South Peninsula Hospital

Nuclear Medicine Department *and* Pharmacy/Infusion Colocation Project

Certificate of Need Application

Submitted July 2023

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SECTION I

General Applicant Information

CERTIFICATE OF NEED APPLICATION
APPLICANT IDENTIFICATION AND CERTIFICATION OF ACCURACY

1. Applicant Identification

Facility Name South Peninsula Hospital (SPH)	**Medicaid Provider Number**
Facility Address (*Street/City/State/Zip Code*) 4300 Bartlett Street/Homer/Alaska/99603	**Medicare Provider Number**
Name and mailing address of organization that operates the facility (if different from above) South Peninsula Hospital, Inc. (same address)	
Facility Administrator (*Name, title, mailing address, including City/State/Zip Code*) Ryan K. Smith, Chief Executive Officer (same mailing address)	**Telephone** (307) 359-0152 **Facsimile** (907) 235-0253 **E-mail** rmith@sphosp.org
Applicant (*Name, title, mailing address, including City/State/Zip Code*) South Peninsula Hospital, Inc. 4300 Bartlett Street/Homer/Alaska/99603	**Telephone** (907) 359-0152 **Facsimile** (907) 235-0253 **E-mail** rsmith@sphosp.org
Principal Contact Person (*Name, title, physical address, mailing address, including City/State/Zip Code*) Angela Hinnegan, Chief Operating Officer 4300 Bartlett Street/Homer/Alaska/99603	**Telephone** (907) 235-0395 **Mobile Phone** (907) 394-2081 **Facsimile** (907) 235-0253 **E-mail** ahinnegan@sphosp.org

2. Ownership Information

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

☐ For profit: individual	**X** Not for profit: government
☐ For profit: partnership	☐ Not for profit: corporation
☐ For profit: corporation	☐ Other:

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 Ryan K. Smith	**Title** CEO South Peninsula Hospital
Signature Ryan K Smith	**Date** 07/19/2023

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:

SOUTH PENINSULA HOSPITAL, INC.
BOARD OF DIRECTORS

Kelly Cooper, President 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx	Todd Boling, DO 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx
Aaron Weisser, Vice President 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx	Keri-Ann Baker 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx
Julie Woodworth, Secretary 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx	Bernadette Wilson 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx
Walter Partridge, Treasurer 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx	Melissa Jacobsen 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx
Matthew Hambrick 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx	Edson Knapp, MD 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx
Beth Wythe 4300 Bartlett Street Homer, AK 99603 907-235-8101 ph 907-235-0253 fx	

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.

South Peninsula Hospital (SPH) was last recertified by the Centers for Medicare and Medicaid Services on December 16, 2021. Please see APPENDIX, Item 1.

SECTION II.

Summary Project Description

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

The South Peninsula Hospital (SPH) Nuclear Medicine Department and Pharmacy/Infusion Colocation Project is a service line expansion, upgrade, and co-location project expected to cost approximately $10,000,000. The project will be financed by the SPH unobligated Plant Replacement and Expansion Fund held by the Kenai Peninsula Borough, SPH Operating Cash, Grant Awards and Philanthropic support. Final project completion is expected to occur on or about December, 2025.

Nuclear Medicine Department Addition – SPECT/CT and Ancillary Space Improvements

The addition of an SPH Nuclear Medicine Department on the second floor of the main Hospital building will include a control room, a stress test room, an equipment room, a procedure (scan) room, a clean room (or hot lab), patient bathroom, and circulation requiring approximately 1,405 SF of existing space to be reprogramed.

Additionally, modifications shall be made to the remaining footprint vacated by the Pharmacy and Respiratory Therapy to create a Reflection Room (approximately 176 SF) and two public bathrooms (approximately 90 SF). Major equipment purchases include a Siemens SPECT/CT which can perform both Computed Tomography and Nuclear Medicine studies, a Biosafety cabinet, an Ultrasound, and a new Stress Test system.

Pharmacy Expansion and Upgrade

The existing Pharmacy Department on the second floor at 1437 SF is unable to meet certain regulatory requirements which go into effect at the end of 2023 due to space constraints. The new Pharmacy location on the first floor will be expanded to 2,047 SF and enable SPH to meet the regulatory requirements set forth by the United States Pharmacopeia (USP) General Chapter 797 and 800. Major equipment purchases for this expansion and upgrade include new compounding hoods, refrigerators, a freezer, and a Medication safe.

Oncology/Infusion Expansion/Relocation

During the Covid-19 pandemic, the Oncology/Infusion Department was temporarily relocated to a freestanding 960 SF leased building south of the main Hospital. The temporary move was meant to provide geographic separation for this vulnerable population, however it has posed many challenges, inefficiencies, and limitations on patient care. The existing 960 SF building does not allow for current or future growth projections for Oncology/Infusion. The new Oncology/Infusion Department will expand to approximately 4,401 SF in the first-floor shelled area and allow for twice our current capacity for oncology / infusion patients. Major equipment purchases will include an Automatic medication distribution system, Exam tables, Warming cabinet, and Infusion chairs.

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	16	0	16
2-bed room/unit			
Other (list)			
ICU Beds	2	0	2
Obstetrics Beds	4	0	4
Pediatric Beds			
Acute Rehab Beds			
Ancillary Services (list) Pharmacy	1	0	1
LONG-TERM CARE			
Acute Beds			
1-bed room/unit			
2-bed room/unit			
Other (list)			
Nursing Beds			
1-bed room/unit			
2-bed room/unit	28	0	28
Other (list) 3 - Bedroom			
DIAGNOSTIC AND DIAGNOSTIC IMAGING SERVICES			
CT Scanner	1	0	1
MRI	1	0	1
PET/CT	0	1 (SPECT/CT)	1
Cardiac Catheterization			
Emerging Med. Tech. (list)			
SURGICAL CARE			
Ambulatory Surgery or Dedicated OP Suites			
Suites for IP & OP	2	0	2
Endoscopy Suites	1	0	1

Type of Service	Current Capacity	Added, Expanded, or Replacement Capacity	TOTAL PROPOSED CAPACITY
Open-Heart Surgery			
Organ Transplantation			
Other Services (list)			
THERAPEUTIC CARE			
Infusion Stations	5	5	10
Renal Dialysis			
Other (List)			
Total Capacity	61	6	67

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.

SPH Nuclear Medicine Service Line Addition– SPECT/CT

At present, SPH's diagnostic imaging services include X-Ray, Computed Tomography (CT), Mammography, Ultrasound, and Magnetic Resonance Imaging (MRI). Although developed in the 1950s, Nuclear Medicine has been the standard of care for diagnosing illnesses and disorders related to Heart Health, Neurology, and Cancer for over 30 years. This certificate of need demonstrates the importance of bringing this vital diagnostic imaging service to the residents of the Southern Kenai Peninsula. This request is for an *addition* of a service line utilizing 1,405 SF of renovated second-floor space to create a Nuclear Medicine Suite near the existing Imaging Department. This location will require displacement of the SPH Pharmacy and the Respiratory Therapy Department.

The addition of a Nuclear Medicine Department and a Single Photon Emission Computed Tomography and Computed Tomography (SPECT/CT) machine is proposed for multiple reasons, including: improved patient care through the addition of radiotracer scan capabilities (which have been the standard of care for some diagnoses since the 1990's), improved patient access to nuclear medicine diagnostics (closest test availability is 76 miles away), reduction of healthcare service gap (20% gap in care observed based on state nuclear medicine scans per capita), increased opportunity for certain surgical procedures to be performed locally due to improved diagnostics, and back-up CT imaging during downtime for the existing CT.

Nuclear medicine is a specialized area of radiology using trace amounts of radioactive material to examine the functioning of organs and other structures to diagnose and treat abnormalities early in disease progression. With the use of SPECT technology, we will be able to detect certain cancers such as thyroid and breast cancer, observe the circulation of blood in the brain and heart, find abnormalities in

kidneys and bones, and identify many other medical conditions. Nationally, chest pain is the most common symptom for which patients seek emergency medical care (Sharma A. R., 2011). Nuclear medicine can provide a faster and more definitive diagnosis of acute coronary syndrome (ACS) preventing inappropriate discharges and unnecessary hospitalizations. Nationally, nuclear medicine is an indispensable tool for patients receiving care across a spectrum of diseases including brain conditions, lung disease, heart disease, endocrine disorders, multiple cancer diagnoses and follow-up of treatment, gallbladder disease, kidney disease, orthopedic problem solving, etc. Currently, patients must travel over 75 miles (150 miles round trip) in order to obtain this important diagnostic information. Many patients are unable to travel due to their conditions and as a result, are unable to receive important medical care, creating a gap in service.

The scope of the Nuclear Medicine Addition will include the complete renovation of 1,405 SF of clinical space on the second floor of the Hospital. The renovated suite will include specially shielded spaces in which trace amounts of radioactive isotopes may be safely stored and administered. A Siemens ProSpecta X3 SPECT/CT will be installed in the scan room which can use “radioactive material inside the body to see how organs or tissue are functioning (for diagnosis) or target and destroy damaged or diseased organs or tissue (for treatment) (N.A., CDC, 2021)". Additionally, a Stress test room in the Nuclear Medicine suite will allow for the use of Nuclear Cardiac Stress Testing (Cardiac SPECT). ‘A Nuclear stress tests uses pharmacologic medication to increase blood flow and stress the heart which enables the diagnosis and monitoring of coronary artery disease (N.A., Cleveland Clinic, 2022) and other suspected heart problems.’

In addition to the relocation of Pharmacy and Respiratory Therapy, construction will create temporary impacts to the Environmental Services (Laundry) and Dietary / Nutrition Departments which are located on the first floor below the Nuclear Medicine space. We also anticipate construction noise and possible patient flow changes to the adjacent Imaging Department, Obstetrics Department and Laboratory Department. Some administrative offices will require temporary relocation to accommodate workflow during construction.

Pharmacy Upgrade and Expansion

The proposed *replacement*, modernization, and *expansion* of the SPH Pharmacy is essential for meeting the regulatory upgrades required by the USP’s Chapter 797 and 800 compounding guidelines and safe handling of hazardous drugs. The importance of facility design and environmental controls required by USP 797 and 800 are: improved safety outcomes for patients, increased staff safety during sterile compounding of hazardous drugs, tight control of humidity, temperature and particulate content of the sterile compounding environment, and control and reduction of contamination to or from hazardous drugs into the compounding environment.

USP 797 is the standard for sterile preparation of compounded pharmaceuticals and includes hazardous and non-hazardous drugs. USP 800 is the standard governing safe handling of hazardous drugs in order

to minimize the risk of exposure to healthcare staff, patients, and the environment. It was revised in December 2019 and delayed several times during the pandemic because of the significant capital burden it placed upon healthcare entities. The existing Pharmacy location on the second floor was built in 2007 and does not adhere to USP 797 or USP 800, nor does it have the ability to incorporate these design elements within its current square footage. Additional square footage, specialized construction, a dedicated Heating, Ventilation and Air Conditioning (HVAC) system, and new compounding hoods are required to meet the USP requirements. As a licensed Hospital, SPH it is required to meet USP guidelines and undergo regular inspections by the Alaska Board of Pharmacy. Non-compliance with USP 797 and 800 can result in serious monetary fines, restricted drug compounding activities, and impact the provision of patient care.

The new Pharmacy location on the first floor will add 610 SF to the existing 1,437 SF size and include 2 compounding rooms with dedicated compounding hoods that meet the USP requirements for proper airflow such as positive pressure ante rooms and negative pressure in the chemotherapy and hazardous drug storage rooms. A biological safety cabinet will also allow for the safe storage and handling of non-chemotherapy hazardous drugs, and a separate Pharmacy-dedicated HVAC system will enable the Pharmacy to pass current certification requirements and be prepared for future needs and governmental requirements. Staff workspace, storage, and security elements will also be improved in the new location. A separate receiving entrance for pharmaceutical deliveries will be added for safety and security of high-cost medications and controlled substances. Currently, the delivery of drugs and supplies to the Pharmacy requires transportation down the main corridor. The new suite will also have direct access doors between the Pharmacy and the Oncology / Infusion suites for efficiency, optimizing staff and patient experience.

Performing this needed upgrade to our Pharmacy at the same time as the addition of Nuclear Medicine, will allow SPH to gain efficiencies and cost savings. The USP guidelines are scheduled to go into effect in November 2023, however with our project plan in motion a temporary waiver of these requirements shall be requested.

Oncology / Infusion Colocation and Expansion

During the Covid-19 pandemic, SPH's Oncology/Infusion Center was temporarily relocated to a 960 SF leased building south of the main Hospital. While the move was meant to provide temporary geographic separation for this vulnerable population, its former location was reprogrammed for use by our growing Neurology patient needs in 2021, capping the volume growth of Oncology/Infusion to their 960 SF location.

The relocation and expansion of the SPH Oncology / Infusion Department is proposed to meet multiple goals, to include meeting increased demand in patient volume, improvement of patient safety, reduction of emergency response time for patients during treatment, improvement of staff workflow and supply transmission, improvement of patient satisfaction and privacy, and colocation of medical services within the main hospital. With a footprint totaling only 960 SF, the building the Hospital leases for

Oncology/Infusion cannot meet the needs of current and future growth in patient volumes. During fiscal year 2018, the Oncology / Infusion department performed 946 procedures which grew to 1,626 procedures by fiscal year 2022 (72% increase since 2018). Only 9 months into the current fiscal year 2023, our Oncology / Infusion department has already outperformed FY22 at 1,695 procedures with a projected year-end volume of 2,260 procedures.

Between 2018 and 2023, SPH has experienced a 139% increase in Oncology/Infusion volumes. However, the existing space is unable to support more. The return of the Oncology/Infusion Department into the Hospital adjacent to the first-floor Pharmacy will improve not only patient and staff experience, but also reduce wait times, improve communication and safety, reduce emergency response times, and increase capacity for volume growth.

The existing 960 SF Oncology / Infusion building can accommodate a maximum of 5 infusion chairs, 4 are in a shared room, and 1 is in a private room. Patient infusions that require privacy cannot be scheduled during the same time due to a lack of space. The delivery of infusion supplies, pharmaceuticals, and labs to and from the department requires staff to leave the building in sometimes dark and inclement weather to retrieve necessary infusion supplies from the Hospital or deliver blood or specimens to the lab. While they are gone, they are unable to offer clinical support to their team members and patient care may be delayed.

The expanded Oncology / Infusion location on the first floor of the hospital will enable twice the current capacity for patient infusions that require privacy or increased infection controls. This *expansion* allows for a corridor which leads to and from the main elevator banks and a separate patient entrance. In addition, there will be a patient waiting area, multiple restrooms, 4 semi-private infusion bays, 1 group infusion bay with 4 chairs, 2 private infusion/exam rooms, a nurse's station, a med room, clinical office spaces, a registration desk, a staff rest area, and ancillary support spaces. With an existing growth rate of more than double our 2018 volumes, the Oncology / Infusion center is a service line which needs immediate expansion.

According to the latest South Peninsula Hospital Community Health Needs Assessment, Cancer was the leading cause of death for the period 2007- 2020. The incidence of cancer per capita on the Kenai Peninsula exceeded the state and averages for the years 2014-2020, driving the increased need for cancer care in our communities: Local (SPH) and borough wide (CPH) .

Other Ancillary Renovations or Improvements

In addition to the renovations, additions, and relocations identified above, there are two additional uses of space for the area surrounding the Nuclear Medicine Department. Currently there are two public bathrooms located in the space which will be converted into the Nuclear Medicine program area. Convenient access to public restrooms is necessary to support staff, patients, and visitors and as such these bathrooms required relocation to the main hallway corridor located on the north side of the

Nuclear Medicine Suite. Both bathrooms will be ADA accessible with one doorway facing the main central corridor, and the second doorway facing the Obstetrics department. The replacement bathrooms will require approximately 100 SF.

Next, we plan to relocate the Reflection Room, a space for visitors, patients, and staff to regenerate and observe their individual spiritual care or wellness needs. At present, the Reflection Room resides on the first floor across from the cafeteria, occupying about 150 SF. The distance of the room from clinical departments limits its convenience and its frequency of use. We believe that the Reflection Room could provide more benefit to visitors, patients, and staff if it were located adjacent to inpatient and frequently used outpatient clinical areas. We have identified the space vacated by the Respiratory Therapy department just south of Nuclear Medicine to be a convenient location for the new Reflection Room, at 176 SF.

As mentioned earlier, the Respiratory Therapy Department will be reduced in size by this construction project to just office space. The existing Respiratory Therapy footprint will be overlapped by the Nuclear Medicine scan room and the Reflection Room. However, an existing office space is available in the main corridor between Surgery and Imaging. This office move will be performed outside of this project scope, and RTs will have access to Stress Testing equipment in the Nuclear Medicine suite.

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

Equipment to be purchased

Figure 1: Nuclear Medicine Department

Description	Vendor	Model	Qty	Unit Price	Total
Dispenser, Soap, Disposable	Owner Supplied	Uline F-3905BK	4	$ 68.00	$ 272.00
Dispenser, Hand Sanitizer, Hands-Free	Owner Supplied	Purell H1950	3	$ 83.00	$ 249.00
Dispenser, Paper Towel, SS, Surface Mounted	Uline	H-2275	2	$ 103.00	$ 206.00
Dispenser, Paper Towel, Sensor, Hands Free	GEORGIA-PACIFIC	59462A	2	$ 156.00	$ 312.00
Waste Disposal Unit, Sharps, Container Shield	Biodex	039-3358556H8556H	1	$ 1,870.00	$ 1,870.00
Waste Disposal Unit, Sharps w/Glove Dispenser	McKesson	2265	1	$ 180.00	$ 180.00
Table, Process, Adj Height, 5 Drawer, 48"W x 24"	Blickman	157892000	1	$ 2,942.00	$ 2,942.00
Cart, Emergency, Mobile, 66"H x 32"W x 22"D	~~Detecto~~ owner supplied	RC33669RED	1	$ 3,913.00	$ 3,913.00
Cart, General Storage, Mobile	Detecto	RC33669WHT	1	$ 2,765.00	$ 2,765.00
Stool, Self Adjusting	Intensa, Inc.	ITS-981	1	$ 340.00	$ 340.00
Footstool, Straight	Blickman	T9FB3079402	1	$ 85.00	$ 85.00
Basket, Wastepaper, Fire Resistant	Rubbermade	254300BK	1	$ 52.00	$ 52.00
Basket, Wastepaper, Step-On	Rubbermade	RCPST12EPLWH	2	$ 283.00	$ 566.00
Waste Receptacle, Radioisotope, Lead Line	Capintec	039-110	1	$ 610.00	$ 610.00
Oven, Microwave, Consumer	Solwave	180MW1000SS	1	$ 358.00	$ 358.00
Calibrator, Radio-isotope	Capintec	CRC-55tR	1	$ 8,531.00	$ 8,531.00
Cabinet, Bio Safety, Class II/A, Radiopharmacy, F	Germfree	Radio	1	$ 52,000.00	$ 52,000.00
Flowmeter, Air, Connect w/50 PSI Supply	Precision Brand	AF-P021P	1	$ 90.00	$ 90.00
Flowmeter, Oxygen, Low Flow	Precision Brand	OF-P021	2	$ 90.00	$ 180.00
Regulator, Vacuum	Gentec	881VR-300	2	$ 355.00	$ 710.00
Chair, Blood Donor, Recliner, Manual or Pneumat	Drive Medical Durable Me	D577-BR	1	$ 1,080.00	$ 1,080.00
Holder, Chart, Patient, Wall or Door Mounted	OFFICEMATE	21431	1	$ 26.00	$ 26.00
Hamper, Linen, Mobile, w/Lid	Global Industria	T9F436911	1	$ 220.00	$ 220.00
Scale, Wheelchair, Portable, 1000 lb Capacity	Health-o-meter	2610KL	1	$ 4,700.00	$ 4,700.00
Stand, IV, Adjustable	MEDSOURCE	MS-47100	1	$ 360.00	$ 360.00
Defibrillator/Monitor Respiratory	Owner Supplied	Zoll 3052000520131000	1	$ 32,600.00	$ 32,600.00
System, Stress Exercise, w/Treadmill	GE Healthcare	Treadmill	1	$ 41,554.00	$ 41,554.00
Aspirator/Pressure Unit, General Purpose	S-Scort Inc.	Scort III	1	$ 2,016.00	$ 2,016.00
Table, Ultrasound, Mobile, Echocardiology	Owner Supplied		1	$ 8,995.00	$ 8,995.00
Cabinet, Storage, Lead Lined	Nuclear Sheilds	SC126	1	$ 1,419.00	$ 1,419.00
Cart, Transport, Radium	Radiation Products Desigr	950-000	1	$ 950.00	$ 950.00
Safe, Storage, Radium	Radiation Products Desigr	998-006	1	$ 6,076.00	$ 6,076.00
Shield, L Block, Radium Handling	Radiation Products Desigr	990-251	1	$ 6,115.00	$ 6,115.00
System, Uptake, Thyroid, Mobile	Captus	4000e\5430-30154	1	$ 16,285.00	$ 16,285.00
Stand, Injection, Nuclear Medicine	Biodex	Biodex 135-022	1	$ 733.00	$ 733.00
Scanner, Nuclear, SPECT, Dual Head	Siemens	Siemens Symbia Pro	1	$ 675,000.00	$ 675,000.00
Radiation Survey Meter	Fluke Biomedical	451P-RYR	1	$ 4,550.00	$ 4,500.00
					$ 878,860.00

Figure 2: Pharmacy Department

Description	Vendor	Model	Qty	Unit Price	Total
Dispenser, Soap, Disposable	Owner Supplied	Uline F-3905BK	2	$ 68.00	$ 136.00
Dispenser, Hand Sanitizer, Hands-Free	Owner Supplied	Purell H1950	2	$ 83.00	$ 166.00
Waste Disposal Unit, Sharps, Mobile with Trolley	BD Recykleen	305091	3	$ 520.00	$ 1,560.00
Shelf, 12" Depth, SS, Surface Mounted	Regency	4060S1845KM65	1	$ 720.00	$ 720.00
Chair, Drafting, Rotary	Cramer	Citrus	2	$ 664.00	$ 1,328.00
Table, Work, Stainless Steel	Regency	T447A	1	$ 665.00	$ 665.00
Hood, Laminar Flow, Horizontal, Bench Top, 4ft	Germfree	TBD	1	$ 17,500.00	$ 17,500.00
Cabinet, Bio Safety, Class II/B2, w/base, 4ft	Germfree	TBD	2	$ 16,601.00	$ 33,202.00
Shelving, Storage, 77hx36wx18d	Steelton	465C1836KE5C	3	$ 360.00	$ 1,080.00
Container, Biohazard Waste, Step-on, Fire Safe	Uline	H-5191	2	$ 169.00	$ 338.00
Table, Instrument/Dressing, CRS	Medical Supplies & Equipn	4108SSume	4	$ 912.00	$ 3,648.00
Refrigerator, Biological, SS, 2 Door, 40 Cu Ft	Owner Supplied	ABS ABT-HC-LP-47-TS	1	$ 9,000.00	$ 9,000.00
Refrigerator, Biological,-2 Door, 40 Cu Ft	ABS	ABS ABT-HC-LP-47-TS	1	$ 15,500.00	$ 15,500.00
Refrigerator, Biological 1 door 16 CuFt	ABS	PH-ABT-HC-16G	1	$ 4,000.00	$ 4,000.00
Refrigerator/Freezer, Biological, Upright, 18 Cu Ft	American BioTech Supply	ABT-RFC-16A	1	$ 5,540.00	$ 5,540.00
Medication Safe	Owner Supplied	BD Pyxis BD-38721	1	$ 120,000.00	$ 120,000.00
Chamber, Pass-Thru, Biosafe, Ss, 24"W X 24"D X 2	Clean Air	CAP18W-SST-24Wx24Hx	2	$ 6,675.00	$ 13,350.00
Undercounter Freezer	ABS 3.2CuFt		1	$ 1,500.00	$ 1,500.00
Shelf Bin Organizer	Uline	H-1772BLU	2	$ 500.00	$ 1,000.00
Ultra Low freezer	So Low 2CuFt	MV85-2	1	$ 10,000.00	$ 10,000.00
Slanted Wire Shelving	Southwest Solutions	Smart Shelf System	6	$ 2,200.00	$ 13,200.00
					$ 253,433.00

Figure 3: Oncology/Infusion Department

Description	Vendor	Model	Qty	Unit Price	Total
Dispenser, Soap, Disposable	Owner Supplied	Uline F-3905BK	11	$ 68.00	$ 748.00
Dispenser, Hand Sanitizer, Hands-Free	Owner Supplied	Purell H1950	13	$ 83.00	$ 1,079.00
Dispenser, Paper Towel, SS, Surface Mounted	Uline	H-2275	7	$ 103.00	$ 721.00
Dispenser, Paper Towel, Sensor, Hands Free	GEORGIA-PACIFIC	59462A	2	$ 156.00	$ 312.00
Waste Disposal Unit, Sharps w/Glove Dispenser	McKesson	2265	4	$ 180.00	$ 720.00
Dispenser, Glove, Surgical/Examination, Wall Mntd	Uline	H-9088	3	$ 103.00	$ 309.00
Waste Disposal Unit, Sharps	Cardinal Health	85131	5	$ 25.00	$ 125.00
Basket, Wastepaper, Step-On	Rubbermade	RCPST12EPLWH	1	$ 283.00	$ 283.00
Transport Cart, Meal Tray, Standard Height	Channel	T447A	1	$ 750.00	$ 750.00
Brewer, Coffee, Auto, Elect, 3 Burner, Front/Back	Bloomfield	8571-D3	1	$ 915.00	$ 915.00
Oven, Microwave, Consumer	Solwave	180MW1000SS	1	$ 358.00	$ 358.00
Television, HD, 40" Class	Samsung	UN40N5200AFXZA	1	$ 570.00	$ 570.00
Flowmeter, Oxygen, Low Flow	Precision Brand	OF-P021	10	$ 90.00	$ 900.00
Chair, Blood Donor, Recliner, Manual or Pneumatic	Drive Medical Durable Mec	D577-BR	8	$ 1,080.00	$ 8,640.00
Chair, Laboratory, Blood Drawing, w/Storage	AdirMed	997-01-BLK	1	$ 1,800.00	$ 1,800.00
Shelving, Storage, Wire, CRS, w/Adjustable Shelve	Uline	H-2945-54	1	$ 565.00	$ 565.00
Shelving, Storage, 77hx36wx18d	Steelton	465C1836KE5C	5	$ 360.00	$ 1,800.00
Hamper, Linen, Mobile, w/Lid	Global Industria	T9F436911	3	$ 220.00	$ 660.00
Container, Biohazard Waste, Step-on, Fire Safe	Uline	H-5191	11	$ 169.00	$ 1,859.00
Cabinet, Warming, F/S, 1 Heated Compartment, Elec	Owner Supplied	Blickman 7924TG	1	$ 10,230.00	$ 10,230.00
Distribution System, Medication, Automatic	BD Pyxis	2 Drawer	1	$ 44,843.00	$ 44,843.00
Scale, Weighing, ~~300~~ 750 Pound Capacity	Befour	MX808	2	$ 2,200.00	$ 1,430.00
Monitor, Vital Signs	GE Healthcare	V100	2	$ 4,160.00	$ 8,320.00
Otoscope/Ophthalmoscope, Wall Mounted	Welch Allyn	WLA-777-PM3WXX-US	2	$ 2,580.00	$ 5,160.00
Stand, IV, Adjustable	MEDSOURCE	MS-47100	9	$ 360.00	$ 3,240.00
Pump, Volumetric, Infusion, Multiple Line	BD Alaris	8100	9	$ 9,090.00	$ 81,810.00
Pump Modular	BD Alaris	8015	9	$ 1,500.00	$ 13,500.00
Syringe Modular	BD Alaris	8110	1	$ 2,250.00	$ 2,250.00
Stretcher, Chair- Transport or procedural	Hillrom	Transport or procedural	1	$ 12,000.00	$ 12,000.00
Wheelchair, Patient Transport, Folding	Medline		2	$ 290.00	$ 580.00
Table, Overbed	Hillrom or Stryker	T9F436965WN	8	$ 186.00	$ 1,488.00
Defibrillator, External, Automated (AED)	Zoll	AA-ZOLL-WC280-100-FA	1	$ 2,800.00	$ 2,800.00
Stand, Mayo	Medline	MPHM1621SS	10	$ 300.00	$ 3,000.00
Table, Examination, Treatment, Electro/Hydraulic	Midmark	646	2	$ 13,699.00	$ 27,398.00
Eyewash, Counter Top	Guardian Equipment	G1775	1	$ 350.00	$ 350.00
Refrigerator, 14 Cubic Feet	Frigidaire	FFHT1425VV	1	$ 980.00	$ 980.00
					$ 242,493.00

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

Figure 4: Oncology / Infusion Department

Equipment Description	Vendor	Model	Qty	Date Placed in Service	Reason for Replacement
Convertible Infusion chairs	Barton Medical Corporation	I-400	3	8/2/2011	These infusion chairs are 12 years old at present and are in disrepair requiring replacement.

Patient Monitor	Mindray DS	Passport V	1	8/15/2011	The patient monitors were replaced with a GE monitoring system. They are no longer in use and will be retired.
Alaris Infusion pumps	Carefusion	Alaris 1720	6	9/30/2016	These infusion pumps are 7 years old and will be obsolete by the time of project completion. With expanded capacity we will standardize the new pumps and replace the Alaris 1720.
Fluid Warmer	Enthermics	1139 246268	1	9/30/2010	The fluid warmer is 13 years old and beyond its average useful life, it requires replacement.
Blanket Warmer	Enthermics Medical Sys	12111 252351	1	8/30/2011	This blanket warmer is 12 years old and will be fully depreciated by the time of project completion. It will be replaced with a warming cabinet.

Figure 5: Pharmacy Department

Equipment Description	**Vendor**	**Model**	**Qty**	**Date Placed in Service**	**Reason for Replacement**
Compounding Hood	Nuaire	1548 277921	1	2/28/2015	This compounding hood does not meet USP specifications and is 8 years old. It requires replacement during the Pharmacy upgrade.
Rx Security System	Simplex Grinnell LP	11111 246708	2	10/26/2010	The pharmaceutical security system is fully depreciated and obsolete. It will be replaced by a drug safe during the Pharmacy upgrade.
Sharps Waste Disposal	Nuaire Inc	1010 241196	1	12/15/2009	The sharps waste disposal system is nearly 14 years old and beyond its useful life. It will be replaced during the Pharmacy upgrade.

Figure 6: Respiratory Therapy Department

Equipment Description	Vendor	Model	Qty	Date Placed in Service	Reason for Replacement
Stress Test System	Philips	275433 1500	1	10/31/2014	Our existing stress test system will be at end of life in 2024. As the Nuclear Medicine department will offer cardiac stress tests, we have decided to replace the old system and share the new system between Respiratory Therapy and Nuclear Medicine.

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

In both the lower floor pharmacy and infusion area and the upper floor imaging area the electrical systems are being replaced and supplemented to support the revised layout and use. Lighting, power, telecom, security, access control, nurse call, and paging systems are being modified in both areas. In the lower floor project area, a new electrical room with additional panels is being created to provide enough circuit space and load capacity to support this remodel. In the upper floor imaging area, a new power feeder is being provided to support the imaging equipment. Fire alarm and fire protection systems are being updated, modified, and supplemented to support the revised floor plans and change of use in these spaces.

HVAC work consists of extending existing services to the pharmacy and infusion areas, and gut and replace affected portions of systems serving the CT scan area. New specialty ventilation systems are needed for Laboratory type rooms in the pharmacy and in nuclear medicine. Building automation control for HVAC systems will also be extended, modified, and upgraded as needed.

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

Because this project involves only the re-programming or development of existing space, the main structural and framing elements are already in place. This phased project will require construction on 2 floors of the hospital; 1)a portion of the first floor's undeveloped, shelled in space, and 2)the second floor space currently occupied by Pharmacy, and Respiratory Therapy.

The structural design for this project includes a new SPECT/CT unit on the 2nd floor of the 1974 edition and some light structural work on the 2009 East Expansion (shelled in space) to replace the existing unreinforced concrete slab with a new slab on grade. The scope of work includes the design and engineering of a structural system that can support the weight and vibration requirements of the

SPECT/CT machine, as well as the necessary infrastructure for the unit which includes electrical, mechanical, and plumbing. To accommodate the new machine on the 2nd floor, a modified gravity structural system will be required. The layout of new equipment will require significant upgrades or modifications to the existing structure such as:

- Demolishing existing concrete floor decking and replacing with metal decking and new concrete
- Other structural modifications to support the Nuclear Medicine space may include duct relocation and concrete floor infill
- Ceiling, plumbing, HVAC, lighting, and other elements support by the second floor may be temporarily supported or removed and replaced/reinstalled after structural upgrades are complete

The scope of work for the 2009 East Expansion partial buildout includes the demolition of the existing slab and replacement with a structural slab on grade. In order to meet local building codes and regulations, the design must take into consideration the specific requirements of the Hospital, including available space, access to utilities, and the Hospital's overall structural integrity.

G. Total square footage in current facility/project.

Our current facility is comprised of 122,482 GSF which includes 9,683 GSF of 1st floor undeveloped, shelled in space and excludes the outside loading dock, the crawlspace, and the helipad.

H. Total square footage of proposed facility/project.

The overall GSF for the facility will not change after project completion, however the developed and usable square footage will increase due to partial build out of the undeveloped shelled in space. The overall project consists of approximately 1,671 SF of renovations to existing clinical space on the second floor, and 6,448 SF of new construction within the first floor shelled-in space.

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

Area for the Nuclear Medicine suite is 1,405 SF. Area for the new Pharmacy is 2,047 SF. Area for the Oncology / Infusion center is 4,401 SF. Area for the Reflection room is 176 SF and area for two public restrooms is 90 SF. There will be 5 new infusion bays in the Oncology suite, and one new SPECT / CT in the Nuclear medicine suite.

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

Approximately ninety-five percent (94.5%) of gross square footage is for direct service (i.e., usable space).

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

Additional service volume is expected in a number of different areas as a result of the addition of Nuclear Medicine, and due to trends in volume growth for Oncology/Infusion. We expect either new or continuing growth in each of the following areas:

1. **Nuclear Medicine** scans will increase in volume from 0 scans annually to as many as 251 scans annually in years 2 through 3 for this new service line (See **Figure 7**.). We believe that volumes will exceed not just those studies which are currently being performed elsewhere for South Kenai Peninsula Hospital Service Areas Residents, but also will capture many of the patients being lost in the Service Gap (31%).

