transferred between Level III and Level II in order to receive the appropriate level of care for the baby. The high volume of critically ill babies affects all of the NICU's in Alaska, with each needing to operate at high census. The addition of six NICU beds supports all the nurseries in keeping babies in Alaska.

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.**
Providence is located in Anchorage, Alaska's largest city with 42% of the State's population. Being in the center of Anchorage, Providence is easily within a half hour's drive for most residents and from the International Airport. PAMC is served by the city transit system. Providence provides care 24 hours a day/ 7 days a week.

<u>Acute Care Review Standards</u>

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

The state's review methodology states that 49 beds are needed by 2013 or an addition of 11 beds. This project is requesting to add 6 beds for a total of 44 beds.

2. **An applicant serving patients from a community with a population of 10,000 or less demonstrates that the transport of patients to or from those areas for medical care or services will be facilitated, directly or through coordinated efforts with other organizations.**
Providence has a neonatal transport team that through the Providence air ambulance service, LifeGuard, travels throughout the state to transport babies that need critical care. A neonatal nurse practioner travels with the baby. Providence also has a perinatal transport team that can transport the mother before the baby is delivered.

Review Methodology

Step One: Projected Caseload = (projected state population x use rate) x service area share

	Year	Projected Statewide Births	PAMC NICU Use Rate	Projected PAMC NICU Patient Days
Projected**	2008	10,877	1.00878869	10,972
Projected**	2009	11,002	1.00878869	11,099
Projected**	2010	11,145	1.00878869	11,243
Projected**	2011	11,288	1.00878869	11,387
Projected**	2012	11,391	1.00878869	11,491
Projected**	2013	11,466	1.00878869	11,567

Projected births times the three year historic average use rate gives projected patient days.

** Projected births are based on the DOL medium growth scenario plus three percent

Step Two: Average Daily Census = projected caseload / service availability

	Year	Projected Statewide Births	PAMC NICU Use Rate	Projected PAMC NICU Patient Days
Projected**	2008	10,877	1.00878869	10,972
Projected**	2009	11,002	1.00878869	11,099
Projected**	2010	11,145	1.00878869	11,243
Projected**	2011	11,288	1.00878869	11,387
Projected**	2012	11,391	1.00878869	11,491
Projected**	2013	11,466	1.00878869	11,567

Projected births times the three year historic average use rate gives projected patient days.

** Projected births are based on the DOL medium growth scenario plus three percent

	Year	PAMC NICU Average Daily Census	Target Occupancy	PAMC NICU Projected Bed Need
Projected	2008	30	0.65	46
Projected	2009	30	0.65	47
Projected	2010	31	0.65	47
Projected	2011	31	0.65	48
Projected	2012	31	0.65	48
Projected	2013	32	0.65	49

The average daily census divided by the target occupancy equals the projected bed need.

Step Three: Projected Bed Need = average daily census / target occupancy

	Year	PAMC NICU Average Daily Census	Target Occupancy	PAMC NICU Projected Bed Need
Projected	2008	30	0.65	46
Projected	2009	30	0.65	47
Projected	2010	31	0.65	47
Projected	2011	31	0.65	48
Projected	2012	31	0.65	48
Projected	2013	32	0.65	49

The average daily census divided by the target occupancy equals the projected bed need.

Step Four: Unmet bed Need = projected bed need – inventory hospital beds

	Year	PAMC NICU Projected Bed Need	PAMC Current Bed Inventory	Additional PAMC NICU Beds Needed
Projected	2008	46	38	8
Projected	2009	47	38	9
Projected	2010	47	38	9
Projected	2011	48	38	10
Projected	2012	48	38	10
Projected	2013	49	38	11

The projected bed need minus the current bed inventory equals the number of additional beds needed

Section VII. Construction Data

A. Please check appropriate boxes:

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

B. Project Development Schedule	**Date**
1. Estimated completion of final drawings and specifications	June 2006
2. Estimated construction begun by	August 2006
3. Estimated construction complete by	1st Quarter 2007
4. Estimated opening of proposed services	1st Quarter 2007

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?
On file with the department.

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.
On file with the department

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).
On file with the department.

4. An architectural master plan including long-range concept and development of total facility.
On file with the department.

5. Schematic floor plan drawings (or conceptual drawings) of proposed activity, including functional use of various rooms.
Figure I is a drawing of the existing NICU and the proposed areas for remodeling. Figure II s shows the NICU after the remodeling.

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

All construction will be done in accordance with established infection control procedures including full containment of construction areas, specific designated routes for construction traffic and HEPA filtered negative air machines.

The project is to be completed in two phases.

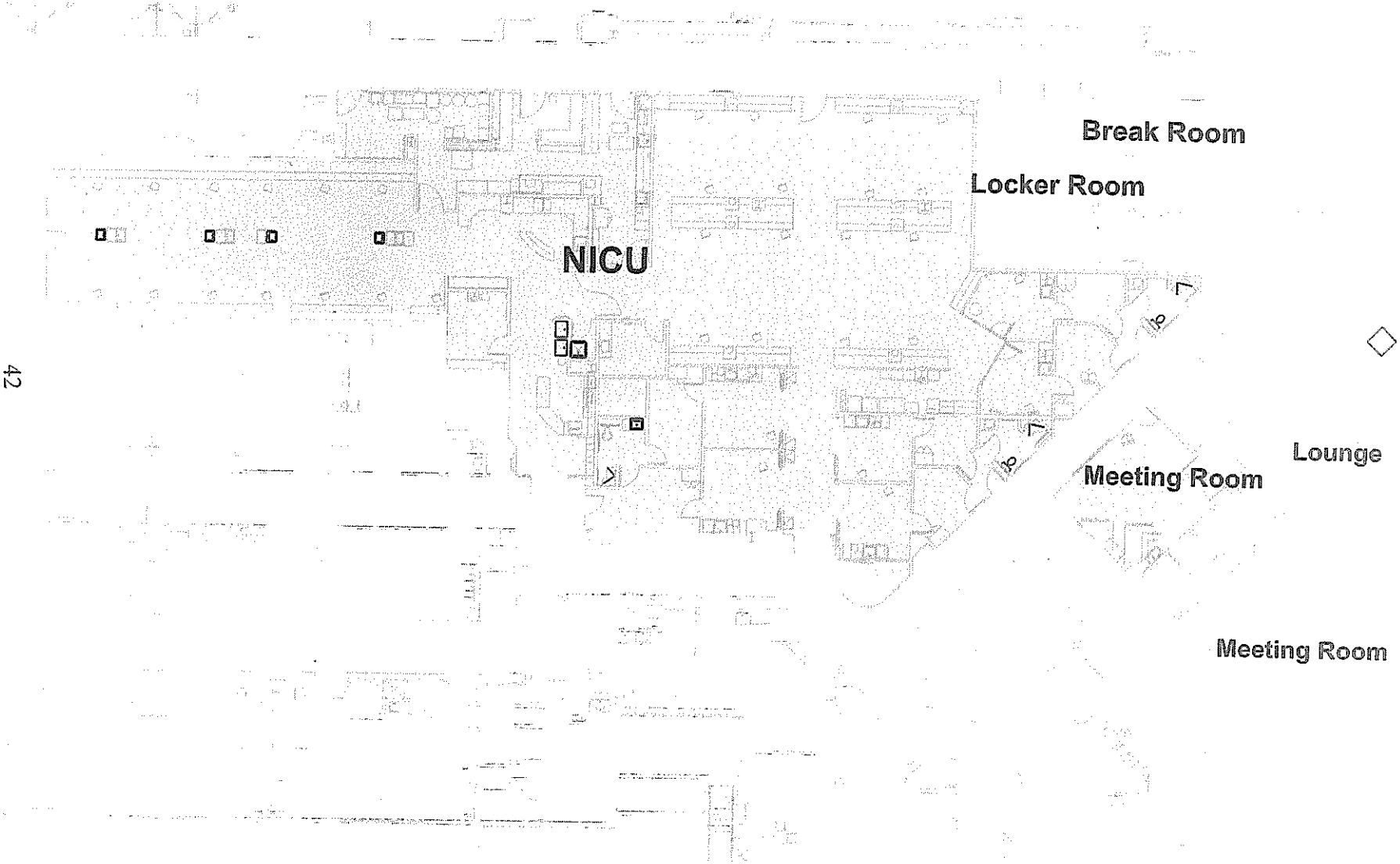
Phase 1 – Locker Room

1) Relocate staff and furnishings from lounge, conference room and part of an education room. These activities can be temporarily absorbed within existing offices and conference rooms in the area.
2) Build-out new locker room and meeting/break room, construction requires basic tenant improvements.
3) Staff to move into and occupy the new locker room and meeting/break room, vacating the phase two construction area.

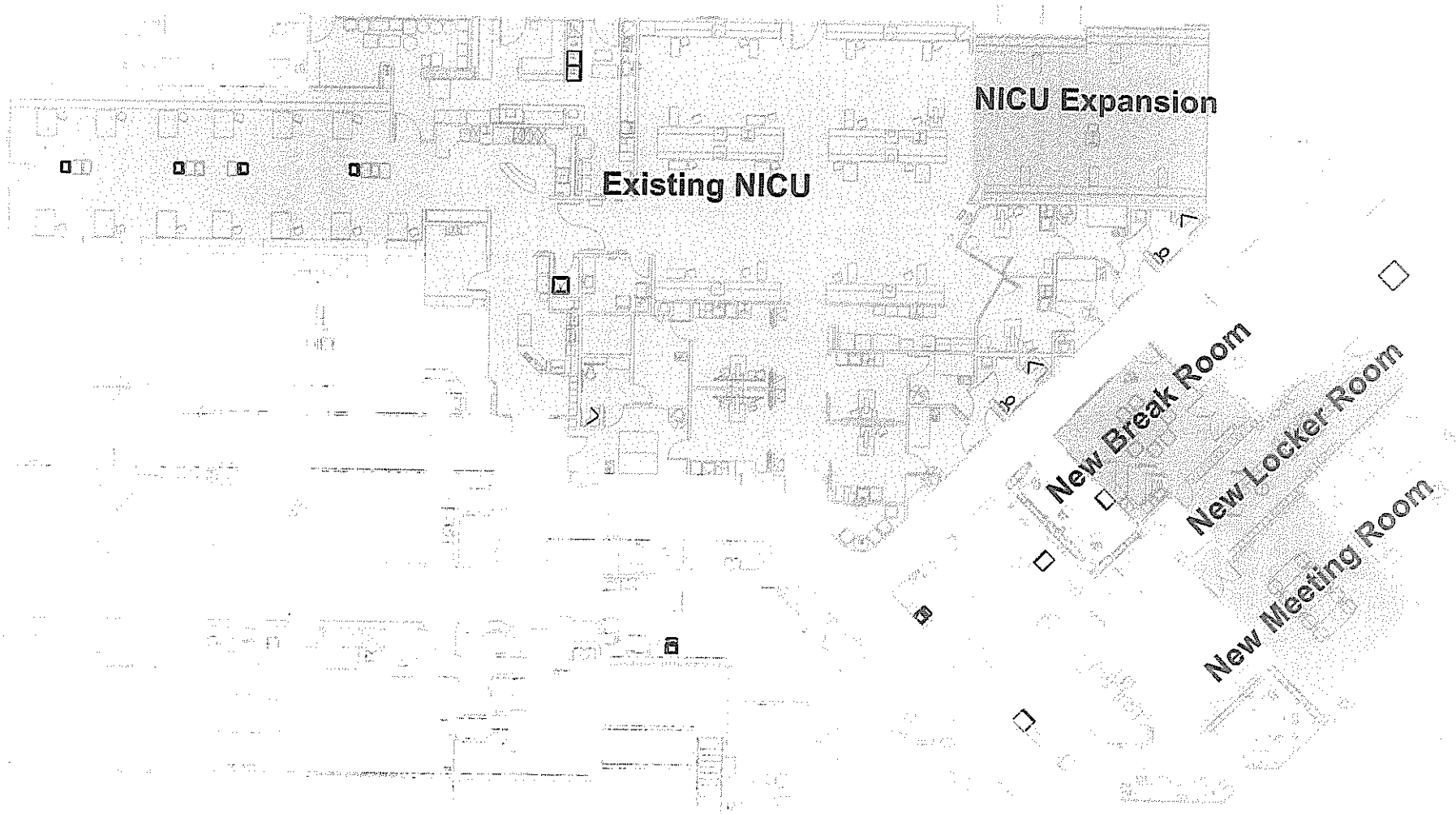
Phase 2 – NICU Patient Area

1) Existing west wall will remain in place to serve as a construction barrier as long as possible. Demolition of the walls and finishes will proceed in the NICU area.
2) Construction
    a. Minimal plumbing modification is required
    b. Medical gas will be tied into existing systems, a service disruption will be required. Providence will work with the med gas inspector to schedule disruptions and provide supplemental tanks and back feeding of the outlets as necessary to maintain service.
    c. Supply fan 17 serves the area and will require some re-work; during construction supply fan 16 can temporarily feed the area.
    d. Any ceiling work in the occupied area, such as HVAC controls and VAV's, will be scheduled on an individual basis to best accommodate patient load, and barriers will be installed as necessary.
    e. Construction barrier wall to be removed.

Existing NICU Space



NICU Expansion - All impacted areas within NICU



Section VIIIB. Financial Data – Construction Only

1. Construction Method (Please check)

a. ☐ Conventional bid **X** Contract management ☐ Design and build

b. ☐ Phased ☐ Single project **X** Fast Track

2. Construction Cost (New Activity)	(Omit cents)
a. Site acquisition (Section VIIIA.2.f)	$ 0
b. Estimated general construction**	$ 947,348
c. Fixed equipment, not included in a**	$ 0
d. Total construction costs (sum of items a, b, and c)**	**$ 947,348**
e. Major movable equipment**	$ 475,100
f. Other cost:**	
(1) Administration expense	$ 65,000
(2) Site survey, soils investigation, and materials testing	$ 0
(3) Architects and engineering fees	$ 175,000
(4) Other consultation fees	$ 50,000
(5) Legal fees	$ 0
(6) Land development and landscaping	$ 0
(7) Building permits and utility assessments	$ 0
(8) Additional inspection fees (clerk of the works)	$ 5, 000
(9) Insurance (included in b. general construction)	$ 0
g. Total project cost (sum of items d, e, f)	**$ 1,717,448**
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.)	**$1,717,448**
j. Anticipated long-term interest rate ___na___ %	
k. Anticipated interim (construction) interest rate ___na___ %	
l. Anticipated long-term interest amount	$ 0
m. Anticipated interim interest amount	$ 0
n. Total items g, l, and m	**$ 1,717,448**
o. Estimated annual debt service requirement	$ 0
p. Construction cost per sq. ft. (2,408sq ft)	$ 393
q. Construction cost per bed	$ 157,891
r. Project cost per sq. ft.	$ 713
s. Project cost per bed (if applicable)	$ 286,241

Section IX

Schedule I.A

INCREMENTAL PROJECTED INCOME STATEMENT (Project Only)

GROSS PATIENT REVENUE:	FY 2008	FY 2009	FY 2010
INPATIENT			
OUTPATIENT	$ 3,733,211	$ 3,889,372	$ 4,058,183
LONG-TERM CARE			
SWING BEDS			
OTHER			
TOTAL PATIENT REVENUE	$ 3,733,211	$ 3,889,372	$ 4,058,183
LESS DEDUCTIONS			
CHARITY CARE			
CONTRACTUAL ALLOWANCES	$ 2,180,056	$ 2,271,248	$ 2,369,827
BAD DEBT	$ 261,325	$ 272,256	$ 284,073
TOTAL DEDUCTIONS	$ 2,441,381	$ 2,543,504	$ 2,653,900
NET OPERATING REVENUES	$ 1,291,831	$ 1,345,868	$ 1,404,283
ALL OTHER REVENUES			$ -
EXPENSES:			
SALARIES	$ 476,545	$ 497,989	$ 520,399
BENEFITS	$ 142,963	$ 149,397	$ 156,120
SUPPLIES	$ 48,442	$ 50,468	$ 52,658
UTILITIES			
PURCHASED SERVICE	$ 9,953	$ 10,370	$ 10,820
PROFESSIONAL FEES	$ 17,379	$ 18,106	$ 18,892
LEASE			
OTHER EXPENSES			
DEPRECIATION	$ 122,764	$ 122,764	$ 122,764
INTEREST			
TOTAL EXPENSES	$ 818,046	$ 849,093	$ 881,652
NET INCOME	$ 473,785	$ 496,775	$ 522,631

Schedule I.B

NCOME STATEMENTS PAMC (Facility)

GROSS PATIENT REVENUE:	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
INPATIENT	$ 381,816	$ 425,019	$ 485,929	$ 540,259	$ 606,096
OUTPATIENT	$ 173,084	$ 204,052	$ 220,132	$ 231,949	$ 256,288
LONG-TERM CARE					
SWING BEDS					
OTHER	$ 8,290	$ 8,938	$ 9,291	$ 9,806	$ 12,375
TOTAL PATIENT REVENUE	$ 563,190	$ 638,009	$ 715,352	$ 782,014	$ 874,759
LESS DEDUCTIONS					
CHARITY CARE	$ 20,411	$ 21,308	$ 32,087	$ 36,507	$ 38,065
CONTRACTUAL ALLOWANCES	$ 211,969	$ 259,964	$ 309,854	$ 341,320	$ 394,569
BAD DEBT	$ 36,991	$ 36,991	$ 43,712	$ 36,818	$ 30,628
TOTAL DEDUCTIONS	$ 269,371	$ 318,263	$ 385,653	$ 414,645	$ 463,262
NET OPERATING REVENUES	$ 293,819	$ 319,746	$ 329,699	$ 367,369	$ 411,497
ALL OTHER REVENUES	$ 17,658	$ 21,391	$ 25,642	$ 18,668	$ 26,849
EXPENSES:					
SALARIES	$ 128,267	$ 128,461	$ 130,262	$ 141,697	$ 156,676
BENEFITS	$ 29,794	$ 34,571	$ 34,763	$ 37,059	$ 40,743
SUPPLIES	$ 57,192	$ 62,684	$ 62,370	$ 70,941	$ 76,223
PURCHASED SERVICE	$ 38,558	$ 52,212	$ 56,879	$ 63,349	$ 73,762
PROFESSIONAL FEES	$ 5,101	$ 7,157	$ 11,161	$ 7,230	$ 7,092
OTHER EXPENSES	$ 14,530	$ 15,548	$ 14,943	$ 18,689	$ 24,649
DEPRECIATION	$ 23,365	$ 23,900	$ 24,815	$ 24,216	$ 26,313
INTEREST	$ 1,441	$ 1,130	$ 668	$ 1,231	$ 2,654
TOTAL EXPENSES	$ 298,248	$ 325,663	$ 335,861	$ 364,412	$ 408,112
NET OPERATING INCOME	$ 16,962	$ 15,474	$ 19,480	$ 21,625	$ 30,234

Schedule II. Facility Balance Sheet (in Thousands)

PAMC BALANCE SHEET	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
CURRENT ASSETS					
CASH & EQUIVALENTS	$ 19,247	$ 8,551	$ 10,789	$ 12,376	$ 35,129
ACCOUNTS RECEIVABLE	$ 76,169	$ 92,741	$ 65,287	$ 63,352	$ 76,551
SUPPLIES INVENTORY	$ 8,021	$ 8,973	$ 10,292	$ 11,564	$ 13,269
OTHER CURRENT ASSETS	$ 1,776	$ 2,868	$ 8,391	$ 16,263	$ 9,035
TOTAL CURRENT ASSETS	$ 105,213	$ 113,133	$ 94,759	$ 103,555	$ 133,984
PROPERTY AND EQUIPMENT					
LAND	$ 17,911	$ 17,760	$ 17,965	$ 32,901	$ 32,169
BUILDING/FIXED EQUIP	$ 250,071	$ 253,844	$ 261,256	$ 283,938	$ 282,914
MAJOR MOVABLE EQUIP	$ 165,805	$ 186,175	$ 204,357	$ 255,520	$ 374,354
ACCUMULATED DEPRECIATION	$ 225,850	$ 248,250	$ 272,763	$ 301,448	$ 322,616
NET PROPERTY AND EQUIPMENT	$ 207,937	$ 209,529	$ 210,815	$ 270,911	$ 366,821
OTHER ASSETS	$ 108,035	$ 188,576	$ 188,672	$ 226,190	$ 243,083
TOTAL ASSETS	$ 421,185	$ 511,238	$ 494,246	$ 600,656	$ 743,888
LIABILITIES/FUND BALANCE					
CURRENT LIABILITIES					
ACCOUNTS PAYABLE	$ 12,744	$ 15,571	$ 13,436	$ 27,833	$ 35,913
ACCRUED EXPENSES	$ 9,313	$ 8,279	$ 8,350	$ 11,404	$ 9,144
ACCRUED COMPENSATION/OTHER	$ 18,623	$ 19,880	$ 16,782	$ 20,372	$ 21,917
TOTAL CURRENT LIABILITIES	$ 40,680	$ 43,730	$ 38,568	$ 59,609	$ 66,974
LONG TERM LIABILITIES					
LONG TERM DEBT	$ 12,624	$ 61,721	$ 55,770	$ 113,517	$ 209,753
OTHER	$ 5,210	$ 22,485	$ 25,133	$ 40,430	$ 37,972
TOTAL LONG TERM LIABILITIES	$ 17,834	$ 84,206	$ 80,903	$ 153,947	$ 247,725
FUND BALANCE	$ 362,671	$ 383,302	$ 374,775	$ 387,100	$ 429,189
TOTAL LIABILITIES & FUND BALANCE	$ 421,185	$ 511,238	$ 494,246	$ 600,656	$ 743,888

Schedule II. Facility Balance Sheet (in Thousands) Unaudited

PAMC BALANCE SHEET		As of May 2007
CURRENT ASSETS		
CASH & EQUIVALENTS	$	37,331
ACCOUNTS RECEIVABLE	$	75,223
SUPPLIES INVENTORY	$	14,385
OTHER CURRENT ASSETS	$	10,278
TOTAL CURRENT ASSETS	**$**	**137,217**
PROPERTY AND EQUIPMENT		
LAND	$	38,487
BUILDING/FIXED EQUIP	$	427,574
MAJOR MOVABLE EQUIP	$	242,610
ACCUMULATED DEPRECIATION	$	334,366
NET PROPERTY AND EQUIPMENT	$	374,305
OTHER ASSETS	$	231,179
TOTAL ASSETS	**$**	**742,701**
LIABILITIES/FUND BALANCE		
CURRENT LIABILITIES		
ACCOUNTS PAYABLE	$	23,057
ACCRUED EXPENSES	$	9,296
ACCRUED COMPENSATION/OTHER	$	25,951
TOTAL CURRENT LIABILITIES	**$**	**58,304**
LONG TERM LIABILITIES		
LONG TERM DEBT	$	209,581
OTHER	$	23,822
TOTAL LONG TERM LIABILITIES	$	233,403
FUND BALANCE	$	450,994
TOTAL LIABILITIES & FUND BALANCE	**$**	**742,701**

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

(In thousands, except Patient Days)	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
(Gross) REVENUES	$ 580,848	$ 659,400	$ 737,861	$ 800,683	$ 874,759
EXPENSES	$ 317,628	$ 362,654	$ 379,575	$ 401,230	$ 438,742
PATIENT DAYS	86,452	84,954	87,497	88,521	90,862
REVENUE PER PATIENT DAY	$ 6.719	$ 7.762	$ 8.433	$ 9.045	$ 9.627
OPERATING & CAPITAL BUDGET SUMMARY					
GROSS REVENUES	$ 580,848	$ 659,400	$ 737,861	$ 800,683	$ 874,759
DEDUCTIONS FROM REVENUE	$ 232,380	$ 281,272	$ 341,941	$ 377,826	$ 432,633
NET REVENUE	$ 348,468	$ 378,128	$ 395,920	$ 422,857	$ 442,126
DIRECT EXPENSE	$ 234,633	$ 262,707	$ 271,109	$ 286,515	$ 304,271
INDIRECT EXPENSE	$ 82,995	$ 99,947	$ 108,466	$ 114,715	$ 134,471
NET INCOME PROJECTED					
RATE COMPUTATION	**N/A - Providence Alaska Medical Center is an Acute Care Facility, not a long-term care facility**				
ANNUAL MEDICAID RATE					
BASE YEAR COST					
LESS ANCILLARY					
PLUS ADMIN. OVERHEAD					
COST BASIS FOR RATE					
BASE YEAR PATIENT DAYS					
COST PER PATIENT DAY					

Source: Hyperion Enterprise reports

Schedule IV. Operating Budget Provide Last Five Years Actual and Projections for Three Years Beyond Project Completion					
Description:	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Number of Beds					
Days in a Year					
Available Bed Days					
Resident Bed Days					
Percent Growth					
Occupancy					
Average Length of Stay					
Patient Bed Days					
Number of Residents					
Daily Room and Board Rate*					
Nursing Revenue					
Nursing Services					
Payer mix					
Medicaid					
Medicare					
Other					
Ancillary Revenue					
Total Revenue					
Rate Computation					
Annual Medicaid Rate					
Base Year Cost					
Less Ancillary					
Plus Admin Overhead					
Cost Basis for Rate					
Base Year Patient Days					
Cost per Patient Day					

The format and line items for Schedule IV-Operating Budget are not applicable to this project. Schedule IA shows the projected three year operating budget for the project.

SECTION IX V-A

Schedule V-A. Debt Service Summary
Provide Current Debt Data and Projections For the Next Three Years

Existing Debt:	[In Thousands]	FY 2007	FY 2008	FY 2009	FY 2010
	Principal	$2,050	$3,243	$20,330	$9,985
	Interest	$8,897	$8,603	$8,327	$7,820

SECTION IX Schedule V B.

Schedule V-B. New Project Debt Service Summary

Attach a debt service cash flow schedule over the life of the debt for the new project

Break out principal, interest and Other

year	Item	Principal	Interest	Other	Total
2006		$ -	$ -	$ -	
2007	PAYMENT	**No new debt issued for this project.**			
2008	PAYMENT				
2009	PAYMENT				
2010	PAYMENT				

SECTION IX Schedule VI

Schedule VI. Reimbursement Sources

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

Fiscal Year 2002				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		18.10%		17.52%
Medicare		26.20%		17.57%
Commercial		43.01%		56.79%
Self Pay		6.11%		4.23%
Other Government		6.59%		5.10%
Other		0.00%		-1.21%
Total		100.01%		100.00%

Fiscal Year 2003				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.27%		13.95%
Medicare		27.82%		18.56%
Commercial		41.13%		55.97%
Self Pay		8.14%		8.58%
Other Government		5.64%		4.27%
Other		0.00%		-1.33%
Total		100.00%		100.00%

Schedule VI. Reimbursement Sources

Schedule VI

Fiscal Year 2004				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.54%		14.24%
Medicare		29.46%		19.87%
Commercial		39.66%		54.97%
Self Pay		7.27%		7.72%
Other Government		6.06%		4.71%
Other		0.00%		-1.51%
Total		99.99%		100.00%

Fiscal Year 2005				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.28%		14.14%
Medicare		28.20%		18.93%
Commercial		40.85%		56.92%
Self Pay		7.60%		7.80%
Other Government		6.07%		4.48%
Other				-2.27%
Total		100.00%		100.00%

Fiscal Year 2006				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.59%		13.95%
Medicare		28.03%		19.02%
Commercial		40.56%		57.13%
Self Pay		7.46%		8.70%
Other Government		6.36%		4.11%
Other				-2.91%
Total		100.00%		100.00%

Fiscal Year 2007				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.89%		13.54%
Medicare		26.87%		17.51%
Commercial		38.89%		55.06%
Self Pay		8.92%		13.05%
Other Government		7.43%		4.88%
Other				-4.04%
Total		100.00%		100.00%

Schedule VI. Reimbursement Sources

Fiscal Year 2008				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.89%		13.54%
Medicare		26.87%		17.51%
Commercial		38.89%		55.06%
Self Pay		8.92%		13.05%
Other Government		7.43%		4.88%
Other				-4.04%
Total		100.00%		100.00%

Fiscal Year 2009				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.89%		13.54%
Medicare		26.87%		17.51%
Commercial		38.89%		55.06%
Self Pay		8.92%		13.05%
Other Government		7.43%		4.88%
Other				-4.04%
Total		100.00%		100.00%

Fiscal Year 2010				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.89%		13.54%
Medicare		26.87%		17.51%
Commercial		38.89%		55.06%
Self Pay		8.92%		13.05%
Other Government		7.43%		4.88%
Other				-4.04%
Total		100.00%		100.00%

Source: Hyperion Enterprise reports

SECTION IX Schedule VII

Schedule VII. Depreciation Schedule				
Schedule includes Fixed, Major Moveable shown in Schedule VIII B. and Additional Major Moveable Equipment. Straight-Line Method				
Equipment to be Purchased				
Fixed Equipment as Reported in Section VIII B				
Equipment Description	**Volume**	**Unit Cost x Volume**	**AHA Life**	**Depreciation Per Year**
None				
Subtotal Fixed Equipment		$ -		
Major Moveable Equipment as Reported in Section VIIIB				
Equipment Description	**Volume**	**Unit Cost x Volume**	**AHA Life**	**Depreciation Per Year**
Recliner chairs	3	$ 7,500	15	$ 500
Privacy screens	3	$ 6,000	15	$ 400
IV poles	6	$ 6,000	15	$ 400
Staff chairs	6	$ 3,600	15	$ 240
Open cribs	2	$ 3,000	15	$ 200
Baby scale and cart	1	$ 2,500	15	$ 167
Baby scale - breastfeeding	1	$ 1,000	15	$ 67
Radiant warmer	6	$ 216,000	10	$ 21,600
Med infusion pumps	6	$ 18,000	10	$ 1,800
Infusion pumps	6	$ 15,000	10	$ 1,500
Biliblanket	3	$ 7,500	10	$ 750
Bili-lights	2	$ 7,000	10	$ 700
Supply carts	6	$ 6,000	10	$ 600
Suction heads and cannisters	6	$ 6,000	10	$ 600
Bili-meter	2	$ 5,000	10	$ 500
Breast pump	1	$ 3,000	10	$ 300
Vapoltherm	1	$ 2,000	10	$ 200
O2 blenders/flowmeters	6	$ 8,000	8	$ 1,000
Monitors	6	$ 150,000	7	$ 21,429
Portable bedside warmer	2	$ 2,000	5	$ 400
Subtotal Major Moveable Equipment/VII B.		**$ 475,100**		
TOTAL ALL DEPRECIABLE EQUIPMENT		**$ 475,100**		

NOTE: $96,460.63 of Equipment in Schedule VIIIB will be directly expensed (not capitalized). The

Joint Commission
on Accreditation of Healthcare Organizations
Setting the Standard for Quality in Health Care

February 8, 2006

George Kuykendall
Administrator
Providence Alaska Medical Center
3200 Providence Drive
Anchorage, AK 99519-6604

Joint Commission ID #: 10208
Accreditation Activity: Evidence of Standards Compliance
Accreditation Activity Completed: 2/8/2006

Dear Mr. Kuykendall:

The Joint Commission would like to thank your organization for participating in the Joint Commission's accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Home Care
- Comprehensive Accreditation Manual for Hospitals.

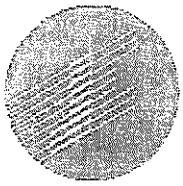
This accreditation cycle is effective beginning October 22, 2005. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months. Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Russell P. Massaro, MD, FACPE
Executive Vice President
Division of Accreditation and Certification Operations



Joint Commission
on Accreditation of Healthcare Organizations
Setting the Standard for Quality in Health Care

Providence Alaska Medical Center

3200 Providence Drive

Anchorage, AK 99519-6604

Organization Identification Number: 10208

Evidence of Standards Compliance Received: 2/8/2006

PROGRAM(S)

Hospital Accreditation Program
Home Care Program

Executive Summary

There is no follow-up due to the Joint Commission as a result of the accreditation activity conducted on the above date.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Frank H. Murkowski, Governor

This is to Certify that a license is hereby granted by the Department of Health and Social Services to:

Providence Alaska Medical Center

to conduct and maintain a 326 Bed Acute Care Hospital including 27 Psychiatric Beds and 10 Rehabilitation Beds

in the premises located at 3200 Providence Drive, Anchorage, Alaska

This License is effective July 1, 2005 through June 30, 2006 and is subject to the provisions of TITLE 18, ALASKA STATUTES. This License shall not be assignable or transferable and shall be subject to revocation, at any time by the Department of Health and Social Services for failure to comply with the laws of Alaska or rules and regulations as provided under the Alaska Administrative Code.

In Witness Whereof I have hereunto set my hand and seal of the Department of Health and Social Services this First day of July, 2005

By _____
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

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

Providence Health System in Alaska

Bruce Lamoureux
Administrator
Providence Alaska Medical Center

David Keith
Assistant Administrator
Ancillary Services

Shara Sutherlin
Chief Nurse Executive
Nursing and Clinical Services

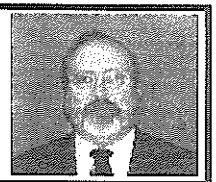
Ronald Christensen
Vice President
Chief of Staff Elect

Jo Norton
Director
Laboratory

Laurie Moore
Director
Palliative Care
Hospice

Val Tobin
Manager
Service Excellence Prog.