   Secondary volumes occurring in tandem with the new service line include the ability to perform nuclear stress tests which could increase stress testing volumes (nuclear medicine enhanced) from 0 to 16 in years 2 through 3.

Figure 7: Nuclear Medicine Volume Projections

	Historical					Projections		
Projected Volumes	**2018**	**2019**	**2020**	**2021**	**2022**	**2025**	**2027**	**2032**
SPH Service Area Utilization	156	155	127	168	136	169	174	176
State of Alaska Utilization						245	251	254
					Service Gap Variance	**76**	**77**	**77**

2. **Oncology / Infusion** procedures are expected to increase as access to more services on the Southern Kenai Peninsula grows. The partnership with Central Peninsula Hospital to provide Oncology Physician services in Homer weekly, beginning in 2019 has significantly increased the volume of patients also receiving their Chemotherapy and Infusion services locally. That growth trajectory, while not as steep, is expected to continue into future years, supporting the need for expansion of our Oncology / Infusion center.

Figure 8: Infusion Services Volume Projections

	Historical						Projections		
Historical & Projected Volumes	**2018**	**2019**	**2020**	**2021**	**2022**	**2023***	**2025**	**2027**	**2032**
SPH Infusion Volume	946	972	1,147	1,621	1,626	2,260	2,480	2,636	2,905

3. Pharmacy doses are expected to increase as a result of volume growth in Oncology / Infusion as nearly 75% of patient visits to Oncology / Infusion require the dispensing of intravenous medications.

Figure 9: Pharmacy Chemo/Infusion Dose Projections

	Historical						Projections		
Historical & Projected Volumes	**2018**	**2019**	**2020**	**2021**	**2022**	**2023***	**2025**	**2027**	**2032**
Chemo/Infusion Doses	1,198	1,604	1,614	3,140	3,074	4,714	4,817	4,962	5,269

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

Five-year history

The proposed project is part of SPH's long range plan that was developed in 2023 and conceptualized in 2019 through the Facilities Master Planning Process. This project is part of a "phased" approach to expansion and infrastructure improvement to meet the current and future needs of the Southern Kenai Peninsula Hospital Service Area. Below is a list of major projects and improvements completed at SPH over the past five years:

2023 – SPH budgeted for a number of projects during FY2023, however many of those projects are in progress or have not yet been completed at this time.

2022 – SPH did not perform any expansion or major construction during this fiscal year due to the Covid-19 Pandemic, however we did successfully complete the following projects:

- minor renovations were made to an existing leased space for the purposes of administering Monoclonal Antibody Infusion treatments
- purchased a 3,800 SF building which it had leased for many years to ensure future clinical space needs were met
- replaced MRI Chiller to reduce MRI downtime for cooling
- replaced X-Ray Machine in Outpatient Orthopedic clinic
- purchased sleep lab equipment and assumed management of sleep program
- Purchased a 16-module Cepheid lab analyzer for Covid-19 and other respiratory test panels

2021 – SPH ended its capital freeze and worked diligently to catch up on projects delayed during the beginning of the pandemic, such as:

- completed construction and installation of CON approved CT Scanner upgraded to a 128-slice CT unit
- major infrastructure replacement and upgrade to the Hospital's Deaerator tank
- purchased a residence near the Hospital and converted it to Medical office space
- purchased OEC Medical C-Arm
- upgraded the HVAC to include an air purifying Ionizer system
- replaced one of three Anesthesia machines

2020 – SPH temporarily placed a hold on Capital projects spending at the end of the fiscal year due to the Covid-19 pandemic. Prior to the spending freeze, SPH:

- replaced its Patient monitoring systems throughout the hospital with GE monitors
- purchased new Philips Ultrasound equipment
- secured grant funding to purchase a new Siemens portable X-Ray machine for use in diagnosing Covid-19.

2019 – SPH staff turnover slowed progress on capital improvements, however we accomplished:

- major upgrades to the Nurse Call System
- replaced the Endoscopy system
- replaced the Zoll Defibrillators

2018 – SPH completed two major bond funded projects during the year and accomplished:

- expansion of our outpatient Family medicine clinic
- upgraded the HVAC in our Operating Room
- Upgraded our Digital Radiology equipment

Facilities Master Plan

In December 2021, South Peninsula Hospital and the Kenai Peninsula Borough (KPB) contracted with Architects Alaska to create a Facilities Master Plan (FMP). The FMP is a conceptual tool that SPH and KPB can use to identify and prioritize the future projects necessary to meet current and future patient care needs on the Southern Kenai Peninsula. The Final FMP report was issued on April 12, 2023.

The SPH Nuclear Medicine and Pharmacy/Infusion Colocation Project not only provides additional healthcare services to the residents of the Southern Kenai Peninsula, but it also meets several long-term master planning goals identified in our FMP (SEE APPENDIX, Item 2.):

- Utilization of the existing Core and Shelled Space
- Consolidation of multiple services currently located around and off campus
- Completion of Pharmacy Upgrades & Compliance requirements
- Provision of better campus wayfinding and entry points

In accordance with these FMP priorities: a) these improvements will use approximately 67% of the Shelled Space built during the 2007/2008 construction of a new acute care wing. The use of this pre-built, unfinished space offers significant efficiency and cost savings, b) the colocation of Oncology/Infusion into the main Hospital building offers significant convenience to patients and staff as well as improvements to quality and safety, c) the relocation of the Pharmacy will allow SPH to design a space that meets USP guidelines for safe pharmaceutical compounding, and d) the proposed Nuclear Medicine location is in the main corridor across from our other SPH Imaging modalities, making patient

wayfinding and staff workflows more seamless and convenient. Additionally, the Oncology/Infusion Department will have its very own entrance on the first floor with convenient, close parking, as well as a direct entry point from the main elevator leading to the second floor.

2008 Certificate of Need

The relocation of the Pharmacy Department will require a partial build out of the first-floor location known as *the shelled space* which was the subject of a previous Certificate of Need (CON) issued on April 1, 2008. Additionally, the Oncology/Infusion Department shall be re-located from its current off-site building into the adjacent first floor shelled space beside the Pharmacy. In this CON, Commissioner Karleen Jackson, PhD indicated that:

> "*The 9,683 square foot of shelled in first floor area located below the new acute care wing must have Certificate of Need staff review prior to any use of the area*".

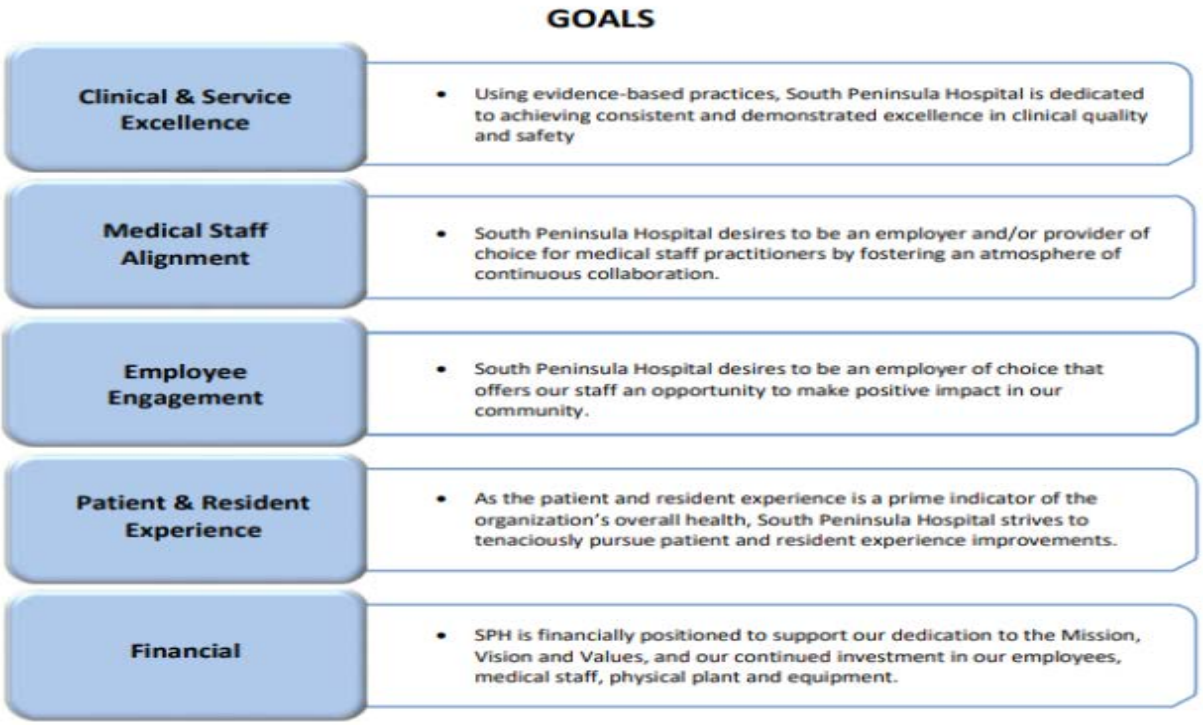
This multi-phase project requires the improvement and use of a portion of the shelled space identified above and as such we will describe each of the project phases and impacts in the scope of this Certificate of need. The total proposed square footage of shelled in first floor space included in this CON is approximately 6,448 SF.

While the addition of a Nuclear Medicine Service line is the primary goal of this CON, there are two equally important secondary goals which will be addressed through this multi-phase project.

SPH Strategic Plan

SPH's strategic plan was updated in 2021 to better reflect its commitment to the Mission and Vision of the organization. Our goals listed below support the need for growth, expansion of service, and the achievement of clinical excellence:

Figure 10: South Peninsula Hospital Strategic Plan



The SPH Nuclear Medicine Expansion and Pharmacy / Infusion Colocation Project will meet each of the Strategic goals defined above in the SPH Strategic Plan while also meeting some of the Master Facility Planning Targets. Below is a brief description of how this project will meet our strategic goals:

Clinical & Service Excellence
SPH is committed to using evidence-based practice for the diagnosis and treatment of disease in our patients, as well as the continuous improvement of quality and safety in our patient care.

The addition of Nuclear Medicine services to the array of imaging services at SPH, will improve the accuracy and quality of diagnoses for organ dysfunction, heart conditions, cancer, hyperthyroidism. Not only can Nuclear medicine identify the location of certain cancers down to the millimeter, when combined with CT it can show active 3D imaging of body structures. Nuclear medicine is the standard of care for many diseases, and as such meets our Clinical Excellence goals.

Medical Staff Alignment
SPH Medical Staff are an integral part of the strategic planning and operation of our Hospital. The Board of Directors, Administration, and Medical Staff collaborate to ensure the SPH is able to provide the highest quality care to our Service Area residents. During 2018, our Medical Staff requested the addition of Nuclear Medicine in order to better diagnose and treat our patients. Further, after the pandemic Medical Staff repeatedly communicated the need to return our Oncology / Infusion Center back into the main Hospital building for Patients, Staff, and Provider quality, safety, and satisfaction.

Employee Engagement

The engagement of our staff to the mission and vision of SPH is vital to the continued success of our recruiting and retention. SPH staff are not only providing patient care, they are also receiving it. Nearly 80% of our Employee Health claims are services performed at SPH facilities. The increase in service line growth, such as Nuclear Medicine will directly impact the care our employees are able to receive themselves. In addition, the improvement of care by upgrading our Pharmacy for staff safety and increasing our capacity to care for Oncology / Infusion patients also directly impacts the health and safety of our staff.

Patient & Resident Experience

The addition of Nuclear medicine will have a significant impact on patient experience by reducing barriers to receiving high quality, evidence based diagnostic care. Currently residents of the South Kenai Peninsula must travel upwards of 76 miles in order to obtain a Nuclear Medicine scan. This geographic distance is estimated to have caused a service gap of nearly 31% in studies ultimately performed due to convenience, immobility, transportation, environmental factors, or other reasons. The provision of nuclear medicine scans at SPH will mean that more patients who need this specialty service will actually receive it, improving health outcomes.

The expansion and colocation of Pharmacy and Oncology / Infusion will impact the patient and resident experience by combining the service location with the areas which support it most. Nearly 75% of Infusion patients receive pharmaceuticals during their treatments and the growth of our Oncology service line has averaged nearly 20% per year since 2018. The isolation of the Oncology / Infusion center in a separate building below the main Hospital has made the transport of pharmaceuticals difficult between the two locations and delayed patient care. The new Oncology / Infusion location in the first-floor shelled space will be convenient for both patients, visitors, and staff, as it lies adjacent to the Pharmacy, and just downstairs from the lab and imaging services used by this patient population.

Financial

SPH's financial goals require continuous investment in our Medical providers, staff, patients, and capital infrastructure. This project is a significant investment in the improved quality and capacity for health care available to our community. Further, this investment demonstrates our commitment to medical staff by providing the tools they need to offer the highest quality diagnoses and treatments to our patients.

Section IV.

Narrative Review Questions

A. RELATIONSHIP TO APPLICABLE PLANS AND NATIONAL TRENDS

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

Overview

The proposed project is not at variance with any known state, regional or local plans or guidelines according to research performed by DHSS, Division of Public Health, or Certificate of Need standards and methodologies.

Consistency with Local and Regional Plans

South Peninsula Hospital (SPH) is a critical access hospital with 9 ER beds, 3 birthing center beds, 19 acute care beds, a co-located 28-bed Long Term Care unit, and numerous ancillary clinics and medical offices.

As a full-service hospital and health system, SPH serves the general Southern Kenai Peninsula (SKP) community, regardless of age, sex, income-level or geographic location within the service area. Some significant populations within the SKP community include: families and children, people age 45 or older, and low-income individuals and families. Through the E.R., Primary care, Home Health, Nursing Home and Specialty clinic, the organization serves individuals from all populations.

As of 2020, the population of the Southern Kenai Peninsula (the SPH service area) was 15,029 people, living in 16 communities.

- These communities range in size from 86 to more than 5,400 people[2].
- The communities of Homer, Fritz Creek, and Anchor Point are home to 65 percent of the service area population.

1 Kachemak Selo, Razdolna, and Voznesenka are not tracked individually, but are included in the Fox River community values.
2 Alaska Department of Labor and Workforce Development Population Estimates
3 2020 Census Estimates, United States Census Bureau

The hospital is the result of a unique partnership between the Kenai Peninsula Borough (service-area tax support for the facility and capital investments), City of Homer (for the land), and SPH, Inc., (the non-profit organization which operates the hospital). The hospital is governed by an eleven-member Board of Directors. An elected Service Area Board provides public recommendation on capital spending with tax dollars and scope of services. The hospital employs over 550 local residents, and is the area's largest employer, contributing over $50,000,000 annually into the local economy in payroll alone. That,

combined with service contracts, materials acquisition and leases, creates significant impact to the southern peninsula's economic well-being. Some ancillary project funding is provided through grants, the South Peninsula Hospital Foundation, Inc. and the South Peninsula Hospital Auxiliary.

Local SPH Planning

The 2022-2023 SPH Community Health Needs Assessment is in the final drafting stages and as such it was consulted but not officially referenced herein. The 2019-2020 South Peninsula Hospital Community Health Needs Assessment (SPH CHNA) assesses the health needs of the South Kenai Peninsula Hospital service area, which is generally the Southern Kenai Peninsula (SKP). The study meets Internal Revenue Service requirements under Section 501(r)(3)(A) to conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.

Significant health needs were identified for the SPH service area based on results of the 2019 -2020 Perceptions of Community Health Survey and an evaluation of health status indicators drawn primarily from the Healthy Alaskans 2020 Leading Health Indicators. The Mobilizing to Action though Planning Partnership (MAPP), the Southern Kenai Peninsula Health Coalition Steering Committee supported the development of the CHNA and utilizes its results in the implementation of health improvement initiatives. The hospital's governing Board adopted the report on June 24, 2020 and an implementation strategy was published in December 2020, found here on the hospital's website.

In the SPH CHNA Implementation Strategy are several Health Priorities which include; 1) Health needs of an aging community, and 2) Strengthen primary and preventative care. These health needs were prioritized largely based on the health trends revealed by the current health status indicator data. Individual strategies which were devised to meet these priority findings that are met by this CON project include:

Health Needs of an Aging Community

- Specialty provider retention and recruitment - (Nuclear medicine technician, Radiologist)
- Strengthen senior based services, including but not limited to outpatient surgery, rehabilitation, swing bed, home health, etc. - (Additional volume/capacity building in Oncology / Infusion Center and Nuclear Medicine studies to support the aging demographic of the Southern Kenai Peninsula)
- Explore alternative funding opportunities such as grants and other means based programs to support equipment and service needs of the growing senior population - (Bond funding, Philanthropy, Grants, Local funds, and Operating funds are all being explored to support this CON)
- Secure space and facilities to support service growth - (building out the shelled in space and investing in current facilities)

Strengthen Primary and Preventative Care

- Access to Care – Review and ensure our services meet the residents where the need is – (Aging demographic and senior care require the use of advanced imaging capabilities as well as capacity growth in our Oncology / Infusion Center)

Facilities Master Plan

In addition to the CHNA (2020), related CHNA Implementation Strategy (2020), and Hospital Strategic Plan (2021-2022), SPH recently completed a Facilities Master Plan (FMP 2022-2032) supporting the needs in this request. The FMP outlines priorities and potential approaches for delivering gaps in care to our community over the next 10 years. The FMP Steering Committee was comprised of a multi-agency stakeholder group which included membership from the Kenai Peninsula Borough (KPB), KPB Assembly, South Kenai Peninsula Hospital Service Area Board, South Peninsula Hospital Operating Board, South Peninsula Hospital Leadership, and the City of Homer. As noted previously, this CON project meets 4 of the 9 Priority level findings. Those 4 priorities are:

#1 Utilize existing Core and Shell Space
#2 Consolidate multiple services currently located around and off Campus
#7 Pharmacy Upgrades & Compliance
#9 Provide better campus wayfinding and entry points

(See Appendix: Item 2)

This review process is also consistent with SPH's Mission:

South Peninsula Hospital promotes community health and wellness by providing personalized, high quality, locally coordinated healthcare.

Due to the community emphasis, and the nature of bond-fund propositions, any major proposed project at SPH will always involve a broad range of stakeholders and unlike many hospitals – a thorough public vetting process. Should we use Hospital Plant Replacement and Expansion Funds, Philanthropic Support, or Grant Funds, those too will go through a multi-level approval process which includes Hospital leadership, SPH Board of Director approval, Service Area Board approval, Kenai Peninsula Borough Assembly approval, and potentially Grantor or Donor approval groups.

State of Alaska Planning

The Division of Public Health's 2022-2025 Strategic is based upon the principle: "Ensure that all Alaskans have full and equal access to opportunities to lead healthy lives." (AKDHSS, Dec. 2021) The state's commitment toward quality healthcare focuses on groups that are underserved, excluded, or marginalized due to geography, infrastructure, resources, education, housing, barriers to access, and community conditions. The SPH Nuclear Medicine addition, Pharmacy upgrade, and Infusion

expansion and colocation project meeting the State of Alaska's proposed strategic plan to expand and provide quality healthcare services to our geographically isolated and resource restricted community members.

National Healthcare Planning

The Center for Disease Control (CDC) issued its 2022-2027 Strategic Plan which aligns with that of the State of Alaska's commitment to health equity and diversity (https://www.cdc.gov/about/strategic-plan/index.html).

Two of the CDC's strategic initiatives which are met by this CON Project include:

- Putting science and advanced technology into action to prevent disease
- Tackling health problems causing death and disability for Americans

CON Standards and Methodologies

Services required to meet specific CON review standards in the proposed project include new Diagnostic Imaging Services (Nuc Med/SPECT/CT). Section VII of the Alaska Certificate of Need Review Standards and Methodologies adopted December 9, 2005 does not contain review methodologies for other services proposed e.g. relocating existing services within the hospital or to off campus locations.

B. DEMONSTRATION OF NEED

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

(a) New Service:

- **Nuclear Medicine** – the problems being addressed by this new service line addition are three-fold:
    1. *Deficit in Technology for patient diagnosis and treatment of certain diseases* – medical providers and patients of the Southern Kenai Peninsula do not have local access to standard diagnostic technology necessary to diagnose and treat diseases of the organs, certain types of breath and thyroid cancers, certain cardiac health issues, neurological abnormalities and more.
    2. *Delayed care for diagnosis and treatment* – patients of the Southern Kenai Peninsula who require a Nuclear medicine exam are required to schedule those services in Soldotna or Anchorage (76 to 160 miles away). Due to seasonal road conditions, reliability of transportation, scheduling constraints, employment limitations and more, the delay in care and treatment can be costly in terms of patient health outcomes.

3. *Gap in Service* – while similar to the problem address in "2." above, a gap in service measures the number of patients for which transportation, time constraints, immobility, or healthcare stability are barriers too great to surpass and as such Nuclear medicine studies are recommended but never performed. Based on state and national averages per capita, we believe the Service Gap for the Southern Kenai Peninsula is approximately 31%.

(b) Expanded Service

- **Expansion and Colocation of Oncology / Infusion Center** – the problems being addressed by this service line expansion and co-location addresses several facility, staff, and patients problems:
    1. *Capacity* – as described previously, the Oncology / Infusion Center volumes have experience tremendous growth in the past 5 years (176%) due to better coverage provided through a partnership with Central Peninsula Hospital's Oncology group. The number of infusion chairs and space is restricted to a maximum of 5 patients and only 1 of those 5 are in a private room. We have reached our current capacity in the 960 square foot offsite building.
    2. *Patient Quality, Safety, and Satisfaction* – SPH performs chemotherapy treatments in its Oncology / Infusion Center which require the implementation of patient safety and quality best practices to protect this often frail and vulnerable population. Access from parking to door, parking lot safety, staff to patient ratios, and overall environment of care are problems which will be solved by the colocation of the Center into the main hospital building. Additionally, access to swift Rapid Response team personnel for patient emergencies will be significantly enhanced by the co-location of the Oncology / Infusion Center into the core of the main Hospital building.
    3. *Staff Safety and Satisfaction* – Oncology / Infusion staff have repeatedly voiced their concerns about the offsite location of the department due to inefficiencies and delays in treatment while they transport pre-infusion lab specimens, gather infusion and chemotherapy supplies, pharmaceuticals, and other department needs from the main building. Food and nourishment are also located in the main building. Finally, inclement weather during the winter and shoulder seasons can create hazardous or uncomfortable walking conditions between the department and the main building.

(c) Upgrade of Existing Service

- **Pharmacy Upgrades** – the problems being addressed by the upgrade of our pharmacy
    1. *Compliance* – This CON project will allow the SPH Pharmacy to meet USP General Chapters 797 and 800 regarding the building requirements for drug compounding and the safe handling and disposal of hazardous materials.

2. *Staff Safety and Satisfaction* – The drug compounding and hazardous materials standards outlined by the US Pharmacopeia have very real staff safety protocols which will keep our team safe from breathing or ingesting unsafe substances or gases. Further, this project will also improve staff satisfaction which is impaired due to the complexity and time lost transporting infusion and chemotherapy supplies in and out of the building by both Pharmacy and Oncology / Infusion staff.
3. *Patient Satisfaction* – The new Pharmacy location next to Oncology / Infusion will result in higher patient satisfaction due to the reduction in wait times for infusion supplies which must be transported between the two departments.

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

Construction of a Nuclear Medicine Department and expansion of our Oncology / Infusion Center fills an unmet need as well as increasing demand for diagnostic imaging services and increased Cancer care for the 15,000+ residents in the South Kenai Peninsula Hospital Service Area. Providing these services expands the diagnostic portfolio of tests that are available locally to identify abnormalities and diseases of the heart and other organs, as well as needed capacity for treating malignant neoplasms (Cancer).

Due to the aging and growing population, these are service lines that have an increased utilization projections over the next 3, 5 and 10 years (*see figure 18*).

The projected volumes in 2025 of 170 – 245 Nuclear Medicine volumes per year is a high enough productivity that quality and/or efficiency standards will not be an issue (*see figure 29*).

With regard to additional Infusion bays, there has been significant volume increases that continue to project out into the future which further emphasizes the need to expand the service to allow for consolidated growth to occur within the infusion center. The projections in 2025 are 2,480 infusions per year. (*see figure 30*).

Mortality and Leading Causes of Death

The leading causes of death in the Southern Kenai Peninsula area since 2000 are Cancer and Heart Disease.

Figure 11: Southern Kenai Peninsula Leading Causes of Death by Year, 2000 – 2021

Year	Rank	Cause of Death	Deaths
2000	1	Diseases of Heart	23
	2	Cancer	17
	3	Cerebrovascular Diseases	6
	4	Alzheimer Disease	<6
	5	Chronic Lower Respiratory Diseases	<6
2001	1	Cancer	14
	2	Diseases of Heart	14
	3	Cerebrovascular Diseases	7
	4	Accidents	7
	5	Chronic Liver Disease and Cirrhosis	<6
2002	1	Diseases of Heart	21
	2	Cancer	13
	3	Cerebrovascular Diseases	<6
	4	Alzheimer Disease	<6
	5	Chronic lower respiratory diseases	<6
2003	1	Diseases of Heart	19
	2	Cancer	12
	3	Accidents	10
	4	Alzheimer Disease	<6
	5	Diabetes Mellitus	<6
2004	1	Cancer	12
	2	Diseases of Heart	9
	3	Cerebrovascular Diseases	<6
	4	Accidents	<6
	5	Diabetes Mellitus	<6

Year	Rank	Cause of Death	Deaths
2011	1	Diseases of heart	23
	2	Cancer	16
	3	Chronic lower respiratory diseases	10
	4	accidents	6
	5	Intentional self harm	<6
2012	1	Diseases of heart	27
	2	Cancer	23
	3	Alzheimer's diseases	8
	4	Diabetes mellitus	7
	5	Intentional self harm	7
2013	1	Cancer	30
	2	Diseases of heart	22
	3	Accidents	13
	4	Alzheimer's diseases	8
	5	Cerebrovascular diseases	7
2014	1	Cancer	40
	2	Diseases of heart	23
	3	Accidents	11
	4	Alzheimer's diseases	<6
	5	Cerebrovascular diseases	<6
2015	1	Cancer	36
	2	Diseases of heart	34
	3	Accidents	13
	4	Cerebrovascular diseases	8
	5	Intentional self harm	<6

Year	Rank	Cause of Death	Deaths
2005	1	Diseases of Heart	13
	2	Cancer	9
	3	Accidents	9
	4	Alzheimer Disease	<6
	5	Cerebrovascular Diseases	<6
2006	1	Cancer	21
	2	Diseases of heart	15
	3	Accidents	10
	4	Chronic Lower Respiratory Diseases	7
	5	Alzheimer's Diseases	<6
2007	1	Cancer	25
	2	Diseases of heart	10
	3	Accidents	<6
	4	Cerebrovascular diseases	<6
	5	Influenza and Pneumonia	<6
2008	1	Diseases of heart	20
	2	Cancer	12
	3	Accidents	6
	4	Diabetes Mellitus	<6
	5	Intentional self -harm	<6
2009	1	Cancer	29
	2	Diseases of heart	23
	3	Chronic lower respiratory diseases	8
	4	Chronic liver diseases and cirrhosis	<6
	5	Diabetes mellitus	<6
2010	1	Diseases of heart	26
	2	Cancer	19
	3	Intentional self harm	<6
	4	Accidents	<6
	5	Chronic liver diseases and cirrhosis	<6
2016	1	Cancer	33
	2	Diseases of heart	31
	3	Accidents	10
	4	Cerebrovascular diseases	8
	5	Alzheimer's disease	7
2017	1	Cancer	34
	2	Diseases of heart	32
	3	Accidents	11
	4	Intentional self harm	6
	5	Diabetes mellitus	<6
2018	1	Cancer	37
	2	Diseases of heart	29
	3	Cerebrovascular diseases	8
	4	Accidents	8
	5	Chronic liver diseases and cirrhosis	7
2019	1	Cancer	39
	2	Diseases of heart	27
	3	Chronic lower respiratory diseases	9
	4	Accidents	9
	5	Cerebrovascular diseases	8
2020	1	Cancer	30
	2	Diseases of heart	30
	3	accidents	9
	4	Diabetes Mellitus	8
	5	Cerebrovascular diseases	8
2021	1	Diseases of heart	38
	2	Cancer	37
	3	Covid-19	25
	4	Accidents	11
	5	Diabetes Mellitus	10

Data Source: Alaska Department of Health

Figure 12: Southern Kenai Peninsula Leading Causes of Death – Cumulative, 2000-2021

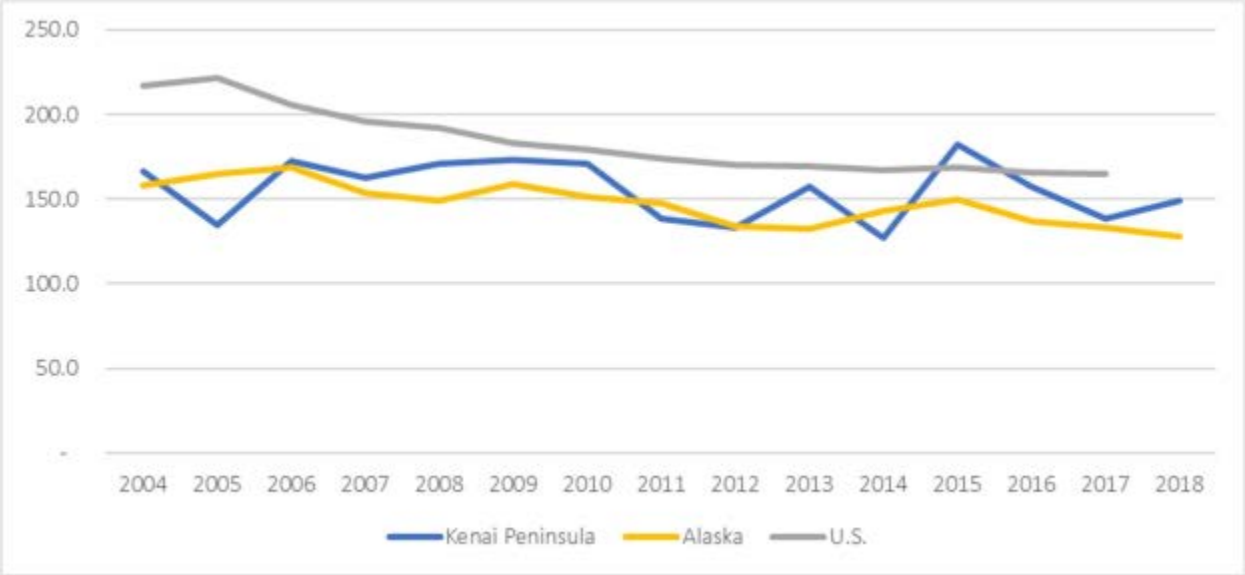
Cause of Death	Deaths
Malignant neoplasms	538
Diseases of heart	509
Accidents	161
Cerebrovascular diseases	90
Alzheimer's Diseases	59
Diabetes mellitus	55
Chronic lower respiratory diseases	46
Intentional self harm	31
Covid-19	25
Chronic liver diseases and cirrhosis	25
Influenza and Pneumonia	6

Data Source: Alaska Department of Health

Heart Disease Mortality Rate

Heart disease is not a single disease, but rather multiple diseases with different causes, risks, and potential interventions. Heart diseases include coronary heart disease, rheumatic heart disease, ischemic heart disease, hypertension, pulmonary heart diseases, heart failure, heart valve disease, cardiomyopathy, and other heart conditions.

Figure 13: Heart disease mortality rate per 100,000 (age-adjusted), 2004-2018



	2004	2005	2006	2007	2008	2009	2010	2011
Kenai Peninsula	166.6	135.0	172.8	162.4	170.9	173.0	171.2	138.8
Alaska	157.9	164.7	169.0	153.6	149.4	159.2	151.3	147.8
U.S.	216.8	221.6	205.5	196.1	192.1	182.8	179.1	173.7

	2012	2013	2014	2015	2016	2017	2018
Kenai Peninsula	133.3	157.4	127.5	182.0	157.4	138.7	149.3
Alaska	134.2	132.2	142.9	149.6	136.7	133.4	128.0
U.S.	170.5	169.8	167.0	168.5	165.6	165.0	**

Data Sources: Kenai Peninsula and Alaska data from the Health Analytics and Vital Records Section (HAVRS), Division of Public Health, Alaska Department of Health and Social Services. U.S. data from the National Vital Statistics System, National Center for Health Statistics, U.S. Centers for Disease Control and Prevention. State and U.S. figures retrieved on 03/30/2020 from Alaska Department of Health and Social Services, Indicator-Based Information System for Public Health (AK-IBIS) website: http://ibis.dhss.alaska.gov/.
Notes: Mortality rates are age-adjusted to the 2000 U.S. standard population. ICD-10 codes I00-I09, I11, I13, I20-I51.
"**" indicates that data are not available.