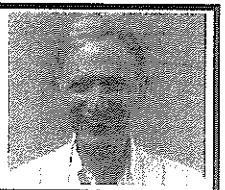
Robert Hughes
Director
Heart Center
Cardio Svcs



Vicki Faciane
Director
Respiratory/Sleep &
Neurodiagnostic

Ted Heffernan, M.D.
Medical Director
Palliative Care

Jeff Lawrence, M.D.
Medical Director
Diabetes Clinic



Providence Health System in Alaska

Shara Sutherlin
Chief Nurse Executive
Nursing and Clinical Services

Jackie Mossakowski
Asst Chief Nurse
Emergency Department

Gary Welch
Asst Chief Nurse
Surgical Services

Vicky Phillips
Asst Chief Nurse

Jeannie Keith
Director
Nursing Practice

Cindy Alkire
Asst Chief Nurse
Children's Hospital

Mardy Lower
Manager
Nursing Float Pool

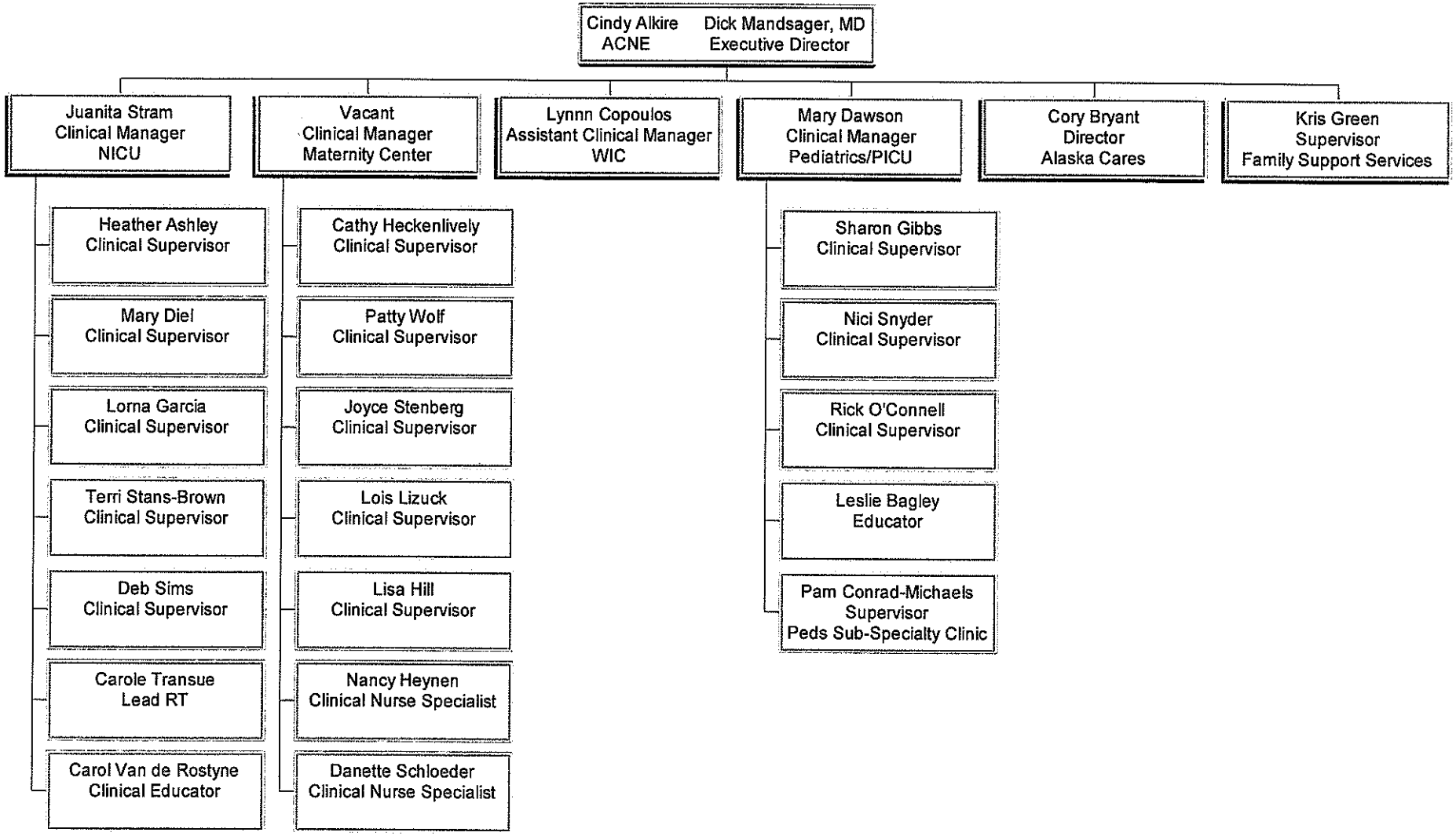
Karen Edmondson
Manager
Patient Care Resources

Pat Reynaga
Manager
Telephone Triage

Lura Willoughby
Director
Case Management &
Social Svcs

CHILDREN'S HOSPITAL AT PROVIDENCE

CHILDREN'S HOSPITAL AT PROVIDENCE



1841 Early View
Anchorage, AK 99508
(907)644-4871 – home
(907)261-2889 - work

Cindy Alkire, RNC, BSN, MHA

Education

BSN Little Rock, Arkansas	University of Arkansas	1979 – 1983
MHA Chapel Hill, North Carolina	University of North Carolina	2000 – 2003

Licenses

South Carolina RN	Certificate # R93819
Alaska RN	Certificate # 25711

Certifications

Advanced Fetal Monitoring	AWHONN
Family Practice Nurse Practitioner	UAMS
National Certification in Obstetric Nursing	NACCOG

Professional Memberships

AWHONN (national)
AONE

Work Experience

4/2006 – present Providence Alaska Medical Center Anchorage, AK
350 bed acute care non-profit faith based facility
Title: Assistant Chief Nurse Executive of The Children's Hospital
Responsibilities:

- Reports to the Chief Nurse Executive
- Directs patient care for the Children's Hospital to include (~ 350 FTEs):
  - 36 bed Level 3 NICU
  - 9 bed PICU
  - 17 bed Peds Unit
  - 9 bed L&D unit with annual births of ~ 2900
  - 36 bed Mother-Baby/Prenatal Unit
  - Pediatric Sub-Specialty Clinic
  - Lactation Center
  - Alaska CARES program
  - WIC clinic
  - Cystic Fibrosis Clinic

12/03-3/2006 Barnwell County Hospital Barnwell, SC
53 bed acute care non-profit county hospital
Title: Chief Nursing Officer
Responsibilities:

- Reports directly to the CEO
- Directs patient care for the nursing department, laboratory, and pharmacy with approximately 90 FTE's

- Oversees PI department, Employee health, Infection control, Discharge planning, Utilization review, Social services, Anesthesia services, and Nursing education
- JCAHO coordinator
- Risk manager
- Physician recruitment
- Develops/maintains budgets for all the departments who directly report to CNO

Accomplishments:

- Wrote and applied for Duke endowment grant – awarded $300,000 for new computerization system
- Restructured the nursing department (staffing mix, agency reduction, management reorganization, OR scheduling, policies/procedures)
- Recruited a new surgeon and new CRNA's
- Purchased new capital equipment to include: new beds, pt. furniture, OR tables, Endoscopy equipment
- Restructured pharmacy and medication supply, distribution, and administration procedures
- Successfully prepared hospital for JCAHO surveys (Hospital and Laboratory)
- Adjusted salaries scales in nursing, pharmacy, and laboratory
- Redesigned the lobby of the hospital
- Developed and implemented plans to start OB services at facility (construction almost completed)
- Assisting with development of hospitalist program
- Developing program to provide clinical program for nursing students
- Developed and implemented mentoring program for high school students
- Developed employee recognition program

10/02 – 12/03 Comanche County Memorial Lawton, OK
350 bed acute care non-profit county hospital

Title: Director Women's Services

Responsibilities:

- Directed patient care for a 24 bed Pediatric/Women's Services unit, 9 bed L&D unit, 15 bed postpartum unit, 6 bed Level 2 NICU, Newborn Nursery, prenatal education department, and Lactation Center – all with approx. 90 FTE's
- Developed/maintained operating budget of $15 million
- JCAHO preparation
- Chairman of Council of Nurse Managers/Directors
- Chairman of hospital/nursing policy and procedure committee
- Member of infection control, product, recruitment, and patient satisfaction committees

Accomplishments:

- Initiated a new lactation program
- Restructured/revamped the nursing orientation process
- Developed marketing and strategic plans for Women's product line

- Implemented new infant security measures
- Successfully recruited new staff resulting in zero vacancies and cessation of agency/temporary nurse usage in Women's services area
- Decreased supply utilization creating cost savings of $147,000 for 2002-2003 budget year
- Improved patient satisfaction scores within Women's services product line
- Instrumental in development of recruitment plan for the nursing department

4/99-10/02 Wilkes Regional Medical Center N. Wilkesboro, NC

130 bed acute care non-profit community hospital

Responsibilities:

- Directed care on – 16 bed Pediatric unit, 6 bed LDR with 1 C/S room, 15 bed mother – baby unit, 4 bed Special Care Nursery, Maternal-Child Education department – 60 FTE's
- Developed/maintained operating budget of $2.5 million and capital equipment budget
- Directed the teen volunteer program for the hospital
- Chairman of the hospital/nursing policy and procedure committee
- Member of forms and medication error committees
- JCAHO preparation

Accomplishments:

- Initiated new Lactation program
- Revamped prenatal education program
- Developed and implemented: Infant hearing screening program, annual competency training for staff
- Developed new name/logo for Women's and Children's services
- Revised job descriptions, policies and procedures for departments
- Published monthly newsletter to citizens of Wilkes County
- Developed plans for renovation of Women's and Children's areas
- Developed marketing and strategic plans for Women's and Children's services

7/98-3/99 Inova Alexandria Hospital Alexandria, VA

300 bed acute care non-profit hospital within a 5 hospital system

Title: Director Maternal Child Services

Responsibilities:

- Managed L&D, Nursery, Postpartum, Diagnostic Center – 100 FTE's
- Member of system-wide Maternal Child task force
- Develop and maintain operating and capital equipment budgets

Accomplishments:

- Started Lactation Center
- Implemented Home monitoring program
- Help create Women's and Children's service line within a 5 hospital system
- Developed plans for renovation of mother-baby unit and nursery.
- Developed system-wide infant abduction plan. Worked in conjunction

with the Center for Missing and Exploited Children

12/96-7/98 Chesapeake General Hospital Chesapeake, VA

200 bed acute care non-profit community hospital

Title: Director Labor and Delivery

Responsibilities:

- Managed 60 FTE's on very busy L&D unit with 350-400 delivery's/month
- Departmental policy/procedure revision, standards of care, and competency evaluations
- Developed and maintained operating and capital budgets
- Member of latex task force, supply and equipment committee, Patient/Family Education Quality Council, Regional Perinatal Coordinating Council

Accomplishments:

- Reorganized department, updated supplies and equipment
- Revised policies/procedures, developed standards of care and a staff competency validation tool
- Developed new documentation criteria
- Investigated, purchased, and implemented a computerized documentation system for Maternal Child services
- Investigated and purchased an infant security system
- Adjunct faculty for Bon Secours Depaul School of Nursing

4/96-12/96 River Oaks Hospital Jackson, MS

80 bed non-profit community hospital

Title: Manager LDRP

Responsibilities:

- Opened new 14 bed LDRP unit with staff of 15
- Developed policies/procedures and operating/capital budgets

Accomplishments:

- Hired staff to work on LDRP unit
- Educated and cross-trained staff to LDRP concept and OR skills
- Developed special care nursery criteria

5/93-4/96 Columbia Doctors Hospital Little Rock, AR

150 bed for profit community hospital

Title: Director Maternal Child/Women's Health

Responsibilities:

- Developed Standards of Care, updated Policies/ Procedures
- Planned/managed operating and capital budgets
- Managed 8 bed LDR, 2 OR suites, newborn nursery, 20 bed mother-baby beds, 10 Pediatric/Women's health unit with 70 FTE's

Accomplishments:

- Investigated and purchased OB documentation and monitoring system
- Revised and developed prenatal education classes

- Implemented the mother-baby philosophy
- Cross-trained staff
- Implemented new discharge teaching process

8/85-5/93 University of Arkansas Medical Sciences Little Rock, AR
600 bed non-profit University hospital
Title: Staff nurse/Charge nurse
Responsibilities:
- Cared for high-risk OB patients
- Became charge nurse – coordinated day-to-day nursing duties and scheduling of staff. Evaluated staff performance
- Trained new staff, CPR and NRP instructor, developed polices/procedures

Accomplishments:
- Designed and implemented a prenatal course for first time parents, including recruitment and training of instructors

1/84-8/85 Arkansas Children's Hospital Little Rock, AR
Title: Staff nurse
Responsibilities:
- Worked in the neonatal intensive care unit

Accomplishments:
- Developed strong foundation in assessment and care of critically ill neonates

Community Service

March of Dimes Team Captain – Chesapeake General	1997
Fetal/Infant Mortality Task force – Chesapeake General	1997-98
Healthy Family Coalition – Chesapeake General	1997-98
Chairman of United Way Campaign – Alexandria Hospital	1998
Team Captain of March of Dimes Campaign – Wilkes Regional	1999-2002
Board Member Wilkes Community Partnership for Children	1999-2002
Member of Wilkes Community Health Foundation	2001-2003
United Way Board of Directors–Lawton Oklahoma	2003-2004
Orangeburg Technical College Advisory Board	2005-2006
Barnwell Career Center Advisory Board	2004-2006
Axis I Advisory Board – Barnwell SC	2004-2006

References

- Available upon request

PROVIDENCE HEALTH SYSTEM IN ALASKA
JOB DESCRIPTION

JOB CODE: 16200-198C

JOB TITLE: ASSISTANT CHIEF NURSE-CHILDREN'S HOSPITAL

PROCESS LEVEL: 198-PROVIDENCE MEDICAL CENTER

REPORTS TO: CHIEF NURSE EXECUTIVE

SUPERVISES: ASSIGNED AREAS AND STAFF

DESCRIPTION STATUS: REVISED 2/02; REVISED 5/05

SUPERSEDES: N/A (OLD JC 7)

POSITION SUMMARY

The Assistant Chief Nurse Executive (ACNE) is accountable for the management of a diverse group of departments; services and programs contribute to the quality, cost-effective patient care. Working within the strategic direction of the health system, the Assistant Nurse Executive provides vision, leadership, managerial support and direction in achieving strategic goals and providing excellent patient care in line with PHSA'a mission. The ACNE is responsible for the implementation of the organizations philosophy, core values, quality improvement targets and policies. The ACNE must have outstanding supervisory, developmental and administrative skills that will direct and delegate the management of patient care services while assuring compliance with the Federal, State, and local laws. The ACNE must be able to develop a Service line approach and analysis in developing Division's programs with team, benchmarks, best practices, and system databases.

ESSENTIAL JOB FUNCTIONS:
(Responsibilities, Accountabilities, and Competencies; May not include all duties of this job)

A. JOB DUTIES: (For performance review, access competence for each essential function using "C" for competent and "NI" for needs improvement)

1. Role models, recognizes and rewards collaborative and synergistic efforts that enable success and outstanding performance.

2. Directs and administers assigned functions to ensure high quality, cost-effective patient services which meet or surpass accreditation standards.

3. Establishes and nurtures collaborative and supportive relationships with staff, physicians, health care facilities and the statewide community. Develops relationships and networks with either tertiar facilities. Make clinical and medical rounds regularly to support and enhance communication and trust.

4. Evaluates organization structure, reporting relationships and position incumbents to ensure high standards of performance are obtained. Assure optimum organizational performance by meeting goals and projections; providing timely, and accurate data as requested; and maintaining compliance with all Federal, State and local laws.

5. Obtains, values and utilizes customer feedback to optimize necessary services and intervene in timely manner.

6. Develop annual operating plans to meet strategic hospital goals and support functions, monitor actual performances and take corrective actions. Develop, implement and maintain the annual operating budget, ensuring that operations are managed within the established guidelines. Establish financial and programmatic goals and conduct an annual evaluation of goal achievement.

7. Directs, coordinate and/or participate in various hospital committees as needed in order to promote the strategic and operational goals of the health system.

8. Selects, trains, develops and evaluates department leaders and management team and initiates personnel actions in accordance with Human Resource policies and organization philosophy. Monitors the progress of employee performance, reviews skills and practices, assesses training needs, and facilitates appropriate training programs. Ensure timely staff performance evaluations, establishes goals and criteria of performance for staff, and implements appropriate action for achievement.

9. Collaborates with colleagues from other divisions within the organization for the purpose of furthering the goals and objectives of the SPHS.

10. Supports and participate in quality improvement, health and safety, environment of care and cost control programs as established by organization policies, processes and procedures.

11. Utilizes available performance and financial tools, specialty databases and systems to monitor departments, services, programs and organizational performance in relation to the budget and quality improvement goals. Intervenes as needed. Supports and encourages medical and medication safety initiatives, variance reporting, root cause analyses and follows up with affected parties. Prepares and submits reports on operations as required, including service line audits.

12. Schedule regular meetings with direct report staff to assure valuable input, support, supervision, communication and collaborative monitoring of facility operations. Conducts and documents annual performance evaluations on each direct report staff.

13. Evaluates, monitors and supports development and implementation of organizational policies and procedures in compliance with State, Federal and other regulatory guidelines. Assure adequate preparation for, and participate in, regulatory compliance surveys.

14. Implement care/services that recognizes and values age/diversity specific needs/issues of customers served.

15. Chief Nurse Executive's (CNE) designee as CNE in hers/his absence.

16. Performs other related duties as required.

B. IDENTIFIED COMPETENCIES

Completes initial and annual Competency Plan for assigned job and department.

C. CORE VALUES

Demonstrates personal and interpersonal qualities that support the Core Values of Providence Health System.

D. ESSENTIAL JOB QUALIFICATIONS: (Any equivalent Combination of Knowledge, Skills, Abilities, Education, and Experience)

1. **Education**: Bachelor's degree. Master's degree in a related health services field preferred.

2. **Experience**: Five to ten years of experience in health care operations with at least three years in a leadership role. Preferred experience in Service line growth, development, and databases.

3. **Licensure/Certification**:

4. **Other Qualifications**: Must possess the knowledge and ability to manage hospital operations through administrative ability, initiative, resourcefulness, executive and analytical ability. Must have experience in strategic planning, organizational assessment, and have highly developed leadership and interpersonal skills.

5. **Attendance**: Regular attendance is a requirement of this position.

6. **English Language**: Must be able to read, write, and speak English.

431 Winfield Circle
Anchorage, AK 99515

(907) 522-0220 Home
(907) 261-5006 Office
(907) 261-4896 Fax

Juanita Stram

Objective — **Neonatal Nursing**

Experience

June 2006-Present — Providence Alaska Medical Center, Anchorage, AK

Clinical Manager/NICU

- Nursing leadership/Shared leadership and management of a 38-44 bed Level IIIb NICU
- Team leadership and development (supervisors, charge nurses & staff)
- Leadership and support of performance improvement processes, quality outcomes, evidence-based practice, and policy and procedure development and implementation.
- Staff /personnel hiring, appraisals, and performance management
- Unit resources, supplies, equipment management
- Collaborate with scheduler and supervisors to provide appropriate staff for all required roles in the NICU.
- Safety and security of NICU environment
- Collaborate with Maternity and Pediatrics in the provision of best care
- Leadership in involvement of unit personnel with Vermont-Oxford Quality Collaborative
- Maintain unit readiness for JCAHO, OHSA, or other regulatory agencies.