The most common form of heart disease is coronary heart disease (CHD), also known as coronary artery disease. CHD is the largest contributor to death from heart disease. Because certain types of heart disease have a long latency period, years might pass before changes in behavior or clinical practice affect heart disease mortality. Certain types of heart disease (e.g., heart valve disease) are not amenable to primary prevention or screening, but most heart diseases can be affected by lifestyle behaviors and

health status.[10] Modifiable risk factors for CHD include behaviors (e.g., tobacco use, physical inactivity, and improper nutrition), health status (e.g., hypertension, hyperlipidemia, overweight, or diabetes), and policies (e.g., smoking policies in restaurants and worksites).[11] Substantial differences in CHD death rates and preventive measures exist by race, age, sex, place of residence, and other demographic factors.[12]

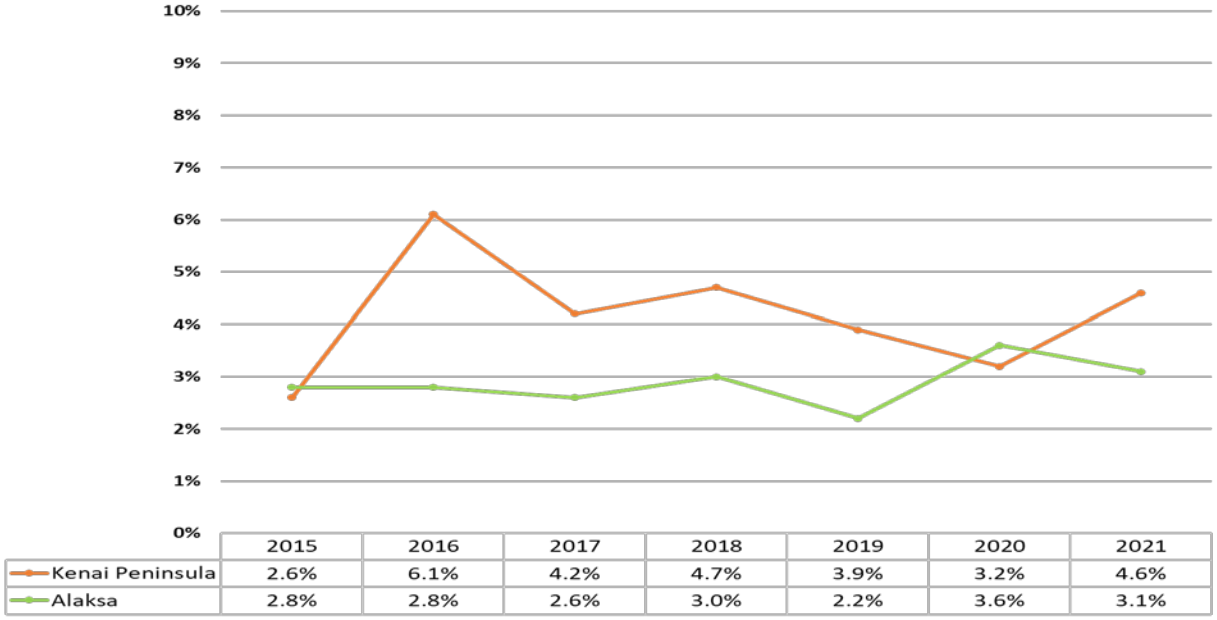
[10] U.S. Centers for Disease Control and Prevention (CDC). Chronic Disease Indicators. http://www.cdc.gov/cdi/. Updated January 15, 2015. Accessed October 6, 2016.
[11] Fryar CD, Chen T, Li X. Prevalence of uncontrolled risk factors for cardiovascular disease: United States, 1999 2010. NCHS Data Brief 2012;103:1-8.
[12] Mozaffarian D, Benjamin EJ, Go AS, Arnett, DK, et al. Heart disease and stroke statistics-2015 update: a report from the American Heart Association. Circulation 2015;131:e29-e322.

Figure 14: Cardiac Risk Factors

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

In addition, the 2023 Draft CHNA indicates that Kenai Peninsula residents are reporting a significant increase (12%) and possible upward trend for those **diagnosed** with any heart disease. Further, in 5 of the last 7 years residents of the Kenai Peninsula showed a higher rate of CHD than other residents of the State of Alaska:

Figure 15: Coronary Heart Disease, 2015-2021



	2015	2016	2017	2018	2019	2020	2021
Kenai Peninsula	2.6%	6.1%	4.2%	4.7%	3.9%	3.2%	4.6%
Alaksa	2.8%	2.8%	2.6%	3.0%	2.2%	3.6%	3.1%

Source: Alaska Behavioral Risk Factor Surveillance System Survey

Multiple Community Health Needs Assessments (CHNA) have demonstrated the need from service area residents for specialty services. The 2020 CHNA summary demonstrates a need for more primary, local care close to home.[1].

KPB Service Needs

The following significant health needs were identified for the SPH service area based on quantitative and qualitative data about the health status of the Southern Kenai Peninsula (SKP) population. Quantitative health status data was drawn primarily from the Healthy Alaskans 2020 25 Leading Health Indicators. Qualitative data are from the 2019-2020 Perceptions of Community Health Survey, which asked respondents to report the factors that most affect the health of themselves, their family and community.

The SPH Board of Directors reviewed the 2020 CHNA data from a sample of 469 service area residents. The following significant health needs were identified by South Peninsula Hospital as priorities to address over the next few years:

- COVID-19 Response
- Senior Health
- Primary and Preventative Care

These health needs were prioritized largely based on the health trends revealed by the current health status indicator data. Overall, the health status data for the SKP suggests that the most significant health needs are for 1) increased and/or improved elder care services, and 2) increased and/or improved preventative and lifestyle care, including community health initiatives. Although preventative and lifestyle care were identified as key areas for improvement, it should be noted that the SKP generally met most health targets. Data for health indicators at the SKP level are nearly always more variable from year-to-year because of its smaller population (and therefore sample size) compared to other geographies, but over time, the general trends often mirror state and national trends and levels.

Senior health was determined as a significant health need because seniors make up a significant and growing population within the Southern Kenai Peninsula, and health care service levels often increase with age. Through the 2020 Community Perceptions of Health Survey, five percent of question responses identified elder care as one of the Southern Kenai Peninsula's greatest weaknesses. The 65 and over age group currently represents 18 percent of the SKP population. This group has been growing as a proportion of the overall SKP population, with a corresponding decrease in the population of the 45-64 age group.[19] With these population dynamics, the SKP has a higher median age than the borough, state or nation. The 65 and over age group is projected to continue to increase through about 2030 in the Kenai Peninsula, then level off through 2045. Within this age group, state projections show the majority

[1] *https://www.sphosp.org/wp-content/uploads/2022/05/2019-2020_SPH_CHNA_FINALcorr.pdf*

of elders between ages 65 and 74 through 2030. After 2030, the majority of elders age into the 75 to 84 age range, and the population aged 85 and older continues to grow through 2045.[20] A similar pattern is anticipated in the Southern Kenai Peninsula.

Resources to Address Senior Health

South Peninsula Hospital will be better positioned to address the health needs of our growing Senior population who are primary users of Nuclear Medicine. It is in the best interest of our Service Area to provide as many community health services as possible locally to ensure access for our vulnerable populations. We believe the primary reason for our 30-40% Service gap in Nuclear Medicine studies is due to mobility and transportation for our Senior population. This CON aligns with the strategic work that SPH has deployed to expand specialty care services for its service members.

Increasing demand: changing demographics

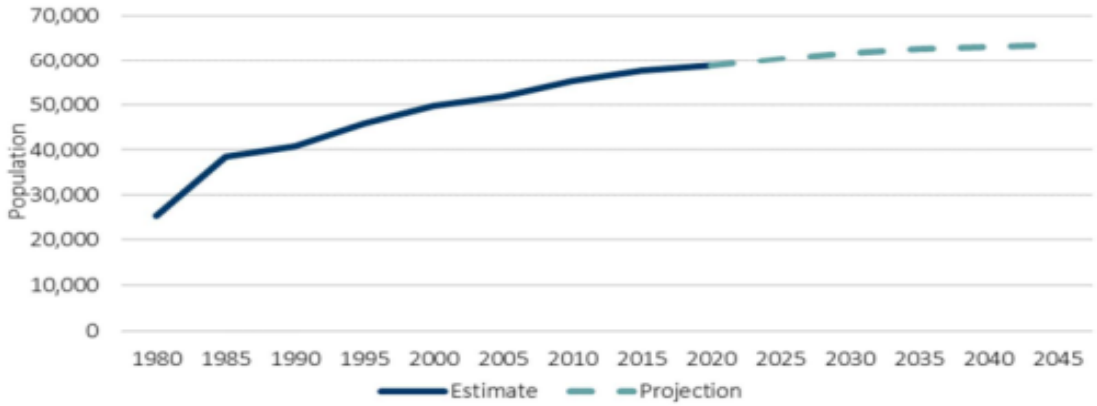
The percentage of seniors (age 65 and older) on the Kenai Peninsula is midstream of a large growth cycle. Because seniors are heavy utilizers of healthcare services, these projections create urgency to respond to increasing demand for services such as Oncology and Advanced imaging. Increasing locally available services provides appropriate and timely care delivery for a vulnerable population.

Figure 16: KPB 65+ Age Projected Growth

Projected Population Trends

Population projections are only available at the Kenai Peninsula Borough (KPB) level. The State of Alaska projects that the KPB's population will continue to grow over the next twenty years, surpassing 63,000 people by the year 2040.[5] Within this overall projected population growth, the trend established since 2010 of a smaller decrease in middle-age residents (age 45-64) with a marked increase in older residents (aged 65 and above) is anticipated to continue.

Figure 5. Kenai Peninsula Borough Population Projections, 1980-2045



According to the Deloitte Center for Health Solutions, seniors (defined as 65 and older) account for 36% of total health care costs. When added to the "Baby Boomer" generation which began retiring in 2011,

seniors and baby boomers combine for a sixty-four percent share of total health care spending.[2] A July 2011 Data Brief on health care spending shows that 5 percent of Americans are responsible for nearly half (47.5%) of all health care spending in the United States. [3] A principal reason why higher health care spending occurs among seniors is due to the fact that nearly half (45%) are suffering from two or more chronic conditions. [4]

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

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

This project seeks to relocate Pharmacy so that it may become USP compliant. Pharmacy compliance is needed for USP General Chapters 797 and 800. Chapter 797 applies to Sterile Compounding while Chapter 800 applies to Hazardous Drug (HD) Compounding. Regulations have become more stringent since the 2018 regulations were published, which has rendered many existing pharmacies non-compliant. Due to the significant capital costs to become compliant and the financial and resource challenges posted by the Covid-19 pandemic, this regulatory requirement has been postponed several times. Currently, Pharmacies are required to be compliant with the USP regulations by November of 2023. The Pharmacy upgrade phase of the CON project will consist of additional footprint, specialized construction, a dedicated HVAC system and new hoods to complete the classified spaces.

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.

As a full-service hospital and health system, South Peninsula Hospital provides care for the Southern Kenai Peninsula (SKP) community, regardless of age, sex, income-level or geographic location within

[2] *"The hidden costs of U.S. health care for consumers: A comprehensive analysis March 2011"*

[3] *"Understanding U.S. Health Care Spending," NIHMC Foundation Data Brief July 2011*

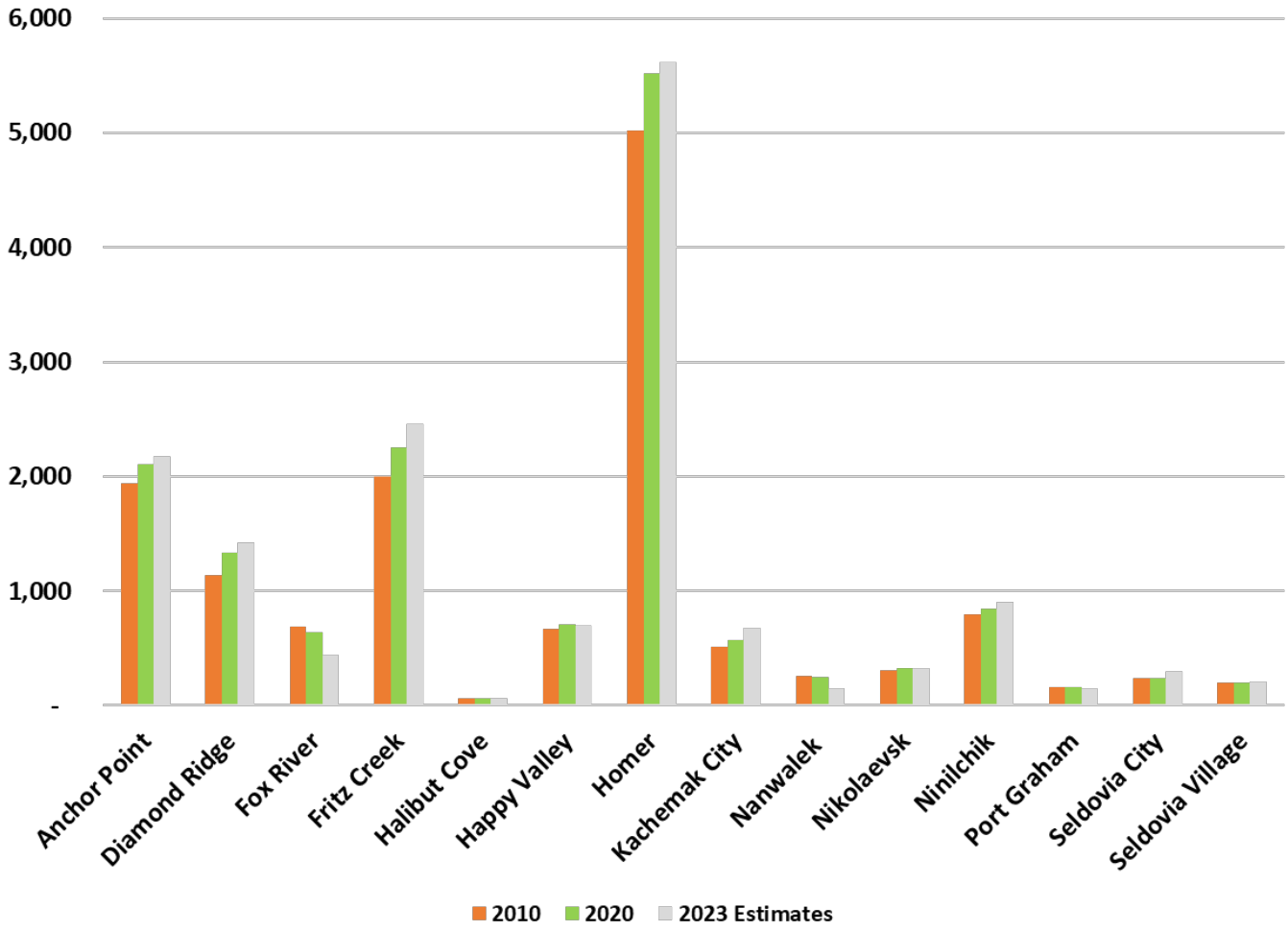
[4] *"Multiple Chronic Conditions Among Adults Aged 45 and Over," Centers for Disease Control 2012*

the service area. Some significant populations within the SKP community include: families and children, people age 45 or older, and low-income individuals and families. Through the E.R., primary care, V.A. clinic, Home Health, Nursing Home and specialty clinic, the organization serves individuals from all populations.

Current Population

As of 2023, the population of the Southern Kenai Peninsula (the SPH service area) is estimated to be 15,575 people, living in 16 communities summarize in the 14 communities below. These communities range in size from 59 to more than 5,600 people. The communities of Homer, Fritz Creek, and Anchor Point are home to 66 percent of the service area population.

Figure 17: Southern Kenai Peninsula Population by Community, 2010, 2021 and 2023 estimates

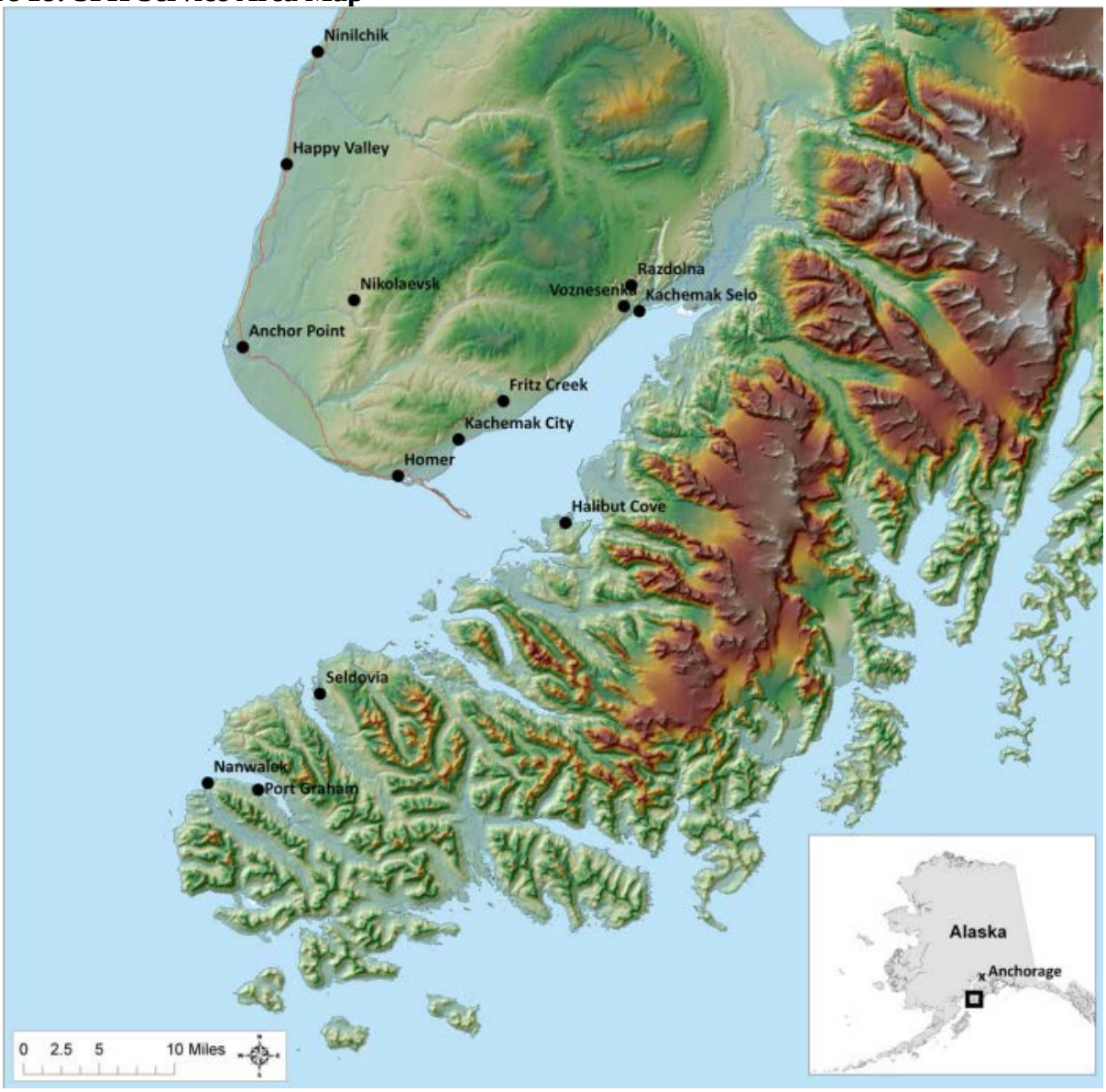


Source: Claritas Environics, Alaska Department of Labor

The communities served by the SPH are illustrated in the map below which includes the Southern Kenai Peninsula communities of Anchor Point, Diamond Ridge, Fox River, Fritz Creek, Halibut Cove, Happy Valley, Homer, Kachemak City, Kachemak Selo, Nanwalek, Nikolaevsk, Ninilchik, Port Graham,

Razdolna, Seldovia and Voznesenka. All of SPH's service area falls within the Kenai Peninsula Borough.

Figure 18: SPH Service Area Map



Source: 2023 Draft South Kenai Peninsula Hospital Community Health Needs Assessment

The service area was created by zip code boundaries within the Kenai Peninsula Borough. The most recent population estimates (primary service area) are shown in the following table.

Figure 19: Primary Service Area Population 2010-2023

	2010		2015		2020		2023 est.	
	Population	**% Change (2005-10)**	**Population**	**% Change (2010-15)**	**Population**	**% Change (2015-20)**	**Population**	**% Change (2020-23)**
Anchor Point	1930	7%	2061	7%	2090	1%	2174	4%
Diamond Ridge	1156	17%	1144	-1%	1330	16%	1421	7%
Fox River	685	7%	666	-3%	672	1%	444	-34%
Fritz Creek	1932	8%	2054	6%	2199	7%	2456	12%
Halibut Cove	76	95%	70	-8%	86	23%	59	-31%
Happy Valley	593	19%	584	-2%	622	7%	702	12%
Homer	5003	3%	5135	3%	5478	7%	5614	3%
Kachemak City	472	2%	487	3%	506	4%	676	33%
Nanwalek	254	7%	291	15%	280	-4%	153	-45%
Nikolaevsk	318	2%	277	-13%	294	6%	329	12%
Ninilchik	883	8%	849	-4%	821	-3%	901	10%
Port Graham	177	24%	177	0%	180	2%	147	-18%
Seldovia City	255	1%	222	-13%	226	2%	294	30%
Seldovia Village	165	11%	168	2%	185	10%	205	11%
Totals	13,899		14,185	2.1%	14,969	5.5%	15,575	4.0%

Source: Alaska Department of Labor and Workforce Development, 2023 Population Estimates.

Within the Southern Kenai Peninsula there are also age and sex breakdowns available to define the target population receiving services from SPH. Over a third of our population is between 55 and 84 yoa.

The most significant area of population growth has been occurring in the 65+ age group, a target population that is most positively impacted by our Certificate of Need project. Below are the projected growth figures from the US Census Bureau for the entire Kenia Peninsula Borough.

Figure 20: Projected Population 65+, Kenai Peninsula 2020-2045

Kenai Peninsula Borough								
Age Group	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**% Change 2020-2030**	**% Change 2020-2045**
65 to 74 years	7,333	8,236	7,576	6,215	5,414	5,451	3%	-26%
75 to 84 years	2,948	4,128	5,405	6,098	5,587	4,565	83%	55%
85+ years	805	1,046	1,495	2,114	2,839	3,255	86%	304%
Total	11,086	13,410	14,476	14,427	13,840	13,271	31%	20%

Source: US Census Bureau

Population of the southern Kenai Peninsula by age group, as compared to state and national numbers, shows the southern Kenai Peninsula is disproportionately higher with senior residents.

Figure 21: Estimated 2023 population by age group of SPH Service Area vs Alaska vs USA

2023 Population By Age	Total	SKP	ALASKA	USA
Age 0-14	2,674	17%	20.2%	18.0%
Age 15-24	1,686	10.8%	13.2%	13.1%
Age 25-54	5,190	33.3%	40.3%	38.4%
Age 55-64	2,446	15.7%	12.0%	12.6%
Age 65-84	3,318	21.3%	13.3%	15.9%
Age 85 and Over	261	1.6%	1.1%	2.1%
Total Population of SKP	15,575			
2023 Est. Average Age		43.2	37.6	40.2
2023 Est. Median Age		44.6	36.0	39.2

Source: Claritas Environics

5. Describe the projected utilization of the proposed services and the method by which this projection was derived. Do not annualize utilization data. It must include the last complete year of operation (indicate if it is a calendar year or fiscal year) and as many prior years as is feasible to show trends. If graphs are used to depict this information, and they do not include the actual utilization numbers, numerical charts must be included. In providing this information:

a. Include evidence of the number of persons from the target population who are currently using these services and who are expected to continue to use the service, including individuals served out of the service area or out of state;

SPH used data from multiple sources, including the US Census Bureau, Alaska Department of Health, the ODHIN (On Demand Hospital Information Network) database for Alaska, and the 2020 CHNA to provide the following utilization tables for the persons who are in our hospital service area and are most likely to use our services.

Figure 22: KPB Borough and SPH Service Area population past five years

	Historical				
Population	2018	2019	2020	2021	2022
KPB	59,609	58,914	59,414	59,768	59,843
SPH Service Area	15,079	14,903	15,029	15,119	15,138

Source: US Census Bureau (2020 Survey), Alaska Dept. of Labor Population Projections

SPH currently provides Oncology and Infusion services to its service area population. Below is a summary of Patient visit data for our Oncology / Infusion Center over the past 5 years. An increase of 139% of volumes has occurred between 2018 and the current fiscal year 2023 which has taxed our current capacity to meet the needs of our service area.

Figure 23: SPH Oncology / Infusion Volumes

	Historical - Fiscal Year					
SPH Infusion Volume	2018	2019	2020	2021	2022	2023*
South Peninsula Hospital	946	972	1,147	1,621	1,626	2,260

2023*: Fiscal year data from July 2022 through April 2023 annualized to show the 39% annual growth increase.
Source: South Peninsula Hospital historical volumes from 2018 to 2022 by Infusion type.

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.*

SPH is proposing the addition of the Nuclear Medicine service line to our diagnostic imaging capabilities. Using the ODHIN database, we were able to determine how many individuals who reside in our service area were receiving this service from other locations within the State of Alaska because they are not available locally.

Figure 24: SPH Nuclear Med Volumes

	Historical				
ODHIN Nuclear Med Volume	2018	2019	2020	2021	2022
Central Peninsula Hospital	123	134	109	149	123
All Other	33	21	18	19	13
SPH Service Area Total	156	155	127	168	136

Source: Alaska OHDIN state clinical database pulled on April 19th, 2023 for Nuclear Medicine volumes.

Nuclear Med Utilization Projection Methodology

South Peninsula Hospital used the utilization rates for its proposed Nuclear Medicine modality based on current SPH utilization rates and the state of Alaska utilization rates. The State of Alaska utilization is higher than the SPH service area utilization and a gap in local care that results in significant patient travel for Nuclear Medicine services. The volume projection range is a data-backed prediction of Nuclear Medicine utilization over a 3, 5, and 10-year period. The utilization projections incorporate the Advisory Board's market demand planner that utilizes local market data and care delivery trends to project utilization rates out until 2032.

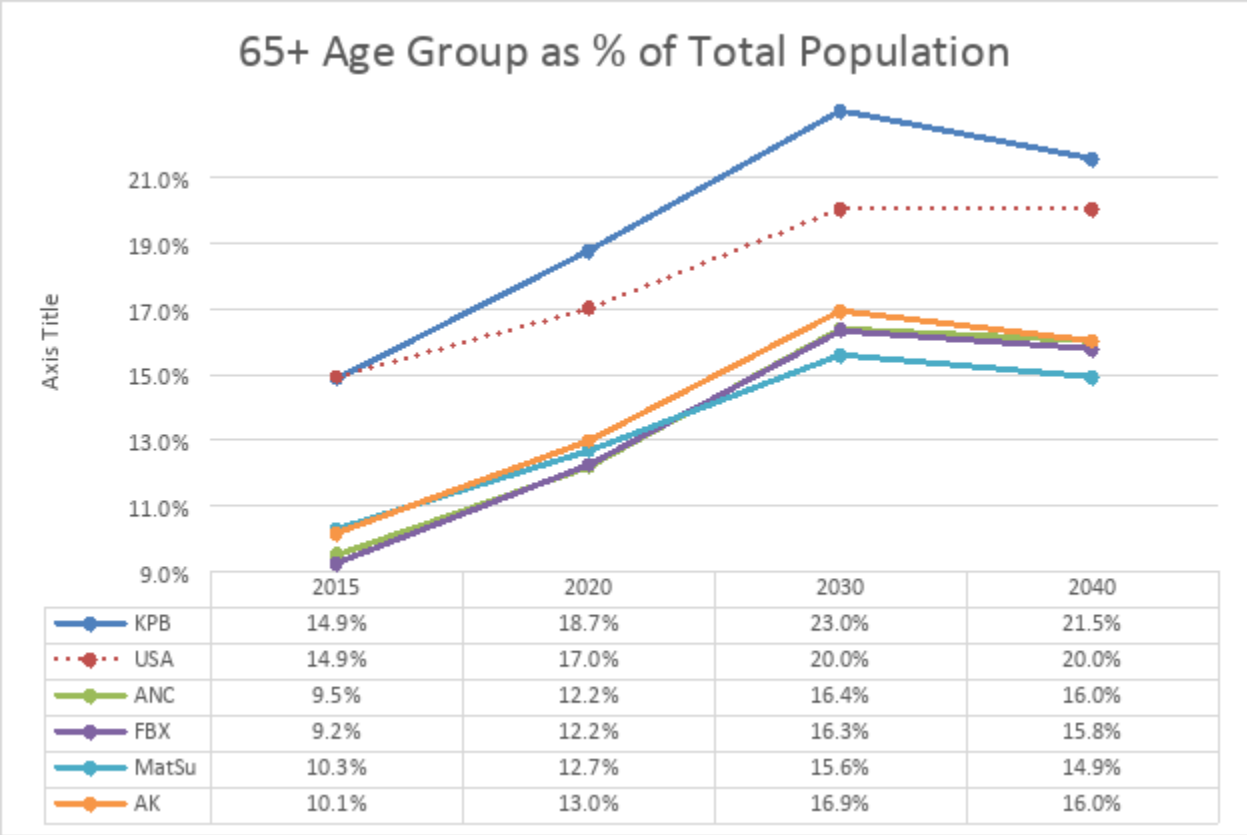
One can see in the Utilization table below (Figure 25), that residents from the SPH Service Area are receiving significantly less Nuclear Medicine studies per year compared to their counterparts from other service areas. The Service gap appears to be as high as 46% less Nuclear Medicine studies performed for SPH area residents in 2020 compared to others in the State of Alaska and 43% less during 2022. These figures are staggering and point to the colossal barriers to healthcare posed by geographic isolation, home-bound patients, our elderly population, and those without transportation.

Figure 25: Nuclear Medicine Utilization Table

	Historical					Projections		
Utilization Rate	2018	2019	2020	2021	2022	2025	2027	2032
SPH Service Area	10.3	10.4	8.5	11.1	9.0	11.1	11.3	11.4
State of Alaska	16.6	16.1	15.6	16.1	15.9	16.1	16.3	16.4
Service Gap Variance	6.3	5.7	7.2	5.0	6.9	5.0	5.0	5.0

While we do not have ODHIN data to report the age of our target population currently receiving Nuclear Medicine Services, we can use general assumptions based on the average age of Cancer patients from the National Cancer Institute, which is 66 years of age. (2021, March 5. NCI.gov) Below is a table showing the expected growth trajectory of the 65+ Age category for the Kenai Peninsula Borough compared to other locations in the State and also to the nation.

Figure 26: 65+ Percent of Total Population Projections

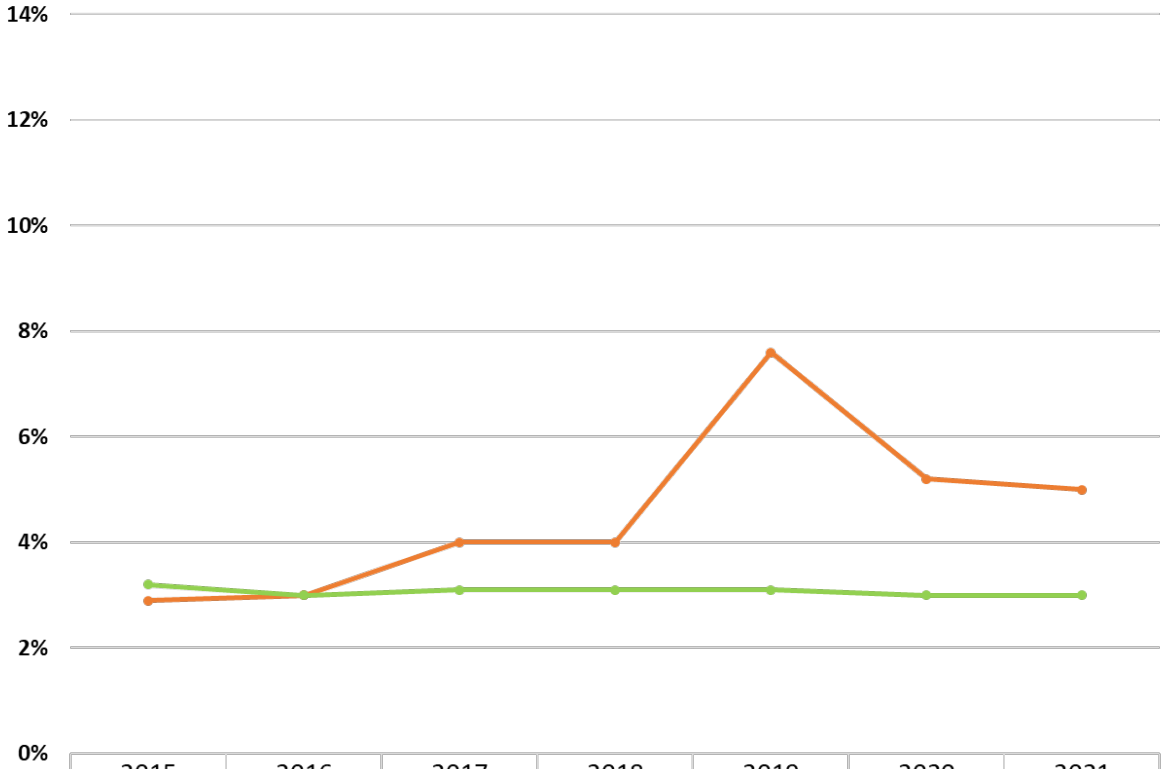


	2015	2020	2030	2040
KPB	14.9%	18.7%	23.0%	21.5%
USA	14.9%	17.0%	20.0%	20.0%
ANC	9.5%	12.2%	16.4%	16.0%
FBX	9.2%	12.2%	16.3%	15.8%
MatSu	10.3%	12.7%	15.6%	14.9%
AK	10.1%	13.0%	16.9%	16.0%

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

In addition to comparing the median age and 65+ population for the KPB to other boroughs and Alaska, an additional data point we have considered is the Heart Disease Mortality Rates which clearly demonstrates and links our aging population with poor heart health. Nuclear Medicine's highest volume studies are generally cardiac patients.

Figure 27: Percentage of Adults who had a Heart Attack 2015-2021



	2015	2016	2017	2018	2019	2020	2021
Kenai Peninsula	2.9%	3.0%	4.0%	4.0%	7.6%	5.2%	5.0%
Alaksa	3.2%	3.0%	3.1%	3.1%	3.1%	3.0%	3.0%

Source: Alaska Behavioral Risk Factor Surveillance System Survey

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

At the date of this certificate of need application, South Peninsula Hospital is the only facility offering Oncology / Infusion services in our service area. While there are certain providers of health and wellness related infusion services, they are not the same level of care, nor do they manage chemotherapy or other highly regulated pharmaceutical drugs. As such the utilization data shown below are for the services currently provided at South Peninsula Hospital only.

Oncology / Infusion Utilization Projection Methodology

While not a new service line, our capacity for continuing to meet the Oncology / Infusion needs of our target population is significantly impaired by their current building. To display this rapid growth, South Peninsula Hospital used its current utilization rates to show the necessity for the proposed Oncology /

Infusion expansion. These utilization projections incorporate the Advisory Board's market demand planner that incorporates local market data and care delivery trends to project current utilization rates out until 2032. The volume projection range is a data-backed prediction of Oncology / Infusion utilization over a 3, 5, and 10 year period.

Figure 28: Oncology/Infusion Services Utilization Table

	Historical - Fiscal Year						Projections		
Utilization Rate	2018	2019	2020	2021	2022	2023*	2025	2027	2032
SPH Service Area	62.7	65.2	76.3	107.2	107.4	149.0	163.1	171.5	187.8

2023: Fiscal year data from July 2022 through April 2023 annualized to show the 39% annual growth increase.*

Data shown above was derived for the SPH service area, a subset of the Kenai Peninsula Borough. This service area includes the following zip codes: 99556, 99568, 99603, 99639, and 99663. The CHNA population estimates, and demographic factors are layered into the historical and future volume projections.

The utilization rate projections use historical utilization rates for SPH infusion services as the baseline. Additionally, the Advisory Board's Market Demand Planner for the SPH service area and the State of Alaska's population estimate forecasts are applied for expected utilization and population changes. The utilization forecast is based upon local growth drivers (i.e. Disease prevalence, insurance policy changes, population changes, care management advancements and technological innovation). The state of Alaska population estimate uses the 2020 census and demographic trends to project the population out to 2060.

Source: Alaska Department of Labor and Workforce Development Population Estimates, Advisory Board Market Demand Planner for the SPH service area accessed on April 16th, 2023.

These volume projections build upon the current utilization of SPH service area members and layer in population and utilization changes from the prior sections. Due to the aging population, Oncology / Infusion will continue its robust growth and SPH should properly expand its capacity to accommodate for the future patient volumes demonstrated below:

Figure 29: Oncology/Infusion Services Volume Projections

	Historical - Fiscal Year						Projections		
Historical & Projected Volumes	2018	2019	2020	2021	2022	2023*	2025	2027	2032
SPH Service Area Utilization	946	972	1,147	1,621	1,626	2,260	2,480	2,636	2,905

Source: Alaska Department of Labor and Workforce Development Population Estimates, Advisory Board Market Demand Planner for the SPH service area accessed on April 16th, 2023.
2023*: Fiscal year data from July 2022 through April 2023 annualized to show the 39% annual growth increase.

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

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.

While not in our Service Area, Soldotna, Alaska is the location where the majority of Nuclear Medicine studies for individuals from our Service Area are performed. Below is the Market Share data for Nuclear Medicine-related CPT codes in the State of Alaska:

Figure 30: Historical Nuclear Medicine Volumes

	Historical				
OHDIN Nuc Med Volume	2018	2019	2020	2021	2022
Central Peninsula Hospital	123	134	109	149	123
All Other	33	21	18	19	13
SPH Service Area Total	156	155	127	168	136

Source: Alaska OHDIN state clinical database pulled on April 19th, 2023 for Nuclear Medicine volumes.

Approximately 90% of Southern Kenai Peninsula Service Area members receive Nuclear Medicine tests at Central Peninsula Hospital compared to other locations.

While the Actual volumes shown above are the sum of completed Nuclear Medicine tests, the Utilization data shown below estimates the amount of tests performed for South Kenai Peninsula residents compared to the number performed for Alaska residents at large:

Figure 31: Nuclear Medicine Utilization (Historical & Projected)

	Historical					Projections		
Utilization Rate	2018	2019	2020	2021	2022	2025	2027	2032
SPH Service Area	10.3	10.4	8.5	11.1	9.0	11.1	11.3	11.4
State of Alaska	16.6	16.1	15.6	16.1	15.9	16.1	16.3	16.4
Service Gap Variance	6.3	5.7	7.2	5.0	6.9	5.0	5.0	5.0

Source: Alaska Department of Labor and Workforce Development Population Estimates, Advisory Board Market Demand Planner for the State of Alaska accessed on April 16th, 2023.

The utilization rate projections use historical rates for the SPH service area and the State of Alaska to demonstrate the likely baseline utilization range. Additionally, the Advisory Board's Market Demand Planner and the State of Alaska's population estimate forecasts are applied for expected utilization and population changes. The utilization forecast is based upon local growth drivers (i.e. Disease prevalence, insurance policy changes, population changes, care management advancements and technological innovation). The state of Alaska population estimate uses the 2020 census and demographic trends to project the population out to 2060.

Volume projections for Nuclear Medicine show a volume range based upon the current utilization of SPH service area members (actual), alongside the State of Alaska's utilization rate for Nuclear Medicine to illustrate the service gap (unmet community need) that should result in normalized volumes if geographic barriers to care are removed:

Figure 32: Nuclear Medicine Volume Projections

	Historical					Projections		
Projected Volumes	**2018**	**2019**	**2020**	**2021**	**2022**	**2025**	**2027**	**2032**
SPH Service Area Utilization	156	155	127	168	136	169	174	176
State of Alaska Utilization						245	251	254
					Service Gap Variance	**76**	**77**	**77**

Source: Alaska Department of Labor and Workforce Development Population Estimates, Advisory Board Market Demand Planner for the State of Alaska accessed on April 16th, 2023.

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).

Increases in utilization are expected in increase in both Oncology / Infusion and also in Nuclear medicine as described in previous sections and also delineated here. First, Oncology / Infusion is anticipated to continue a consistent growth trajectory in keeping with our again population's growth. While the increased utilization will not be as steep as the five year period from 2018 to 2022, it will continue modest increases.

Figure 33: Oncology/Infusion Service Utilization

	Historical - Fiscal Year						Projections		
Utilization Rate	2018	2019	2020	2021	2022	2023*	2025	2027	2032
SPH Service Area	62.7	65.2	76.3	107.2	107.4	149.0	163.1	171.5	187.8

Source: Alaska Department of Labor and Workforce Development Population Estimates, Advisory Board Market Demand Planner for the SPH service area accessed on April 16th, 2023.
2023*: Fiscal year data from July 2022 through April 2023 annualized to show the 39% annual growth increase.

The utilization rate projections use historical utilization rates for SPH infusion services as the baseline. Additionally, the Advisory Board's Market Demand Planner for the SPH service area and the State of Alaska's population estimate forecasts are applied for expected utilization and population changes. The utilization forecast is based upon local growth drivers (i.e. Disease prevalence, insurance policy changes, population changes, care management advancements and technological innovation).

Meanwhile, we expect 30% to 40% growth in the utilization of Nuclear Medicine services for Southern Kenai Peninsula residents due to the gap in care identified, in addition to slow growth related to our aging demographic.

Figure 34: Nuclear Medicine Utilization

	Historical					Projections		
Utilization Rate	2018	2019	2020	2021	2022	2025	2027	2032
SPH Service Area	10.3	10.4	8.5	11.1	9.0	11.1	11.3	11.4
State of Alaska	16.6	16.1	15.6	16.1	15.9	16.1	16.3	16.4
Service Gap Variance	6.3	5.7	7.2	5.0	6.9	5.0	5.0	5.0

Source: Alaska Department of Labor and Workforce Development Population Estimates, Advisory Board Market Demand Planner for the State of Alaska accessed on April 16th, 2023.

Also mentioned above in Section 5d. The utilization rate projections use historical utilization rates for the SPH service area and the State of Alaska to demonstrate the likely baseline utilization range. Additionally, the Advisory Board's Market Demand Planner and the State of Alaska's population estimate forecasts are applied for expected utilization and population changes. The utilization forecast is based upon local growth drivers (i.e. Disease prevalence, insurance policy changes, population changes, care management advancements and technological innovation).

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

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

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

SPH is a community owned, not-for-profit hospital seeking to provide a full-continuum of high quality care to patients in our service area and those who seek care here from throughout the Southern Kenai Peninsula. The mission of South Peninsula hospital to provide high quality care as close to home as possible reduces barriers to care such as access, transportation, and geography. You will see in future sections that profit motive is not the leading driver for this CON. Instead, SPH seeks to provide for the healthcare needs of the community it serves.

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

Advancing this project required considerable public discussion. This discussion included the hospital operating Board of Directors, The South Kenai Peninsula Hospital Service Area Board, the elected KPB Mayor and his administration, and finally the elected KPB Assembly. Letters of support from our closest stakeholders can be found in the APPENDIX.

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

Please see the following tables containing historical volumes and future projections for the nuclear medicine proposal. The calculations were derived using historical volumes, population, and utilization growth rates and 3, 5, and 10 year volume projections for the SPH service area.

Figure 35: Nuclear Medicine Needs Assessment

SOUTH PENINSULA HOSPITAL

CERTIFICATE OF NEED - NUCLEAR MEDICINE

	Historical					Projections		
Population	2018	2019	2020	2021	2022	2025	2027	2032
KPB	59,609	58,914	59,414	59,768	59,843	60,144	60,382	60,822
SPH Service Area	15,079	14,903	15,029	15,119	15,138	15,214	15,274	15,386

	Historical				
ODHIN Nuc Med Volume	2018	2019	2020	2021	2022
Central Peninsula Hospital	123	134	109	149	123
All Other	33	21	18	19	13
SPH Service Area Total	156	155	127	168	136

	Historical				
ODHIN Nuc Med Volume	2018	2019	2020	2021	2022
Alaska Total	10,832	10,487	10,159	10,502	10,372

*Advisory Board market data shows 6,000 Nuc Med tests completed outside of the hospital setting in Alaska in 2021

	Historical					Projections		
Utilization Rate	2018	2019	2020	2021	2022	2025	2027	2032
SPH Service Area	10.3	10.4	8.5	11.1	9.0	11.1	11.3	11.4
State of Alaska	16.6	16.1	15.6	16.1	15.9	16.1	16.3	16.4
Service Gap Variance	6.3	5.7	7.2	5.0	6.9	5.0	5.0	5.0

	Historical					Projections		
Projected Volumes	2018	2019	2020	2021	2022	2025	2027	2032
SPH Service Area Utilization	156	155	127	168	136	169	174	176
State of Alaska Utilization					241	245	251	254
					Service Gap Variance	76	77	77

Figure 36: Oncology/Infusion Needs Assessment

SOUTH PENINSULA HOSPITAL

CERTIFICATE OF NEED - INFUSION SERVICES

	Historical						Projections		
Population	2018	2019	2020	2021	2022	2023*	2025	2027	2032
KPB	59,609	58,914	59,414	59,768	59,843	59,943	60,144	60,382	60,822
SPH Service Area	15,079	14,903	15,029	15,119	15,138	15,163	15,214	15,274	15,386

	Historical - Fiscal Year					
SPH Infusion Volume	2018	2019	2020	2021	2022	2023*
South Peninsula Hospital	946	972	1,147	1,621	1,626	2,260

	Historical - Fiscal Year						Projections		
Utilization Rate	2018	2019	2020	2021	2022	2023*	2025	2027	2032
SPH Service Area	62.7	65.2	76.3	107.2	107.4	149.0	163.1	171.5	187.8

	Historical - Fiscal Year						Projections		
Historical & Projected Volumes	2018	2019	2020	2021	2022	2023*	2025	2027	2032
SPH Service Area Utilization	946	972	1,147	1,621	1,626	2,260	2,480	2,636	2,905

An additional need identified prior to the writing of this CON is the current capacity and heavy use of our CT machine. SPH has only one CT which is used extensively for both routine and emergency patient diagnostics. Due to the high volumes of use, we expect to have greater downtime for maintenance and a shorter useful life. The Siemens SPECT/CT will provide additional redundancy for CT services during downtime. Below are the historical and future volume projects for our single CT machine:

Figure 37: CT Needs Assessment

SOUTH PENINSULA HOSPITAL

CERTIFICATE OF NEED - CT SERVICES

	Historical						Projections		
Population	2018	2019	2020	2021	2022	2023*	2025	2027	2032
KPB	59,609	58,914	59,414	59,768	59,843	59,943	60,144	60,382	60,822
SPH Service Area	15,079	14,903	15,029	15,119	15,138	15,163	15,214	15,274	15,386

	Historical - Fiscal Year					
SPH Infusion Volume	2018	2019	2020	2021	2022	2023*
South Peninsula Hospital	3,491	3,843	3,469	3,753	4,540	4,714

	Historical - Fiscal Year						Projections		
Utilization Rate	2018	2019	2020	2021	2022	2023*	2025	2027	2032
SPH Service Area	231.5	257.9	230.8	248.2	299.9	310.9	316.86	322.8	340.7

	Historical - Fiscal Year						Projections		
Historical & Projected Volumes	2018	2019	2020	2021	2022	2023*	2025	2027	2032
SPH Service Area Utilization	3,491	3,843	3,469	3,753	4,540	4,714	4,817	4,962	5,269

C. AVAILABILITY OF LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

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

Alternatives for Nuclear Medicine

The alternatives to Nuclear Medicine have been thoroughly considered and employed at SPH for many years. There are several imaging modalities which offer *some*, but not *all* of the diagnostic imaging capabilities of Nuclear Medicine Studies. South Peninsula Hospital has employed the use of Computed Tomography (CT), X-Ray, Mammography, Magnetic Resonance Imaging (MRI), Ultrasound, and Dual X-ray Absorptiometry (DEXA) to provide the appropriate level of diagnostic tools to support our Service Area's health needs. However, the simple detection of anomalies in the heart, organ dysfunction, and proper blood flow within organ tissues, tumors, cancer, their exact size or locations in order to support diagnosis and surgical or other interventions are not being sufficiently met with our existing imaging exams. It is after many years of research, upgrades to existing technologies, and waiting for healthcare market disruptors, SPH has determined that there is no equivalency to the healthcare outcomes of Nuclear Medicine exams.

Do Nothing (status quo): Currently the only option for residents on the Kenai Peninsula to receive Nuclear Medicine services is for patient travel up to 90 minutes or more to Central Peninsula Hospital in Soldotna. For some Service Area residents, this trip is too great and their physician orders for a Nuclear Medicine exam go untouched, or a lower quality exam is ordered and the resulting image is not sufficient to properly diagnose or treat the patient, thereby requiring yet another advanced imaging exam and an increase in healthcare costs to the patient and insurer.

Providing Nuclear Medicine services will improve quality for SPH patients, particularly the aging and vulnerable. For that reason alone, "doing nothing" prevents residents from receiving a basic diagnosis close to home.

Alternatives for Infusion Bay Expansion

Do Nothing (status quo): On its current growth trajectory, SPH runs the risk of reaching its patient capacity over the next two years, requiring one of three inevitable outcomes: 1) patients would need to leave the service area to obtain their Oncology / Infusion services in Soldotna, or 2) another healthcare entity will come and provide infusion care in a separate location within the service area, or 3) in order to meet continued growth and long duration of treatment times Oncology / Infusion services would displace another hospital service line or location in order to accommodate expansion, or the service line would be split into multiple locations. SPH is committed to providing for its community and does not believe that these three alternative scenarios would improve the quality or effectiveness of patient care or the patient experience.

Expand the Oncology / Infusion Center: One alternative is to remodel the current department in place. Although this option would allow for incremental growth and for the service to remain consolidated on the SPH campus, it does pose some additional complexities which could be limiting:

a. The current building is not owned by South Peninsula Hospital, but rather it is leased. The significant and costly investment into the expansion of that building would not be financial responsible if SPH is not able to purchase it.
b. The current building footprint offers significant parking surrounding it, which if lost could create other negative down streams impacts to an already congested parking situation at SPH.
c. Leaving the Oncology / Infusion services offsite while it increases in volumes will only exacerbate the patient quality, staff concerns, and environmental hazards which exist today.

Given the alternatives, SPH believes that on-site co-location and expansion of the Oncology / Infusion Center is the best option for meeting the future healthcare needs of the Southern Kenai Peninsula.

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.

South Peninsula Hospital is one of 13 designated Critical Access Hospital's (CAH) in the State of Alaska. A CAH is defined in the Code of Federal Regulations (CFR) under 42 CFR 485 subpart F. CAHs are a separate provider type that was created to support the health needs of rural communities and have their own Medicare Conditions of Participation (COP) in §485.601-485.647. Some of the criteria required by the Center for Medicare and Medicaid Services (CMS) to be considered a CAH are found at https://dhss.alaska.gov/health/dhcs/Pages/hflc/fac_cah.aspx and summarized below:

- The Hospital must be located in a State that has established a State Medicare Rural Hospital Flexibility Program
- The Hospital must also be designated by the State as a CAH
- The main Hospital campus must be located in a rural area or an area that is treated as rural
- The main Hospital campus must be located either more than 35-miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified as a CAH based on State designation as a "necessary provider" of health care services to residents in the area
- The Hospital may have no more than 25 inpatient beds that can be used for either inpatient or swing-bed services
- The Hospital's annual average length of stay for inpatients may not exceed 96 hours (excluding swing-bed)
- Must remain in compliance with the CAH COPs found at 42 CFR Part 485 subpart F
- Must provide 24-hour emergency care services 7 days a week

As a CAH, SPH has been granted "swing-bed" approval to provide post-hospital Skilled Nursing Facility-level care in its inpatient beds.

South Peninsula Hospital meets all of the CMS COPs as well as each of the criteria above. These criteria were specifically written to define and create support mechanisms for a special category of hospital that meets the health needs of small rural communities which may otherwise not have access to care due to their geographic isolation and patient volumes.

Access to healthcare services is a significant issue for our elderly and low income populations due to immobility, lack of transportation, and financial resources. With the addition of Nuclear Medicine and the expansion of Oncology / Infusion, SPH will be able to reduce the Service Gap for our area residents as well as reduce transportation costs and time spent commuting to other facilities to receive care.

D. THE RELATIONSHIP OF THE PROPOSED PROJECT TO EXISTING HEALTH CARE SYSTEM AND TO ANCILLARY OR SUPPORT SERVICES

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

There are no existing comparable services in the primary service area for Nuclear Medicine. Central Peninsula Hospital has primarily served the needs for SPH service area residents who are willing and able to travel outside of their community. The cost of travel, time, and access to transportation we believe has significantly impacted the utilization of this service at other facilities.

There are also no existing comparable services in the primary service area for Oncology / Infusion. The second largest provider of community health services (SVT Health and Wellness) does not include the provision of essential Cancer treatment protocols such as Chemotherapy, or Infusion treatments for other chronic illnesses. The same access issues apply for residents of the Southern Kenai Peninsula when our volumes exceed the current capacity of our 960 square foot Oncology / Infusion center.

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

The addition of Nuclear Medicine with a SPECT-CT will complement our existing diagnostic imaging tools very well by adding redundancy to our high-volume CT Scanner, to supplying an unmet need for a

different variant of diagnostic testing which is required for certain diseases affecting the heart and internal organs. Further, the addition of this service will allow certain patients to receive the entire complement of care from diagnosis to treatment or surgery in our local service area. It will also reduce the overall time elapsed between assessment, diagnosis and treatment, resulting in better patient outcomes.

b. provide an alternative or unique service

Nuclear medicine is a unique diagnostic imaging tool which will expand the depth and breadth of diagnostic results and quality of diagnosis within our service area. Its 3-dimensional imaging capabilities far surpass our existing options for making sound clinical judgements and treatment recommendations.

c. provide a service for a specific target population

While there is not specific target population for Nuclear Medicine and Oncology Infusion, we can draw upon certain hospital statistics to predict that these services are more heavily utilized by our aging residents. The Southern Kenai Peninsula's aging population is growing at a much faster rate than both national and state growth projections.

d. provide needed competition

There are no local providers of Nuclear Medicine exams or Oncology / Infusion services, and as such no competition is expected to occur by the addition or expansion of these services.

Statewide Alternatives

According to market share information from the OHDIN database, residents from the South Peninsula Hospital service area zip codes are receiving Nuclear Medicine exams in other locations, primarily Soldotna and Anchorage. While we can say there will be an effect on Nuclear Medicine volumes at Central Peninsula Hospital (CPH), the decline in Southern Peninsula resident volumes will have two positive impacts on CPH: 1) access to Nuclear medicine studies will be increased and wait times will be decreased for residents of the CPH Service Areas, and 2) the longevity or useful life of CPH's Nuclear Medicine equipment will be extended.

While reducing volumes to other providers is always a concern, the most important factor for SPH to consider is the health outcome of its service area residents. A service gap of 30 to 40% of residents who are not receiving the proper diagnostic imaging test is not a health disparity that SPH is willing to accept. We believe that the only way to reduce this gap in care is by providing these services locally in order to reduce travel times, out of pocket costs, and transportation concerns. The reduction in volumes

from SPH residents would also provide CPH capacity back for a service that is currently at or near its own capacity.

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.

SPH is the only hospital in the Southern Kenai Peninsula service area. Our services include a 24/7 Emergency room, 22-bed hospital, 28-bed long term care, home health services, and several outpatient family and specialty medicine clinics such as: primary care, obstetrics/gynecology, neurology, sleep lab, general surgery, orthopedics, behavioral health, ENT, urology, wound care, endocrinology, pulmonology, and functional medicine. SPH employs its own Hospitalist team to care for hospitalized patients, as well as a full-time board certified interventional radiologist. Finally, SPH offers numerous community health and wellness programs.

SPH has a helipad that is serviced by two separate helicopter transport groups (Guardian and Lifemed) and holds transfer agreements with Providence Medical Center, Alaska Regional, and Alaska Native Medical Center in Anchorage. The air ambulances transport patients with acute trauma, cardiac, and stroke concerns as well as pediatrics and other high acuity cases. In addition SPH has an agreement for electronic ICU and Psychiatric monitoring by Providence Medical Center. Many of our specialty physicians are the result of collaborative partnerships with medical clinics in Soldotna and Anchorage and with Central Peninsula Hospital, ensuring that residents of the Southern Peninsula can access quality care without travelling far from home.

Figure 38: SPH Transfer Agreements

SPH Transfer Agreements			
Receiving Hospital	**Transferring Hospital**	**Effective Date**	**Description**
Providence Alaska Medical Center	South Peninsula Hospital	4/1/2011 to present	Patient Transfer Agreement
Alaska Regional Hospital	South Peninsula Hospital	1/1/2016 to present	Patient Transfer Agreement
Alaska Native Medical Center	South Peninsula Hospital	1/1/2016 to present	Patient Transfer Agreement
Central Peninsula Hospital	South Peninsula Hospital	6/22/2016 to present	Patient Transfer Agreement
Central Peninsula Heritage Place	South Peninsula Long Term Care	4/6/2021 to present	Longterm Care Resident Transfer Agreement
Harborview Medical Center	South Peninsula Hospital	3/25/2016 to present	Patient Transfer Agreement

In addition to our transfer agreements for hospitalized patients, SPH regularly collaborates with Central Peninsula Hospital, and Providence Hospital, to support staff training, coordinated care and other healthcare issues. Finally, SPH has a strong collaborative relationship with numerous local stakeholders that are part of the MAPP Coalition (Mobilizing for Action through Planning and Partnerships) such as

the City of Homer, Homer Public Health, Kachemak Bay Campus, SVT Health & Wellness, Sprout Family Services, South Peninsula Behavioral Health Services, South Peninsula Haven House, Bunnell Street Arts Center, Sustainable Homer, Kachemak Bay Family Planning Clinic, and Homer United Methodist Church. With the help of the triennial Community Health Needs Assessment, the MAPP Coalition was created to make the Southern Kenai Peninsula a healthier place to live as defined by the eight dimensions of wellness.

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.

Prior to demonstrating the financial implications of our project, we wish to highlight the projected number of department procedures or visits upon which our estimates are based. Using the volume projects shown previously in this Certificate of Need document, below are the projected volumes of nuclear medicine exams for years 1 through 5 and the associated revenue and expenses for this additional service line.

Figure 39: Nuclear Medicine Volume Projections (Years 1-5)

	75% Capacity	100% Capacity			
	Projections				
Projected Volumes	Year 1	Year 2	Year 3	Year 4	Year 5
SPH Service Area Utilization	181	243	245	248	251

Figure 40: Nuclear Medicine Profit and Loss

Nuclear Medicine Profit and Loss Statement

	75% Capacity	*100% Capacity*			
Hospital Revenues	Year 1	Year 2	Year 3	Year 4	Year 5
Inpatient Hospital Revenue	$ 26,638	$ 37,908	$ 40,514	$ 43,470	$ 46,636
Outpatient Hospital Revenue	$ 417,329	$ 593,899	$ 634,714	$ 681,035	$ 730,630
Deductions from Revenue (incl Bad Debt/Charity)	$ (199,785)	$ (284,313)	$ (303,853)	$ (326,028)	$ (349,770)
Total Net Patient Revenue	$ 244,182	$ 347,494	$ 371,375	$ 398,478	$ 427,496
Hospital Expenses					
Labor Costs	$ 186,199	$ 201,095	$ 217,183	$ 234,558	$ 253,322
Supply Costs	$ 126,938	$ 180,645	$ 193,060	$ 207,150	$ 222,235
Depreciation Expense	$ 354,237	$ 354,237	$ 354,237	$ 354,237	$ 354,237
Other Direct Costs	$ 60,990	$ 64,650	$ 68,529	$ 72,640	$ 76,999
Total Direct Costs	$ 728,365	$ 800,627	$ 833,009	$ 868,584	$ 906,793
Operating Income (Loss)	$ (484,183)	$ (453,133)	$ (461,633)	$ (470,106)	$ (479,296)

The financial feasibility and long-term viability of the proposed project cannot be demonstrated by displaying only the Nuclear Medicine service line profit and loss statement. This CON project provides for increased patient service volumes throughout the hospital due to the interconnectedness of improved diagnostic capabilities for the remainder of our hospital service lines such as Oncology / Infusion, Surgical Services, Respiratory Therapy, and more. While the impact of this new service line on other departments can be estimated, the impact on our communities' health and wellness is immeasurable. Further, the ability to service greater volumes of Oncology / Infusion patients will not only provide for one of our Service area's top identified health needs, it will also provide additional financial stability for SPH.

Patients currently in need of nuclear medicine services are required to obtain those tests in Soldotna or Anchorage, the two closest locations for nuclear medicine services. This project will lower the cost of receiving these services for the consumer, in terms of lost work time and travel expenses not covered by insurance. Further, patients will benefit from the convenience of easy access, familiarity of our systems, people, and processes. For ordering physicians within our health system, the nuclear medicine report will be easy to access on our Electronic Medical Record (EMR) reducing administrative time to transfer records between health facilities.

As pointed out previously, some consumers are unable to obtain vital services to maintain their health status when those services cannot be obtained locally. Thus, lack of local services can result in some consumers neglecting to receive appropriate care, which leads to more costly healthcare for these individuals in the future, as unaddressed issues turn into more costly illness and disease. This too impacts the consumer, state, region and community served. We call this, the service gap.

Cost savings for Alaska Medicaid patients will be seen through the approval of the project as well. Currently, Medicaid patient travel is costly to the state and to the patient and medical provider to arrange. Recent changes to the State Medicaid intermediary have cause significant backlogs, delays, and cancellations in Medicaid travel authorizations, further complicating the completion of much needed diagnostic imaging and other medical travel needs.

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

The proposed project will be funded by several financial sources including but not limited to: 1)property tax revenues received from the South Kenai Peninsula Hospital Service Area mill levy ($2.0M), 2)SPH Plant Replacement & Expansion funds ($5.7M), Philanthropic support ($500k), and SPH Operating cash ($1.8M). These sources of funding amount to $10.0 million in total project costs. The operations of the Nuclear medicine department, Oncology / Infusion expansion, and Pharmacy upgrade will be financed

through revenues generated by patient charges. Without the use of bond indebtedness, SPH will be able to make a significant capital investment in itself and improve the health and wellness of the Southern Kenai Peninsula residents without the burden of future principle and interest payments.

Figure 41: CON Project Funding Schedule

Project Description	Estimated Cost	KPB Admin Fee	Total Project
CON Construction	$ 8,188,421	$ 81,884	$ 8,188,421
CON Equipment	$ 1,374,786	$ 6,874	$ 1,374,786
CON Project Design	$ -	$ 6,598	$ 659,783
KPB Admin Fee	$ -		$ 95,356
KPB Project Mgmt Fee	$ 368,479		$ 368,479
Total CON	**$ 9,563,207**	**$ 95,356**	**$ 10,686,825**
CON Application Fee			$ 10,687
SKPH Service Area Funds (design)			$ (659,783)
SKPH Service Area Funds 21SHD & 23SHA			$ (928,673)
SPH Plant Replacement & Expansion Funds			$ (5,700,000)
Philanthropy / Grants			$ (500,000)
Re-appropriation of de-obligated Service Area Funds			$ (1,100,000)
SPH Operating Cash			$ (1,809,056)
Project Surplus / (Shortfall)			**$ (0)**

Below is the most current unaudited Balance Sheet for South Peninsula Hospital demonstrating its financial resources and stability. The Current Debt to Equity ratio for SPH is 0.104, meaning that it generates most of its profits from owned assets rather than from assets financed with debt. Further, SPH's operating cash exceeds 87 days of operating expenses, and its total cash from all sources exceeds $42 million.

Figure 42: SPH Balance Sheet, May 2023

South Peninsula Hospital

BALANCE SHEET

	As of May 31, 2023
ASSETS	
CURRENT ASSETS:	
CASH AND CASH EQUIVALENTS	25,333,334
EQUITY IN CENTRAL TREASURY	8,347,613
TOTAL CASH	33,680,947
PATIENT ACCOUNTS RECEIVABLE	30,250,113
LESS: ALLOWANCES & ADJ	(15,375,533)
NET PATIENT ACCT RECEIVABLE	14,874,580
PROPERTY TAXES RECV - KPB	105,476
LESS: ALLOW PROP TAX - KPB	(4,165)
NET PROPERTY TAX RECV - KPB	101,311
OTHER RECEIVABLES - SPH	428,809
INVENTORIES	1,892,655
NET PENSION ASSET- GASB	5,052,584
PREPAID EXPENSES	780,325
	-
TOTAL CURRENT ASSETS	56,811,211
ASSETS WHOSE USE IS LIMITED	
PREF UNOBLIGATED	6,634,037
PREF OBLIGATED	2,347,446
OTHER RESTRICTED FUNDS	46,409
	9,027,891
PROPERTY AND EQUIPMENT:	
LAND AND LAND IMPROVEMENTS	4,114,693
BUILDINGS	63,059,362
EQUIPMENT	27,516,737
BUILDINGS INTANGIBLE ASSETS	2,456,899
EQUIPMENT INTANGIBLE ASSETS	462,427
IMPROVEMENTS OTHER THAN BUILDINGS	309,171
CONSTRUCTION IN PROGRESS	1,356,454

LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(57,024,950)
LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(824,623)
NET CAPITAL ASSETS	41,426,170
GOODWILL	6,000
TOTAL ASSETS	107,271,272

3. Provide a description and estimate of:

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

It is the customary pricing practice of South Peninsula Hospital to set its charges at or about the average for Alaska hospital's Diagnostic Related Groups (DRG's). As a result, patients who receive Nuclear Medicine, Oncology / Infusion, and Pharmacy services at SPH will pay at or about standard pricing for the same services at another Alaska facility. Those in the target population needing Nuclear medicine services will see an overall decrease for the cost to receive these services locally due to decreased transportation costs, and lost time.

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

Not Applicable

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

In Section IX. Part D, Schedule IV you will see that our 5-year income statement projections demonstrate the long-term financial feasibility of SPH operations after project completion by increased gross patient revenues, net patient revenues and operating margins. While the individual Nuclear Medicine Service line may not pay for itself due to its moderate volumes, the ancillary services, surgeries, and other patient volumes generated will improve overall hospital 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.

Significant health needs were identified for the SPH service area based on quantitative and qualitative data about the health status of the Southern Kenai Peninsula (SKP) population. Quantitative health status data was drawn primarily from the Healthy Alaskans 2020-25 Leading Health Indicators. Qualitative data are from the 2019-2020 Perceptions of Community Health Survey, which asked respondents to report the factors that most affect the health of themselves, their family and community.

After its most recently published Community Health Needs Assessment (CHNA) in 2020, The SPH Board of Directors reviewed the accumulated data from a sample of 469 service area residents. The following significant health needs were identified by South Peninsula Hospital as priorities to address over the next few years:

- COVID-19 Response
- Senior Health
- Primary and Preventative Care

These health needs were prioritized largely based on the health trends revealed by the current health status indicator data. Overall, the health status data for the SKP suggests that the most significant health needs are for 1) increased and/or improved elder care services, and 2) increased and/or improved preventative and lifestyle care, including community health initiatives. Although preventative and lifestyle care were identified as key areas for improvement, it should be noted that the SKP generally met most health targets. Data for health indicators at the SKP level are nearly always more variable from year-to-year because of its smaller population (and therefore sample size) compared to other geographies, but over time, the general trends often mirror state and national trends and levels.

The 2020 CHNA was prepared during the COVID-19 pandemic, which revealed the additional need for response preparedness. The pandemic also precluded the MAPP of the SKP Steering Committee from participating in the development of this CHNA as much as would have been ideal. The MAPP of the Southern Kenai Peninsula Steering Committee is supportive of this CHNA and will utilize its results in the advancement of community health improvement initiatives. Below are data on the target population related to Senior Health and Primary and Preventative Health:

Senior Health

Senior health was determined as a significant health need because seniors make up a significant and growing population within the Southern Kenai Peninsula, and health care service levels often increase with age. Through the 2020 Community Perceptions of Health Survey, five percent of question responses identified elder care as one of the Southern Kenai Peninsula's greatest weaknesses. The 65 and over age group currently represents 18 percent of the SKP population. This group has been growing as a proportion of the overall SKP population, with a corresponding decrease in the population of the 45-

64 age group.[19] With these population dynamics, the SKP has a higher median age than the borough, state or nation. The 65 and over age group is projected to continue to increase through about 2030 in the Kenai Peninsula, then level off through 2045. Within this age group, state projections show the majority of elders between ages 65 and 74 through 2030. After 2030, the majority of elders age into the 75 to 84 age range, and the population aged 85 and older continues to grow through 2045.[20] A similar pattern is anticipated in the Southern Kenai Peninsula.

Resources to Address Senior Health

The South Peninsula Hospital will address this health need with the following hospital resources.

- Align outpatient services, especially the specialty clinic offerings, to meet the needs of an aging population.
- Work with Medicare and Medicaid to ensure residents are receiving maximum coverage and care.
- Build capacity in Home Health and Long-Term Care in anticipation of senior in home and residential needs.
- Work with local partners (such as Homer Senior Citizens Inc, Hospice, etc.) to ensure wraparound services which are not duplicative in a small community.

While the 2022/2023 CHNA is nearly complete, it has not yet been finalized and published as of the date of this CON. Certain data elements gathered during the production of that report have been used herein to support this application, however a strategic plan to address the needs will not be created until after the report has been published.

Data acquired during the production of the 2022/2023 CHNA does not clearly define demographic data on the **Southern** Kenai Peninsula for numerous metrics such as race and sex, and as such the data displayed below is representative of the entire Kenai Peninsula Borough. We believe this data to be materially accurate despite the inclusion of residents from more than one hospital service area. No data was captured to define the number of persons with a medical disability, however it does provide racial and ethnic minority as well as age and sex. The tables below show the ratio of race, sex, and age among our target population. Access to care for these different groups can be greatly affected by not only age, race, and sex, but also by income and geographic location.