2004-2006 — Providence/St. Vincent Hospital and Medical Center, Portland, Oregon

NICU Nurse Manager

- Nursing Leadership for 42-bed Level IIIb NICU
- Quality outcomes monitoring/auditing/program development
- Performance Improvement processes; evidence based practice implementation, policy and procedure development and implementation.
- Communication and Collaboration with multidisciplinary team
- Team leadership, mentoring and coaching
- Staffing
- Personnel hiring and performance appraisals, performance management and staff development (charge nurses, RN's, HUC's, C.N.A.'s)
- Resource management
- Budgeting and productivity
- Equipment & supply management, developed product and supply specialist position.
- Responsible for unit safety and security, code P.I.N.K. drills, education, etc.
- Promote unit involvement in Vermont Oxford NICU Quality Collaborative
- Preparation and maintenance of JCAHO and OHSA readiness.
- Participated in Magnet Status application process and on-going process

2000-2004 Providence/St. Vincent Hospital and Medical Center, Portland, Oregon

NICU Clinical Coordinator

- NICU Leadership/ Strategic Planning
- Personnel hiring and Performance Appraisal
- Quality Assessment, management, evaluation
- Utilization of database information
- Safety & unit security
- Communications
- Staff Development (Charge & relief charge nurses, workgroup leadership, nursing and administrative staff)
- Collaboration with Perinatal Leadership
- Collaboration with Vermont-Oxford Quality Program
- Policy & Procedure development / education
- Equipment & supply
- Preparation for regulatory agencies (JACHO, OHSA, etc.)
- Unit Resource management
- Problem solving/ systems analysis & review
- Development of Culture of change
- Implementation of evidence-based practice changes

1985-2000 Providence/St. Vincent Portland, Oregon

Charge Nurse

- Management of day –to-day operations in the unit
- Communications & Collaboration (Perinatal, Neonatalogists, NNP's, etc.)
- Scheduling/ Staffing
- Resource Management
- Staff development / orientation & preceptor
- Staff performance appraisals
- Staff certification, continuing education
- Resuscitation Team leader
- Manage workflow of admissions & discharges, patient movement within the unit
- Leadership role in workgroups and meetings
- Leadership role in safety, meeting regulatory requirements
- Leadership role in quality management
- Participation in policy & procedure development & implementation
- Conflict resolution, families & staff
- Unit role model for nursing

1980–1985 Providence/ St. Vincent Portland, Oregon

Staff RN/ Newborn Nursery & Postpartum

- Assessment & nursing care of patients (Postpartum, newborn)
- Patient care planning
- D/C teaching/ education
- D/C classes taught
- Prenatal classes & tours

- Medications & treatments
- Follow-up home visits for first-time mothers & babies

1979-1990 King City Convalescent Care Tigard, Oregon

RN Team Leader

- Assessments, evaluations
- Care Planning
- Collaboration with families/ MD's
- Supervision of C.N.A.s
- Medications & treatments
- Resource management

Education

1976-1979 University of Oregon Health Sciences Center
Portland, Oregon

- B.S.N. Bachelors of Science in Nursing

1975-1976 University of Oregon Eugene, Oregon

- Undergraduate/ Pre-Nursing

Interests

Missions:

- Local- Tigard Christian Church Youth Worker.. leading youth to serve the elderly, trips to Mexico/ building for the poor.
- Portland Rescue Mission to the homeless.
- International- Northwest Medical Teams (Mexico)

Health-Career Promotion: (Particularly Nursing)

- Board of Directors (position: secretary) of the *Northwest Perinatal Resource Network*: Collaboration of Perinatal educators to provide and promote quality education to Perinatal nurses in the greater Portland area.
- Annual participation in the Columbia-Willamette Health Occupation Student Convention Day in October—Seminar on Neonatal Nursing
- Job fairs at St. Vincent
- Classes for Medical Explorers
- Classes for Beaverton High School Health Career Students
- Presentations to groups on nursing, neonatal nursing or other related subjects. (i.e. Recent class on the " Impact of the Civil War on nursing & medicine"

Other: Reading history, visiting museums, visiting Alaska, walking, hanging out with family & friends.

PROVIDENCE HEALTH SYSTEM IN ALASKA
JOB DESCRIPTION

JOB CODE: 18000-198A

JOB TITLE: CLINICAL MANAGER

PROCESS LEVEL: 198 – PROVIDENCE MEDICAL CENTER

REPORTS TO: DIVISIONAL DIRECTOR OR ASSISTANT ADMINISTRATOR

SUPERVISES: STAFF IN ASSIGNED AREA

DESCRIPTION STATUS: NEW: 1/97; REV 2/01

SUPERSEDES: N/A (OLD JC 160)

POSITION SUMMARY

Coordinates team to deliver patient care in a compassionate and ethical manner according to recognized standards and care model. Exercises independent judgement with 24-hour accountability for clinical and operational issues of assigned area(s). Responsible for business plans, fiscal management and clinical and resource utilization. Facilitates change and promotes teamwork. Clinical practice supports patient care and professional specialty.

ESSENTIAL JOB FUNCTIONS:
(Responsibilities, Accountabilities, and Competencies; May not include all duties of this job)

A. **JOB DUTIES**

1. HUMAN RESOURCE STEWARDSHIP: Direct and administer assigned functions to ensure high quality, cost-effective patient services which meet or surpass accreditation standards. Uses appropriate interpersonal skills to guide others to accomplish objectives, facilitates teamwork, participation and cooperation. Delegates work so subordinates have the necessary direction, authority and skills to complete assignments

2. OPERATIONS: Utilizes staffing management principles to assure adequate supply nurses to meet patient cars needs and market demand. Plans for seasonal fluctuations and anticipates market changes which may impact volumes. Explores options for expanding services and providing different services. Involves staff and physicians in budget planning. Utilizes staffing management principles to assure adequate resources to meet market demand. Plans for fluctuations and anticipates market changes which may impact volumes. Explores options for expanding services and providing different services.

3. CONTINUOUS IMPROVEMENT: Facilitates the annual development and implementation of QI plan, addressing all aspects of clinical and business objectives and strategic plan.

Indicators are identified and improvement processes utilize PDCA structure. Seeks input from customer group(s) as a first step in planning process.

4. CORE VALUES: SEE "C" BELOW.

5. SERVICE EXCELLENCE: Collaborates with all appropriate Departments to promote optimal patient care and customer service. Models and mentors Health of Providence Stands of Service Excellence.

6. LEADERSHIP: Provides visionary leadership. Uses leadership principles to anticipate and influence change. Determines resources and actions needed to accomplish objectives. Set priorities and manage time effectively. Identify potential problems/opportunities and plan contingent action. Develop new and unique ideas to improve existing systems or operations, and when new organizational approaches are needed. Encourage innovative efforts in others. Seek creative methods to resolve conflicts.

7. PROFESSIONAL STANDARDS: Provides clinical cares that role models the department practice model. Develops, modifies and implements patient care standards, policies, procedures and protocols. Establishes clear clinical practice expectations for patient care areas using department philosophy.

8. TEAMWORK AND COMMUNICATION: Assigns work and responsibly directs staff. Creates supporting systems that enable staff to jointly plan and deliver care. Role models collaboration and partnership with physicians, primary staff, patients, families and other departments. Schedules regular meetings with direct report staff to provide supervision, assure communication and to monitor facility operations. Conduct and document annual performance evaluations on each direct report staff.

9. PLANNING: Develops, implements, evaluates and modifies programs and services need to meet patient care and staff development needs. Exercises independent judgement to implement plans for operations in areas of responsibility.

10. COMPLIANCE: INSERT HR STANDARD STATEMENTS ON INTEGRITY AND DIVERSITY. INSERT SAFETY CLAUSE. Direct and administer assigned functions to ensure high quality, cost-effective patient services which meet or surpass accreditation standards. Maintain and guide the implementation of organization policies and procedures in compliance with state, Federal and other regulatory guidelines. Assure adequate preparation for, and participate in, regulatory compliance surveys.

11. PROFESSIONAL DEVELOPMENT: Maintains and uses managerial, organization and technical knowledge of area responsibility. Assumes responsibility for obtaining current information and expanding job knowledge.

B. IDENTIFIED COMPETENCIES

Completes Competency Plan for assigned job and department.

C. **CORE VALUES**

Demonstrates personal and interpersonal qualities that support the Core Values of Providence Health System.

ESSENTIAL JOB QUALIFICATIONS:
(Any equivalent Combination of Knowledge, Skills, Abilities, Education, and Experience)

1. **Education**: Completion of a technical training program relevant to assigned field is required. Bachelor degree in technical area preferred.

2. **Experience**: Two years of recent clinical supervisory experience.

3. **Licensure/Certification**: Licensed in Alaska in area of expertise, if applicable.

4. **Other Qualifications**: Regular attendance is a requirement of this position. Must be able to read, write and speak English.

5. **Attendance**: Regular attendance is a requirement of this position.

6. **English Language**: Must be able to read, write, and speak English.

This Job Description reflects Providence Health System in Alaska's best effort to describe the essential functions and qualifications of the job described. It is not an exhaustive statement of all the duties, responsibilities or qualifications of the job. This document is not intended to exclude an opportunity for modifications consistent with providing reasonable accommodation. This is not intended to be a contract. Your signature indicates you have read this Job Description and understand the essential functions and essential qualifications of the job.

Employee Printed Name: _____ Date: _____

Employee Signature: _____ SSN: _____

PROVIDENCE HEALTH SYSTEM IN ALASKA
JOB DESCRIPTION

JOB CODE: 45000-198A

JOB TITLE: STAFF REGISTERED NURSE (RN)

PROCESS LEVEL: 198-PROVIDENCE MEDICAL CENTER

REPORTS TO: CLINICAL MANAGER OR DESIGNEE

SUPERVISES: N/A

DESCRIPTION STATUS: NEW: 10/96; 8/03; 03/04; 2/07

SUPERSEDES: Old JC 261

POSITION SUMMARY

The registered nurse is accountable for the delivery and supervision of safe, quality care that is individualized for their assigned patients and follows the nursing process in accordance with the Nurse Practice Act (assessment, planning implementation, evaluation). She/He is responsible for the assessment, treatment and care of patients in populations and ages as assigned. The registered nurse accepts and promotes professional development as an integral part of nursing practice. She/He will access, analyze, customize, coordinate and communicate the patient's plan of care and activities collaboratively with other members of the health care team. Families and or significant others will be included within the plan of care as appropriate. She/He will direct, delegate and manage the care delivered by colleagues and subordinates. The registered nurse performs all duties in a manner that respects and supports the family centered care model. Collegial and collaborative care will reflect the philosophy of the Division of Nursing, the Mission and Core Values of the Sisters of Providence, and National Patient Safety Standards.

KEY RELATIONSHIPS

1. Students, staff and leadership of the Nursing Division.
2. Medical Staff, Residents and medical students
3. Patients, Families, Significant Others
4. All other Allied Health Professionals providing direct patient care.

ESSENTIAL FUNCTIONS/STANDARDS OF PERFORMANCE

(Responsibilities, Accountabilities, and Competencies; May not include all duties of this job)

A. JOB DUTIES

(For performance review, assess competence for each essential function using "C" for competent and "NI" for needs improvement)

1. Possesses knowledge of developmental needs and competent in the assessment and treatment as it relates to the age of the patient population served. Conducts and documents a comprehensive patient assessment upon admission. Continually reassesses and applies appropriate advocacy and interventions as indicated. Competent in the interpretation of a patient's self-assessment and behavior. This information must be interpreted with an understanding of the cognitive, physical emotional, psychosocial and chronological maturation process. Actively involves patient and family in the collaborative plan of care.

2. Consistently demonstrates and promotes safe patient care practices: (i.e. Hand washing/Patient ID, Communication, Reduction of infection Risks, Medication Safety & Reconciliation, Falls Prevention, No Preventable Deaths/Injuries, Inclusion of patients/families concerns and access to healthcare team)

3. Collaborates with the patient, family and members of the healthcare team; develops, documents, implements and monitors an individualized plan of care which reflects a standard of care based on best practice and evidence-based medicine. Provides, documents, and consults to assure necessary patient and family education in support of the treatment plan. Adaptive to change and updated patient care practices within an evolving healthcare environment.

4. Collaborate with team members, the patient, the patient's family and others as appropriate in the development of a proactive discharge plan.

5. Performs procedures and treatments according to accepted department/unit protocols, guidelines, standards and the Nurse Practice Act.

6. Legibly and electronically documents patient care activities and information in an accurate, concise, and timely manner. Competent in the input and retrieval of information within the various forms of written and electronic documentation.

7. Provides safe quality care in an efficient, cost effective manner.

8. Supports and assists with orientation of new staff and students. Acquires necessary training and skills to competently perform the preceptor and charge nurse function when selected and functioning in those roles.

9. Demonstrates advancement of professional nursing practice through continuing education, required training, certification, and participation in department and unit activities. Assures all competencies, certifications, safety information and courses are completed as required.

10. Identifies concerns and takes appropriate action(s) to involve colleagues and management in the development and promotion of a safe patient care environment. Actively engages in positive communication, feedback, and the on-going development of self and team. Takes an active role in building and maintaining an environment that fosters open communication, patient and family-centered care and healthy collegial relationships. Demonstrates adaptive/timely communication based on individual patient/family needs. . Attends and participates in a minimum of 50% of scheduled staff meetings or has read the minutes and signed off on them, and is responsible for meeting content regardless of attendance.

11. Promotes and role models collaborative practice and relationships with other health care professionals. Recognizes the role that the cultural diversity of patients and their families, employees, medical staff, volunteers and community members plays in achieving productive and positive relationships. Rounds with physicians and other team members to promote continuity of care and patient's confidence in their care delivery team.

12. Monitors patient's condition, notes changes in status, utilizes judgment and takes appropriate action. Communicates patient status to colleagues and physicians to include: situation, background, assessment, and recommendations (S.B.A.R). Utilizes tools adopted through quality and safety initiatives when communicating patient status change and at the time of patient handoff. Uses the Providence Early Assessment Team (P.E.A.T.) when indicated by changes in patient's conditions or concerns.

13. Promotes and routinely offers comfort and pain management measures. Documentation reflects assessment, treatment and re-assessment as required to meet patient goals.

14. Consistently demonstrates and incorporates principles and policies of safety and infection control as defined by policy and procedure, National Patient Safety Goals and Emergency Response procedures. Complies with Hospital standards to assure continued compliance and regulatory requirements are met. Examples include but are not limited to: JCAHO, OSHA, State and Federal requirements.

15. Actively participates in Departmental and Unit based activities, including Quality Improvement Programs and processes. Participates in departmental activities that improve patient care and process systems, Participates in Tracer Rounds and actively assists others in transitioning and applying knowledge to the clinical and operational setting

16. Performs other related duties as required.

17. Safeguards all forms (Electronic, written and oral) of confidential information as it relates to patients, their families, medical staff and employees. Is aware of and compliant with organizational polices regarding Fraud and Abuse, Conflict of Interest and the Code of Conduct.

18. Adheres to all hospital and department policies and procedures.

B. IDENTIFIED COMPETENCIES

Completes initial and annual Competency Plan for assigned job and department. Competencies may include mandatory unit required competencies, and BLS. ACLS, PALS, NRP, as designated.

C. CORE VALUES

Demonstrates personal and interpersonal qualities that support the Core Values of Providence Health System.

D. ESSENTIAL JOB QUALIFICATIONS

(Any equivalent Combination of Knowledge, Skills, Abilities, Education, and Experience)

1. Education: Graduate of an accredited/approved school of Nursing.

2. Experience: One year Registered Nurse experience in an acute care hospital preferred unless hired as an intern or fellow.

3. Licensure/Certification: Licensed as a Registered Nurse in the State of Alaska.

4. Other Qualifications: Schedule varies to meet department needs. Must be able to prioritize multiple tasks, and work with a variety of health unit teams.

5. English Language: Must be able to read, write, and speak English.

REFERENCES

'Nursing Scope & Standards of Practice'; American Nursing Association
'Meeting the Joint Commission's National Patient Safety Goals'; Joint Commission Resources '07
American Nurses Credentialing Center (ANCC)
'Transforming Care at the Bedside'; Innovation Series '04: Institute for Healthcare Improvement
'Wall of Silence;' Rosemary Gibson and Janardan Prasad Singh; '03
Magnet Standards
SBAR Communication Standard: Situation-Background-Assessment-Recommendations
Alaska Statues and Regulations / Nursing 2006 / Article 9 General Provisions

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Employee Printed Name: _____ Date: _____

Employee Signature: _____ SSN: _____

Lily J. Lou, M.D.

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Anchorage, Alaska 99516
lilylou@mindspring.com

Alaska Neonatology Associates
3340 Providence Drive
Anchorage, Alaska 99508
(907) 563-3026 phone
(907) 562-6445 fax

Education

University of California @ Davis	B.S. Genetics	June 1979.
University of North Carolina @ Chapel Hill	M.D.	May 1986.