Figure 43: Comparison of KPB Population to Alaska Population by Sex

Borough/Census Area	Total Responses		
	Total	Male	Female
ALASKA	791,034	406,633	384,401
ALASKA	100%	51%	49%
KPB	62,708	32,486	30,222
KPB	100%	52%	48%

Notes: These data were developed through a combination of estimates from the Alaska Department of Labor and Workforce Development, and the U.S. Census Bureau.
Sources: Alaska Department of Labor and Workforce Development, Research and Analysis Section; and U.S. Census Bureau

The target population for SPH is skewed slightly toward more male than female patients at 52% and 48%, respectively. This imbalance of male and female patients is one percent more pronounced than the statewide average of 51% to 49%, respectively.

Figure 44: Distribution of KPB Population to Alaska Population by Race

	Total Responses*	White	Alaska Native/ American Indian	Black/ African American	Asian	Native Hawaiian/ Pacific Islander	Hispanic
ALASKA	791,034	520,281	149,292	39,761	64,962	16,738	54,335
ALASKA	100%	66%	19%	5%	8%	2%	7%
KPB	62,708	52,060	7,387	925	1,948	388	2,663
KPB	100%	83%	12%	1%	3%	1%	4%

* The number of responses are higher than the population because multi-race individuals have multiple responses.
Notes: These data were developed through a combination of estimates from the Alaska Department of Labor and Workforce Development, and the U.S. Census Bureau.
Sources: Alaska Department of Labor and Workforce Development, Research and Analysis Section; and U.S. Census Bureau

Demographic data for racial and ethnic groups on the Kenai Peninsula from the Alaska Department of Labor and Workforce Development, indicate that minority ethnic groups make up approximately 17% of SPH's target population, compared to 34% statewide. The single largest minority population is comprised of Alaska Native Indians, followed by Hispanic, and Asian community members. While this data may indicate that the Southern Kenai Peninsula is less diverse in terms of standard race metrics than the remainder of the State, there are significantly more cultural differences which exist within the White category than this data might suggest. The Southern Kenai Peninsula Hospital Service Area is home to several Russian Orthodox communities including Nikolaevsk, Vosnesenka, and Rasdolna.

Cultural, language, and religious beliefs for our Russian Communities can differ from many Western practices including medicine as do other ethnic and minority groups. The care team at SPH is representative of the racial and ethnic diversity of our target population and as such prepares our team well for meeting the diverse needs and differences of our patients. Language barriers experienced by our patients and staff can often be managed through the translation efforts of our diverse on-site caregivers. When on-site translation services are unavailable, SPH uses a remote translating service which can be reached 24/7 by phone to ensure the best possible care is being delivered to our target population.

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

Over the past two years SPH has seen a decrease in Charity Care due to reductions in the allowances put in place during the pandemic which were unrealized. The amount of charity care provided is projected to grow as an aging population transitions to Medicare coverage with increased cost shares to Medicare patients who are often on fixed incomes.

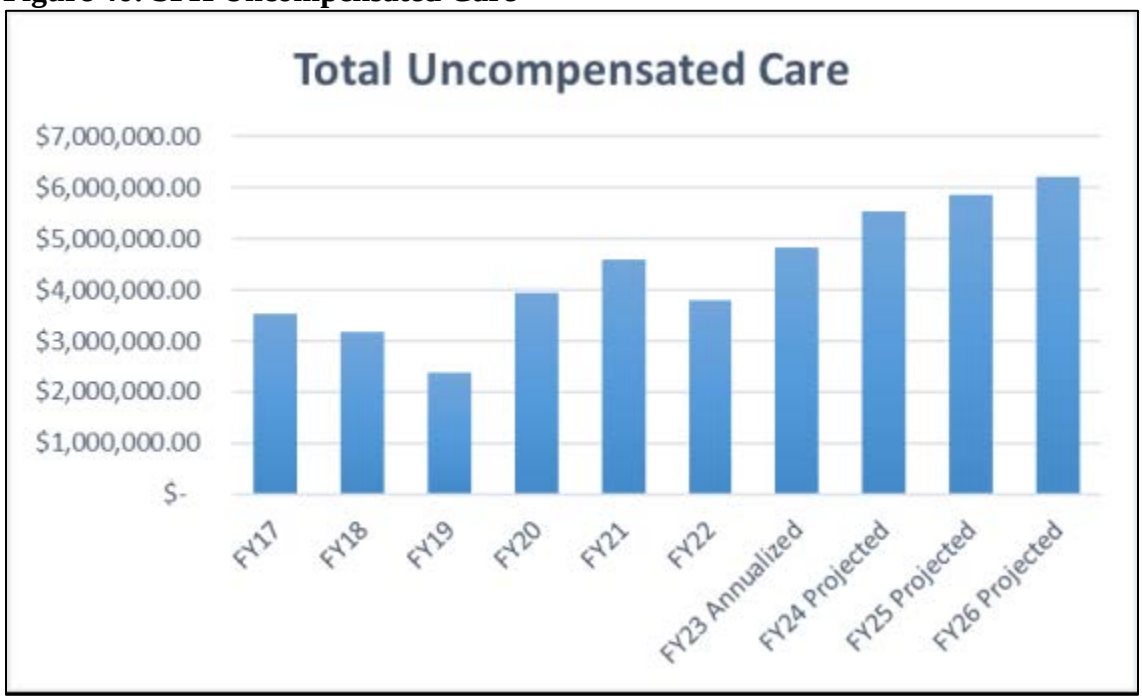
The following table identifies the Revenue Deductions, Contractual Allowances, Charity Care and Total Deductions from Gross Patient Revenue from 2017 to 2023 (annualized) and projected forward to 2026.

Figure 45: Deductions including Charity Care and Bad Debt

Fiscal Year	Charity Care	Bad Debt	Contractual Allowances	Total
FY17	$ 1,841,409.00	$ 1,678,691.00	$ 37,034,191.00	$ 40,554,291.00
FY18	$ 1,476,663.00	$ 1,699,188.00	$ 47,187,900.00	$ 50,363,751.00
FY19	$ 1,574,550.00	$ 794,189.00	$ 45,277,799.00	$ 47,646,538.00
FY20	$ 2,323,402.00	$ 1,632,346.00	$ 50,551,121.00	$ 54,506,869.00
FY21	$ 1,266,505.00	$ 3,332,151.00	$ 62,766,688.00	$ 67,365,344.00
FY22	$ 226,294.00	$ 3,568,228.00	$ 78,140,540.00	$ 81,935,062.00
FY23 Annualized	$ 1,915,525.33	$ 2,905,906.67	$ 81,629,321.33	$ 86,450,753.33
FY24 Projected	$ 2,456,514.06	$ 3,070,642.58	$ 86,527,080.61	$ 92,054,237.25
FY25 Projected	$ 2,603,904.91	$ 3,254,881.13	$ 91,718,705.45	$ 97,577,491.49
FY26 Projected	$ 2,760,139.20	$ 3,450,174.00	$ 97,221,827.78	$ 103,432,140.98

South Peninsula Hospital expects to encounter continued increases year over year in uncompensated care. Uncompensated care provided to the community is defined as the sum of Bad Debt and Charity Care. The uncompensated care trend can be seen in the following chart with growth from $3.5M in FY2017 to $6.2M projected for FY2026.

Figure 46: SPH Uncompensated Care



3. Address the following access issues:

a. transportation and travel time to the facility;

Transportation and travel time to the SPH facility to receive Nuclear Medicine studies will reduce both time lost, and travel related expenses for residents of the Southern Kenai Peninsula. Further, increased access for Oncology / Infusion patients will mean that as our volumes continue to grow, the likelihood that patients can receive their cancer treatments close to home will be improved.

Conversely, without the approval of this CON we believe that the existing gap in health services will continue to exist for our elderly and low income patients as well as patients unable to secure an entire day to receive out of town services. The distance for service area members to the closes Nuclear Medicine department ranges from 45 – 120 minutes one way by car, and longer for patient residing across Kachemak Bay.

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

The location of the SPH Nuclear Medicine and Oncology / Infusion departments are specially designed to reduce walking distances for patients from both the lower and the upper parking lots. When possible, the most mobile patient populations are located furthest from the door or on higher floors. For patients with longer treatments, such as Oncology / Infusion, we attempted to improve the access to natural light, pleasant views, and beautiful architecture by situating our treatment bays by the external windows

overlooking Kachemak Bay. Scientific evidence suggests that beautiful architecture, art, and music can help facilitate the healing process. In addition, we have ensured that our architecture remain compliant with all Federal, State, and local laws such as the Americans with Disabilities Act.

c. hours of operation; and

SPH Nuclear Medicine studies will be performed between Monday and Fridays, 2 to 3 days per week, 48 weeks per year between the hours of 8:00 am and 5:00 pm. This will be gradually increased over the first three years to reach the full projected capacity of approximately 250 studies per year. With the presence of this diagnostic service line in our local area, we expect that Medical providers will order Nuclear Medicine exams more often because the burden on the patient will be less costly.

SPH's Oncology / Infusion Center will be open Monday through Friday, 8:00 am to 5:00pm, and closed on major holidays.

SPH's Pharmacy Department is open from 7:00 am to 7:00pm, 7 days a week with on-site pharmacists and technicians, and after hours pharmacy reviews are performed by a contract pharmacy service.

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

SPH corporate policy, HW-068 Patient & Resident Rights: See APPENDIX.

Section V.

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

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.***

South Peninsula Hospital received its State designation as a Critical Access Hospital (CAH) on August 8, 2007 from the Alaska Department of Health and Social Services (AK DHSS License #GACH-010)). South Peninsula Hospital received its Federal designation as a Critical Access Hospital on September 5, 2008 from the United State Department of Health and Human Services (US DHHS). Copies of documents are provided in APPENDIX.

As a CMS certified CAH, all services provided within this CON project will follow regulatory standards set by the Centers for Medicare and Medicaid Services. It is SPH's intent to continue as a CMS Hospital, and therefore current practices and regulatory adherence will continue. Certification was received from CMS after our most recent on-site recertification survey performed on November 17, 2021. The recertification is valid for a period of up to 36 months. All CMS CAHs must follow certain Conditions of Participation (CoP) for both their state and their federal compliance which can be found at:

Federal CoPs: Title 42, Chapter IV, Subchapter G, Part 485, Subpart F
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F

Alaska State CoPs: State Operations Manual, Appendix W https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

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

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

The primary focus of the quality program is to identify opportunities to improve processes which will lead to high quality care and exceptional patient outcomes. Our goal is that zero harm should reach our patients. All incidents reported are tracked in a quality management system and reviewed by multiple layers of our clinical, quality, and management team for optimal resolution. Periodically, our incidents are also evaluated for trends and when trends are identified actions are taken to improve processes. The SPH quality program is committed to the opportunity to improve care by examining the systems and processes by which care is provided. For incidences where patient or staff safety was at risk, a root cause analysis (RCA) may be performed. Outcomes from an RCA result in process changes, new or updated policies, staff education and training, and more.

Ultimately, it is the Board of Directors of South Peninsula Hospital that is accountable for safety in the organization due to their legal responsibility and operational authority for hospital performance. Under the governance of the operating board, the CEO and members of senior management set patient safety goals annually in the organization Balance Scorecard. The goal of each quality target on the Balanced Scorecard is to use real time, fail safe patient data to guide patient care resources in making process improvements that ensure the highest level of safety for our patient. Members of Senior leadership are responsible for ensuring that adequate resources, including staff, training, and technology are provided to address goals and monitor outcomes. (See APPENDIX, SPH Balanced Scorecard)

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

The Quality Department, led by an RN Director of Quality Management, is responsible for collecting and analyzing data pertaining to patient safety, for disseminating analyzed data to the Board of Directors, Patient Centered Care Quality Committee (PCCQ), Medical Executive Committee (MEC), SPH Administration (Admin), Department Directors, and to staff through a variety of established communication tools. The Quality Department is also responsible for investigating incidents of patient harm occurring at the hospital or as a result of care received at the hospital, for facilitating root cause analyses (RCAs), and for assisting department directors in developing plans to improve patient safety, largely through the employment of the Plan, Do, Study, Act (PDSA) Quality Improvement Change model. (See APPENDIX, Corporate policy HW-267)

Department Directors are responsible for identifying opportunities to improve safety from a variety of sources such as patient comments and surveys, feedback from staff, and internal data showing favorable or unfavorable trends compared to other organizations (i.e. benchmarking). Directors are also responsible for being agents of change, building consensus and collaborating with their teams to find solutions, overseeing the change in processes, setting staff and patient expectations, and monitoring effectiveness of changes implemented. As subject matter experts for their areas, they generally lead discussions about patient safety issues that exist on their units, or highlight areas of risk that have potential to impact their units.

Staff are responsible for following established safety policies and procedures such as hand washing, time outs, using two patient identifiers, and more. Staff are also responsible for reporting their safety concerns and when known, opportunities for improvement. As you will see in the Appendix, our Quality Plan encourages all staff to “speak-up and speak-out” in order to keep our patients and staff safe. SPH follows the *Just Culture* philosophy of quality improvement which supports a blame-free environment where staff can safely share their comments and concerns about any practice in a supportive and psychologically safe organization.

Physicians are also responsible for following established safety procedures and protocols such as hand washing, time outs, using two patient identifiers, site marking, facilitating teamwork, and practicing effective hand off communication, etc. The Medical Staff Peer Review Committee is responsible for reviewing cases involving safety concerns or patient harm and providing meaningful feedback or suggestions for improvement to peers. The Peer Review Committee is also beginning to pull a random sample of charts from each active medical staff member in order to provide more value to our quality review and evaluation program for Medical staff members. Findings from case reviews are presented to the MEC and when necessary, appropriate actions are taken to counsel medical providers, provide feedback, continuing education, or other measures as deemed necessary. The CEO, COO, and CNO also attend MEC meetings to provide feedback, receive updates, and continue to collaborate and support the Medical Staff of the Hospital. Actions from MEC are shared with the SPH Board of Directors on a monthly basis.

Physicians take responsibility for communicating with patients and/or families when patient harm has occurred. In the case of a sentinel event (see APPENDIX: HW-160) the Physician and CEO are responsible for communicating with the patient/family and an RCA is performed to identify the cause of the event.

To ensure that patients receive the highest quality care, quality is a major element of the Balanced Scorecard (APPENDIX) and the organizational culture at SPH.

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

Nuclear Medicine – As this is a new service line, SPH does require an increase in staffing in order to performed nuclear medicine exams. Nuclear Medicine requires specialized skills and training in order to safely perform examinations. Currently, none of our existing imaging staff members possess this training. As such SPH will need to hire a Nuclear Medicine Technician. Based on the number of expected tests, SPH will require no more than 0.75 – 1.0 Full time equivalent (FTE) which equates to 1,560 to 2,080 worked hours. This level of staffing will be more than sufficient to perform the expected 181 to 251 exams per year. Further, we expect that the additional time not spent with patients will allow for quality, safety, and regulatory tasks and performing back-up/overflow CT procedures.

Oncology / Infusion – Our Oncology / Infusion Center currently employees 3 nurses and 1 contract nurse, a Patient Care Technician, and 2 administrative / scheduling staff. We believe that the current number of staff is sufficient for the next 1 – 2 years. Due to projected volume growth, we expect that additional nursing staff will need to be added over years 3 – 5. Safe nursing to patient to staffing ratios for Oncology / Infusion according to the *Oncology Nursing News* rely upon numerous factors (Oncology Nurse Staffing Is Variable and Multifactorial (oncnursingnews.com). All things being equal, we believe that our staffing for 4 infusion bays will nearly double for the proposed 10 infusion bays.

Pharmacy – Our Pharmacy Department currently operates with 1 Pharmacy Director, 3 Full-time Pharmacists, and 5 to 6 Pharmacy Technicians. As Oncology / Infusion requires a great deal of interdepartmental collaboration and teamwork with the Pharmacy, we expect that increases in Oncology / Infusion volumes will require that we increase the number of Pharmacists and potentially Technicians on our staff. The preparation of Chemotherapy and other highly regulated medications is highly labor intensive. When our new Oncology / Infusion Center reaches 75 – 100% capacity we expect to have a full-time dedicated Pharmacist to manage the day-to-day workload.

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***

N/A: There are no programs associated with this proposal that will reduce inpatient services.

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.***

Nuclear Medicine

The proposed CON's primary purpose is to introduce a new service line (Nuclear Medicine) to the Southern Kenai Peninsula. While this technology is not "new" in terms of medical technology, it is considered the preferred diagnostic imaging procedure for many types of organ, heart, and cancer-related diagnoses. The addition of Nuclear Medicine to the complement of imaging modalities already provided at SPH will not only enhance the accuracy and reliability of our medical staff's decision making abilities, it will reduce patient service gaps which currently exist, reduce the time elapsed between symptom reporting and treatment, and ultimately improve patient outcomes for Southern Kenai Peninsula residents.

The exact technology we propose to use, the Siemens Symbia Pro.specta SPECT/CT, possesses what it calls 'crystal technology' which can reliably manage system energies and collimators (narrowing of the beam of particles) for each type of isotope. A copy of the vendor brochure can be found in APPENDIX.

Pharmacy Upgrade

The CON's secondary purpose is to upgrade our Pharmacy so that it meets USP safety regulations and guidelines for compounding pharmaceuticals and for the treatment and handling of hazardous materials and related waste. The architectural design team has identified the most current compounding Laminar Flow and Biosafety hoods, Medication safes, and medical-grade Biological Refrigerators/Freezer to keep our staff and patients safe. While this project does not improve the accuracy or reliability of diagnostic or treatment procedures, it is a required project and the relocation of the Pharmacy Department is required to enable the addition of Nuclear Medicine.

Oncology / Infusion

The CON's tertiary purpose is to expand and co-locate our medical Oncology / Infusion center next to the new Pharmacy department. Our design team has identified upgraded equipment such as new automated Medication distribution systems (Pyxis), warming cabinets, new IV infusion pumps, chairs, and other equipment to ensure that our patients receive the highest degree of accuracy, reliability, quality, and comfort during their treatments.

The latest in technology will be purchased for placement in the proposed project at the time of project initiation. Major diagnostic equipment is necessary for the Nuclear Medicine department as noted above, and displayed in APPENDIX. SPH has already considered the top nuclear medicine equipment vendors, makes, and models in this service line and determined that the best quality, compatibility, and staff success would be found with a unit that was similar in nature to our existing CT.

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

Labor and efficiency savings are built into the proposed project by colocation of specialty services such as Pharmacy with Oncology / Infusion and Nuclear Medicine with the Imaging Department. As previously discussed, the Nuclear Medicine services will be located directly across the hallway from the existing imaging department. This location provides efficiencies both for staff and patients in the event of emergent case. While not generally used for emergencies, the SPECT/CT does have the capacity to perform CTs during downtime or periods of increased volume as overflow. Because of this reason, the proximity of the SPECT/CT to the emergency department was considered.

Further, we believe that the colocation of the Pharmacy and the Oncology / Infusion Center will provide the greatest amount of labor cost savings and time efficiencies. In its current location, all supplies, pharmaceuticals, intravenous fluids, and labs must be carried by hand from building to building, passing through a congested and often icy parking lot. Patients who arrive for Oncology / Infusion treatments, often begin with lab draws to ensure that they may be safely treated. The inefficiencies caused by transporting lab specimens to and from the main Hospital building, followed by the mixing and transportation of medications used for treatment causes significant burdens on staff time and unnecessary delays in patient care. We believe this colocation initiative will provide significant efficiencies for our patients and staff from our Oncology / Infusion Center and Pharmacy Departments.

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

South Peninsula Hospital performs monthly, quarterly, and annual statistical review of our patient volumes, financial operations, patient satisfaction, and quality metrics. We are also responsive to identified community needs and feedback from our service area population. The need for the proposed

project was identified by medical staff feedback and our triennial Community Health Needs Assessment, and is supported through local data, and the strategic plan of the hospital.

SPH Administration plans to use internal statistical data capturing the number of Nuclear Medicine studies performed at SPH compared to total market share of service area residents by zip code (State of Alaska OHDIN database) to monitor improvement in our Service Area's Gap in care. While the service gap has been estimated at 35% to as much as 46% annually, we believe that we can reduce this gap in care to 10% or less within the first three years of project completion.

SPH will continue the assessment of both staff and patient satisfaction through standardized customer satisfaction surveys (Press Ganey) and staff engagement surveys (Press Ganey) in addition to real time discussions and department meetings to ensure the our Oncology / Infusion Center colocation and expansion and the Pharmacy Upgrades meet our expectations. SPH's Quality Improvement Department will continue to measure occurrences and report out on customer satisfaction scores for the Hospital's Balanced Scorecard. SPH strongly believes that patient utilization projections will be fulfilled and that patients will be pleased with the expanded and modernized Oncology / Infusion Center.

In addition to internal mechanisms that measure success, SPH will maintain CMS certification, and State of Alaska licensing, as well as meet all CMS CoPs. Hospital quality metrics are monitored on the Balanced Scorecard and by using publicly reported quality and patient satisfaction measures provided by the Centers for Medicaid and Medicare Services Care Compare website. *https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital*

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

South Peninsula Hospital has a multi-level leadership and governance team that represents many different layers of the community in which it resides. From employed hospital administrative staff, to a self-elected Operating Board of Directors, a community elected Service Area Board of Directors, and an elected Mayor and Borough Assembly members. The South Peninsula Hospital ownership and governance structure is complex and best shown by reviewing our Organizational chart, Board Roster, and Ownership/Governance chart (see APPENDIX, Figures 10 through 12).

In addition to this multi-layered governance structure, SPH also participates in a community led organization called MAPP (Mobilizing for Action through Planning and Partnerships) whose purpose is to collect and review community health data, and identify plans for improving community health. The MAPP coalition was started in 2008 to support long term planning for community wellbeing and continues to be one of the major sources for identifying community health needs and connecting

community partners and agencies dedicated to meeting those needs. A copy of the steering committee members for the MAPP organization is located in APPENDIX, Figure 13.

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.***

Nuclear Medicine Department

In addition to the Radiologist, Department Director, which is already employed by South Peninsula Hospital, there will be one new staff FTE position and one partial Radiologist position needed to provide services in the nuclear medicine program:

- Radiologist 0.375 FTE (1.0 existing, 0.375 new)
- Imaging Director 1.0 FTE (existing)
- Certified Nuclear Medicine Technologist (CNMT) 0.75 - 1.0 FTE (new)
- Nurse 0.05-0.10 FTE (existing)

The Nuclear Medicine service line is a highly regulated imaging discipline which will require the skills and education of a certified nuclear medicine technologist in order to ensure quality patient care and staff competence. According the Nuclear Medicine Technology Certification Board, a combination of both an entry-level examination and annual continuing education coupled with active performance of nuclear medicine studies each year will allow a CNMT to remain in good standing with the Board. While the exact number of studies performed each year is not enumerated, we believe the projected SPH exam volumes will be more than sufficient for a 1.0 CNMT to remain proficient.

The approximate staffing and FTE levels were obtained from the International Atomic Energy Agency (IAEA) Nuclear Medicine staffing recommendations report (located at: 21-02577E_PUB1965_Body_24_10_2022-Print-PDF.indd (iaea.org)). Further, in the excerpts from that report below you will see the general responsibilities of each major position:

Figure 47: IAEA Nuclear Medicine Attending Physician responsibilities

3.1. NUCLEAR MEDICINE/ATTENDING PHYSICIANS

The nuclear medicine/attending physician has the following responsibilities [6]:

(a) Interviewing patients;
(b) Defining the clinical appropriateness of and justification for the request or referral, for both diagnostics and therapy;

(c) In accordance with departmental SOPs, giving instructions for the appropriate tests and protocols, keeping in mind the safety of both the patient and staff;
(d) When necessary, tailoring protocols to the needs and condition of the patient;
(e) Interpreting results of diagnostic or therapeutic procedures, based also on clinical information and providing a diagnosis to the extent possible;
(f) Providing training (and education) for technical and junior medical staff;
(g) When in a managerial position, ensuring proper operation of the department and adherence to quality management procedures;
(h) Developing and reviewing departmental SOPs on a regular basis;
(i) Attending multidisciplinary team meetings;
(j) Discussing cases with referring clinicians;
(k) Performing periodic audits of clinical activities;
(l) Reporting adverse events as needed;
(m) Contributing to the departmental quality management system and to internal and external audits.

Figure 48: IAEA Nuclear Medicine Technologist responsibilities

3.3. NUCLEAR MEDICINE TECHNOLOGISTS OR RADIOGRAPHERS

The responsibilities of a nuclear medicine technologist typically include some or all of the following:

(a) Preparing the scanner for imaging procedures;
(b) Preparing patients prior to study acquisition;
(c) Administering prepared radiopharmaceuticals (in accordance with local regulations);
(d) Acquiring images;
(e) Processing data;
(f) Displaying images or data;
(g) When needed, preparing in a safe and aseptic manner and dispensing radiopharmaceuticals, and performing quality control;
(h) Measuring the activity of prepared radiopharmaceuticals;
(i) Performing routine quality control of instrumentation;
(j) Contributing to the departmental quality management system and to internal and external audits;
(k) Contributing to the safe handling of radioactive waste.

Pharmacy Department

Pharmacy staffing will remain roughly the same as it is now, however with 1 Pharmacy Director, 3 Pharmacists and 5 to 6 Pharmacy Technicians, there is little room to absorb continued growth in our Oncology Infusion Center. While many staff time efficiencies will be gained from the co-location of the Center, the addition of up to 555 patient visits annually over the next 4 years will require an increase in staff pharmacy time.

The staffing matrix for support of our growing Oncology / Infusion Center was based upon the data found in the ASHP Specialty Pharmacy Practitioners report found at: https://www.ashp.org/-/media/69EC2B66EE724539AC462647D019CE8A.pdf which indicates that an appropriately staffed Pharmacy could process on the average 2,500 RXs per technician per months, fulfill 1,500 RX requests each month, place up to 1,000 orders, or handle 1,000 calls per month. These

hidden duties of our pharmacy technicians are hard to quantify in terms of the number of additional patient visits we will experience. Further, high cost chemotherapy and infusion drugs require significant administrative input to obtain prior authorizations and coordinate care with patients.

Meanwhile, the average experienced retail pharmacist can verify up to 2,500 RXs per month. By contrast, retail pharmacy does not take into account the requirements for safe compounding and handling of chemotherapy drugs, making a Hospital Oncology pharmacist significantly less productive.

While it is challenging to estimate the exact number of FTEs which will be required of the SPH Pharmacy to manage the additional volumes generated from the Oncology / Infusion Center expansion, we estimate that volume could justify an additional 0.5 FTE Pharmacy Tech and a 0.5 FTE Pharmacist.

Oncology / Infusion Department

Oncology staffing will follow a very similar model as currently exists in our Oncology / Infusion center. Because of the multi-use purpose of the Oncology / Infusion center, we staff to the lowest nurse-to-patient ratio recommended for patients receiving chemotherapy, 1:3. At minimum, SPH attempts to have two nurses on-site with patients while they are receiving their treatments. This higher nurse-to-patient ratio will occur when there are 3 patients or less receiving treatment at any time. After our Oncology / Infusion center expands to nearly double the current patient capacity, we expect that so too will our volumes (based on historical trends).

Our current staffing matrix for Oncology / Infusion which supports and estimated 2,260 visits per year and an estimated 9 patients per day is:

Nurses	2.2 FTEs
MA	1.0 FTEs
Registration	0.75 FTE
Manager	0.25 FTE
Total	4.20 FTEs

Our projected volumes for 2025 through 2032 after the expansion project is an increase from 2,480 to 2,905 patients visits, or 10 to 12 patients per day. The fractional increase in staffing expected for this volumes will be:

Nurses	3.0 FTEs
MA	1.5 FTEs
Registration	1.2 FTE
Manager	0.25 FTE
Total	5.95 FTEs

We acknowledge that there are many factors which determine safe staffing ratios for medical oncology and infusion patients, our staffing ratios are in line with recommendations of the respondents of Oncology Nursing News. According to the ONS July 2012 article, the safe care of 9-12 patients per day requires 3 full time nurses, which is also consistent with the 29% increase in volume (Goodman, 2021).

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.***

N/A - The size of the proposed spaces are within industry standards and are not significantly smaller or larger.

Section VI.

Narrative Description of How Project Meets Applicable Review Standards

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

General Review Standard #1 – Documented Need:

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

In Section IV., we demonstrated a need for nuclear medicine diagnostic imaging services and increased Cancer care for the 15,000+ residents in the South Kenai Peninsula Hospital Service Area. Providing these services expands the diagnostic tests that are available locally to identify abnormalities and diseases of the heart and other organs, as well as needed capacity for treating malignant neoplasms (Cancer). Due to our aging and growing population, these service lines will have increased utilization over the next 3, 5 and 10 years.

With regard to additional Oncology / Infusion bays, there has been significant volume increases that continue to project into the future, emphasizing the need to expand our center to allow for continued growth.

Mortality and Leading Causes of Death

The leading causes of death in the Southern Kenai Peninsula area since 2000 is Cancer and Heart Disease. (*see figure 12*)

In addition, the 2023 Draft CHNA indicates that Kenai Peninsula residents are reporting a significant increase (12%) and possible upward trend for those **diagnosed** with any heart disease. Further, in 5 of the last 7 years residents of the Kenai Peninsula showed a higher rate of CHD than other residents of the State of Alaska (*see Figure 15*)

Multiple Community Health Needs Assessments (CHNA) have demonstrated the need from service area residents for specialty services. The 2020 CHNA summary demonstrates a need for more primary, local care close to home.

Increasing demand: changing demographics

The percentage of seniors (age 65 and older) on the Kenai Peninsula is midstream of a large growth cycle. Because seniors are heavy utilizers of healthcare services, these projections create urgency to respond to increasing demand for services such as Oncology and Advanced imaging. Increasing locally

available services provides appropriate and timely care delivery for a vulnerable population. (*see Figure 16*)

According to the Deloitte Center for Health Solutions, seniors (defined as 65 and older) account for 36% of total health care costs. When added to the "Baby Boomer" generation which began retiring in 2011, seniors and baby boomers combine for a sixty-four percent share of total health care spending.[5] A July 2011 Data Brief on health care spending shows that 5 percent of Americans are responsible for nearly half (47.5%) of all health care spending in the United States. [6] A principal reason why higher health care spending occurs among seniors is due to the fact that nearly half (45%) are suffering from two or more chronic conditions. [7]

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

Nuclear Medicine Need

The State of Alaska utilization is higher than the SPH service area utilization and a gap in local care that results in significant patient travel for Nuclear Medicine services. One can see in the Utilization table in Figure 25 that residents from the SPH Service Area are receiving significantly less Nuclear Medicine studies per year compared to their counterparts from other service areas. The Service gap appears to be as high as 46% less Nuclear Medicine studies performed for SPH area residents in 2020 compared to others in the State of Alaska and 43% less during 2022. These figures are staggering and point to the colossal barriers to healthcare posed by geographic isolation, home-bound patients, our elderly population, and those without transportation.

Oncology / Infusion Expansion Need

At the date of this certificate of need application, South Peninsula Hospital is the only facility offering Oncology / Infusion services in our service area. While there are certain providers of health and wellness related infusion services, they are not the same level of care, nor do they manage chemotherapy or other highly regulated pharmaceutical drugs. As such the utilization data shown below are for the services currently provided at South Peninsula Hospital only.

While not a new service line, our capacity for continuing to meet the Oncology / Infusion needs of our target population is significantly impaired by their current building size of 960 square feet. The rapid

[5] *"The hidden costs of U.S. health care for consumers: A comprehensive analysis March 2011"*

[6] *"Understanding U.S. Health Care Spending," NIHMC Foundation Data Brief July 2011*

[7] *"Multiple Chronic Conditions Among Adults Aged 45 and Over," Centers for Disease Control 2012*

growth of South Peninsula Hospital's Oncology / Infusion department since 2018 is demonstrated in Figure 28, and has more than doubled in 5 years.

Pharmacy Upgrade Need

Earlier in this application, we demonstrated the needs for an upgrade to our Hospital Pharmacy which will also be met by this CON Project. The primary needs are:

Compliance – This CON project will allow the SPH Pharmacy to meet USP General Chapters 797 and 800 regarding the building requirements for drug compounding and the safe handling and disposal of hazardous materials.

Staff Safety and Satisfaction – The drug compounding and hazardous materials standards outlined by the US Pharmacopeia have very real staff safety protocols which will keep our team safe from breathing or ingesting unsafe substances or gases. Further, this project will also improve staff satisfaction which is impaired due to the complexity and time lost transporting infusion and chemotherapy supplies in and out of the building by both Pharmacy and Oncology / Infusion staff.

General Review Standard #2 – Relationship to Applicable Plans:

The applicant demonstrates that the project, including the applicant's long-range development plans, augments and integrates with relevant community, regional, state, and federal health planning, and incorporates or reflects evidence-based planning and service delivery. A 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.

Consistency with Local and Regional Plans

South Peninsula Hospital (SPH) is a critical access hospital with 9 ER beds, 3 birthing center beds, 19 acute care beds, a co-located 28-bed Long Term Care unit, and numerous ancillary clinics and medical offices.

As a full-service hospital and health system, SPH serves the general Southern Kenai Peninsula (SKP) community, regardless of age, sex, income-level or geographic location within the service area. Through the E.R., Primary care, Home Health, Nursing Home and Specialty clinic, the organization serves individuals from all demographics in 16 communities throughout its service area, as well as visitors to the Southern Kenai Peninsula.

The hospital is the result of a unique partnership between the Kenai Peninsula Borough (service-area tax support for the facility and capital investments), City of Homer (for the land), and SPH, Inc., (the non-profit organization which operates the hospital). The hospital is governed by an eleven-member Board of Directors. An elected Service Area Board provides public recommendation on capital spending with tax dollars and scope of services.

Local SPH Planning

The 2022-2023 SPH Community Health Needs Assessment is in the final publication stages and as such it was consulted but not officially referenced herein. The 2019-2020 South Peninsula Hospital Community Health Needs Assessment (SPH CHNA) assesses the health needs of the South Kenai Peninsula Hospital service area, which is generally the Southern Kenai Peninsula (SKP). The study meets Internal Revenue Service requirements under Section 501(r)(3)(A) to conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.