Post-graduate Clinical Training

7/86-6/1989 Internship & Residency in Pediatrics.
University of Minnesota Hospitals & Clinics
Minneapolis, MN

7/89-6/1992 Fellowship in Neonatal and Perinatal Medicine.
Yale University School of Medicine
New Haven, CT

Academic Positions

7/1/2002 Associate Professor
Department of Pediatrics (Neonatology)
UNM Health Sciences Center, School of Medicine
Albuquerque, NM

11/98-6/2002 Assistant Professor
Department of Pediatrics (Neonatology)
UNM Health Sciences Center, School of Medicine
Albuquerque, NM

7/96-10/1998 Clinical Assistant Professor (Neonatology)
UNC-Chapel Hill School of Medicine
Chapel Hill, NC

7/93-6/1996 Assistant Professor in Pediatrics (Neonatology)
Yale University School of Medicine
New Haven, CT

2/92-6/1993 Instructor in Pediatrics (Neonatology)
Yale University School of Medicine
New Haven, CT

Hospital Appointments

1/1/2007-present	Medical Director, NICU The Children's Hospital at Providence Alaska
7/2002-present	Neonatologist Alaska Neonatology Associates Providence Alaska Medical Center Anchorage, AK
7/2002-present	Neonatologist Alaska Neonatology Associates Alaska Regional Hospital Anchorage, AK
11/98-6/2002	Faculty Department of Pediatrics (Neonatology) New Mexico Children's Hospital Albuquerque, NM
11/98-6/2002	Neonatologist Pediatric Section St. Joseph's NE Heights Hospital Albuquerque, NM
11/98-6/2002	Consulting Neonatologist Lovelace Hospital Albuquerque, NM
7/96-10/1998	Staff Neonatologist The Women's Hospital of Greensboro Greensboro, NC
7/96-10/1998	Faculty (Neonatology) UNC-Chapel Hill School of Medicine Chapel Hill, NC
2/92-6/1996	Faculty in Neonatology Yale University School of Medicine New Haven, CT
2/92-6/1996	Neonatologist Lawrence and Memorial Hospital New London, CT

Board Certification

National Board of Medical Examiners. July 1, 1987. Certificate No. 335399

American Board of Pediatrics. November 1991. Recertified 2001-2007

ABP/Subspecialty Board of Neonatology. Sept 1993. Recertified 2001-2007

Medical Licensure

Minnesota Board of Medical Examiners. License No. 032411	1986-1989
Connecticut State Medical Board. License No. 031873	1989-1998
North Carolina Medical Board. License No. 96-00988	1996-1998
New Mexico Board of Medical Examiners. License No. 98-319	1998-2002
Alaska State Medical Board. License No. 4888	2002-present

Undergraduate Honors

University of California Regents' Scholar.	1974-1979.
National Merit Scholar.	1974-1979.
UC Chancellor's Senior Recognition Award.	June 1979.
Merck Award.	May 1986.

Awards, Grants and Fellowships

Outstanding Teacher Award - Alaska Family Practice Residency. April 18, 2005

UNM Medical Education Scholars Program. 1 year fellowship. Jan-Dec 2001

Howard Hughes Medical Institute Postdoctoral Research Fellowship for Physicians. Selected for 3 year award, beginning January 1, 1992.

Physician Scientist Award, NICHD. 5 years support, beginning December 1, 1991. *Neural Deformed (Dfd) regulation in Drosophila and vertebrates.*

Child Health Research Center New Investigator Award. Two years support, beginning October 1, 1993.

Research Interests

I am currently interested in applying my interests and experience in the areas of education, provision of medical care at a distance and multilevel team composition to the challenges facing the medical community in Alaska. In addition, I remain fascinated by the basic science underlying the clinical care we provide at the bedside, and believe strongly in evidence-based medicine as a lifelong practice and an important principle to instill in care providers in training.

I conducted my Neonatalogy fellowship research with Dr. William McGinnis, Yale University Department of Molecular Biophysics & Biochemistry. This molecular embryology project involved an autoregulatory neural enhancer identified via P-element transformation. I was also involved with the development of a paired vector-host system with a divided retroviral genome, to facilitate transgene expression in a dynamic vertebrate embryologic model. My basic science research interests have included the study of early patterning genes in vertebrate systems, and how errors in the regulation of these genes may ultimately result in congenital malformations, such as those seen in the clinical care of newborns.

In addition to laboratory research, I have participated in various clinical trials carried out at Yale and at UNM, in their roles as NIH Neonatal Network centers. I was also involved in the experimental design and preliminary data collection for a Yale study of the effects of an exercise training program (bicycle ergometer) in 6-11 year old patients with a history of bronchopulmonary dysplasia. While in North Carolina I served as site Principal Investigator for a multicenter clinical trial comparing pulsed versus continuously weaning dexamethasone for the treatment of chronic lung disease in neonates (this role was continued by another physician when I left North Carolina to return to academia).

In New Mexico I became interested in educational theory, as relevant to undergraduate and resident medical training. I completed a one-year Medical Education Scholars fellowship, directed by Stewart Mennin, which included training and research opportunities in the areas of cognitive psychology, problem based learning, scholarship in education, leadership, the change process and faculty development. In addition, I have been interested and involved in the planning and implementation of clinical programs and research projects in the clinical setting and in the environments of telemedicine and distance learning.

Our group currently participates in several clinical trials involving immune protection, toxicology screening and surfactant replacement therapy.

Prior Research Experience

7/89-3/90	Research with Dr. Edward Benz, Yale University Medical School Division of Hematology. PCR analysis of erythroid specific alternative splicing in Protein 4.1, a membrane cytoskeletal component.
4/86-5/86	Research with Dr. Richard Clark, UNC-Chapel Hill Department of Radiology. Study of the effects of Cyclosporin A on renal microvasculature.
5/84-6/84	Research with Drs. Richard Boucher and James Yankaskas, UNC-Chapel Hill Department of Pulmonary Medicine. Ion transport derangement in cystic fibrosis respiratory epithelium.
7/83-8/83	Research with Dr. Clyde Hutchison, UNC-Chapel Hill Department of Microbiology. Microinjection of $\bar{}$x174 DNA to establish transgenic mouse line, set-up of transgenic facility.
10/79-7/82	Senior Research Technician, Laboratory of Molecular Virology, Duke University Medical Center. Laboratory of Dr. W. K. Joklik. Several projects, including cloning/sequencing in RNA (Reo) and DNA (Pox, Vaccinia) viruses.
6/79-10/79	Normal Volunteer Program, National Institutes of Health. Research in Laboratory of Molecular Biology, NIAMDD, involving repression of Tn10-mediated transposition in E. coli, with Dr. J. Lee Rosner.
9/77-3/78	Research with Dr. Carl Schmid, UC-Davis Department of Chemistry. Comparative restriction analysis of human/primate repetitive and satellite DNA.

Publications

Clifford W. Bogue, Lily J. Lou, Hema Vasavada, Christine Wilson and Harris C. Jacobs. *Expression of Hoxb genes in the developing mouse foregut and lung.* Am J Respir Cell Mol Biol. 1996 Aug;15(2):163-71.

Lily Lou, Clare Bergson and William McGinnis (1995*) Deformed expression in the Drosophila central nervous system is controlled by an autoactivated cistronic enhancer.* Nucleic Acids Research, 1995, 13(17), 3481-3487.

Lily J. Lou and William McGinnis. *A Drosophila Deformed (Dfd) neural enhancer is autoregulated and evolutionarily conserved.* Pediatric Research 31 (4):47A. Abstract, poster symposium presentation at 1992 SPR, Baltimore MD.

Publications (continued)

L. J. Lou, C. M. Bergson, W. J. McGinnis. *A region within the Deformed (Dfd) homeotic selector gene intron directs expression of a reporter gene in developing neural tissue*. Pediatric Research. Abstract, presented at 1991 SPR, New Orleans, LA.

L. Lou, J. Fraser, S. Huang, T. Tang, J. Cho, V.T. Marchesi, E.J. Benz. *Generation of the erythroid form of protein 4.1 by tissue specific alternative mRNA splicing: late onset of expression of the erythroid specific spectrin-actin binding domain*. Blood 76 (Suppl 1): 12a. Abstract, presented at 1990 ASH/ISH, Boston, MA.

UNM Teaching

1. Medical Students

a. School of Medicine
Phase I: Genetics Block. August 30-September 17, 1999
Tutorial group leader

b. School of Medicine
Phase I: Genetics Block. August 30-September 17, 1999
Lecturer: *developmental genetics*

c. School of Medicine
Phase I: Genetics Block. September 4-22, 2000
Tutorial group leader

d. School of Medicine
Phase I: Genetics Block. September 4-22, 2000
Lecturer: *Developmental genetics*

e. School of Medicine
Phase I: Genetics Block. September 4-21, 2001
Tutorial group leader

f. School of Medicine
Phase I: Genetics Block. September 4-21, 2001
Lecturer: *Developmental genetics*

e. School of Medicine
Phase I: Mechanisms of Disease. October 29-November 16, 2001
Lecturer: *Developmental genetics*

UNM Teaching (continued)

Medical Students (continued)

f. School of Medicine
Phase II: Pediatrics rotation. January 4 – February 25, 2000
Tutorial group leader.

i. School of Medicine
Phase II: Pediatrics rotation. January 3 – February 23, 2001
Tutorial group leader.

j. School of Medicine
Phase II: Pediatrics rotation. January 7 – March 1, 2002
Tutorial group leader.

2. Residents

a. Supervision of Pediatric, OB/GYN, Family Medicine, Anesthesia residents while rotating on Newborn Intensive Care service

i. Teaching rounds. Daily while on service on Neonatal Intensive Care Unit – 26 weeks per year 1998-2000, 25 weeks per year 2000-2001.

ii Neonatology Core Curriculum Lectures. Monday-Tuesday-Friday while on service on Neonatal Intensive Care Unit –26 weeks per year 1998-2000, 25 weeks per year 2000-2001.

b. Pediatric Noon Conference Presentations.

i. Physical Exam Findings in the Newborn. October 5, 2001.

ii. Case Studies in Neonatal Distress. April 15, 2002

c. Lecturer and Participant at weekly Perinatal Grand Rounds

d. Presenter and Participant at weekly Neonatal Grand Rounds

f. Mentor for Rossana Chang from PGY-1 through PGY-3 status

3. Fellows

a. Responsible for supervising/training fellows on service in the NICU

b. Participate in conferences with fellows:

UNM Teaching (continued)

3. Fellows

   c. Participate in conferences with fellows (continued):

      Neonatal Grand Rounds -- weekly
      Perinatal Grand Rounds -- weekly
      Neonatal Morbidity and Mortality -- monthly
      Neonatal Research Conference -- monthly
      Neonatal Journal Club -- monthly

   d. Responsible for fellow tutorials in the areas of
      Medical Genetics
      Perinatal Asphyxia

   e. Participated in training of Neonatal-Perinatal fellows at UNM:

Connie Anderson	1999-2002
Kate Stanley	2000-2002
Becca Moran	2001-2002
Erica Fernandez	2001-2002
Rossana Chang	2002
Scott Snyder	2002

   f. Participated in training of Neonatal-Perinatal Medicine fellows at Yale:

J. Jeffrey Reese	1992-1995
Magdy Galal	1993-1996
Meredith Hull	1993-1996
Mario Rojas	1994-1996
Nieves Madrid	1994-1996
Maria Quevedo	1995-1996
Robin Lee	1995-1996

UNM Teaching (continued)

4. Postgraduate/Continuing Medical Education

   a. *(1) Respiratory Physiology, Ventilator Management and CPAP in the Newborn. (2) Updates in Neonatology Issues.* Eastern New Mexico Medical Center. Roswell, New Mexico. May 20, 1999.

   b. *(1) Beyond Sepsis, Invasive Infections in the Neonate (2) Transport Review.* Gila Regional Medical Center. Silver City, New Mexico. January 13, 2000.

   c. *Neonatal Resuscitation Program. Provider Course for physicians.* Holy Cross Hospital. Taos, New Mexico. March 18, 2000.

   d. *Update on Neonatal Group B Strep Prevention and Management.* Mimbres Memorial Hospital. Deming, New Mexico. April 13, 2000.

   e. *PCEP Skills Lab.* North Eastern Regional Hospital. Las Vegas, New Mexico. September 11, 2000.

   f. *PCEP Skills Lab.* Lincoln County Medical Center. Ruidoso, New Mexico. September 13, 2000.

   g. *PCEP Skills Lab.* Mimbres Memorial Hospital. Deming, New Mexico. September 18, 2000.

   h. *When the Baby is not Bouncing: Case Studies of Distress in the Newborn.* Colfax Miners' Hospital. Raton, New Mexico. November 13, 2001.

   i. *When the Baby is not Bouncing: Case Studies of Distress in the Newborn.* St. Vincent's Hospital. Santa Fe, New Mexico. March 27, 2002.

   j. Neonatal Resuscitation Program [Regional Trainer since 6/8/89]

      i. Hospital-based Trainer Course
         for UNM Department of Family and Community Medicine Faculty
         12/10/99

      ii. Hospital-based Trainer Course
         for Pediatric practitioners from Las Cruces.
         2/17/2000

      iii. Hospital-based Trainer Course
         for UNM Neonatology and Pulmonary Faculty
         3/29/2000

UNM Teaching (continued)

k. Journal Club presentations:

i. *New concepts in the management of hyperbilirubinemia.* March 23, 2000

ii. *Comparison of different CPAP modalities (continuous flow vs. flow driver)* September 20, 2001

5. Allied Health/Public/Miscellaneous

a. New Mexico Association of Neonatal Nurses Annual Meeting. *Glucose Metabolism in the Neonatal Period.* October 23, 2001

b. New Mexico Association of Neonatal Nurses Annual Meeting. *Physical Findings in Newborns.* October, 1999

c. St. Joseph's Northeast Heights Continuing Education Series.
(1) Molecular Biology for the Clinician
(2) Retinopathy of Prematurity
(3) Physical Exam Abnormalities in the Nursery
(4) Blood Gas Interpretation
(5) Respiratory Support of the Newborn
(6) Twins - Complications of Multiple Gestation Pregnancy

d. Current Concepts in Perinatal Care. *(1) Potpourri of Hot Topics in Neonatology. (2) New Technologies in Neonatal Care.* September 17-19, 1999.

e. UNM Newborn Special Care Nursing Orientation Series: Neonatal Continuum of Care. 1999, 2000, 2001, 2002.

f. UNM Women in Medicine Organization. May 1999 .

g. UNM Premedical Student Organization. March 8, 2000.

h. Adams State College. Alamosa, Colorado. Introduction to Writing guest lecture: *Ethics in the Newborn Intensive Care Unit.* March 31, 2000.

Standardized Educational Programs

N.R.P . (Neonatal Resuscitation Program) Regional Trainer since 6/8/1989

S.T.A.B.L.E. Instructor since 8/2005

P.C.E.P. (Perinatal Continuing Education Program) National Training Seminar. September 24-25, 1999.

UNM Training

Tutor Training. July 13-15, 1999.

Case Development Workshop. March 30, 2000.

Performance Review Overview. February 24, 2000.

Developing Goals & Performance Standards. February 22 & 25, 2000.

Web Site Development. Fall 1999.

Lecturing and Formal Presentations Workshop, January 10, 2001

Inpatient Teaching Workshop, June 14, 2001

HRRC on-line training course and examination, June 26, 2001

Alaska Teaching

Clinical Teaching

Development, implementation and continuing administration of Neonatal Medicine educational curriculum for 6-week medical student rotation.

Development, implementation and ongoing administration of Neonatal Medicine curriculum for a 4-week family medicine resident NICU experience.

Participated in Development of Problem-based Nursing Orientation Program for new NICU staff at Providence Alaska Medical Center

Participation in Ongoing Teaching and Orientation Program for new nursing staff in the NICU, PAMC.

Alaska Teaching (continued)

Presentations

Improving Maternal and Neonatal DHA Nutrition. Enfamil Fall Festival—a Nurses Conference. October 3, 2005.
Jaundice, Kernicterus & Navigating the Neonatal Bilirubin Curve. Valley Hospital Pediatric Grand Rounds. June 17, 2005.

Our NICU—Providence Alaska Medical Center. Video Production and Presentation. Vermont Oxford Collaborative. Your Ideal NICU conference. Portland OR. April 18, 2005.

Jaundice, Kernicterus & Navigating the Neonatal Bilirubin Curve. Family Practice Winter Update. March 12, 2005.

Post-discharge Nutrition of the NICU Graduate. Alaska Statewide WIC Conference. February 23, 2005.

Jaundice, Kernicterus & Navigating the Neonatal Bilirubin Curve. Anchorage Pediatric (Perinatal) Grand Rounds. November 9, 2004

DHA and ARA Supplementation in Infant Formula: Levels Outcomes and your Practice. Enfamil Fall Festival. September 24, 2004.

Baby's Breath—or What to do when the Baby is not Bouncing. ANMC Pediatric Critical Care Conference. June 23, 2004.

Jaundice, Kernicterus & Navigating the Neonatal Bilirubin Curve. Central Peninsula General Hospital, Soldotna, AK. April 8, 2004.

Neonatal Case Studies Workshop. Lifeguard Critical Care Conference. March 20, 2004.

Thicker the Water: Neonatal Hypercoagulability. (with Rod Smith) Anchorage Pediatric Grand Rounds. December 16, 2003.

Neonatology in the Middle of Nowhere. Lifeguard Critical Care Conference. March 3, 2003.

Twins: Complications of Multiple Gestations. Anchorage Pediatric Grand Rounds. January 14, 2003.

Alaska Training and Development

Pediatrix Medical Group: Certified Medical Leader Program. Module 1: Managing Human Resources. September 14-16, 2005. Sunrise FL.

Pediatrix Medical Group: Certified Medical Leader Program. Module 2: Managing Capital Resources. December 14-16, 2005. Sunrise, FL.

Pediatrix Medical Group: Certified Medical Leader Program. Module 3: Legal Considerations for the Medical Director. February 8-10, 2006. Sunrise FL.