Significant health needs were identified for the SPH service area based on results of the 2019 -2020 Perceptions of Community Health Survey and an evaluation of health status indicators drawn primarily from the Healthy Alaskans 2020 Leading Health Indicators. The Mobilizing to Action though Planning Partnership (MAPP), the Southern Kenai Peninsula Health Coalition Steering Committee supported the development of the CHNA and utilizes its results in the implementation of health improvement initiatives. The hospital's governing Board adopted the report on June 24, 2020 and an implementation strategy was published in December 2020: https://www.sphosp.org/wp-content/uploads/2020/12/2020-Implementation-Strategy-no-background.pdf

In the SPH CHNA Implementation Strategy are several Health Priorities which include; 1)Health needs of an aging community, and 2)Strengthen primary and preventative care. These health needs were prioritized largely based on the health trends revealed by the current health status indicator data. In addition, findings from the most recently published CHNA indicate that cancer, and heart disease continue to be the top two causes of death for the Kenai Peninsula. This CON project is in support of these findings and will provide diagnostic tools and treatments to address the leading cause of death in the communities served by SPH.

Facilities Master Plan

In addition to the CHNA (2020), related CHNA Implementation Strategy (2020), and Hospital Strategic Plan (2021-2022), SPH recently completed a Facilities Master Plan (FMP 2022-2032) supporting the needs in this request. The FMP outlines priorities and potential approaches for delivering gaps in care to our community over the next 10 years. The FMP Steering Committee was comprised of a multi-agency stakeholder group which included membership from the Kenai Peninsula Borough (KPB), KPB Assembly, South Kenai Peninsula Hospital Service Area Board, South Peninsula Hospital Operating Board, South Peninsula Hospital Leadership, and the City of Homer. As noted previously, this CON project meets 4 of the 9 Priority level findings. Those 4 priorities are:

#1 Utilize existing Core and Shell Space
#2 Consolidate multiple services currently located around and off Campus

#7 Pharmacy Upgrades & Compliance
#9 Provide better campus wayfinding and entry points

Funding sources which will finance this project will come from Hospital Plant Replacement and Expansion Funds, Philanthropic Support, Grant Funds, and Service Area Property tax revenues which go through a multi-level approval process including Hospital leadership, SPH Board of Director approval, Service Area Board approval, Kenai Peninsula Borough Assembly approval, and Grantor or Donor approval groups.

State of Alaska Planning

The Division of Public Health's 2022-2025 Strategic is based upon the principle: "Ensure that all Alaskans have full and equal access to opportunities to lead healthy lives." (AKDHSS, Dec. 2021) The state's commitment toward quality healthcare focuses on groups that are underserved, excluded, or marginalized due to geography, infrastructure, resources, education, housing, barriers to access, and community conditions. The SPH Nuclear Medicine addition, Pharmacy upgrade, and Infusion expansion and colocation project meeting the State of Alaska's proposed strategic plan to expand and provide quality healthcare services to our geographically isolated and resource restricted community members.

SPH contacted the state Certificate of Need Coordinator and asked for any relevant state plans with regard to local Nuclear Medicine services on the Southern Kenai Peninsula. The response indicated there were no specific plans from other entities to provide this service within our Service Area. SPH has demonstrated in Section IV.A that our long-range development plans augment and integrate with relevant community, regional, state and federal health plans. Planning at the local level is typically done by SPH in conjunction with the KPB. The most recent community health needs assessment was conducted in 2022/23 and the results are currently being published.

National Healthcare Planning

The Center for Disease Control (CDC) issued its 2022-2027 Strategic Plan which aligns with that of the State of Alaska's commitment to health equity and diversity (https://www.cdc.gov/about/strategic-plan/index.html).

Two of the CDC's strategic initiatives which are met by this CON Project include:

- Putting science and advanced technology into action to prevent disease
- Tackling health problems causing death and disability for Americans

The proposed project is certainly consistent with and augments plans at all levels. The proposed project is intended to improve access to care, reduce service gaps, create efficiencies and cost savings for patients and provide lifesaving diagnostics and treatment for our target population. SPH has an outstanding record for patient satisfaction and quality of service as demonstrated on the Care Compare website. SPH Finance leaders compare pricing of patient care services annually in relation to other Hospitals throughout the state to ensure that our prices are competitive.

General Review Standard #3 – Stakeholder Participation:

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

The stakeholder participation for the proposed project design included SPH Managers and staff, SPH Administration, Hospital Operating Board (SPH, Inc. public meetings), members of the medical staff, KPB Mayor, Capital Works and Finance staff, public hearings and so far, unanimous approval by the KPB Assembly following those public hearings.

General Review Standard #4 – Alternatives Considered:

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

Alternatives for Nuclear Medicine

The alternatives to Nuclear Medicine have been thoroughly considered and employed at SPH for many years. There are several imaging modalities which offer *some*, but not *all* of the diagnostic imaging capabilities of Nuclear Medicine Studies. South Peninsula Hospital has employed the use of Computed Tomography (CT), X-Ray, Mammography, Magnetic Resonance Imaging (MRI), Ultrasound, and Dual X-ray Absorptiometry (DEXA) to provide the appropriate level of diagnostic tools to support our Service Area's health needs. However, the simple detection of anomalies in the heart, organ dysfunction, and proper blood flow within organ tissues, tumors, cancer, their exact size or locations in order to support diagnosis and surgical or other interventions are not being sufficiently met with our existing imaging exams. It is after many years of research, upgrades to existing technologies, and waiting for healthcare market disruptors, SPH has determined that there is no equivalency to the healthcare outcomes of Nuclear Medicine exams.

Do Nothing (status quo): Currently the only option for residents on the Kenai Peninsula to receive Nuclear Medicine services is for patient travel up to 90 minutes or more to Central Peninsula Hospital in Soldotna. For some Service Area residents, this trip is too great and their physician orders for a Nuclear Medicine exam go untouched, or a lower quality exam is ordered and the resulting image is not sufficient to properly diagnose or treat the patient, thereby requiring yet another advanced imaging exam and an increase in healthcare costs to the patient and insurer.

Providing Nuclear Medicine services will improve quality for SPH patients, particularly the aging and vulnerable. For that reason alone, "doing nothing" prevents residents from receiving a basic diagnosis close to home.

Alternatives for Infusion Bay Expansion

Do Nothing (status quo): On its current growth trajectory, SPH runs the risk of reaching its patient capacity over the next two years, requiring one of three inevitable outcomes: 1) patients would need to

leave the service area to obtain their Oncology / Infusion services in Soldotna, or 2) another healthcare entity will come and provide infusion care in a separate location within the service area, or 3) in order to meet continued growth and long duration of treatment times Oncology / Infusion services would displace another hospital service line or location in order to accommodate expansion, or the service line would be split into multiple locations. SPH is committed to providing for its community and does not believe that these three alternative scenarios would improve the quality or effectiveness of patient care or the patient experience.

Expand the Oncology / Infusion Center: One alternative is to remodel the current department in place. Although this option would allow for incremental growth and for the service to remain consolidated on the SPH campus, it does pose some additional complexities which could be limiting:

d. The current building is not owned by South Peninsula Hospital, but rather it is leased. The significant and costly investment into the expansion of that building would not be financial responsible if SPH is not able to purchase it.
e. The current building footprint offers significant parking surrounding it, which if lost could create other negative down streams impacts to an already congested parking situation at SPH.
f. Leaving the Oncology / Infusion services offsite while it increases in volumes will only exacerbate the patient quality, staff concerns, and environmental hazards which exist today.

Given the alternatives, SPH believes that on-site co-location and expansion of the Oncology / Infusion Center is the best option for meeting the future healthcare needs of the Southern Kenai Peninsula.

Alternatives for Pharmacy Upgrades

Unfortunately, there are no alternative solutions to upgrading our Pharmacy to meet USP General Chapter 797 and 800 guidelines. This project must be done or we risk the continued licensure and operation of our facility in accordance with National and State guidelines.

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

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

Residents of the SKPHSA have consistently communicated through multiple community health needs surveys the need for additional Cancer care options and Access to standard care. Cancer care has never been significantly addressed in SPH medical facility expansion efforts.

Impact on Local Health Care System

There are no existing comparable services in the primary service area for Nuclear Medicine. Central Peninsula Hospital has primarily served the needs for SPH service area residents who are willing and able to travel outside of their community. The cost of travel, time, and access to transportation we believe has significantly impacted the utilization of this service at other facilities.

There are also no existing comparable services in the primary service area for Oncology / Infusion. The second largest provider of community health services (SVT Health and Wellness) does not include the provision of essential Cancer treatment protocols such as Chemotherapy, or Infusion treatments for other chronic illnesses. The same access issues apply for residents of the Southern Kenai Peninsula when our volumes exceed the current capacity of our 960 square foot Oncology / Infusion center.

Impact on Statewide Health Care System

According to market share information from the OHDIN database, residents from the South Peninsula Hospital service area zip codes are receiving Nuclear Medicine exams in other locations, primarily Soldotna and Anchorage. While we can say there will be an effect on Nuclear Medicine volumes at Central Peninsula Hospital (CPH), the decline in Southern Peninsula resident volumes will have two positive impacts on CPH: 1) access to Nuclear medicine studies will be increased and wait times will be decreased for residents of the CPH Service Areas, and 2) the longevity or useful life of CPH's Nuclear Medicine equipment will be extended.

While reducing volumes to other providers is always a concern, the most important factor for SPH to consider is the health outcomes of its service area residents. A service gap of 30 to 40% of residents who are not receiving the proper diagnostic imaging test is a health disparity that cannot be ignored. We believe that the only way to reduce this gap in care is by providing these services locally. By doing so, SPH can reduce travel times, out of pocket costs, and transportation concerns. Further, the reduction in volumes from SPH residents would also provide CPH capacity back for a service that is currently at or near its own capacity.

General Review Standard #6 – Access:

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

SPH emergency services is open 24/7 to meet the emergency health care needs of its service area. The proposed project is located on the hospital campus located in the heart of Homer which is easily accessible by road, plane, and boat to the majority of our service residents. Homer is the location of the Kenai Peninsula's largest boat harbor, and also nearly at the center of the 16 communities which make up the SKPHSA. (See Figure 18) The services in this application are all located in the hospital.

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

II. Acute Care Hospital Services to VI. Long-Term Nursing Care: Review Standards are <u>not applicable</u> to this Certificate of Need request.

VII. Diagnostic Imaging Services: B. Review Standard for Nuclear Medicine (Positron Emission Tomography, including PET/PET-CT):

This Certificate of Need request is for the addition of a SPECT/CT used for the provision of Nuclear Medicine tests, however there are no specific Review Standards for SPECT/CT. At the recommendation of the CON Program Coordinator, we have applied the guidance for PET services and also for CT services for our request: 1) SPECT and PET scans use radioactive isotopes which must be produced or shipped to the site, and 2) Both SPECT and PET scans use radiotracers during the procedure. SPECT measures photon emissions, while PET measures radiolabeled glucose molecules (2016, July. NIH).

1. *An applicant who seeks to establish a new PET service demonstrates the ability to provide a minimum of 750 PET scans per year by the end of the third operational year, dating from the initiation of the service*.

Our data suggests that total projected volumes of nuclear medicine studies performed for our service area shall be approximately 251 scans per year by 2027. While these projections do not exceed the 750 needed to meet this review standard, we respectfully request an exception to this review standard for the following reasons:

a. The Review Standards for PET were published in December 2005 and have not been updated in nearly 18 years. At the time of publishing, Single Photon Emission Computed Tomography (SPECT) was still in its relative infancy as a common diagnostic tool. The 3D images produced by nuclear medicine scans are now the *standard of care* for assessing, diagnosing, and treating numerous diseases such as breast and thyroid cancer. It is our contention that residents of the lower Kenai Peninsula deserve to have equal access to health services as their more urban counterparts. Reducing health disparities created by geographic isolation and population size is one of the Center for Disease Control's Strategic goals for achieving *Health Equity* and reducing preventable differences in the disease burden experienced by certain populations (2022, July 1). Further, it is the mission of South Peninsula Hospital to promote community health and wellness by providing personalized, high quality, *locally coordinated* healthcare. We believe that Nuclear Medicine is a key diagnostic imaging tool which will allow us to further our mission and improve health and wellness of the Southern Kenai Peninsula.

b. Current market data retrieved from the State of Alaska ODHIN database suggests that patients with residential zip codes from within the South Kenai Peninsula Hospital Service area have a 31% service gap in Nuclear Medicine studies performed compared to the average State of Alaska utilization rate. The reason for that gap in care is largely due to geographic isolation and the

inability to receive a nuclear medicine study at South Peninsula Hospital. The consequences of such are poor patient outcomes due to significant delays in diagnosis and treatment of serious diseases. We believe that a 31% service gap is simply too great a statistic to ignore for our service area as it represents the number of patients who are unable to travel a significant distance to receive their nuclear medicine exam.

2. ***No new PET scanners will be approved at a location that is less than one hour travel time of an existing PET scanner performing fewer than 750 scans per year, or of a CON-approved, but not yet operational, PET scanner*****.**

South Peninsula Hospital is located at 4300 Bartlett Street in Homer, Alaska and serves as the medical home for the majority of Southern Kenai Peninsula Hospital Service Area residents. Our Service Area spans over 16 separate communities from Ninilchik on the northern border, to Nanwalek in the south, and crossing Cook Inlet and Kamishak Bay.

There are no Nuclear Medicine scanners within the Southern Kenai Peninsula to serve the diagnostic health needs of this vulnerable, and geographically disbursed population. The closest Nuclear Medicine scanner resides within the Central Kenai Peninsula Hospital Service Area at Central Peninsula Hospital at 250 Hospital Place, Soldotna, Alaska. The distance between the two hospitals is 75.9 miles and driving time at posted speed limits takes approximately 1 hour, 26 minutes without winter elements, or traffic.

While a 90-minute car ride may seem inconsequential to some, it poses a major barrier for many patients who require a nuclear medicine scan. The estimated service gap of 31% (patients not receiving this diagnostic service) indicates that this geographic barrier is too great for nearly 1/3 of the patients for whom it is needed.

3. ***In a community that produces isotopes locally, no new PET scanner will be approved in the service area unless average use of each existing PET scanner exceeds 1,300 scans per year*****.**

N/A - South Peninsula Hospital does not intend to produce its own isotopes locally.

4. ***In a community that is dependent upon shipped isotopes, no new PET scanner will be approved in the service area unless average use of each existing PET scanner exceeds 1,000 scans per year.***

South Peninsula Hospital intends to obtain its radioisotopes weekly in a radionuclide generator which can produce short-lived medical radionuclides for use in nuclear medicine scans. While the number of nuclear medicine scans performed at South Peninsula Hospital three years from project completion are not expected to exceed 1,000 scans per year, we respectfully request an exception to this review standards for the following reasons:

a. The Review Standards for PET were published in December 2005 and have not been updated in nearly 18 years. At the time of publishing, PET and SPECT technology were still considered relatively new diagnostic tools used only in large, urban institutions. Nuclear medicine scans have now been the *standard of care* for diagnosis and treatment of organ functioning, cardiac disease, and many cancers for many years.
b. Safety standards for the transport and waste safety of nuclear and radioactive materials was overhauled in the mid-1990s by a multi-national agency of with the United States is a Member State. The outcome of this regulatory coalition resulted in safety standards established by the International Atomic Energy Agency (IAEA) in 2006, a year after the State of Alaska's 2005 review standards were published (2006, IAEA). The shipment, use, and disposal of radioisotopes and radionuclide generators is now a common practice with over 17 years of proven application of these safety guidelines.

5. ***An applicant who seeks to expand a PET service demonstrates an average service volume of at least 1,300 PET scans annually for each PET scanner at the service site.***

N/A - South Peninsula Hospital does not currently provide Nuclear Medicine services.

6. ***PET services must be located in the same community as, or co-located with, facilities offering comprehensive oncology, cardiovascular, and neurology services.***

South Peninsula Hospital provides a variety of services to the residents of the Southern Kenai Peninsula, including the services required in this standard:

a. *Oncology* – SPH offers Oncology and Infusion services 5 days per week, 8 hours per day at a 5-chair center located adjacent to the main Hospital Building. It is also part of the subject matter in this Certificate of Need due to its rapid growth in the past 5 years. While South Peninsula Hospital does not employ its own Oncologists, credentialed Oncology Physicians and Advanced Practice Providers (APPs) travel to Homer each Friday to see patients in our clinic. Prior to 2019, an Oncology Physician travelled from Anchorage to the Southern Kenai Peninsula to provide this vital service. Since that time, Central Peninsula Hospital has partnered with South Peninsula Hospital to provide Oncology Physician and APP services to the Southern Kenai Peninsula.

b. *Cardiovascular* – SPH supports cardiovascular health through numerous diagnostic programs and Cardiac clinic offerings. Our respiratory therapy department currently performs EKGs and cardiac stress tests to determine the rhythm of the heart and how well it works during physical activity. The addition of the nuclear medicine scanner will offer even more valuable data to these stress tests and include the ability to offer chemical induced stress testing options.

Additionally, SPH ultra-sonographers perform echocardiograms (ECGs) to look at the heart and its nearby blood vessels. Finally, a Cardiologist from Alaska Heart & Vascular Institute in Anchorage, travels to Homer for two days each month to see patients with cardiovascular needs.

c. *Neurology* – SPH understand the importance of Neurology to its service area residents and contracts with a half-time Neurologist to provide care to its patients. In support of our neurology services, Ultra-sonographers provide ECG services year-round to diagnose neurological disorders, seizures, motor skill impairment, comprehension, and memory.

VII. Diagnostic Imaging Services: Review Standard C. Computed Tomography (CT):

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 CT Review Standard has also included as aforementioned, because a SPECT/CT may be used interchangeably as a Nuclear Medicine scanner and a CT scanner (without radioactive isotopes). South Peninsula Hospital has one CT machine, and additional CT capability will add the redundancy needed to support our existing CT unit.

1. ***An applicant who seeks to establish a new CT service in an urban area (population of 70,000 or more) demonstrates the ability to provide a minimum of 3,000 CT scans per year by the end of the third operational year, dating from the initiation of the service.***

N/A - SPH already offers CT services and is not considered an urban area.

2. ***An applicant who seeks to establish a new CT service in a rural area demonstrates the ability to provide a minimum of 1,000 CT scans per year by the end of the third operational year, dating from the initiation of the service.***

N/A - SPH already offers CT services in its rural service area.

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

N/A - SPH already offers CT services in its rural service area.

4. ***An applicant who seeks to expand an existing CT service must demonstrate an average service volume of at least 4,000 CT scans annually for each existing CT scanner at the service site.***

SPH has offered Computed Tomography (CT) services to the Southern Kenai Peninsula Hospital Service Area for many years. CT imaging remains the gold standard for diagnosis and treatment of patients with injuries sustained from trauma. Our CT machine must remain in operation 24/7 to appropriately care for potential patient emergencies, a nearly impossible task for such a complex machine. Unplanned downtime for our CT machine can ultimately have life or death consequences for patients in need of quick diagnosis, treatment, stabilization, or shipment to a higher-level trauma center. The Siemens SPECT/CT will give South Peninsula Hospital much-needed redundancy during both planned and unplanned downtime of our primary CT.

SPH demonstrates in the following table (Figure 50) that for the past 2 years, its CT imaging procedures have exceeded 4,000 annually, supporting the expansion of its CT service line. The addition of a SPECT/CT will add CT capacity to an already heavily utilized CT scanner which was added in 2021. The new unit will support overflow CTs as well as supplemental use during downtime and routine maintenance of the main scanner.

Figure 49: South Peninsula Hospital CT Scan Procedures FY 2018 – 2023, annualized, projections for 2025-2032

	Historical - Fiscal Year						Projections		
Historical & Projected Volumes	2018	2019	2020	2021	2022	2023*	2025	2027	2032
SPH Service Area CT Scans	3,491	3,843	3,469	3,753	4,540	4,714	4,817	4,962	5,269

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
September 2023
2. Estimated construction begun by
December 2024
3. Estimated construction complete by
June 2026
4. Estimated opening of proposed services
July 2026

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

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

The legal description of the proposed site identified on the KPB Parcel Viewer is found at https://gis.kpb.us/map/index.html?viewer=express and is listed as:

- Parcel ID: 17504024
- Physical Address: 4300 Bartlett Street, Homer, AK 99603
- Legal Description: T 6S R 13W SEC 18 SEWARD MERIDIAN HM 2008092 SOUTH PENINSULA HOSPITAL SUB 2008 ADDN TRACT A2
- Acreage: 7.12
- Owner: City of Homer
- Plat Map: SPH Subdivision 2008 Addition (see APPENDIX, Figure 14)

2. Diagrammatic plan showing:

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

N/A – This Certificate of Need Project does not require the creation or expansion of new structures, changes to easements, rights-of-way, or encroachments.

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

N/A – This Certificate of Need Project does not require the creation or location of new utilities services to the site. Existing utilities will be used.

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

N/A – This Certificate of Need Project does not require the creation of new service roads, parking facilities, or walkways to access the hospital or construction site.

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

SEE APPENDIX

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

SEE APPENDIX

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

SEE APPENDIX

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

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

Section VIIIA.

Financial Data - Acquisitions

1. Acquisition type: (Please check applicable boxes)

☐ Lease ☐ Rent ☐ Donation ☐ Purchase ☐ Stock Transaction

****N/A – this CON does not require the acquisition of a new building. We are proposing that we renovate existing space, and build out shelled in space from the 2007/2008 CON Project.**

2. Cost data (Omit cents)

a. Total acquisition cost*	$ 0
b. Amount to be financed	$ 0
c. Difference between items (a) and (b) (list available resources to be used, e.g. available cash, investments, grants, etc.)	$ 0
d. Anticipated interest rate ___% , term ___ years.	N/A
e. Total anticipated interest amount	$ 0
f. Total of (a) and (e)	$ 0
g. Estimated annual debt service requirements	$ 0

3. Describe how you expect to finance the project.

Note: Acquisition costs must include (as appropriate):

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

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

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

Section VIIIB.

Financial Data – Construction Only

1. Construction Method (Please check)

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

b. ☐ Phased ☐ Single project ☐ Fast Track

2. Construction Cost (New Activity)

a. Site acquisition (Section VIIIA.2.f)	$ N/A
b. Estimated general construction**	$7,995,767
c. Fixed equipment, not included in a**	$ N/A
d. Total construction costs (sum of items a, b, and c)**	**$7,995,767**
e. Major movable equipment**	$1,374,786
f. Other cost:**	
(1a) KPB Administration expense	$ 95,356
(1b) KPB Project Management expense	$ 368,479
(2) Site survey, soils investigation, and materials testing	$ N/A
(3) Architects and engineering fees	$ 659,783
(4) Other consultation fees (preparation of application included)	$ N/A
(5) Legal fees	$ N/A
(6) Land development and landscaping	$ N/A
(7) Building permits and utility assessments (including water, sewer, electrical, phones, etc.)	$ N/A
(8) Additional inspection fees (clerk of the works)	$ TBD
(9) Insurance (required during construction period)	$ 192,654
g. **Total project cost (sum of items d, e, f)**	**$10,686,825**
h. Amount to be financed	$ N/A
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.)	$10,686,825
j. Anticipated long-term interest rate	N/A %
k. Anticipated interim (construction) interest rate	N/A %
l. Anticipated long-term interest amount	$ N/A
m. Anticipated interim interest amount	$ N/A
n. **Total items g, l, and m**	**$10,686,825**
o. Estimated annual debt service requirement	$N/A
p. Construction cost per sq. ft. (8,119 sq ft)	$984
q. Construction cost per bed	$0
r. Project cost per sq. ft. (8,119 sq ft)	$1,316
s. Project cost per bed (if applicable)	$0

*Site acquisition should be stated as "book" value, i.e., actual purchase price (or estimate of value if donated) plus costs of development. If desired, the applicant may elect to state as "fair market value" (in which case, so indicate). A form for use

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

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

Section IX.

Financial Data – All Proposed Activities

A. Schedule I – Facility Income Statement

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

The following table displays the most recent five full fiscal years of Income Statements for South Peninsula Hospital (SPH) from Fiscal Year 2018 through 2022.

Figure 50: Facility Income Statement 2018-2022

Schedule I. Facility Income State - Last 5 Complete Years (Actual)

Description	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
PATIENT SERVICE REVENUE					
INPATIENT	$ 33,441,442	$ 31,857,621	$ 28,295,059	$ 28,328,773	$ 36,792,371
OUTPATIENT	$ 80,472,482	$ 88,767,016	$ 93,824,395	$ 117,018,357	$ 134,629,773
LONG TERM CARE	$ 9,509,341	$ 8,136,075	$ 8,466,702	$ 7,614,567	$ 10,335,758
Total PATIENT SERVICE REVENUE	**$123,423,265**	**$128,760,712**	**$130,586,156**	**$152,961,697**	**$181,757,902**
DEDUCTIONS FROM REVENUE					
MEDICARE	$ 19,043,699	$ 22,534,099	$ 23,326,585	$ 31,768,778	$ 37,850,182
MEDICAID	$ 15,044,303	$ 15,267,095	$ 17,406,965	$ 19,054,608	$ 24,401,597
CHARITY CARE	$ 1,476,663	$ 1,574,550	$ 2,323,402	$ 1,266,505	$ 226,294
OTHER ADJUSTMENTS	$ 13,099,896	$ 7,476,606	$ 9,817,570	$ 11,943,302	$ 15,888,764
BAD DEBT	$ 1,699,188	$ 794,188	$ 1,632,346	$ 3,332,151	$ 3,568,225
Total DEDUCTIONS FROM REVENUE	**$ 50,363,749**	**$ 47,646,538**	**$ 54,506,868**	**$ 67,365,344**	**$ 81,935,062**
NET PATIENT SERVICES	$ 73,059,516	$ 81,114,174	$ 76,079,288	$ 85,596,353	$ 99,822,840
OTHER REVENUE	$ 2,065,971	$ 575,995	$ 597,503	$ 635,047	$ 675,414
TOTAL OPERATING REVENUES	**$ 75,125,487**	**$ 81,690,169**	**$ 76,676,791**	**$ 86,231,400**	**$100,498,254**
OPERATING EXPENSES					
SALARY & WAGES	$ 32,848,670	$ 34,292,233	$ 36,586,330	$ 43,867,020	$ 47,034,508
EMPLOYEE BENEFITS	$ 15,559,249	$ 14,932,464	$ 14,116,266	$ 14,611,588	$ 20,387,855
OTHER OP EXPENSE	$ 923,156	$ 1,139,555	$ 1,427,475	$ 894,307	$ 1,206,739
SUPPLIES DRUGS & FOOD	$ 7,231,089	$ 7,638,500	$ 7,966,362	$ 9,732,515	$ 13,722,585
CONTRACT STAFFING	$ 1,210,831	$ 1,571,779	$ 2,408,830	$ 3,362,632	$ 5,926,912
PROFESSIONAL FEES	$ 6,420,757	$ 5,551,183	$ 4,877,491	$ 4,989,523	$ 5,969,141
UTILITIES & TELEPHONE	$ 3,170,236	$ 1,451,681	$ 1,531,994	$ 1,618,910	$ 1,673,368
INSURANCE	$ 528,711	$ 603,459	$ 656,656	$ 632,594	$ 654,421
DUES BOOKS SUBSCRIPTIONS	$ 266,119	$ 207,567	$ 206,694	$ 243,641	$ 232,511
SOFTWARE MAINT/SUPPORT	$ 1,149,075	$ 1,570,769	$ 1,436,636	$ 1,484,150	$ 1,893,549
TRAVEL MEETINGS EDUCATION	$ 356,254	$ 354,558	$ 309,322	$ 365,068	$ 552,188
REPAIRS & MAINTENANCE	$ 1,222,280	$ 1,165,745	$ 1,235,753	$ 1,658,843	$ 1,635,706
LEASE & RENTALS	$ 662,688	$ 730,038	$ 751,861	$ 651,132	$ 314,977
DEPRECIATION & AMORTIZATION	$ 3,072,224	$ 3,285,034	$ 3,288,093	$ 3,888,174	$ 4,360,582
Total OPERATING EXPENSES	**$ 74,621,339**	**$ 74,494,565**	**$ 76,799,763**	**$ 88,000,097**	**$105,565,042**
GAIN (LOSS) FROM OPERATIONS	**$ 504,148**	**$ 7,195,604**	**$ (122,972)**	**$ (1,768,697)**	**$ (5,066,788)**

Over the past five completed fiscal years, SPH has seen Total Patient Revenues increase from $123,423,265 in FY 2018 to $181,757,902 in FY 2022. With the exception of FY 2020, SPH has seen stable volume and patient revenue growth. During the last quarter of FY 2020, the Covid-19 pandemic led to the shutdown of non-emergent outpatient services such as Surgery, Outpatient visits, Diagnostic Imaging, Lab tests, and minor Emergency room visits. In FY 2021, non-emergent patient services began to resume and inpatient volumes were impacted by the Delta and Omicron variants of Covid-19. As a result, SPH experienced significant growth in areas such as Acute Care stays and Emergency room visits during FY 2021 and 2022.

Total Operating Revenue is the amount of Gross Patient Charges which SPH expect to collect. In the past five fiscal years (Gross Patient Revenues less Charity Care, Contractual Allowances, and Bad Debt), has shown growth in each year except for FY 2020 due to the pandemic. Overall growth occurred between FY 2018 and FY 2022 from $75,125,487 to $100,498,254, respectively. Year-over-year growth in the past five years shows a high of 17% and a low of -6%. Operating Revenue Growth is a combination of changes in patient volume and changes in pricing.

Total Expenses appear to be flat from FY 2018 to FY 2019, however a significant decline occurred in the amount of USAC Telephone subsidies ($1.7M) an in-kind contribution offset by Other Revenue. Since FY 2020, expenses have grown exponentially in the wake of Covid-19 related staffing and supply chain shortages. FY 2022 Contract labor costs were nearly three times pre-pandemic amounts ($1.5M in 2019 vs. $5.9M in 2022).

Despite the bleak picture painted by our Operating Margin, numerous operating subsidies and grants were received by SPH to supplement its volume declines and increased Contract laborer expenses. Not shown in the template above are Provider Relief Funds, Grant Revenues, and a Paycheck Protection Program Loan from various Covid-19 related subsidy programs. As you can see in Figure 51 below, Non-Operating revenues streams for Covid-19 related events between FY2020 and FY2022 allowed SPH to meet or exceeded its pre-pandemic total Net Income. Net Income amounts for each year are as follows:

FY 2018	$ 4,008,963
FY 2019	$11,456,133
FY 2020	$10,131,120
FY 2021	$12,780,090
FY 2022	$ 4,960,692

Included in total net income is approximately $4.5 to $4.6 million in annual Service Area Property tax revenue.

Figure 51: Non-Operating Revenues and Expenses FY 2018-FY2022

NON-OPERATING REVENUES	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
GENERAL PROPERTY TAXES	$ 4,498,923	$ 4,530,430	$ 4,675,175	$ 4,691,422	$ 4,689,619
INVESTMENT INCOME	$ 117,123	$ 441,832	$ 510,036	$ 72,520	$ (155,225)
OTHER NON OPERATING REVENUE	$ 500	$ 52,547	$ 4,876,098	$ 6,623,389	$ 25,040
GAIN (LOSS) ON DISPOSAL	$ (12,450)	$ 27,491	$ (1,055)	$ 32,049	$ -
SPH AUXILIARY	$ 14,657	$ 7,914	$ 6,298	$ 3,061	$ 46
Total NON-OPERATING REVENUES	**$ 4,618,753**	**$ 5,060,214**	**$ 10,066,552**	**$ 11,422,441**	**$ 4,559,480**
NON-OPERATING EXPENSES					
SERVICE AREA BOARD	$ 189,484	$ 108,750	$ 55,027	$ 113,593	$ 91,653
OTHER NON OP EXP	$ 397,931	$ 5,950	$ 11,561	$ 4,346	
INTEREST EXPENSE	$ 546,529	$ 689,880	$ 315,193	$ 493,738	$ 510,810
Total NON-OPERATING EXPENSES	**$ 1,133,944**	**$ 804,580**	**$ 381,781**	**$ 611,677**	**$ 602,463**
GRANTS					
GRANT REVENUE	$ 20,006	$ 4,895	$ 569,321	$ 3,738,022	$ 6,070,463
GRANT EXPENSE	$ -	$ -		$ 1	$ -
TOTAL NON-OPERATING GAINS, NET	**$ 20,006**	**$ 4,895**	**$ 569,321**	**$ 3,738,023**	**$ 6,070,463**
NET INCOME	**$ 4,008,963**	**$ 11,456,133**	**$ 10,131,120**	**$ 12,780,090**	**$ 4,960,692**

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

The following spreadsheet, provides total SPH organization estimates for Fiscal Years 2025 through 2026.

Figure 52: Facility Income Statement FY 2025-2026

Schedule I. Facility Income State - Construction Period

Description	FY 2025	FY 2026
PATIENT SERVICE REVENUE		
INPATIENT	$ 33,852,621	$ 35,883,778
OUTPATIENT	$ 175,823,805	$ 186,373,233
LONG TERM CARE	$ 15,040,290	$ 15,942,708
Total PATIENT SERVICE REVENUE	**$ 224,716,716**	**$ 238,199,719**

DEDUCTIONS FROM REVENUE		
MEDICARE	$ 44,211,022	$ 46,863,683
MEDICAID	$ 27,825,659	$ 29,495,199
CHARITY CARE	$ 2,459,070	$ 2,606,614
OTHER ADJUSTMENTS	$ 19,539,401	$ 20,711,765
BAD DEBT	$ 3,271,528	$ 3,467,819
Total DEDUCTIONS FROM REVENUE	**$ 97,306,679**	**$ 103,145,080**
NET PATIENT SERVICES	$ 127,410,037	$ 135,054,639
OTHER REVENUE	$ 975,489	$ 1,034,019
TOTAL OPERATING REVENUES	**$ 128,385,526**	**$ 136,088,658**
OPERATING EXPENSES		
SALARY & WAGES	$ 61,581,942	$ 64,661,040
EMPLOYEE BENEFITS	$ 26,410,467	$ 27,730,991
OTHER OP EXPENSE	$ 1,933,855	$ 2,030,548
SUPPLIES DRUGS & FOOD	$ 14,736,139	$ 15,472,946
CONTRACT STAFFING	$ 1,481,013	$ 1,555,064
PROFESSIONAL FEES	$ 7,015,351	$ 7,366,119
UTILITIES & TELEPHONE	$ 1,920,808	$ 2,016,848
INSURANCE	$ 921,626	$ 967,707
DUES BOOKS SUBSCRIPTIONS	$ 279,358	$ 293,326
SOFTWARE MAINT/SUPPORT	$ 2,351,099	$ 2,468,654
TRAVEL MEETINGS EDUCATION	$ 1,144,224	$ 1,201,435
REPAIRS & MAINTENANCE	$ 2,067,587	$ 2,170,966
LEASE & RENTALS	$ 932,584	$ 979,213
DEPRECIATION & AMORTIZATION	$ 4,600,000	$ 4,800,000
Total OPERATING EXPENSES	**$ 127,376,054**	**$ 133,714,856**
GAIN (LOSS) FROM OPERATIONS	**$ 1,009,473**	**$ 2,373,801**

During the construction period running from FY 2025 through FY 2026, it is projected that SPH will experience continued growth. Total Patient Revenues are projected to increase from $224,716,716 in FY 2025 to $238,199,719 in FY 2026. This shows growth in patient revenues over the period of 6% each year.