Pediatrix Medical Group: Certified Medical Leader Program. Module 4: Managing as a Medical Director. April 19-21, 2006. Sunrise, FL.

Administrative Duties

Program Chair. 31st Annual AAP District VIII Annual Conference on Neonatal and Perinatal Medicine. Girdwood, Alaska. June29 – July 2nd, 2006.

Alaska Representative to District VIII AAP Section on Perinatal Pediatrics Council. 2002 – present.

Medical director, PAMC Neonatal Nurse Practitioner Program, 2002-present

PAMC Perinatal Ethics Advisory Council, 2003-present

Medical Director, UNM Neonatal Nurse Practitioner/Neonatal Transport Program, 1999-2002.

UNM-Presbyterian Air Emergency Services Oversight Committee. 2001-2002.

Medical Director, NM Perinatal Continuing Education Program, 1998-2002.

Neonatal Morbidity and Mortality Review, 1998-2001.

Pediatric Research Committee, 1998-2002.

UNM Hospital Maternal Child Health Committee, 1998-2001.

Department of Pediatrics work group on Mentoring, 1998-1999.

Children's Hospital Development Council, 1999-2002.

Breast Feeding Task Force, 1998-2002.

Search Committee for Pediatric Nephrology faculty position, 1999.

Administrative Duties (continued)

Search Committee for Neonatal Nurse Practitioner Manager, 1999-2002.

Search Committee for Neonatal Nurse Practitioner. 2000-2002.

Search Committee for Vice Chair of Research, Department of Pediatrics, 2000.

Education Council *ad hoc* group on EC Composition and Appointment, 2000.

Search Committee for Pediatric Pulmonary faculty position, 2001-2002.

Search Committee for Chief of Division of Neonatology, 2001.

Community Service:

State of Alaska Hearing Screening Advisory Committee. October 2005-present.

Alaska Newborn Metabolic Screening Advisory Committee. 2002-present.

Alaska March of Dimes, Program Services Committee. 2002-present.

Alaska March of Dimes, Community Grants Subcommittee. 2002-2003.

Alaska March of Dimes, Prematurity Subcommittee. Chair 2002-2004. Vice-Chair 2004-2005.

Women's Community Association (sponsor of Domestic Violence Shelter and Treatment Program). Board of Directors Member, 2000-2002. Board Co-secretary, 2001-2002.

New Mexico March of Dimes, Program Services Committee, 1998-2002.

New Mexico March of Dimes, Community Grants Committee, 1998-2002.

New Mexico Birth Defects Prevention Task Force, 1999-2002.

North Carolina March of Dimes, Program Services Committee, 1996-1998.

North Carolina March of Dimes, Community Grants Committee, 1996-1998.

Special Projects:

Neonatal Resuscitation Program Instructor in Sichuan, China. First of 5 year annual collaborative project between the American Academy of Pediatrics and Heart to Heart International. June 2000.

Proposal to New Mexico legislature for mandated insurance coverage of medically appropriate return transports of infants to regional level II facilities to accommodate demand on limited level III NICU beds. August-Nov 2000.

Statewide (NM) telemedicine project involving store-and-forward genetics consultation in the neonatal period (digital camera placement in referring nurseries, training, encryption software). April 2002-present.

Table 2–1. Recommended Registered Nurse/Patient Ratios for Perinatal Care Services

Registered Nurse/Patient Ratio	Care Provided
Intrapartum	
1:2	Patients in labor
1:1	Patients in second stage of labor
1:1	Patients with medical or obstetric complications
1:2	Oxytocin induction or augmentation of labor
1:1	Coverage for initiating epidural anesthesia
1:1	Circulation for cesarean delivery
Antepartum/Postpartum	
1:6	Antepartum and postpartum patients without complications
1:2	Patients in postoperative recovery
1:3	Antepartum and postpartum patients with complications but in stable condition
1:4	Newborns and those requiring close observation
Newborns	
1:6–8*	Newborns requiring only routine care
1:3–4	Normal mother–newborn couplet care
1:3–4	Newborns requiring continuing care
1:2–3	Newborns requiring intermediate care
1:1–2	Newborns requiring intensive care
1:1	Newborns requiring multisystem support
1:1 or greater	Unstable newborns requiring complex critical care

*This ratio reflects traditional well newborn nursery care. If breastfeeding or couplet care is provided, a registered nurse coordinates and administers care for the mother and newborn couple (1:3–4 couples). If it is necessary to separate the well mother and newborn couple, and return the newborn to a central nursery, the mother–newborn registered nurse is still responsible for the mother–newborn couple. Another registered nurse would provide care for the newborn in the central nursery. At least one registered nurse should be available at all times in each occupied basic care nursery when newborns are physically present in the nursery. In special care and subspecialty care nurseries, a minimum of two registered nurses, with training and expertise in neonatal nursing, should be in immediate attendance (National Association of Neonatal Nurses. Minimum staffing in NICUs. NANN Position Statement 3009. Glenview [IL]: NANN 1999. Available at www.nann.org/public/articles/309.doc. Retrieved June 10, 2002). Direct care of newborns in the nursery may be provided by ancillary personnel under the registered nurse's direct supervision. Adequate staff is needed to respond to acute and emergency situations at all times.

American Academy of Pediatrics
American College of OB/GYN

NICU ACUITY SHEET

Classification	2	3	4	5
Description of patient		Stable grower on monitor, Nasal cannula, Sat monitor	Stable CPAP/vapotherm sat monitor with added TC monitor, isolation, inability to self control <30 weeks gestation	<1250 grams, any vent, admits labile CPAP, acutely unstable infant requiring constant supervision, unstable post-op
Mobility	Rmin-in with all D/C teaching done	Q3-4 Cares tolerates handling well parents doing most of the cares, but nurse still supervising	Baby on CPAP/vapotherm who tolerates positioning changes, babies with splints, harnesses, or limb immobilization, reflux or wedge < 30 weeks gestation significant developmental needs	Vented or unstable with cares or position changes. On norcuron, PH study, requires constant holding
ADL	Parent doing all cares unassisted	Stable infant, open crib PO/OG bolus feeds or eating nipple or breast NPO < 24 hours	Stable post-surgical baby first 24 hrs, Facial deformities that cause feeding problems, Feeding lasting > 30 minutes, any SSBD, OG/OJ NON-BOLUS feeds, ostomy with routine bag care, isolette, NPO> 24 hrs <30 weeks gestation	VLBW infant (<100 gms) in Humidity PPHN, infant on norcuron or pavulor On sedation
Treatment	Parent doing home meds	1-2 IV fluids or Q3-4 hr stable feeds, 1 to 7 doses of meds, EPO, immunizations, routine phototherapy, normal/easy CVC dsg change	Intubations, multiple residuals, feeding problems, feeding study, septic W/U, CBC, BC, TA, Events requiring bagging or Blow-by, >or = to 2 bili lites, placement of line lasting > 1 hour, 3-4 IV fluids, circumcision, IV meds, multiple IV starts, lab draws >2 shift, replogle, 8 or more med doses, complicated CVC dsg change or repair, developmental care of an inconsolable pt.	Adding LP & Cath urine to septic W/U, exchange transfusion, BAER study, radiology or surgical procedure that is off unit (not circ) or PDA, PPHN on NO, resuscitation or code, >4 IV fluids, blood transfusion, PH study
Teaching	No parent/family contact	RI with minimal support, parent requiring standard teaching, ongoing support and updates	Foster, teen, developmentally delayed/disabled parent teaching, parents that require extensive teaching, New admit 1st 24 hrs. Rooming in with extra support needed. Post-op teaching first 36 hours. (not circ), supplemental home monitor training, <30 weeks gestation	Teaching requiring multi-agency teaching, Parents with multiple social needs, parents learning home vent, parents with baby weighing < or = to 1000 grams
Assessment	Rooming in	Q3-6 assessments, some A's and B's mostly self recovered or occasional desats	Observing for NEC, > or = to Q12 hr. x-ray, unstable glucose but NO insulin, single chest tube, 4-8 A's & B's that require intervention. More frequent IV checks due to hard IV starts, multiple IV starts, infiltration, newly extubated this shift, uac/uvc monitoring, broviac, freq desats and very labile, PH study, < 30 weeks gestation	First 12 hours post-op (not circ), or post cardiac procedures unstable glucose ON insulin, vulnerable fluid status for VLBW or lg babies multiple chest tubes or chest tube and replogle, >8 A's & B's requiring intervention, norcuron, sedation, Q1hr VS with interventions needed. Minimal handling
Emotional Social		Parents that are active, involved, appropriate with baby and staff. No contact with parents so nurse gives baby TLC.	DFY referral with limits on family, transport parents first 36 hours, parents requiring multiple phone calls, lengthy phone intervention, baby requiring constant holding to console, baby using withdrawal scale. New admit first 24 hrs. Parent that require lots of attention.	Disruptive families, families with unstable multiples, PPHN babies requiring extensive family support, parents having lost one or more multiple, terminal infant, infant being sent out of state for care

PATIENT MUST HAVE AT LEAST 4 CHECKS IN A COLUMN TO BE CONSIDERED THAT ACUITY

NICU Expansion
Providence Alaska Medical Center
Prepared for PAMC by Estimations

Construction Cost Estimate
Schematic Estimate
June 18, 2007

Description				Estimated Cost	Div.
Basic Bid					
01 - GENERAL REQUIREMENTS				$241,062	1
02 - SITEWORK				$59,187	2
06 - WOOD AND PLASTIC				$37,361	6
07 - THERMAL & MOISTURE PROTECTION				$1,142	7
08 - DOORS AND WINDOWS				$8,136	8
09 - FINISHES				$70,935	9
10 - SPECIALTIES				$26,063	10
11 - EQUIPMENT				$5,599	11
15 - MECHANICAL				$240,116	15
16 - ELECTRICAL				$115,024	16
Subtotal:				**$804,625**	**<<<<<**
Estimating Contingency:			10.0%	$80,462	
Escalation For Inflation:	14 Mths	@ 6.0%	7.0%	$62,261	
Total Estimated Cost - Basic Bid:				**$947,348**	**<<<<<**

Application Fee – Determination and Certification of Amount

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

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

A. the amount listed on page 20 of this packet under Section VIIIA, Financial Data – Acquisitions, subsection (2), item "a" (total acquisition cost of land and buildings): $ 0

plus

B. the amount listed on page 21 of this packet under Section VIIIB, Financial Data – Construction Only, item "g" (total project cost, which is the sum of items d, e, and f): $ 1,717,448

Estimated Value of the Activity for (1) (sum of A & B above) **$ 1,717,448**

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

Estimated Fair Market Value for (2): ($632,000 x 40 yrs) $ 0

Estimated Value for (1) from above: $ 0

Total Estimated Value of the Activity (sum of (1) and (2)): **$ 1,717,448**

Amount of Application Fee submitted with this application (see 7 AAC 07.079 to calculate amount due): minimum $2,500 $ 2,500

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: 6-22-2007
Facility Name and Address: Providence Alaska Medical Center, 3200 Providence Drive, Anchorage, AK

Name and Title of Person Determining Application Fee: Lisa Wolf

Lisa Wolf
Signature of Certifying Officer of the Organization

Section IX

Schedule I.A

INCREMENTAL PROJECTED INCOME STATEMENT (Project Only)

GROSS PATIENT REVENUE:	**FY 2008**	**FY 2009**	**FY 2010**
INPATIENT	$ 3,733,211	$ 3,889,372	$ 4,058,183
OUTPATIENT			
LONG-TERM CARE			
SWING BEDS			
OTHER			
TOTAL PATIENT REVENUE	$ 3,733,211	$ 3,889,372	$ 4,058,183
LESS DEDUCTIONS			
CHARITY CARE			
CONTRACTUAL ALLOWANCES	$ 2,180,056	$ 2,271,248	$ 2,369,827
BAD DEBT	$ 261,325	$ 272,256	$ 284,073
TOTAL DEDUCTIONS	$ 2,441,381	$ 2,543,504	$ 2,653,900
NET OPERATING REVENUES	$ 1,291,831	$ 1,345,868	$ 1,404,283
ALL OTHER REVENUES			$ -
EXPENSES:			
SALARIES	$ 476,545	$ 497,989	$ 520,399
BENEFITS	$ 142,963	$ 149,397	$ 156,120
SUPPLIES	$ 48,442	$ 50,468	$ 52,658
UTILITIES			
PURCHASED SERVICE	$ 9,953	$ 10,370	$ 10,820
PROFESSIONAL FEES	$ 17,379	$ 18,106	$ 18,892
LEASE			
OTHER EXPENSES			
DEPRECIATION	$ 122,764	$ 122,764	$ 122,764
INTEREST			
TOTAL EXPENSES	$ 818,046	$ 849,093	$ 881,652
NET INCOME	$ 473,785	$ 496,775	$ 522,631

Schedule I.B

INCOME STATEMENTS PAMC (Facility)

GROSS PATIENT REVENUE:	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
INPATIENT	$ 381,816	$ 425,019	$ 485,929	$ 540,259	$ 606,096
OUTPATIENT	$ 173,084	$ 204,052	$ 220,132	$ 231,949	$ 256,288
LONG-TERM CARE					
SWING BEDS					
OTHER	$ 8,290	$ 8,938	$ 9,291	$ 9,806	$ 12,375
TOTAL PATIENT REVENUE	$ 563,190	$ 638,009	$ 715,352	$ 782,014	$ 874,759
LESS DEDUCTIONS					
CHARITY CARE	$ 20,411	$ 21,308	$ 32,087	$ 36,507	$ 38,065
CONTRACTUAL ALLOWANCES	$ 211,969	$ 259,964	$ 309,854	$ 341,320	$ 394,569
BAD DEBT	$ 36,991	$ 36,991	$ 43,712	$ 36,818	$ 30,628
TOTAL DEDUCTIONS	$ 269,371	$ 318,263	$ 385,653	$ 414,645	$ 463,262
NET OPERATING REVENUES	$ 293,819	$ 319,746	$ 329,699	$ 367,369	$ 411,497
ALL OTHER REVENUES	$ 17,658	$ 21,391	$ 25,642	$ 18,668	$ 26,849
EXPENSES:					
SALARIES	$ 128,267	$ 128,461	$ 130,262	$ 141,697	$ 156,676
BENEFITS	$ 29,794	$ 34,571	$ 34,763	$ 37,059	$ 40,743
SUPPLIES	$ 57,192	$ 62,684	$ 62,370	$ 70,941	$ 76,223
PURCHASED SERVICE	$ 38,558	$ 52,212	$ 56,879	$ 63,349	$ 73,762
PROFESSIONAL FEES	$ 5,101	$ 7,157	$ 11,161	$ 7,230	$ 7,092
OTHER EXPENSES	$ 14,530	$ 15,548	$ 14,943	$ 18,689	$ 24,649
DEPRECIATION	$ 23,365	$ 23,900	$ 24,815	$ 24,216	$ 26,313
INTEREST	$ 1,441	$ 1,130	$ 668	$ 1,231	$ 2,654
TOTAL EXPENSES	$ 298,248	$ 325,663	$ 335,861	$ 364,412	$ 408,112
NET OPERATING INCOME	$ 16,962	$ 15,474	$ 19,480	$ 21,625	$ 30,234

Schedule III C (Equipment to be Purchased)

NICU Expansion

Description	Make	Model	Volume	Cost
Radiant warmer	Ohmeda	Giraffe Omni-bed	6	$ 216,000
Open cribs	Hard, Inc	Medium size	2	$ 3,000
Monitors	Phillips	Viridia	6	$ 150,000
Infusion pumps	Aleris	3 channel	6	$ 15,000
Med infusion pumps	Medex	3500	6	$ 18,000
Supply carts	Hill-rom	L carts	6	$ 6,000
Suction heads and cannisters	Ohmeda	Suction regulator	6	$ 6,000
Biliblanket	Ohmeda	portable	3	$ 7,500
Bili-lights	Natus	Generation 2 - neoblue	2	$ 7,000
Bili-meter	Ohmeda	Bili light meter	2	$ 5,000
Portable bedside warmer	Fischer-Payxel	Baby control	2	$ 2,000
O2 blenders/flowmeters	Ohmeda	Regular & Low-flow	6	$ 8,000
Baby scale - breastfeeding	Medela	Baby weigh	1	$ 1,000
Baby scale and cart	Olympic	Warm Scale	1	$ 2,500
Breast pump	Medela	Symphany	1	$ 3,000
Privacy screens	Hill-rom	Large	3	$ 6,000
Recliner chairs	Hill-rom	Procedural Recliner	3	$ 7,500
Vapoltherm	Vapotherm	2000i	1	$ 2,000
IV poles	IV League Med	Single pole w/4 hooks	6	$ 6,000
Staff chairs	Fixture furniture/ Jami, Inc.	Straight chairs/vinyl seat	6	$ 3,600