Total Operating Revenue is projected to experience similar growth with increases from $128,385,526 in FY 2025 to $136,088,658 in FY 2026.

Total Operating Expenses are projected to show measured growth which is slightly less than that of Patient Revenues, from $127,376,054 in FY 2025 to $133,714,856 in FY 2026. Total growth in operating expenses is expected to be 5% each year.

Operating Income is projected to increase from $1,009,473 in FY 2025 to $2,373,801 in FY 2026.

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

Figure 53: SPH Income Statement 2027-2029

Schedule I. Facility Income State - Project Completion			
Description	**FY 2027**	**FY 2028**	**FY 2029**
PATIENT SERVICE REVENUE			
INPATIENT	$ 38,036,805	$ 40,319,013	$ 42,738,154
OUTPATIENT	$ 197,555,627	$ 209,408,965	$ 221,973,503
LONG TERM CARE	$ 16,899,270	$ 17,913,226	$ 18,988,020
Total PATIENT SERVICE REVENUE	**$ 252,491,702**	**$ 267,641,204**	**$ 283,699,677**
DEDUCTIONS FROM REVENUE			
MEDICARE	$ 49,675,504	$ 52,656,034	$ 55,815,396
MEDICAID	$ 31,264,911	$ 33,140,805	$ 35,129,254
CHARITY CARE	$ 2,763,011	$ 2,928,791	$ 3,104,519
OTHER ADJUSTMENTS	$ 21,954,471	$ 23,271,739	$ 24,668,043
BAD DEBT	$ 3,675,889	$ 3,896,442	$ 4,130,228
Total DEDUCTIONS FROM REVENUE	**$ 109,333,785**	**$ 115,893,812**	**$ 122,847,441**
NET PATIENT SERVICES	$ 143,157,917	$ 151,747,392	$ 160,852,236
OTHER REVENUE	$ 1,096,060	$ 1,161,823	$ 1,231,533
TOTAL OPERATING REVENUES	**$ 144,253,977**	**$ 152,909,216**	**$ 162,083,769**
OPERATING EXPENSES			
SALARY & WAGES	$ 67,894,092	$ 71,288,796	$ 74,853,236
EMPLOYEE BENEFITS	$ 29,117,540	$ 30,573,417	$ 32,102,088
OTHER OP EXPENSE	$ 2,132,076	$ 2,238,679	$ 2,350,613
SUPPLIES DRUGS & FOOD	$ 16,246,593	$ 17,058,923	$ 17,911,869

CONTRACT STAFFING	$ 1,632,817	$ 1,714,458	$ 1,800,181
PROFESSIONAL FEES	$ 7,734,425	$ 8,121,146	$ 8,527,203
UTILITIES & TELEPHONE	$ 2,117,691	$ 2,223,575	$ 2,334,754
INSURANCE	$ 1,016,093	$ 1,066,897	$ 1,120,242
DUES BOOKS SUBSCRIPTIONS	$ 307,992	$ 323,392	$ 339,561
SOFTWARE MAINT/SUPPORT	$ 2,592,087	$ 2,721,691	$ 2,857,776
TRAVEL MEETINGS EDUCATION	$ 1,261,507	$ 1,324,582	$ 1,390,811
REPAIRS & MAINTENANCE	$ 2,279,514	$ 2,393,490	$ 2,513,164
LEASE & RENTALS	$ 1,028,174	$ 1,079,582	$ 1,133,561
DEPRECIATION & AMORTIZATION	$ 5,154,237	$ 5,150,000	$ 5,150,000
Total OPERATING EXPENSES	**$ 140,514,836**	**$ 147,278,629**	**$ 154,385,061**
GAIN (LOSS) FROM OPERATIONS	**$ 3,739,141**	**$ 5,630,587**	**$ 7,698,708**

Project completion is expected to occur by the end of FY 2026 and the following three year's projected income demonstrate financial stability. Total Patient Service Revenues are projected to increase from $252,491,702 in FY 2027 to $283,699,677 in FY 2029. This increase demonstrates steady growth in patient revenues year over year with a total increase of 12% from FY 2027 to FY 2029.

Total Operating Revenue (net of Deductions from Revenue), is projected to increase from $144,253,977 in FY 2027 to $162,083,769 in FY 2029. Meanwhile, Operating Expense is projected to show controlled growth annually of 5% from $140,155,092 in FY 2027 to $154,520,989 in FY 2029.

As a result of consistent revenue growth paired with responsible expense management, the overall Operating Gain from Operations is projected to show growth from $3,739,141 in FY 2027 to $7,698,708 in FY 2029. This increase demonstrates steady growth year over year with an increase from FY 2027 to FY 2029 of 106%.

B. Schedule II – Facility Balance Sheet

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

The following attached schedule II provides Balance Sheet information for South Peninsula Hospital covering the previous five completed fiscal years from 2018 through 2022.

Figure 54: Facility Balance Sheet – Last 5 Complete Years

Schedule II. SPH Balance Sheet - Last 5 Complete Years (Actual)

Fiscal Year	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Assets and Deferred Outflows of Resources					
Current Assets					
Cash and cash equivalents	$ 14,164,543	$ 19,537,381	$ 24,938,717	$ 23,990,124	$ 25,722,672
Equity in central treasury of Kenai Peninsula Borough	$ 5,102,250	$ 6,867,941	$ 7,785,320	$ 6,276,576	$ 7,327,807
Total cash and cash equivalents	$ 19,266,793	$ 26,405,322	$ 32,724,037	$ 30,266,700	$ 33,050,479
Patient receivables, net of contractual allowances	$ 19,810,353	$ 16,851,744	$ 15,459,226	$ 17,850,843	$ 19,419,058
Less estimated uncollectibles	$ (3,977,483)	$ (3,193,750)	$ (4,302,193)	$ (4,744,533)	$ (3,836,453)
Net patient receivables	$ 15,832,870	$ 13,657,994	$ 11,157,033	$ 13,106,310	$ 15,582,605
Property taxes receivable	$ 167,889	$ 163,770	$ 175,851	$ 135,749	$ 102,233
Less estimated uncollectible taxes	$ (3,519)	$ (3,463)	$ (3,599)	$ (6,325)	$ (4,165)
Property taxes receivable, net of allowance	$ 164,370	$ 160,307	$ 172,252	$ 129,424	$ 98,068
Other receivables	$ 218,534	$ 183,264	$ 805,404	$ 619,778	$ 614,427
Inventory	$ 1,700,305	$ 1,670,856	$ 1,557,289	$ 1,808,615	$ 2,062,504
Net pension asset	$ 273,936	$ 1,946,417	$ 3,164,836	$ 8,600,712	$ 4,675,709
Cash and Cash Equivalents - stimulus funds			$ 18,328,631		
Prepaid expenses	$ 598,655	$ 627,662	$ 704,806	$ 654,007	$ 760,219
Total Current Assets	$ 38,055,463	$ 44,651,822	$ 68,614,288	$ 55,185,546	$ 56,844,011
Assets Whose Use is Limited					
Unspent bond proceeds	$ 109,418	$ 86,148	$ 72,544	$ 23,838	$ 23,254
Plant replacement and expansion fund	$ 194,293	$ 3,373,370	$ 4,318,831	$ 10,359,499	$ 7,904,096
Other	$ 33,022	$ 29,801	$ 23,609	$ 26,543	$ 23,796
Total Assets Whose Use is Limited	$ 336,733	$ 3,489,319	$ 4,414,984	$ 10,409,880	$ 7,951,146
Land and Land Improvements	$ 3,816,772	$ 3,816,772	$ 3,816,772	$ 3,857,422	$ 4,114,643
Buildings and Building Improvements	$ 61,872,854	$ 62,334,004	$ 62,732,513	$ 66,244,668	$ 67,421,851
Equipment	$ 24,270,201	$ 24,979,904	$ 27,005,986	$ 28,687,804	$ 30,084,168
Improvements other than buildings	$ 140,475	$ 140,475	$ 140,475	$ 213,358	$ 77,029
Right of Use leased assets	$ -	$ -	$ -	$ 2,803,350	$ 3,179,176
Construction in Progress	$ 34,738	$ 462,180	$ 288,705	$ 385,206	$ 651,950
Less: Accumulated Depreciation	$ (47,783,640)	$ (51,068,674)	$ (54,356,767)	$ (57,987,653)	$ (62,284,887)
Capital assets, net	$ 42,351,400	$ 40,664,661	$ 39,627,684	$ 44,204,155	$ 43,243,930
Total Assets	**$ 80,743,596**	**$ 88,805,802**	**$ 112,656,956**	**$ 109,799,581**	**$ 108,252,445**

Deferred Outflows of Resources					
Pension related	$ 1,539,805	$ 1,640,396	$ 1,981,311	$ 2,536,008	$ 4,624,231
Goodwill				$ 29,000	$ 17,000
Unamortized deferred charge on refunding	$ 702,614	$ 586,881	$ 497,800	$ 426,177	$ 354,766
Total Deferred Outflows of Resources	$ 2,242,419	$ 2,227,277	$ 2,479,111	$ 2,991,185	$ 4,995,997
Total Assets and Deferred Outflows of Resources	**$ 82,986,015**	**$ 91,033,079**	**$ 115,136,067**	**$ 112,790,766**	**$ 113,248,442**
Liabilities, Deferred Inflows of Resources and Net Position					
Current Liabilities					
Accounts and contracts payable	$ 2,086,199	$ 2,724,422	$ 1,560,724	$ 2,690,272	$ 1,985,020
Accrued liabilities	$ 6,526,786	$ 4,475,802	$ 5,032,964	$ 5,535,887	$ 6,784,926
Medical claims reserve	$ 1,696,606	$ 1,766,480	$ 1,781,435	$ 1,333,116	$ 1,326,000
Unearned revenue	$ 72,471	$ 155,549	$ 1,549,245	$ 15,859	$ 29,927
Current portion of bonds payable	$ 1,495,000	$ 1,565,000	$ 1,630,000	$ 1,705,000	$ 1,785,000
Current portion of leases payable	$ 66,253	$ 71,208	$ 2,657,059	$ 307,903	$ 375,821
Bond interest payable	$ 187,353	$ 225,000	$ 143,958	$ 128,549	$ 110,899
Due to third-party payors	$ 4,593,996	$ 4,237,923	$ 13,120,478	$ 1,376,416	$ 1,212,604
Total Current Liabilities	$ 16,724,664	$ 15,221,384	$ 27,475,863	$ 13,093,002	$ 13,610,197
Long-term Liabilities					
Bonds payable, net of current portion	$ 15,150,000	$ 13,585,000	$ 11,955,000	$ 10,250,000	$ 8,465,000
Long-term Notes Payable	$ -		$ 3,881,070		
Unamortized premium on bonds payable	$ 1,623,247	$ 1,354,435	$ 925,577	$ 715,206	$ 535,373
Leases payable, net of current portion	$ 89,827	$ 9,498	$ -	$ 2,282,350	$ 2,164,807
Total Long-term Liabilities	$ 16,863,074	$ 14,948,933	$ 16,761,647	$ 13,247,556	$ 11,165,180
Total Liabilities	$ 33,587,738	$ 30,170,317	$ 44,237,510	$ 26,340,558	$ 24,775,377
Deferred Inflows of Resources					
Pension related	$ 321,561	$ 354,235	$ 237,539	$ 3,104,615	$ 93,314
Property taxes received in advance	$ 549,471	$ 525,149	$ 546,520	$ 451,005	$ 524,471
Total Deferred Inflows of Resources	$ 871,032	$ 879,384	$ 784,059	$ 3,555,620	$ 617,785
Net Position					
Net investment in capital assets	$ 24,739,105	$ 24,752,549	$ 25,677,953	$ 29,391,194	$ 30,509,307
Restricted	$ 25,286	$ 25,286	$ 141,944	$ 63,366	$ 59,345
Unrestricted	$ 23,762,854	$ 35,205,543	$ 44,294,601	$ 53,440,028	$ 57,286,628
Total Net Position	$ 48,527,245	$ 59,983,378	$ 70,114,498	$ 82,894,588	$ 87,855,280
Total Liabilities, Deferred Inflows of Resources and Net Position	**$ 82,986,015**	**$ 91,033,079**	**$ 115,136,067**	**$ 112,790,766**	**$ 113,248,442**

2. Current fiscal of calendar year to date

The following attached schedule II provides Balance Sheet information for South Peninsula Hospital covering the current fiscal year as of May 31, 2023.

Figure 55: Facility Balance Sheet – Current Fiscal Year 2023 as of May 31, 2023

Schedule II. SPH Balance Sheet - Current Fiscal Year, May 31, 2023

Fiscal Year	FY 2023
Assets and Deferred Outflows of Resources	
Current Assets	
Cash and cash equivalents	$ 24,314,334
Equity in central treasury of Kenai Peninsula Borough	$ 8,347,613
Total cash and cash equivalents	$ 32,661,947
Patient receivables, net of contractual allowances	$ 19,232,253
Less estimated uncollectibles	$ (4,357,672)
Net patient receivables	$ 14,874,581
Property taxes receivable	$ 105,476
Less estimated uncollectible taxes	$ (4,165)
Property taxes receivable, net of allowance	$ 101,311
Other receivables	$ 428,809
Inventory	$ 1,892,655
Net pension asset	$ 5,052,584
Cash and Cash Equivalents - stimulus funds	
Prepaid expenses	$ 780,325
Total Current Assets	$ 55,792,211
Assets Whose Use is Limited	
Unspent bond proceeds	$ 23,254
Plant replacement and expansion fund	$ 8,981,482
Other	$ 23,155
Total Assets Whose Use is Limited	$ 9,027,891
Land and Land Improvements	$ 4,114,693
Buildings and Building Improvements	$ 63,059,362
Equipment	$ 27,516,738
Improvements other than buildings	$ 309,171
Right of Use leased assets	$ 2,919,326
Construction in Progress	$ 1,356,454
Less: Accumulated Depreciation	$ (57,849,573)
Capital assets, net	$ 41,426,171
Total Assets	**$ 106,246,273**

Deferred Outflows of Resources		
Pension related	$	4,530,917
Goodwill	$	6,000
Unamortized deferred charge on refunding	$	292,756
Total Deferred Outflows of Resources	$	4,829,673
Total Assets and Deferred Outflows of Resources	**$**	**111,075,946**
Liabilities, Deferred Inflows of Resources and Net Position		
Current Liabilities		
Accounts and contracts payable	$	1,687,892
Accrued liabilities	$	5,587,953
Medical claims reserve	$	1,281,693
Unearned revenue	$	(38,606)
Current portion of bonds payable	$	1,850,000
Current portion of leases payable	$	403,847
Bond interest payable	$	65,254
Due to third-party payors	$	913,761
Total Current Liabilities	$	11,751,795
Long-term Liabilities		
Bonds payable, net of current portion	$	6,615,000
Long-term Notes Payable		
Unamortized premium on bonds payable	$	401,535
Leases payable, net of current portion	$	1,895,116
Total Long-term Liabilities	$	8,911,651
Total Liabilities	$	20,663,446
Deferred Inflows of Resources		
Pension related	$	-
Property taxes received in advance	$	-
Total Deferred Inflows of Resources	$	-
Net Position		
Net investment in capital assets	$	30,915,276
Restricted	$	25,286
Unrestricted	$	59,471,938
Total Net Position	$	90,412,500
Total Liabilities, Deferred Inflows of Resources and Net Position	**$**	**111,075,946**

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

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

1. ***For the most recent five prior full fiscal or calendar years (information may be obtained on total patient load, directly from your respective years' Medicare Cost Reports)***

Figure 56: Average Patient Cost Per Day

Schedule III. Average Patient Cost per Day and Revenue Amounts - Last 5 Complete Fiscal Years

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Revenues (Net of Deductions)	$ 73,059,516	$ 81,114,174	$ 76,079,288	$ 85,596,353	$ 99,822,840
Less: Longterm Care Revenue	$ 9,509,341	$ 8,136,075	$ 8,466,702	$ 7,614,567	$ 10,335,758
Patient Days	2,709	2,797	2,837	2,865	2,894
Revenue Per Patient Day	$ 23,459	$ 26,092	$ 23,832	$ 27,215	$ 30,921
Operating & Capital Budget Summary					
Gross Revenues	$ 123,423,265	$ 128,760,712	$ 130,586,156	$ 152,961,697	$ 181,757,902
Deductions from Revenue	$ 50,363,749	$ 47,646,538	$ 54,506,868	$ 67,365,344	$ 81,935,062
Net Revenue	$ 73,059,516	$ 81,114,174	$ 76,079,288	$ 85,596,353	$ 99,822,840
Other Operating Revenue	$ 2,065,971	$ 575,995	$ 597,503	$ 635,047	$ 675,414
Direct Expense	$ 6,437,117	$ 4,851,041	$ 5,178,609	$ 3,726,393	$ 5,975,176
Indirect Expense	$ 3,072,224	$ 3,285,034	$ 3,288,093	$ 3,888,174	$ 4,360,582
Net Income Projected	$ 65,616,146	$ 73,554,094	$ 68,210,089	$ 78,616,833	$ 90,162,496
Rate Computations					
Annual Medicaid Rate	$ 3,500	$ 3,672	$ 5,352	$ 5,506	$ 5,665
Base Year Cost	$ 4,747	$ 4,880	$ 5,022	$ 5,172	$ 5,327
Less Ancillary	$ (2,224)	$ (2,287)	$ (2,353)	$ (2,423)	$ (2,496)
Plus Admin Overhead	$ 321	$ 325	$ 330	$ 334	$ 338
Cost Basis for Rate	Days	Days	Days	Days	Days
Base Year Patient Days	591		583	669	571
Cost per Patient Day	$ 3,510	$ 2,909	$ 2,984	$ 2,657	$ 3,571

2. Current fiscal or calendar year to date

Figure 57: Current Fiscal Year Average Cost Per Day

Schedule III. Average Patient Cost per Day - Current Fiscal Year

	FY23 Annualized
Revenues (Net of Deductions)	$ 107,034,006
Less: Longterm Care Revenue	$ 10,591,350
Patient Days	2,923
Revenue Per Patient Day	$ 32,995
Operating & Capital Budget Summary	
Gross Revenues	$ 192,710,230
Deductions from Revenue	$ 85,676,223
Net Revenue	$ 107,034,007
Other Operating Revenue	$ 753,236
Direct Expense	$ 6,230,768
Indirect Expense	$ 4,360,582
Net Income Projected	$ 97,195,893
Rate Computations	
Annual Medicaid Rate	$ 5,829
Base Year Cost	$ 5,487
Less Ancillary	$ (2,571)
Plus Admin Overhead	$ 341
Cost Basis for Rate	Days
Base Year Patient Days	414
Cost per Patient Day	$ 3,623

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

Figure 58: SPH 2026 to 2030 Average Patient Cost per Day

Schedule III. Average Patient Cost per Day - 5 Years after Project Completion					
	FY 2026	**FY 2027**	**FY 2028**	**FY 2029**	**FY 2030**
Revenues (Net of Deductions)	$ 135,054,639	$ 143,157,917	$ 151,747,392	$ 160,852,236	$ 173,060,921
Less: Longterm Care Revenue	$ 15,040,290	$ 15,942,708	$ 16,899,270	$ 17,913,226	$ 18,988,020
Patient Days	3,012	3,042	3,072	3,103	3,134
Revenue Per Patient Day	$ 39,852	$ 41,824	$ 43,895	$ 46,068	$ 55,224
Operating & Capital Budget Summary					
Gross Revenues	$ 238,199,719	$ 252,491,702	$ 267,641,204	$ 283,699,677	$ 173,060,921
Deductions from Revenue	$ 103,145,080	$ 109,333,785	$ 115,893,812	$ 122,847,441	$ 109,233,084
Net Revenue	$ 135,054,639	$ 143,157,917	$ 151,747,392	$ 160,852,236	$ 63,827,837
Other Operating Revenue	$ 1,034,019	$ 1,096,060	$ 1,161,823	$ 1,231,533	
Direct Expense	$ 10,240,290	$ 10,788,471	$ 11,749,270	$ 12,763,226	$ 13,529,020
Indirect Expense	$ 4,800,000	$ 5,154,237	$ 5,150,000	$ 5,150,000	$ 5,459,000
Net Income Projected	$ 121,048,368	$ 128,311,269	$ 136,009,945	$ 144,170,543	$ 44,839,817
Rate Computations					
Annual Medicaid Rate	$ 7,286	$ 7,497	$ 7,718	$ 7,945	$ 8,179
Base Year Cost	$ 6,881	$ 7,087	$ 7,300	$ 7,519	$ 7,744
Less Ancillary	$ (2,809)	$ (2,894)	$ (2,981)	$ (3,070)	$ (3,162)
Plus Admin Overhead	$ 406	$ 410	$ 418	$ 427	$ 435
Cost Basis for Rate	Days	Days	Days	Days	Days
Base Year Patient Days	427	431	435	439	444
Cost per Patient Day	$ 4,994	$ 5,241	$ 5,501	$ 5,773	$ 6,059

D. Schedule IV – Operating Budget

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

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

Figure 59: SPH Operating Budget 2023 to 2029

D. Schedule IV - Operating Budget

Description	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029
PATIENT SERVICE REVENUE							
INPATIENT	$ 30,065,550	$ 31,936,435	$ 33,852,621	$ 35,883,778	$ 38,036,805	$ 40,319,013	$ 42,738,154
OUTPATIENT	$ 149,935,060	$ 165,871,514	$ 175,823,805	$ 186,373,233	$ 197,555,627	$ 209,408,965	$ 221,973,503
LONG TERM CARE	$ 12,709,620	$ 14,188,953	$ 15,040,290	$ 15,942,708	$ 16,899,270	$ 17,913,226	$ 18,988,020
Total PATIENT SERVICE REVENUE	**$192,710,230**	**$211,996,902**	**$224,716,716**	**$238,199,719**	**$252,491,702**	**$267,641,204**	**$283,699,677**
DEDUCTIONS FROM REVENUE							
MEDICARE	$ 37,462,915	$ 41,708,511	$ 44,211,022	$ 46,863,683	$ 49,675,504	$ 52,656,034	$ 55,815,396
MEDICAID	$ 25,850,989	$ 26,250,622	$ 27,825,659	$ 29,495,199	$ 31,264,911	$ 33,140,805	$ 35,129,254
CHARITY CARE	$ 1,751,210	$ 2,319,877	$ 2,459,070	$ 2,606,614	$ 2,763,011	$ 2,928,791	$ 3,104,519
OTHER ADJUSTMENTS	$ 17,989,685	$ 18,433,397	$ 19,539,401	$ 20,711,765	$ 21,954,471	$ 23,271,739	$ 24,668,043
BAD DEBT	$ 2,621,424	$ 3,086,347	$ 3,271,528	$ 3,467,819	$ 3,675,889	$ 3,896,442	$ 4,130,228
Total DEDUCTIONS FROM REVENUE	**$ 85,676,223**	**$ 91,798,754**	**$ 97,306,679**	**$103,145,080**	**$109,333,785**	**$115,893,812**	**$122,847,441**
NET PATIENT SERVICES	$ 107,034,006	$ 120,198,148	$ 127,410,037	$ 135,054,639	$ 143,157,917	$ 151,747,392	$ 160,852,236
OTHER REVENUE	$ 753,236	$ 920,273	$ 975,489	$ 1,034,019	$ 1,096,060	$ 1,161,823	$ 1,231,533
TOTAL OPERATING REVENUES	**$107,787,242**	**$121,118,421**	**$128,385,526**	**$136,088,658**	**$144,253,977**	**$152,909,216**	**$162,083,769**
OPERATING EXPENSES							
SALARY & WAGES	$ 53,411,452	$ 58,649,469	$ 61,581,942	$ 64,661,040	$ 67,894,092	$ 71,288,796	$ 74,853,236
EMPLOYEE BENEFITS	$ 22,595,380	$ 25,152,826	$ 26,410,467	$ 27,730,991	$ 29,117,540	$ 30,573,417	$ 32,102,088
OTHER OP EXPENSE	$ 1,675,078	$ 1,841,767	$ 1,933,855	$ 2,030,548	$ 2,132,076	$ 2,238,679	$ 2,350,613
SUPPLIES DRUGS & FOOD	$ 12,224,471	$ 14,034,418	$ 14,736,139	$ 15,472,946	$ 16,246,593	$ 17,058,923	$ 17,911,869
CONTRACT STAFFING	$ 2,994,845	$ 1,410,489	$ 1,481,013	$ 1,555,064	$ 1,632,817	$ 1,714,458	$ 1,800,181
PROFESSIONAL FEES	$ 6,537,598	$ 6,681,287	$ 7,015,351	$ 7,366,119	$ 7,734,425	$ 8,121,146	$ 8,527,203
UTILITIES & TELEPHONE	$ 1,766,808	$ 1,829,341	$ 1,920,808	$ 2,016,848	$ 2,117,691	$ 2,223,575	$ 2,334,754
INSURANCE	$ 714,211	$ 877,739	$ 921,626	$ 967,707	$ 1,016,093	$ 1,066,897	$ 1,120,242
DUES BOOKS SUBSCRIPTIONS	$ 224,324	$ 266,055	$ 279,358	$ 293,326	$ 307,992	$ 323,392	$ 339,561
SOFTWARE MAINT/SUPPORT	$ 2,030,600	$ 2,239,142	$ 2,351,099	$ 2,468,654	$ 2,592,087	$ 2,721,691	$ 2,857,776
TRAVEL MEETINGS EDUCATION	$ 583,584	$ 1,089,737	$ 1,144,224	$ 1,201,435	$ 1,261,507	$ 1,324,582	$ 1,390,811
REPAIRS & MAINTENANCE	$ 1,852,158	$ 1,969,130	$ 2,067,587	$ 2,170,966	$ 2,279,514	$ 2,393,490	$ 2,513,164
LEASE & RENTALS	$ 765,282	$ 888,175	$ 932,584	$ 979,213	$ 1,028,174	$ 1,079,582	$ 1,133,561
DEPRECIATION & AMORTIZATION	$ 4,066,572	$ 4,435,314	$ 4,600,000	$ 4,800,000	$ 5,154,237	$ 5,150,000	$ 5,150,000
Total OPERATING EXPENSES	**$111,442,362**	**$121,071,236**	**$127,376,054**	**$133,714,856**	**$140,514,836**	**$147,278,629**	**$154,385,061**
GAIN (LOSS) FROM OPERATIONS	**$ (3,655,120)**	**$ 47,184**	**$ 1,009,473**	**$ 2,373,801**	**$ 3,739,141**	**$ 5,630,587**	**$ 7,698,708**

NON-OPERATING REVENUES								
GENERAL PROPERTY TAXES	$ 4,886,080	$ 4,543,798	$ 4,543,798	$ 4,543,798	$ 4,543,798	$ 4,543,798	$ 4,543,798	
INVESTMENT INCOME	$ 403,768	$ 414,249	$ 414,249	$ 414,249	$ 414,249	$ 414,249	$ 414,249	
OTHER NON OPERATING REVENUE	$ 6,683	$ 5,033	$ 5,033	$ 5,033	$ 5,033	$ 5,033	$ 5,033	
GAIN (LOSS) ON DISPOSAL	$ 7,886	$ -	$ -	$ -	$ -	$ -	$ -	
SPH AUXILIARY	$ 3,860	$ 4,500	$ 4,500	$ 4,500	$ 4,500	$ 4,500	$ 4,500	
Total NON-OPERATING REVENUES	**$ 5,308,277**	**$ 4,967,580**	**$ 4,967,580**	**$ 4,967,580**	**$ 4,967,580**	**$ 4,967,580**	**$ 4,967,580**	
NON-OPERATING EXPENSES								
SERVICE AREA BOARD	$ 109,604	$ 25,000	$ 26,250	$ 27,563	$ 28,941	$ 30,388	$ 31,907	
OTHER NON OP EXP	$ 23,905	$ 72,677	$ 72,677	$ 72,677	$ 72,677	$ 72,677	$ 72,677	
INTEREST EXPENSE	$ 466,733	$ 412,729	$ 392,093	$ 372,488	$ 353,864	$ 336,170	$ 319,362	
Total NON-OPERATING EXPENSES	**$ 600,242**	**$ 510,406**	**$ 491,020**	**$ 472,727**	**$ 455,481**	**$ 439,235**	**$ 423,946**	
GRANTS								
GRANT REVENUE	$ 333,833	$ 806,596	$ 806,596	$ 806,596	$ 806,596	$ 806,596	$ 806,596	
GRANT EXPENSE	$ 30,012	$ 421,900	$ 421,900	$ 421,900	$ 421,900	$ 421,900	$ 421,900	
TOTAL NON-OPERATING GAINS, NET	**$ 303,821**	**$ 384,696**	**$ 384,696**	**$ 384,696**	**$ 384,696**	**$ 384,696**	**$ 384,696**	
NET INCOME	**$ 2,557,220**	**$ 4,889,054**	**$ 5,870,729**	**$ 7,253,350**	**$ 8,635,936**	**$ 10,543,628**	**$ 12,627,038**	

Figure 60: SPH Line Item Capital Budget for CON Project

D. Schedule IV. Capital Budget

Capital Description	Total
Aspirator/Pressure Unit, General Purpose	$ 2,016
Cabinet, Bio Safety, Class II/A, Radiopharmacy, F/S 4FT	$ 52,000
Cabinet, Bio Safety, Class II/B2, w/base, 4ft	$ 33,202
Cabinet, Storage, Lead Lined	$ 1,419
Cabinet, Warming, F/S, 1 Heated Compartment, Elect	$ 10,230
Cart, Emergency, Mobile, 66"H x 32"W x 22"D	$ 3,913
Cart, General Storage, Mobile	$ 2,765
Chair, Blood Donor, Recliner, Manual or Pneumatic	$ 8,640
Chair, Blood Donor, Recliner, Manual or Pneumatic	$ 1,080
Chair, Laboratory, Blood Drawing, w/Storage	$ 1,800
Chamber, Pass-Thru, Biosafe, Ss, 24"W X 24"D X 24"H	$ 13,350
Defibrillator, External, Automated (AED)	$ 2,800
Defibrillator/Monitor Respiratory	$ 32,600
Distribution System, Medication, Automatic	$ 44,843
Dose Calibrator, Radio-isotope	$ 8,531
Hood, Laminar Flow, Horizontal, Bench Top, 4ft	$ 17,500

Medication Safe	$	120,000
Monitor, Vital Signs	$	8,320
Otoscope/Ophthalmoscope, Wall Mounted	$	5,160
Pump Modular	$	13,500
Pump, Volumetric, Infusion, Multiple Line	$	81,810
Radiation Survey Meter	$	4,500
Refrigerator, Biological 1 door 16 CuFt	$	4,000
Refrigerator, Biological,-2 Door, 40 Cu Ft	$	15,500
Refrigerator, Biological, SS, 2 Door, 40 Cu Ft	$	9,000
Refrigerator/Freezer, Biological, Upright, 18 Cu Ft	$	5,540
Safe, Storage, Radium	$	6,076
Scale, Weighing, 750 Pound Capacity	$	1,430
Scale, Wheelchair, Portable, 1000 lb Capacity	$	4,700
Scanner, Nuclear, SPECT, Dual Head	$	675,000
Shield, L Block, Radium Handling	$	6,115
Slanted Wire Shelving	$	13,200
Small furnishings and fixtures	$	39,452
Stretcher, Chair- Transport or procedural	$	12,000
Syringe Modular	$	2,250
System, Stress Exercise, w/Treadmill	$	41,554
System, Uptake, Thyroid, Mobile	$	16,285
Table, Examination, Treatment, Electro/Hydraulic	$	27,398
Table, Process, Adj Height, 5 Drawer, 48"W x 24"D	$	2,942
Table, Ultrasound, Mobile, Echocardiology	$	8,995
Ultra Low freezer	$	10,000
Undercounter Freezer	$	1,500
Waste Disposal Unit, Sharps, Container Shield	$	1,870
General Building Requirements	$	2,628,580
Building Existing Conditions	$	274,853
Concrete	$	125,201
Metals	$	111,246
Wood and Plastic	$	220,489
Thermal & Moisture Protections	$	166,799
Openings	$	496,610
Finishes	$	944,786
Specialties	$	324,616
Special Construction	$	161,235
Conveying	$	112,824
Fire Suppression	$	110,969
Plumbing	$	513,191
HVAC	$	617,188
Integrated Automation	$	284,417
Electrical	$	688,651

Communications	$	145,467
Electronic Safety & Security	$	221,286
Equipment	$	4,866
Furnishings	$	20,730
Utilities	$	14,417
Project Design Fees	$	659,783
KPB Project Administration	$	95,356
KPB Project Management	$	368,479
	$	**10,686,825**

E. Schedule V – A. Debt Service Summary

N/A – This project will not be funded with Debt

V – B. New Project Debt Service Summary

South Peninsula Hospital has decided not to incur bond indebtedness for this CON project. Instead, the Hospital intends to use a variety of funding sources to pay for the project which are delineated below:

Figure 61: CON Project Funding Schedule

Project Description	**Estimated Cost**	**KPB Admin Fee**	**Total Project**
CON Construction	$ 8,188,421	$ 81,884	$ 8,188,421
CON Equipment	$ 1,374,786	$ 6,874	$ 1,374,786
CON Project Design	$ -	$ 6,598	$ 659,783
KPB Admin Fee	$ -		$ 95,356
KPB Project Mgmt Fee	$ 368,479		$ 368,479
Total CON	**$ 9,563,207**	**$ 95,356**	**$ 10,686,825**
CON Application Fee			$ 10,687
SKPH Service Area Funds (design)			$ (659,783)
SKPH Service Area Funds 21SHD & 23SHA			$ (928,673)
SPH Plant Replacement & Expansion Funds			$ (5,700,000)
Philanthropy / Grants			$ (500,000)
Re-appropriation of de-obligated Service Area Funds			$ (1,100,000)
SPH Operating Cash			$ (1,809,056)
Project Surplus / (Shortfall)			**$ (0)**