TOTAL	**$ 475,100.00**

Schedule IV. Operating Budget Provide Last Five Years Actual and Projections for Three Years Beyond Project Completion									
Description:	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Number of Beds	38	38	38	38	38	38	44	44	44
Days in a Year	365	365	366	365	365	365	366	365	365
Available Bed Days	13,870	13,870	13,908	13,870	13,870	13,870	16,104	16,060	16,060
Resident Bed Days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent Growth	N/A	N/A	6.4%	-4.1%	13.0%	21.0%	-12.6%	1.1%	1.3%
Occupancy	Not Avail.	70.6%	74.8%	72.0%	81.4%	98.4%	74.1%	75.1%	76.1%
Average Length of Stay	22.5	20.9	21.1	20.8	20.3	20.3	20.3	20.3	20.3
Patient Bed Days	8,711	9,786	10,410	9,984	11,286	13,651	11,928	12,065	12,222
Number of Residents	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Daily Room and Board Rate*	Not Avail.	2,992	3,266	3,560	4,318	4,448	4,581	4,719	4,860
Nursing Revenue									
Nursing Services	24,842,000	29,280,000	33,997,000	35,547,000	48,737,833	60,719,454	54,647,242	56,933,144	59,404,227
Payer mix									
Medicaid	47.5%	54.9%	56.9%	50.6%	54.2%	54.6%	54.6%	54.6%	54.6%
Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	52.5%	45.1%	43.1%	49.4%	45.8%	45.4%	45.4%	45.4%	45.4%
Ancillary Revenue									
Total Revenue	**N/A - Providence Alaska Medical Center is an Acute Care**								
Rate Computation	**Facility, not a long-term care facility**								
Annual Medicaid Rate									
Base Year Cost									
Less Ancillary									
Plus Admin Overhead									
Cost Basis for Rate									
Base Year Patient Days									
Cost per Patient Day									

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

(In thousands, except Patient Days)	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
(Gross) REVENUES	$ 580,848	$ 659,400	$ 737,861	$ 800,683	$ 874,759
EXPENSES	$ 317,628	$ 362,654	$ 379,575	$ 401,230	$ 438,742
PATIENT DAYS	86,452	84,954	87,497	88,521	90,862
REVENUE PER PATIENT DAY	$ 6.719	$ 7.762	$ 8.433	$ 9.045	$ 9.627
OPERATING & CAPITAL BUDGET SUMMARY					
GROSS REVENUES	$ 580,848	$ 659,400	$ 737,861	$ 800,683	$ 874,759
DEDUCTIONS FROM REVENUE	$ 232,380	$ 281,272	$ 341,941	$ 377,826	$ 432,633
NET REVENUE	$ 348,468	$ 378,128	$ 395,920	$ 422,857	$ 442,126
DIRECT EXPENSE	$ 234,633	$ 262,707	$ 271,109	$ 286,515	$ 304,271
INDIRECT EXPENSE	$ 82,995	$ 99,947	$ 108,466	$ 114,715	$ 134,471
NET INCOME PROJECTED					
RATE COMPUTATION					
ANNUAL MEDICAID RATE					
PER-DAY IP RATE	1,584.39	1,635.24	1,736.88	1,794.18	1,856.59
OP % OF CHARGES	44.05%	44.05%	45.41%	45.41%	45.41%
BASE YEAR COST					
LESS ANCILLARY	**N/A - Providence Alaska Medical Center is an Acute Care**				
PLUS ADMIN. OVERHEAD	**Facility, not a long-term care facility**				
COST BASIS FOR RATE					
BASE YEAR PATIENT DAYS					
COST PER PATIENT DAY					

Source: Hyperion Enterprise reports

Project: NICU Expansion
Ancillary Service: Neonatal Intensive Care
Pro-Forma

	2008	2009	2010	2011	2012
GROSS REVENUE					
Acute Care-Inpatient					
Medicaid	$ 2,038,034	$ 2,123,285	$ 2,215,442	$ 2,311,031	$ 2,402,093
Commercial	$ 250,858	$ 261,352	$ 272,695	$ 284,461	$ 295,670
Other Gov't	$ 478,483	$ 498,498	$ 520,134	$ 542,577	$ 563,956
Private Pay	$ 965,837	$ 1,006,238	$ 1,049,912	$ 1,095,212	$ 1,138,366
Total Acute Care - Inpatient	$ 3,733,211	$ 3,889,372	$ 4,058,183	$ 4,233,281	$ 4,400,085
Total Gross Revenue	$ 3,733,211	$ 3,889,372	$ 4,058,183	$ 4,233,281	$ 4,400,085
DEDUCTIONS Inpatient					
Medicaid	$ 1,401,065	$ 1,459,671	$ 1,523,026	$ 1,588,739	$ 1,651,340
Commercial	$ 62,947	$ 65,580	$ 68,426	$ 71,378	$ 74,191
Other Gov't	$ 335,884	$ 349,934	$ 365,122	$ 380,876	$ 395,883
Private Pay	$ 380,161	$ 396,063	$ 413,254	$ 431,084	$ 448,070
Total Deductions Inpatient	$ 2,180,056	$ 2,271,248	$ 2,369,827	$ 2,472,078	$ 2,569,485
Total Deductions	$ 2,180,056	$ 2,271,248	$ 2,369,827	$ 2,472,078	$ 2,569,485
Net Patient Service Revenue	$ 1,553,155	$ 1,618,124	$ 1,688,356	$ 1,761,203	$ 1,830,600
Rental and Education Revenue	$ -	$ -	$ -	$ -	$ -
Other Operating Revenue	$ -	$ -	$ -	$ -	$ -
Total Net Operating Revenue	$ 1,553,155	$ 1,618,124	$ 1,688,356	$ 1,761,203	$ 1,830,600
DIRECT EXPENSES					
Salaries & Wages					
Management	$ -	$ -	$ -	$ -	$ -
Technician	$ -	$ -	$ -	$ -	$ -
Clinical	$ 476,545	$ 497,989	$ 520,399	$ 543,817	$ 568,288
Other	$ -	$ -	$ -	$ -	$ -
Employee Benefits	$ 142,963	$ 149,397	$ 156,120	$ 163,145	$ 170,487
Professional Fees	$ 17,379	$ 18,106	$ 18,892	$ 19,707	$ 19,636
Supplies	$ 48,442	$ 50,468	$ 52,658	$ 54,930	$ 54,733
Purchased Services	$ 9,953	$ 10,370	$ 10,820	$ 11,287	$ 11,246
Depreciation	#REF!	#REF!	#REF!	#REF!	#REF!
Interest & Amortization	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Bad Debts	$ 261,325	$ 272,256	$ 284,073	$ 296,330	$ 308,006
Other Expense	$ 91,110	$ 11,574	$ 12,077	$ 12,598	$ 12,552
Total Operating Expenses	#REF!	#REF!	#REF!	#REF!	#REF!
INCOME (LOSS)					
Operating Income (Loss)	#REF!	#REF!	#REF!	#REF!	#REF!
Non-Operating Gain (Loss)	$ -	$ -	$ -	$ -	$ -
Net Income (Loss)	**#REF!**	**#REF!**	**#REF!**	**#REF!**	**#REF!**

Project: NICU Expansion
Ancillary Service: Neonatal Intensive Care
Pro-Forma

	2008	2009	2010	2011	2012
ASSUMPTIONS:					
Procedure Volume					
Patient Days	815	824	835	846	853
Charge per Patient Day	4,581	4,719	4,860	5,006	5,156
Total Gross Charges	3,733,211	3,889,372	4,058,183	4,233,281	4,400,085
Increase in Patient-Days	5.7%	1.1%	1.3%	1.3%	0.9%
Price Inflation Factor	3.0%	3.0%	3.0%	3.0%	3.0%
Payor Mix					
Medicare	0.0%	0.0%	0.0%	0.0%	0.0%
Medicaid	54.6%	54.6%	54.6%	54.6%	54.6%
Commercial	6.7%	6.7%	6.7%	6.7%	6.7%
Other Gov't	12.8%	12.8%	12.8%	12.8%	12.8%
Private Pay	25.9%	25.9%	25.9%	25.9%	25.9%
Total	100.00%	100.00%	100.00%	100.00%	100.00%
Gross Patient Service Revenue					
Contractual Patient Fees:					
Medicare	$ -	$ -	$ -	$ -	$ -
Medicaid	$ 2,038,034	$ 2,123,285	$ 2,215,442	$ 2,311,031	$ 2,402,093
Commercial	$ 250,858	$ 261,352	$ 272,695	$ 284,461	$ 295,670
Other Gov't	$ 478,483	$ 498,498	$ 520,134	$ 542,577	$ 563,956
Private Pay	$ 965,837	$ 1,006,238	$ 1,049,912	$ 1,095,212	$ 1,138,366
Total Gross Patient Service Revenue	$ 3,733,211	$ 3,889,372	$ 4,058,183	$ 4,233,281	$ 4,400,085
	TRUE	TRUE	TRUE	TRUE	TRUE
Deduction Rates					
Contractual Patient Fees:					
Medicare	39.1%	39.1%	39.1%	39.1%	39.1%
Medicaid	68.7%	68.7%	68.7%	68.7%	68.7%
Commercial	25.1%	25.1%	25.1%	25.1%	25.1%
Other Gov't	70.2%	70.2%	70.2%	70.2%	70.2%
Private Pay	39.4%	39.4%	39.4%	39.4%	39.4%
Deductions from Revenue					
Contractual Patient Fees:					
Medicaid	1,401,065	1,459,671	1,523,026	1,588,739	1,651,340
Commercial	62,947	65,580	68,426	71,378	74,191
Other Gov't	335,884	349,934	365,122	380,876	395,883
Private Pay	380,161	396,063	413,254	431,084	448,070
Total Deductions from Revenue	$ 2,180,056	$ 2,271,248	$ 2,369,827	$ 2,472,078	$ 2,569,485

Project: NICU Expansion
Ancillary Service: Neonatal Intensive Care
Pro-Forma

	2008	2009	2010	2011	2012
Net Patient Service Revenue					
Medicaid	636,969	663,614	692,417	722,292	750,753
Commercial	187,912	195,772	204,269	213,083	221,479
Other Gov't	142,599	148,564	155,012	161,701	168,072
Private Pay	585,675	610,174	636,658	664,127	690,296
Total Net Patient Service Revenue	$ 1,553,155	$ 1,618,124	$ 1,688,356	$ 1,761,203	$ 1,830,600
Average Reimbursement Rate	41.60%	41.60%	41.60%	41.60%	41.60%
	TRUE	TRUE	TRUE	TRUE	TRUE

Project: NICU Expansion
Ancillary Service: Neonatal Intensive Care
Pro-Forma

	2008	2009	2010	2011	2012
.					
OTHER OPERATING EXPENSES					
Salaries & Wages					
Number of FTEs by Job Category					
Management	-	-	-	-	-
Clinical	6.0	6.0	6.0	6.0	6.0
Technician	-	-	-	-	-
Other	-	-	-	-	-
Average Salary by Job Category					
Clinical	$ 79,424	82,998	86,733	90,636	94,715
Other	$ 34,617	36,175	37,803	39,504	41,281
Salary Inflation Factor	4.5%	4.5%	4.5%	4.5%	4.5%
Salary Expense by Job Category					
Clinical	$ 476,545	$ 497,989	$ 520,399	$ 543,817	$ 568,288
Other	$ -	$ -	$ -	$ -	$ -
Total Salary Expense	$ 476,545	$ 497,989	$ 520,399	$ 543,817	$ 568,288
% of Year in Operation	100%	100%	100%	100%	100%
Adjusted Total Salary Expense	$ 476,545	$ 497,989	$ 520,399	$ 543,817	$ 568,288
Salaries & Wages					
Management	$ -	$ -	$ -	$ -	$ -
Technician	$ -	$ -	$ -	$ -	$ -
Clinical	$ 476,545	$ 497,989	$ 520,399	$ 543,817	$ 568,288
Other	$ -	$ -	$ -	$ -	$ -
Total Salaries and Wages	**$ 476,545**	**$ 497,989**	**$ 520,399**	**$ 543,817**	**$ 568,288**
Benefits	**142,963**	**149,397**	**156,120**	**163,145**	**170,487**
OTHER OPERATING EXPENSES					
Professional Fees					
Professional Fees	$17,378.73	$18,105.68	$18,891.53	$19,706.64	$19,635.91
Professional Fees	**$17,378.73**	**$18,105.68**	**$18,891.53**	**$19,706.64**	**$19,635.91**
Supplies					
Supplies NICU	$48,441.53	$50,467.84	$52,658.31	$54,930.35	$54,733.21
Total Supplies	**$48,441.53**	**$50,467.84**	**$52,658.31**	**$54,930.35**	**$54,733.21**
Purchased Services					
Purch Services	$9,953.46	$10,369.81	$10,819.89	$11,286.74	$11,246.23
Total Purchased Services	**$9,953.46**	**$10,369.81**	**$10,819.89**	**$11,286.74**	**$11,246.23**
Depreciation					
Building	#REF!	#REF!	#REF!	#REF!	#REF!
Equipment	$53,353.00	$53,353.00	$53,353.00	$53,353.00	$53,353.00
Depreciation Total	**#REF!**	**#REF!**	**#REF!**	**#REF!**	**#REF!**
Interest & Amortization	$0.00	$0.00	$0.00	$0.00	$0.00

Project: NICU Expansion
Ancillary Service: Neonatal Intensive Care
Pro-Forma

	2008	2009	2010	2011	2012
Bad Debts	$261,324.80	$272,256.05	$284,072.84	$296,329.67	$308,005.94
Other Expense					
Other Operating Expenses	$11,109.53	$11,574.25	$12,076.61	$12,597.67	$12,552.46
Administrative - Construction	$65,000.00	$0.00	$0.00	$0.00	$0.00
Building Permits & Assessments	$5,000.00	$0.00	$0.00	$0.00	$0.00
Add'l Inspection Fees	$10,000.00	$0.00	$0.00	$0.00	$0.00
Total Other Expense	**$91,109.53**	**$11,574.25**	**$12,076.61**	**$12,597.67**	**$12,552.46**
Total Operating Expenses	**#REF!**	**#REF!**	**#REF!**	**#REF!**	**#REF!**
Operating Income (Loss)	**#REF!**	**#REF!**	**#REF!**	**#REF!**	**#REF!**
Non-Operating Gain (Loss)					
Net Income (Loss)					

Schedule III C (Equipment to be Purchased)

NICU Expansion

Description	Make	Model	Volume	Cost
Radiant warmer	Ohmeda	Giraffe Omni-bed	6	$ 216,000
Open cribs	Hard, Inc	Medium size	2	$ 3,000
Monitors	Phillips	Viridia	6	$ 150,000
Infusion pumps	Aleris	3 channel	6	$ 15,000
Med infusion pumps	Medex	3500	6	$ 18,000
Supply carts	Hill-rom	L carts	6	$ 6,000
Suction heads and cannisters	Ohmeda	Suction regulator	6	$ 6,000
Biliblanket	Ohmeda	portable	3	$ 7,500
Bili-lights	Natus	Generation 2 - neoblue	2	$ 7,000
Bili-meter	Ohmeda	Bili light meter	2	$ 5,000
Portable bedside warmer	Fischer-Payxel	Baby control	2	$ 2,000
O2 blenders/flowmeters	Ohmeda	Regular & Low-flow	6	$ 8,000
Baby scale - breastfeeding	Medela	Baby weigh	1	$ 1,000
Baby scale and cart	Olympic	Warm Scale	1	$ 2,500
Breast pump	Medela	Symphany	1	$ 3,000
Privacy screens	Hill-rom	Large	3	$ 6,000
Recliner chairs	Hill-rom	Procedural Recliner	3	$ 7,500
Vapoltherm	Vapotherm	2000i	1	$ 2,000
IV poles	IV League Med	Single pole w/4 hooks	6	$ 6,000
Staff chairs	Fixture furniture/ Jami, Inc.	Straight chairs/vinyl seat	6	$ 3,600

TOTAL	**$ 475,100.00**

Neonatal Intensive Care Unit
SCHEDULE VIII B CONSTRUCTION

NOTE: The actual schedule contains more lines than this. These are the only ones for which Providence should supply information related to this C of N.

Section VIII B

2.	Construction			
a	Site Acquisition		$	-
b	Estimated General Construction		$	804,625
c	Fixed Equipment not Included in a		$	-
d	Total Construction Costs Sum of a,b,and c		$	804,625
e	Major Moveable Equipment		$	475,100
f	Other			
	(1)	Adminstrative expense	$	65,000
	(2)	Site survey, soils investigation, and materials tes	$	-
	(3)	Architects and engineering fees	$	175,000
	(4)	Other Consultation Fees	$	50,000
	(7)	Building Permits & Utility Assessments	$	5,000
	(8)	Add'l Inspection Fees	$	10,000
g	Total Project Costs		$	1,584,725

Disposition of Costs		
Construction & Equipment	$	1,279,725.00
Allocated to FXAS, depreciated	$	225,000.00
Add Adminstrative Back In (Expensed)	$	80,000
New Total	$	1,584,725
Total from above	$	1,584,725
Difference	$	-

Section IX

Schedule I.A
INCREMENTAL PROJECTED INCOME STATEMENT (Project Only)

GROSS PATIENT REVENUE:	**FY 2008**	**FY 2009**	**FY 2010**
INPATIENT	$ 3,733,211	$ 3,889,372	$ 4,058,183
OUTPATIENT			
LONG-TERM CARE			
SWING BEDS			
OTHER			
TOTAL PATIENT REVENUE	$ 3,733,211	$ 3,889,372	$ 4,058,183
LESS DEDUCTIONS			
CHARITY CARE			
CONTRACTUAL ALLOWANCES	$ 2,180,056	$ 2,271,248	$ 2,369,827
BAD DEBT	$ 261,325	$ 272,256	$ 284,073
TOTAL DEDUCTIONS	$ 2,441,381	$ 2,543,504	$ 2,653,900
NET OPERATING REVENUES	$ 1,291,831	$ 1,345,868	$ 1,404,283
ALL OTHER REVENUES			$ -
EXPENSES:			
SALARIES	$ 476,545	$ 497,989	$ 520,399
BENEFITS	$ 142,963	$ 149,397	$ 156,120
SUPPLIES	$ 48,442	$ 50,468	$ 52,658
UTILITIES			
PURCHASED SERVICE	$ 9,953	$ 10,370	$ 10,820
PROFESSIONAL FEES	$ 17,379	$ 18,106	$ 18,892
LEASE			
OTHER EXPENSES			
DEPRECIATION	#REF!	#REF!	#REF!
INTEREST			
TOTAL EXPENSES	#REF!	#REF!	#REF!
NET INCOME	#REF!	#REF!	#REF!

Schedule I.B

INCOME STATEMENTS PAMC (Facility)

GROSS PATIENT REVENUE:	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
INPATIENT	$ 381,816	$ 425,019	$ 485,929	$ 540,259	$ 606,096
OUTPATIENT	$ 173,084	$ 204,052	$ 220,132	$ 231,949	$ 256,288
LONG-TERM CARE					
SWING BEDS					
OTHER	$ 8,290	$ 8,938	$ 9,291	$ 9,806	$ 12,375
TOTAL PATIENT REVENUE	$ 563,190	$ 638,009	$ 715,352	$ 782,014	$ 874,759
LESS DEDUCTIONS					
CHARITY CARE	$ 20,411	$ 21,308	$ 32,087	$ 36,507	$ 38,065
CONTRACTUAL ALLOWANCES	$ 211,969	$ 259,964	$ 309,854	$ 341,320	$ 394,569
BAD DEBT	$ 36,991	$ 36,991	$ 43,712	$ 36,818	$ 30,628
TOTAL DEDUCTIONS	$ 269,371	$ 318,263	$ 385,653	$ 414,645	$ 463,262
NET OPERATING REVENUES	$ 293,819	$ 319,746	$ 329,699	$ 367,369	$ 411,497
ALL OTHER REVENUES	$ 17,658	$ 21,391	$ 25,642	$ 18,668	$ 26,849
EXPENSES:					
SALARIES	$ 128,267	$ 128,461	$ 130,262	$ 141,697	$ 156,676
BENEFITS	$ 29,794	$ 34,571	$ 34,763	$ 37,059	$ 40,743
SUPPLIES	$ 57,192	$ 62,684	$ 62,370	$ 70,941	$ 76,223
PURCHASED SERVICE	$ 38,558	$ 52,212	$ 56,879	$ 63,349	$ 73,762
PROFESSIONAL FEES	$ 5,101	$ 7,157	$ 11,161	$ 7,230	$ 7,092
OTHER EXPENSES	$ 14,530	$ 15,548	$ 14,943	$ 18,689	$ 24,649
DEPRECIATION	$ 23,365	$ 23,900	$ 24,815	$ 24,216	$ 26,313
INTEREST	$ 1,441	$ 1,130	$ 668	$ 1,231	$ 2,654
TOTAL EXPENSES	$ 298,248	$ 325,663	$ 335,861	$ 364,412	$ 408,112
NET OPERATING INCOME	$ 16,962	$ 15,474	$ 19,480	$ 21,625	$ 30,234

SECTION IX Schedule II

Schedule II. Facility Balance Sheet (in Thousands)

PAMC BALANCE SHEET	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
CURRENT ASSETS					
CASH & EQUIVALENTS	$ 19,247	$ 8,551	$ 10,789	$ 12,376	$ 35,129
ACCOUNTS RECEIVABLE	$ 76,169	$ 92,741	$ 65,287	$ 63,352	$ 76,551
SUPPLIES INVENTORY	$ 8,021	$ 8,973	$ 10,292	$ 11,564	$ 13,269
OTHER CURRENT ASSETS	$ 1,776	$ 2,868	$ 8,391	$ 16,263	$ 9,035
TOTAL CURRENT ASSETS	$ 105,213	$ 113,133	$ 94,759	$ 103,555	$ 133,984
PROPERTY AND EQUIPMENT					
LAND	$ 17,911	$ 17,760	$ 17,965	$ 32,901	$ 32,169
BUILDING/FIXED EQUIP	$ 250,071	$ 253,844	$ 261,256	$ 283,938	$ 282,914
MAJOR MOVABLE EQUIP	$ 165,805	$ 186,175	$ 204,357	$ 255,520	$ 374,354
ACCUMULATED DEPRECIATION	$ 225,850	$ 248,250	$ 272,763	$ 301,448	$ 322,616
NET PROPERTY AND EQUIPMENT	$ 207,937	$ 209,529	$ 210,815	$ 270,911	$ 366,821
OTHER ASSETS	$ 108,035	$ 188,576	$ 188,672	$ 226,190	$ 243,083
TOTAL ASSETS	$ 421,185	$ 511,238	$ 494,246	$ 600,656	$ 743,888
LIABILITIES/FUND BALANCE					
CURRENT LIABILITIES					
ACCOUNTS PAYABLE	$ 12,744	$ 15,571	$ 13,436	$ 27,833	$ 35,913
ACCRUED EXPENSES	$ 9,313	$ 8,279	$ 8,350	$ 11,404	$ 9,144
ACCRUED COMPENSATION/OTHER	$ 18,623	$ 19,880	$ 16,782	$ 20,372	$ 21,917
TOTAL CURRENT LIABILITIES	$ 40,680	$ 43,730	$ 38,568	$ 59,609	$ 66,974
LONG TERM LIABILITIES					
LONG TERM DEBT	$ 12,624	$ 61,721	$ 55,770	$ 113,517	$ 209,753
OTHER	$ 5,210	$ 22,485	$ 25,133	$ 40,430	$ 37,972
TOTAL LONG TERM LIABILITIES	$ 17,834	$ 84,206	$ 80,903	$ 153,947	$ 247,725
FUND BALANCE	$ 362,671	$ 383,302	$ 374,775	$ 387,100	$ 429,189
TOTAL LIABILITIES & FUND BALANCE	$ 421,185	$ 511,238	$ 494,246	$ 600,656	$ 743,888

Schedule II. Facility Balance Sheet (in Thousands)	Unaudited	
PAMC BALANCE SHEET		**As of May 2007**
CURRENT ASSETS		
CASH & EQUIVALENTS	$	37,331
ACCOUNTS RECEIVABLE	$	75,223
SUPPLIES INVENTORY	$	14,385
OTHER CURRENT ASSETS	$	10,278
TOTAL CURRENT ASSETS	**$**	**137,217**
PROPERTY AND EQUIPMENT		
LAND	$	38,487
BUILDING/FIXED EQUIP	$	427,574
MAJOR MOVABLE EQUIP	$	242,610
ACCUMULATED DEPRECIATION	$	334,366
NET PROPERTY AND EQUIPMENT	$	374,305
OTHER ASSETS	$	231,179
TOTAL ASSETS	**$**	**742,701**
LIABILITIES/FUND BALANCE		
CURRENT LIABILITIES		
ACCOUNTS PAYABLE	$	23,057
ACCRUED EXPENSES	$	9,296
ACCRUED COMPENSATION/OTHER	$	25,951
TOTAL CURRENT LIABILITIES	**$**	**58,304**
LONG TERM LIABILITIES		
LONG TERM DEBT	$	209,581
OTHER	$	23,822
TOTAL LONG TERM LIABILITIES	$	233,403
FUND BALANCE	$	450,994
TOTAL LIABILITIES & FUND BALANCE	**$**	**742,701**

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

(In thousands, except Patient Days)	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
(Gross) REVENUES	$ 580,848	$ 659,400	$ 737,861	$ 800,683	$ 874,759
EXPENSES	$ 317,628	$ 362,654	$ 379,575	$ 401,230	$ 438,742
PATIENT DAYS	86,452	84,954	87,497	88,521	90,862
REVENUE PER PATIENT DAY	$ 6.719	$ 7.762	$ 8.433	$ 9.045	$ 9.627
OPERATING & CAPITAL BUDGET SUMMARY					
GROSS REVENUES	$ 580,848	$ 659,400	$ 737,861	$ 800,683	$ 874,759
DEDUCTIONS FROM REVENUE	$ 232,380	$ 281,272	$ 341,941	$ 377,826	$ 432,633
NET REVENUE	$ 348,468	$ 378,128	$ 395,920	$ 422,857	$ 442,126
DIRECT EXPENSE	$ 234,633	$ 262,707	$ 271,109	$ 286,515	$ 304,271
INDIRECT EXPENSE	$ 82,995	$ 99,947	$ 108,466	$ 114,715	$ 134,471
NET INCOME PROJECTED					
RATE COMPUTATION					
ANNUAL MEDICAID RATE					
PER-DAY IP RATE	1,584.39	1,635.24	1,736.88	1,794.18	1,856.59
OP % OF CHARGES	44.05%	44.05%	45.41%	45.41%	45.41%
BASE YEAR COST					
LESS ANCILLARY	**N/A - Providence Alaska Medical Center is an Acute Care**				
PLUS ADMIN. OVERHEAD	**Facility, not a long-term care facility**				
COST BASIS FOR RATE					
BASE YEAR PATIENT DAYS					
COST PER PATIENT DAY					

Source: Hyperion Enterprise reports

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

(In thousands, except Patient Days)	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
(Gross) REVENUES	$ 24,843	$ 29,280	$ 33,997	$ 35,547	$ 48,738
EXPENSES	$ 5,828	$ 6,399	$ 6,735	$ 6,833	$ 7,832
PATIENT DAYS	9,500	10,323	10,279	10,283	11,525
REVENUE PER PATIENT DAY	$ 2.615	$ 2.836	$ 3.307	$ 3.457	$ 4.229
OPERATING & CAPITAL BUDGET SUMMARY					
GROSS REVENUES	$ 24,843	$ 29,280	$ 33,997	$ 35,547	$ 48,738
DEDUCTIONS FROM REVENUE	$ -	$ -	$ -	$ -	$ -
NET REVENUE	$ 24,843	$ 29,280	$ 33,997	$ 35,547	$ 48,738
DIRECT EXPENSE	$ 5,828	$ 6,399	$ 6,735	$ 6,833	$ 7,832
INDIRECT EXPENSE	$ -	$ -	$ -	$ -	$ -
NET INCOME PROJECTED	**$ 19,015**	**$ 22,881**	**$ 27,262**	**$ 28,714**	**$ 40,906**
RATE COMPUTATION					
ANNUAL MEDICAID RATE					
PER-DAY IP RATE	1,584.39	1,635.24	1,736.88	1,794.18	1,856.59
OP % OF CHARGES	44.05%	44.05%	45.41%	45.41%	45.41%
BASE YEAR COST					
LESS ANCILLARY	**N/A - Providence Alaska Medical Center is an Acute Care Facility, not a long-term care facility**				
PLUS ADMIN. OVERHEAD					
COST BASIS FOR RATE					
BASE YEAR PATIENT DAYS					
COST PER PATIENT DAY					

Source: Hyperion Enterprise reports

Schedule IV. Operating Budget Provide Last Five Years Actual and Projections for Three Years Beyond Project Completion									
Description:	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Number of Beds	38	38	38	38	38	38	44	44	44
Days in a Year	365	365	366	365	365	365	366	365	365
Available Bed Days	13,870	13,870	13,908	13,870	13,870	13,870	16,104	16,060	16,060
Resident Bed Days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent Growth	N/A	N/A	6.4%	-4.1%	13.0%	21.0%	-12.6%	1.1%	1.3%
Occupancy	Not Avail.	70.6%	74.8%	72.0%	81.4%	98.4%	74.1%	75.1%	76.1%
Average Length of Stay	22.5	20.9	21.1	20.8	20.3	20.3	20.3	20.3	20.3
Patient Bed Days	8,711	9,786	10,410	9,984	11,286	13,651	11,928	12,065	12,222
Number of Residents	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Daily Room and Board Rate*	Not Avail.	2,992	3,266	3,560	4,318	4,448	4,581	4,719	4,860
Nursing Revenue									
Nursing Services	24,842,000	29,280,000	33,997,000	35,547,000	48,737,833	60,719,454	54,647,242	56,933,144	59,404,227
Payer mix									
Medicaid	47.5%	54.9%	56.9%	50.6%	54.2%	54.6%	54.6%	54.6%	54.6%
Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	52.5%	45.1%	43.1%	49.4%	45.8%	45.4%	45.4%	45.4%	45.4%
Ancillary Revenue									
Total Revenue	**N/A - Providence Alaska Medical Center is an Acute Care**								
Rate Computation	**Facility, not a long-term care facility**								
Annual Medicaid Rate									
Base Year Cost									
Less Ancillary									
Plus Admin Overhead									
Cost Basis for Rate									
Base Year Patient Days									
Cost per Patient Day									

SECTION IX V-A

Schedule V-A. Debt Service Summary
Provide Current Debt Data and Projections For the Next Three Years

Existing Debt:	[In Thousands]	FY 2007	FY 2008	FY 2009	FY 2010
	Principal	$2,050	$3,243	$20,330	$9,985
	Interest	$8,897	$8,603	$8,327	$7,820

SECTION IX Schedule V B.

Schedule V-B. New Project Debt Service Summary

Attach a debt service cash flow schedule over the life of the debt for the new project

Break out principal, interest and Other

year	Item	Principal	Interest	Other	Total
2006		$ -	$ -	$ -	
2007	PAYMENT	**No new debt issued for this project.**			
2008	PAYMENT				
2009	PAYMENT				
2010	PAYMENT				

SECTION IX Schedule VI

Schedule VI. Reimbursement Sources

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

Fiscal Year 2002				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		18.10%		17.52%
Medicare		26.20%		17.57%
Commercial		43.01%		56.79%
Self Pay		6.11%		4.23%
Other Government		6.59%		5.10%
Other		0.00%		-1.21%
Total		100.01%		100.00%

Fiscal Year 2003				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.27%		13.95%
Medicare		27.82%		18.56%
Commercial		41.13%		55.97%
Self Pay		8.14%		8.58%
Other Government		5.64%		4.27%
Other		0.00%		-1.33%
Total		100.00%		100.00%

Schedule VI. Reimbursement Sources

Schedule VI

Fiscal Year 2004				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.54%		14.24%
Medicare		29.46%		19.87%
Commercial		39.66%		54.97%
Self Pay		7.27%		7.72%
Other Government		6.06%		4.71%
Other		0.00%		-1.51%
Total		99.99%		100.00%

Fiscal Year 2005				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.28%		14.14%
Medicare		28.20%		18.93%
Commercial		40.85%		56.92%
Self Pay		7.60%		7.80%
Other Government		6.07%		4.48%
Other				-2.27%
Total		100.00%		100.00%

Fiscal Year 2006				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.59%		13.95%
Medicare		28.03%		19.02%
Commercial		40.56%		57.13%
Self Pay		7.46%		8.70%
Other Government		6.36%		4.11%
Other				-2.91%
Total		100.00%		100.00%

Fiscal Year 2007				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.89%		13.54%
Medicare		26.87%		17.51%
Commercial		38.89%		55.06%
Self Pay		8.92%		13.05%
Other Government		7.43%		4.88%
Other				-4.04%
Total		100.00%		100.00%

Schedule VI. Reimbursement Sources

Fiscal Year 2008				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.89%		13.54%
Medicare		26.87%		17.51%
Commercial		38.89%		55.06%
Self Pay		8.92%		13.05%
Other Government		7.43%		4.88%
Other				-4.04%
Total		100.00%		100.00%

Fiscal Year 2009				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.89%		13.54%
Medicare		26.87%		17.51%
Commercial		38.89%		55.06%
Self Pay		8.92%		13.05%
Other Government		7.43%		4.88%
Other				-4.04%
Total		100.00%		100.00%

Fiscal Year 2010				
Reimbursement Source	Number of Patients	Gross Patient Charges	Deductions	Net Patient Revenues
Medicaid		17.89%		13.54%
Medicare		26.87%		17.51%
Commercial		38.89%		55.06%
Self Pay		8.92%		13.05%
Other Government		7.43%		4.88%
Other				-4.04%
Total		100.00%		100.00%

Source: Hyperion Enterprise reports

SECTION IX Schedule VII

Schedule VII. Depreciation Schedule

Schedule includes Fixed, Major Moveable shown in Schedule VIII B. and Additional Major Moveable Equipment. Straight-Line Method

Equipment to be Purchased

Fixed Equipment as Reported in Section VIII B

Equipment Description	Volume	Unit Cost x Volume	AHA Life	Depreciation Per Year
None				
Subtotal Fixed Equipment		**$ -**		

Major Moveable Equipment as Reported in Section VIIIB

Equipment Description	Volume	Unit Cost x Volume	AHA Life	Depreciation Per Year
Recliner chairs	3	$ 7,500	15	$ 500
Privacy screens	3	$ 6,000	15	$ 400
IV poles	6	$ 6,000	15	$ 400
Staff chairs	6	$ 3,600	15	$ 240
Open cribs	2	$ 3,000	15	$ 200
Baby scale and cart	1	$ 2,500	15	$ 167
Baby scale - breastfeeding	1	$ 1,000	15	$ 67
Radiant warmer	6	$ 216,000	10	$ 21,600
Med infusion pumps	6	$ 18,000	10	$ 1,800
Infusion pumps	6	$ 15,000	10	$ 1,500
Biliblanket	3	$ 7,500	10	$ 750
Bili-lights	2	$ 7,000	10	$ 700
Supply carts	6	$ 6,000	10	$ 600
Suction heads and cannisters	6	$ 6,000	10	$ 600
Bili-meter	2	$ 5,000	10	$ 500
Breast pump	1	$ 3,000	10	$ 300
Vapoltherm	1	$ 2,000	10	$ 200
O2 blenders/flowmeters	6	$ 8,000	8	$ 1,000
Monitors	6	$ 150,000	7	$ 21,429
Portable bedside warmer	2	$ 2,000	5	$ 400
Subtotal Major Moveable Equipment/VII B.		**$ 475,100**		
TOTAL ALL DEPRECIABLE EQUIPMENT		**$ 475,100**		

NOTE: $96,460.63 of Equipment in Schedule VIIIB will be directly expensed (not capitalized). The