E. Schedule VI – Reimbursement Sources

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

Figure 62: SPH Payor Mix 2019-2023

FY 2019				
Revenue	*# Patients*	*Gross Revenue*	*Deductions*	*Net Patient Revenue*
Medicaid	1613	$ 37,340,607	$ 15,267,092	$ 22,073,515
Medicare	2311	$ 50,216,678	$ 22,534,099	$ 27,682,579
Private Insur.	3880	$ 36,053,000	$ 7,476,609	$ 28,576,391
Self Pay	957	$ 5,150,428	$ 794,189	$ 4,356,239
Charity Care	899		$ 1,574,550	$ (1,574,550)
Other				
Total	9660	$ 128,760,712	$ 47,646,539	$ 81,114,173

FY 2020				
Revenue	*# Patients*	*Gross Revenue*	*Deductions*	*Net Patient Revenue*
Medicaid	1198	$ 37,869,985	$ 17,406,965	$ 20,463,020
Medicare	2288	$ 48,316,878	$ 23,326,585	$ 24,990,293
Private Insur.	4399	$ 40,481,708	$ 9,817,570	$ 30,664,138
Self Pay	796	$ 3,917,585	$ 1,632,346	$ 2,285,239
Charity Care	1575		$ 2,323,402	$ (2,323,402)
Other				
Total	10256	$ 130,586,156	$ 54,506,868	$ 76,079,288

FY 2021				
Revenue	*# Patients*	*Gross Revenue*	*Deductions*	*Net Patient Revenue*
Medicaid	1445	$ 36,710,808	$ 19,054,608	$ 17,656,199
Medicare	2369	$ 62,714,296	$ 31,768,778	$ 30,945,519
Private Insur.	4306	$ 47,418,126	$ 11,943,302	$ 35,474,824
Self Pay	1847	$ 6,118,468	$ 3,332,151	$ 2,786,317
Charity Care	678		$ 1,266,505	$ (1,266,505)
Other				
Total	10645	$ 152,961,698	$ 67,365,344	$ 85,596,354

FY 2022				
Revenue	*# Patients*	*Gross Revenue*	*Deductions*	*Net Patient Revenue*
Medicaid	1475	$ 45,439,476	$ 24,401,598	$ 21,037,878
Medicare	2528	$ 73,066,677	$ 37,850,170	$ 35,216,507
Private Insur.	3948	$ 56,890,223	$ 15,888,772	$ 41,001,452
Self Pay	1461	$ 6,361,527	$ 3,568,228	$ 2,793,299
Charity Care	1072		$ 226,294	$ (226,294)
Other				
Total	10484	$ 181,757,902	$ 81,935,062	$ 99,822,840

FY 2023				
Revenue	*# Patients*	*Gross Revenue*	*Deductions*	*Net Patient Revenue*
Medicaid	1235	$ 48,537,410	$ 26,112,825	$ 22,424,585
Medicare	2664	$ 78,048,155	$ 38,544,093	$ 39,504,062
Private Insur.	4291	$ 60,768,837	$ 17,982,719	$ 42,786,118
Self Pay	1575	$ 6,617,080	$ 2,711,108	$ 3,905,972
Charity Care	1288		$ 1,959,733	$ (1,959,733)
Other				
Total	11053	$ 193,971,481	$ 87,310,477	$ 106,661,004

Figure 63: SPH Payor Mix 2027-2029

FY 2027				
Revenue	*# Patients*	*Gross Revenue*	*Deductions*	*Net Patient Revenue*
Medicaid	1613	$ 55,548,174	$ 31,264,911	$ 24,283,263
Medicare	2311	$ 108,571,432	$ 49,675,504	$ 58,895,928
Private Insur.	3880	$ 78,272,428	$ 21,954,471	$ 56,317,957
Self Pay	957	$ 10,099,668	$ 3,675,889	$ 6,423,779
Charity Care	899		$ 2,763,011	$ (2,763,011)
Other				
Total	9660	$ 252,491,702	$ 109,333,786	$ 143,157,916

FY 2028				
Revenue	*# Patients*	*Gross Revenue*	*Deductions*	*Net Patient Revenue*
Medicaid	1198	$ 56,204,653	$ 33,140,805	$ 23,063,848
Medicare	2288	$ 117,762,130	$ 52,656,034	$ 65,106,096
Private Insur.	4399	$ 82,968,773	$ 23,271,739	$ 59,697,034
Self Pay	796	$ 10,705,648	$ 3,896,442	$ 6,809,206
Charity Care	1575		$ 2,928,791	$ (2,928,791)
Other				
Total	10256	$ 267,641,204	$ 115,893,811	$ 151,747,393

FY 2029				
Revenue	*# Patients*	*Gross Revenue*	*Deductions*	*Net Patient Revenue*
Medicaid	1445	$ 56,739,935	$ 35,129,254	$ 21,610,681
Medicare	2420	$ 130,501,851	$ 55,815,396	$ 74,686,455
Private Insur.	4306	$ 85,109,903	$ 24,668,043	$ 60,441,860
Self Pay	1847	$ 11,347,987	$ 4,130,228	$ 7,217,759
Charity Care	678		$ 3,104,519	$ (3,104,519)
Other				
Total	10696	$ 283,699,677	$ 122,847,440	$ 160,852,237

G. Schedule VII – Depreciation Schedules

Show a depreciation schedule for all items acquired through the proposed project. Indicate on the depreciation schedule or separately which major movable equipment is being purchased for the project.

Figure 64: Depreciation Schedule, Phase One: Pharmacy / Infusion

Schedule VII. Depreciation Schedule Phase One: Pharmacy / Infusion			
CONSTRUCTION AND EQUIPMENT DESCRIPTION	**COST**	**AHA LIFE**	**ANNUAL DEPRECIATION**
GENERAL REQUIREMENTS	$ 1,645,986	15	$ 109,732
EXISTING CONDITIONS	$ 75,911	15	$ 5,061
CONCRETE	$ 102,112	40	$ 2,553
METALS	$ 6,407	40	$ 160
WOOD AND PLASTIC	$ 203,113	15	$ 13,541
THERMAL & MOISTURE PROTECTION	$ 151,076	10	$ 15,108
OPENINGS	$ 430,016	15	$ 28,668
FINISHES	$ 642,645	15	$ 42,843
SPECIALTIES	$ 197,207	10	$ 19,721
EQUIPMENT	$ 4,866	7	$ 695
FURNISHINGS	$ 20,730	7	$ 2,961
FIRE SUPRESSION	$ 76,699	25	$ 3,068
PLUMBING	$ 357,038	20	$ 17,852
HVAC	$ 413,371	15	$ 27,558
INTEGRATED AUTOMATION	$ 173,598	15	$ 11,573
ELECTRICAL	$ 460,511	20	$ 23,026
COMMUNICATIONS	$ 93,879	10	$ 9,388
ELECTRONIC SAFETY & SECURITY	$ 177,277	10	$ 17,728
UTILITIES	$ 14,416	25	$ 577
Dispenser, Soap, Disposable	$ 748	7	$ 107
Dispenser, Hand Sanitizer, Hands-Free	$ 1,079	7	$ 154
Dispenser, Paper Towel, SS, Surface Mounted	$ 721	7	$ 103
Dispenser, Paper Towel, Sensor, Hands Free	$ 312	7	$ 45
Waste Disposal Unit, Sharps w/Glove Dispenser	$ 720	7	$ 103
Dispenser, Glove, Surgical/Examination, Wall Mntd	$ 309	7	$ 44
Waste Disposal Unit, Sharps	$ 125	7	$ 18
Basket, Wastepaper, Step-On	$ 283	7	$ 40
Transport Cart, Meal Tray, Standard Height	$ 750	10	$ 75
Brewer, Coffee, Auto, Elect, 3 Burner, Front/Back	$ 915	5	$ 183
Oven, Microwave, Consumer	$ 358	5	$ 72
Television, HD, 40" Class	$ 570	5	$ 114
Flowmeter, Oxygen, Low Flow	$ 900	5	$ 180

Chair, Blood Donor, Recliner, Manual or Pneumatic	$ 8,640	10	$ 864
Chair, Laboratory, Blood Drawing, w/Storage	$ 1,800	15	$ 120
Shelving, Storage, Wire, CRS, w/Adjustable Shelves	$ 565	20	$ 28
Shelving, Storage, 77hx36wx18d	$ 1,800	20	$ 90
Hamper, Linen, Mobile, w/Lid	$ 660	7	$ 94
Container, Biohazard Waste, Step-on, Fire Safe	$ 1,859	7	$ 266
Cabinet, Warming, F/S, 1 Heated Compartment, Elect	$ 10,230	10	$ 1,023
Distribution System, Medication, Automatic	$ 44,843	7	$ 6,406
Scale, Weighing, 300 750 Pound Capacity	$ 1,430	10	$ 143
Monitor, Vital Signs	$ 8,320	5	$ 1,664
Otoscope/Ophthalmoscope, Wall Mounted	$ 5,160	7	$ 737
Stand, IV, Adjustable	$ 3,240	15	$ 216
Pump, Volumetric, Infusion, Multiple Line	$ 81,810	10	$ 8,181
Pump Modular	$ 13,500	10	$ 1,350
Syringe Modular	$ 2,250	10	$ 225
Stretcher, Chair Transport or procedural	$ 12,000	10	$ 1,200
Wheelchair, Patient Transport, Folding	$ 580	5	$ 116
Table, Overbed	$ 1,488	15	$ 99
Defibrillator, External, Automated (AED)	$ 2,800	5	$ 560
Stand, Mayo	$ 3,000	15	$ 200
Table, Examination, Treatment, Electro/Hydraulic	$ 27,398	10	$ 2,740
Eyewash, Counter Top	$ 350	15	$ 23
Refrigerator, 14 Cubic Feet	$ 980	10	$ 98
Dispenser, Soap, Disposable	$ 136	7	$ 19
Dispenser, Hand Sanitizer, Hands-Free	$ 166	7	$ 24
Waste Disposal Unit, Sharps, Mobile with Trolley	$ 1,560	7	$ 223
Shelf, 12" Depth, SS, Surface Mounted	$ 720	7	$ 103
Chair, Drafting, Rotary	$ 1,328	10	$ 133
Table, Work, Stainless Steel	$ 665	15	$ 44
Hood, Laminar Flow, Horizontal, Bench Top, 4ft	$ 17,500	10	$ 1,750
Cabinet, Bio Safety, Class II/B2, w/base, 4ft	$ 33,202	15	$ 2,213
Shelving, Storage, 77hx36wx18d	$ 1,080	20	$ 54
Container, Biohazard Waste, Step-on, Fire Safe	$ 338	7	$ 48
Table, Instrument/Dressing, CRS	$ 3,648	15	$ 243
Refrigerator, Biological, SS, 2 Door, 40 Cu Ft	$ 9,000	10	$ 900
Refrigerator, Biological, 2 Door, 40 Cu Ft	$ 15,500	10	$ 1,550
Refrigerator, Biological 1 door 16 CuFt	$ 4,000	10	$ 400
Refrigerator/Freezer, Biological, Upright, 18 Cu Ft	$ 5,540	10	$ 554
Medication Safe	$ 120,000	20	$ 6,000
Chamber, Pass-Thru, Biosafe, Ss, 24"W X 24"D X 24"H	$ 13,350	15	$ 890
Undercounter Freezer	$ 1,500	10	$ 150
Shelf Bin Organizer	$ 1,000	10	$ 100
Ultra Low freezer	$ 10,000	10	$ 1,000
Slanted Wire Shelving	$ 13,200	20	$ 660
Total	**$ 5,742,784**		**$ 396,552**

Figure 65: Depreciation Schedule, Phase Two: Nuclear Medicine

Schedule VII. Depreciation Schedule Phase Two: Nuclear Medicine			
CONSTRUCTION AND EQUIPMENT DESCRIPTION	COST	AHA LIFE	ANNUAL DEPRECIATION
GENERAL REQUIREMENTS	$ 982,594	15	$ 65,506
EXISTING CONDITIONS	$ 198,942	15	$ 13,263
CONCRETE	$ 23,089	40	$ 577
METALS	$ 104,839	40	$ 2,621
WOOD AND PLASTIC	$ 17,376	15	$ 1,158
THERMAL & MOISTURE PROTECTION	$ 15,723	10	$ 1,572
OPENINGS	$ 66,594	15	$ 4,440
FINISHES	$ 302,141	15	$ 20,143
SPECIALITIES	$ 127,409	10	$ 12,741
SPECIAL CONSTRUCTION	$ 161,235	10	$ 16,124
CONVEYING	$ 112,824	15	$ 7,522
FIRE SUPRESSION	$ 34,270	25	$ 1,371
PLUMBING	$ 156,153	20	$ 7,808
HVAC	$ 203,817	15	$ 13,588
INTEGRATED AUTOMATION	$ 110,819	15	$ 7,388
ELECTRICAL	$ 228,140	20	$ 11,407
COMMUNICATIONS	$ 51,588	10	$ 5,159
ELECTRONIC SAFETY & SECURITY	$ 44,009	10	$ 4,401
Dispenser, Soap, Disposable	$ 272	7	$ 39
Dispenser, Hand Sanitizer, Hands-Free	$ 249	7	$ 36
Dispenser, Paper Towel, SS, Surface Mounted	$ 206	7	$ 29
Dispenser, Paper Towel, Sensor, Hands Free	$ 312	7	$ 45
Waste Disposal Unit, Sharps, Container Shield	$ 1,870	7	$ 267
Waste Disposal Unit, Sharps w/Glove Dispenser	$ 180	7	$ 26
Table, Process, Adj Height, 5 Drawer, 48"W x 24"D	$ 2,942	15	$ 196
Cart, Emergency, Mobile, 66"H x 32"W x 22"D	$ 3,913	10	$ 391
Cart, General Storage, Mobile	$ 2,765	10	$ 277
Stool, Self Adjusting	$ 340	10	$ 34
Footstool, Straight	$ 85	10	$ 9
Basket, Wastepaper, Fire Resistant	$ 52	7	$ 7
Basket, Wastepaper, Step-On	$ 566	7	$ 81
Waste Receptacle, Radioisotope, Lead Line	$ 610	7	$ 87
Oven, Microwave, Consumer	$ 358	5	$ 72
Dose Calibrator, Radio-isotope	$ 8,531	5	$ 1,706
Cabinet, Bio Safety, Class II/A, Radiopharmacy, F/S 4FT	$ 52,000	15	$ 3,467
Flowmeter, Air, Connect w/50 PSI Supply	$ 90	7	$ 13
Flowmeter, Oxygen, Low Flow	$ 180	7	$ 26

Regulator, Vacuum	$	710	7	$	101
Chair, Blood Donor, Recliner, Manual or Pneumatic	$	1,080	10	$	108
Holder, Chart, Patient, Wall or Door Mounted	$	26	7	$	4
Hamper, Linen, Mobile, w/Lid	$	220	7	$	31
Scale, Wheelchair, Portable, 1000 lb Capacity	$	4,700	10	$	470
Stand, IV, Adjustable	$	360	15	$	24
Defibrillator/Monitor Respiratory	$	32,600	7	$	4,657
System, Stress Exercise, w/Treadmill	$	41,554	10	$	4,155
Aspirator/Pressure Unit, General Purpose	$	2,016	10	$	202
Table, Ultrasound, Mobile, Echocardiology	$	8,995	15	$	600
Cabinet, Storage, Lead Lined	$	1,419	15	$	95
Cart, Transport, Radium	$	950	10	$	95
Safe, Storage, Radium	$	6,076	20	$	304
Shield, L Block, Radium Handling	$	6,115	7	$	874
System, Uptake, Thyroid, Mobile	$	16,285	5	$	3,257
Stand, Injection, Nuclear Medicine	$	733	7	$	105
Scanner, Nuclear, SPECT, Dual Head	$	675,000	5	$	135,000
Radiation Survey Meter	$	4,500	8	$	563
Total	**$**	**3,820,422**		**$**	**354,237**

NOTE: Useful lives are from the American Hospital Association 2018 Revised Edition "Estimated Useful Lives of Depreciable Hospital Assets". For Building component items that do not appear in the AHA guide, a composite weighted average useful life of the remaining components was calculated at 15 years.

FAIR MARKET VALUE – HOW TO CALCULATE

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

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

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

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

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

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 102 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 104 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): **$10,686,825**

Estimated Value of the Activity for (1) (sum of A & B above) **$10,686,825**

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

Estimated Fair Market Value for (2): $____N/A____

Estimated Value for (1) from above: **$10,686,825**

Total Estimated Value of the Activity (sum of (1) and (2)): **$10,686,825**

Amount of Application Fee submitted with this application (see 7 AAC 07.079 to calculate amount due) 0.1% x total project cost: **$ 10,687**

Certification of Individual Determining Application Fee

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

Date: July 17, 2023

Facility Name and Address: South Peninsula Hospital, Inc.
4300 Bartlett Street/Homer/Alaska/99603

Name and Title of Person Determining Application Fee:
Ryan K. Smith, Chief Executive Officer

Signature of Certifying Officer of the Organization

APPENDIX A

Item 1: CMS Recertification Letter 12/16/2021

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health and Social Services

DIVISION HEALTH CARE SERVICES
Health Facilities Licensing & Certification

4601 Business Park Blvd, Bldg. K
Anchorage, AK 99503
Main: 907-334-2460
Toll free: 888-387-9387
Fax: 907-334-2682

December 16, 2021

Ryan Smith, Administrator
South Peninsula Hospital
4303 Bartlett St.
Homer, AK 99603

rsmith@sphosp.org

CMS Certification Number (CCN): 02-1313

Dear Mr. Smith:

This is to notify you we have received and accepted your written Plan of Correction (PoC) required for the CMS-2567 report for the Federal Medicare/Medicaid recertification survey conducted at your facility on 11/17/21. **The PoC will serve as the facility's allegation of compliance.**

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

If you have further questions, you may call me at 907-334-2664.

Sincerely,

M.L. Thomas

Matthew Thomas RN, CFI, FF
Nurse Consultant II-Program Manager

cc: Susan Shover, Director of Quality Management sms@sphosp.org
Licensing and Certification provider file

Item 2: SPH Facilities Master Plan Priority Levels

1 Summary of Key Findings + Strategic Recommendations

The following summarizes the key findings and recommendations as part of this analysis. Detail is provided herein. SPH and the Design Team established a priority list of items, and the FMP is organized around this list; however, it is not a list of projects in itself. Careful consideration was given to the current facility and community needs and concerns for Cost and compliance.

	Priority Level
Utilize existing Core and Shell space	1
Consolidate multiple services currently located around and off Campus	2
Deferred Maintenance & Aging Facilities Considerations	3
Power Plant Replacement (Generator Compliance)	4
Expand Surgery Department & Provide more efficient PACU capacity and throughput	5
Provide more parking readily accessible to services	6
Pharmacy Upgrades & Compliance	7
Expand Long-Term Care Facility (LTC)	8
Provide better campus wayfinding and entry points	9

Item 3: SPH Corporate Policy HW-068 Patient & Resident Rights

South Peninsula Hospital	**SUBJECT:** Patient & Resident Rights	**POLICY #** HW-068 **Page 1** of **3**
SCOPE: Hospital-Wide **RESPONSIBLE DEPARTMENT:** Patient Care Services; Long Term Care Facility		**ORIGINAL DATE:** 2/27/96 **REVISED:** 6/29/98; 4/26/00; 4/14/03; 2/10/11; 9/10/15; 12/16/15; 6/22/21; 12/9/21; 4/26/23
APPROVED BY: Acute Care Nursing Director; LTC Nursing Director; Chief Nursing Officer/LTC Administrator; MEC		**EFFECTIVE:** 4/26/23

PURPOSE:
Outline of rights and responsibilities for Patients and Residents.

DEFINITION(S):
N/A

POLICY:

A. South Peninsula Hospital will respect each Patient or Resident in the provision of care in accordance with fundamental human, civil, constitutional, and statutory rights. South Peninsula Hospital and South Peninsula Hospital Long Term Care recognizes that each Patient or Resident is an individual with unique health care needs. To the best of our ability, we will provide considerate, respectful care focusing on the individual's needs and of those defined in both Patient and Resident Rights.
B. South Peninsula Hospital affirms the Patient or Resident's right to make decisions regarding his or her care, including the decision to discontinue treatment, to the extent permitted by law.
C. All staff will support and role model SPH's values and expected behaviors while caring and communicating on behalf of our Patients and Residents.
D. A nursing facility or hospital Patient or Resident has the right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility.
E. The patient or Resident has the right to exercise his or her rights as a Patient or Resident of the facility and as a citizen of the United States.
F. The Patient or Resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.
G. In the case of a Patient or Resident adjudged incompetent under the laws of Alaska by a court of competent jurisdiction, the rights of the patient or Resident are exercised by the person appointed under State law to act on their behalf. If the Patient or Resident has not been judged incompetent, any legal surrogate designated in accordance with State law may exercise the patient or Resident's rights to the extent provided by State law.
H. Whenever a patient or Resident elects to have another person act on their behalf, or a court has made an adjudication, the person or legal surrogate must provide a copy of the documentation to SPH.
I. Patients and Residents must be informed both orally and in writing (in a language that the Patient and Resident understands), of his or her rights and all rules governing Patient and Resident conduct and responsibilities during the stay in the facility. Such notification will be made upon admission and during the Patient or Resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.
J. At the time of registration or admission, the following will be distributed to the Patient, Resident, or their legal representative:

Admit to	Documents
Long Term Care	• Consumer Voice Resident Rights Resident Rights Acknowledgement form (signed at admission) • Admission Agreement
Swing Bed	• 70165169, Swing Bed Patient Information Packet (verbal review required)
Acute Care	• 70164743, Patient Rights & Responsibilities (oral review not necessary)
Outpatient	• 70164743, Patient Rights & Responsibilities (oral review not necessary

K. The rights will be reviewed orally (except where noted above) item by item with the Resident/patient or his/her representative.
L. The Resident Rights Acknowledgment form or the Swing Bed Patient Acknowledgement form will be signed by the Resident/patient or his/her representative and kept in the medical record.
M. Except as otherwise provided in AS 47.30.825, a Patient or nursing facility Resident has rights that include, but are not limited to, the following:
    - To obtain a copy of our Notice of Privacy Practices at time of admission and upon request. This notice is also available to view electronically on our web site at https://www.sphosp.org/wp-content/uploads/2021/03/NoticeofPrivacy2-21.pdf.
    - To associate and communicate privately with persons of the Patient's or Resident's choice
    - To have reasonable access to a telephone to make and receive confidential calls.
    - To mail and receive unopened correspondence
    - To be informed of the facility's grievance procedure for handling complaints relating to Patient or Resident care
    - To be free from physical or chemical restraints except as specified in AS 47.30.825 or 7AAC 12.258
    - The right to be free from abuse (corporal punishment, mental, verbal and sexual), neglect, misappropriation of property, exploitation and involuntary seclusion
    - To be treated with consideration and recognition of the Patient's or Resident's own dignity and individuality
    - To confidentiality of the Patient's or Resident's medical records and treatment
    - To be free from unnecessary or excessive medications
    - To private visits by his or her spouse, except in a general acute care hospital, and in a nursing facility, to share a room if both spouses are Residents in the home, unless medical reasons or space problems require separation
    - To be informed, (in language the patient or Resident understands), before or at the time of admission and during the patient's stay, of services that are available in the facility and their cost, including any costs for services or personal care items not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act
    - To be informed by a physician of the patient's or Resident's medical condition, in a language the patient understands
    - To accept or refuse medical treatment
    - To refuse to participate in experimental research, psychosurgery, lobotomy, electroconvulsive therapy, or aversion conditioning
    - To participate in the development of the plan of care or discharge plan, and to receive instructions for self-care and treatment which include explanation of adverse symptoms and necessary precautions as appropriate
    - To be informed of the rights listed here and of all rules and regulations governing patient or Resident conduct and responsibility in a language the patient or Resident understands
    - To inspect and obtain a copy of their protected health information that is contained in a designated record set for as long as we maintain the protected health information. A written authorization is required and SPH may charge a reasonable fee to cover the cost of generating the copy.
    - To request an amendment or correction to their protected health information. While we will accept requests for amendment or correction to protected health information, we are not required to agree to the amendment/correction.
    - To request that staff communicate with the Resident using alternative means or at an alternative location. The hospital will accommodate reasonable requests when possible.
    - To request in writing that the hospital does not use or disclose any part of the Resident's protected health information for treatment, payment or health care operations. Your request must tell us (1) what information you want restricted; (2) whether you want to restrict use, disclosure, or both; (3) to whom you want the restriction to apply; and (4) an expiration date. If SPH believes the restriction is not in the best interest of either party, or if SPH cannot reasonably accommodate the request, SPH is not required to agree.
    - To request that we provide an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations.

- To formulate an Advance Directive and an Alaska POLST (Physicians Orders for Life Sustaining Treatment);
- To a written description of his or her legal rights
- To not be required to perform services for the facility that are not included for therapeutic purposes in his or her plan of care
- To manage his or her personal financial affairs; and
- To have the facility, upon written authorization of the Resident, hold, safeguard, manage, and account for personal funds deposited with the facility.
- To file a written complaint with the SPH Privacy Officer or the Department of Health and Human Services Office of Civil Rights if you believe your privacy rights have been violated.
- To have knowledge of and access to the State of Alaska LTC Ombudsman's Office

For Persons with Hearing Impairment

A. TDD (Telecommunications Device for the Deaf) is located at the Acute Care Nurses Station. Instructions for use of the TDD device are kept with it. The TDD phone number is 235-0357. This device may be signed out and utilized anywhere in the facility. An amplified telephone is also available at the Admissions desk, the Acute Care nurses' station and in the Long Term Care Facility

For Non-English Speaking Persons

A. An interpreter will be provided for non-English speaking persons when possible. A family member may serve as interpreter at the request of the patient or Resident.
B. When an interpreter is the chosen method of communication, the interpreter should be present any time clear, effective communication is necessary. These situations include, but are not limited to:
   1. Obtaining the person's medical history.
   2. Explanation of medical procedures/treatments.
   3. Obtaining consent for medical procedures/treatments.
   4. Patient or family teaching.
   5. Discharge instruction and follow-up.
   6. Emergency situations that may arise.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. State of Alaska Interpretive Surgery Guidelines
2. Nursing Home Certification Regulations
3. AAC 12.890
4. South Peninsula Hospital's Values and Behaviors as adopted by the Board of Directors
5. Consumer Voice: Resident's Rights

CONTRIBUTOR(S):
LTC Nursing Director; Quality Management Director; Policy Committee

Item 4: Federal Critical Access Hospital Designation Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

September 5, 2008

Robert Letson, Administrator
South Peninsula Hospital
4300 Bartlett Street
Homer, Alaska 99603

CMS Certification Number (CCN): 02-1313
CMS Certification Number (CCN) for Swing-Bed Services: 02-Z313

Dear Mr. Letson:

This letter is to notify you that South Peninsula Hospital meets the Medicare requirements of Title 42, Part 485 of the Code of Federal Regulations (CFR) for participation as a critical access hospital (CAH), with swing beds, effective August 7, 2008. The effective date of this approval is the last day of the survey that demonstrated South Peninsula Hospital was in full compliance with the CAH and Swing Bed Conditions of Participation.

With the approval of South Peninsula Hospital as a CAH, its participation as an acute care hospital under CMS Certification Number (CCN) 02-0014, will be cancelled effective August 6, 2008. The new CCN for critical access hospital status is 02-1313. This CAH provider number should be used on all correspondence and billing to the Medicare program, relating to critical access hospital acute care services.

Likewise, the CCN for swing-bed services, CCN 02-U014, will be cancelled effective August 6, 2008. Your new CCN for swing-bed services is like your general Medicare CCN, except that the "third digit" is changed to the alpha-character "Z." It is important that this sub-provider CCN, 02-Z313, be entered on all forms, claims, and correspondence relating to skilled nursing care services.

The change in status of South Peninsula Hospital will require that limited services begin no later than October 5, 2008. The hospital may operate no more than 25 beds. The average stay for all hospital inpatients may not be greater than 96 hours.

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Seattle Regional Office
2201 Sixth Avenue, RX-48
Seattle, WA 98121

All billing for patient services through August 6, 2008, should be billed under CCN 02-0014 (for skilled nursing care, CCN 02-U014). All hospital services furnished on or after August 7, 2008, should be billed under CCN 02-1313 (for skilled nursing care, CCN 02-Z313).

This Medicare certification approval is contingent on the expectation that South Peninsula Hospital meets all Title VI and other pertinent civil rights requirements of the Office for Civil Rights. If South Peninsula Hospital does not meet these requirements, its agreement will become void retroactive to our approval date. This will require repayment by the agency of any additional Medicare money received.

Please report any changes in staffing, services and other characteristics that might affect compliance with the regulations to the Department of Public Health, Licensing and Certification (State survey agency). They will forward this information to the CMS Regional Office.

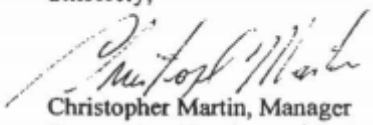
South Peninsula Hospital's Medicare fiscal intermediary continues to be Noridian Administrative Services. Questions concerning billings and other fiscal matters should be directed to the intermediary.

CMS has received a copy of South Peninsula Hospital's request to the Alaska Department of Health, dated August 11, 2008, requesting an adjustment of the effective date to October 25, 2007. After careful consideration, CMS has denied this request, based on requirements set forth at 42 CFR § 489.13.

If you have any questions, please contact Jerilyn McClain of my staff, at (206) 615-2316 or by email at Jerilyn.McClain@cms.hhs.gov.

We welcome your participation as a critical access hospital in the Medicare program.

Sincerely,



Christopher Martin, Manager
Survey, Certification and Enforcement Branch

Enclosure

cc: Jane Urbanovsky, Alaska Licensing and Certification
Noridian Administrative Services
Pat Carr, Rural Health Program Manager, DHS
Mountain-Pacific Quality Health Foundation

Item 5: Alaska Critical Access Hospital Designation letter

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
CERTIFICATION AND LICENSING

Sarah Palin, Governor

619 East Ship Creek Avenue
Suite 232
Anchorage, AK 99501-1667
Telephone: (907) 334-2483
Fax: (907) 334-2682

August 8, 2007

Charles Franz, Administrator
South Peninsula Hospital
4300 Bartlett Street
Homer, Alaska 99603

RE: Application for Initial Designation as a Critical Access Hospital

Dear Mr. Franz:

On August 2, 2007 we received your application for designation and conversion to Critical Access Hospital status under Medicare (42 CFR 485.601 -- 645). After review, your application was found to be complete and you were informally notified at that time. This letter confirms that South Peninsula Hospital was approved for designation with the effective date of August 2, 2007.

It is recommended, if you have not already done so, that you contact your fiscal intermediary and advise them of your planned conversion and planned date of the conversion. CMS will determine what the actual conversion date will be following successful initial survey.

I would like to offer to you or your staff our services to answer any questions about CAH compliance or requirements under Medicare if needed. You may contact our office at 907-334-2483. Thank you for your application, and good luck in this new designation.

Sincerely,
CERTIFICATION and LICENSING

Jane Urbanovsky
Chief

cc: Jerilyn McClain, CMS

Item 6: State of Alaska Hospital License, GACH-010, June 21, 2022

STATE OF ALASKA
DEPARTMENT OF HEALTH

This is to Certify that a license is hereby granted to

South Peninsula Hospital
License # GACH-010

To conduct business as a **Critical Access Hospital, with 22 beds**

The business is located at **4300 Bartlett St., Homer AK, 99603**

This License is effective **July 1st, 2022, through June 30th, 2024**, and is subject to the provisions of ALASKA STATUTES 47.32 and regulations adopted under authority of AS 47.32. This License is not assignable or transferable and shall be subject to revocation at any time by the Department of Health for failure to comply with the laws of Alaska, including the applicable provisions of the Alaska Administrative Code.

In Witness Whereof I have hereunto set my hand and seal of the Department of Health this **Tuesday June 21st, 2022**

By: M.L. Thomas
Department of Health
This License Must Be Posted in a Conspicuous Place on the Premises

Item 7: SPH Balanced Scorecard; First Quarter 2023

South Peninsula Hospital
Hospital Board of Trustees Balanced Scorecard Report
1st Quarter Calendar 2023 ***(Jan, Feb, Mar)***

Overall Indicators	Q 2023	Target	n	Note
Medicare Care Compare Overall Hospital Star Rating	N/A	5		There are too few measures or measure groups reported to calculate.
Medicare Care Compare Overall Hospital Survey Star Rating	4	5		
Medicare Care Compare Overall Nursing Home Star Rating	5	5		
Medicare Merit Based Incentive Payment System Total Score	32.61	25		2019-- 60.6; 2020--75.2; 2021--81.34
Quality of Care / Patient Safety	**1Q 2023**	**Target**	**n**	**Note**
Severe Sepsis & Septic Shock Care	100%	>75%	58	*(Care Compare : 24 cases - 71%, 4/1/21-3/31/22)*
Sepsis *(% of patients who received appropriate care for sepsis and/or septic shock.)*				# of cases passing/total # of cases-exceptions *(58 cases reviewed: 27 pass, 0 fail, 31 exclusions)*
Stroke Care	71%	> 95%	21	*(Care Compare N/A, 4/1/21-3/31/22)*
Percentage of patients who came to ED w/Stroke symptoms and received CT/MRI within 45 minutes of arrival.				Numerator = CT/MRI within 45 min & documented last known well. Denominator = Patients with Stroke presenting within 2 hours of symptoms. *(15- pass, 6- failed, 0- excluded)*
Median Emergency Room Time	193 min	180 min	1195	**Target *(minutes)*** *(Care Compare: 158 min, 4/1/21-3/31/22)*
Average time spent in department before leaving.				Average throughput time of all ED visits
Readmission	6.7%	< 15%	209	*(Care Compare 15.8%, 7/1/18-6/30/21)*
The readmission measures are estimates of the rate of unplanned readmission to an acute care hospital in 30 days after discharged from a hospitalization. Patients may have had an unplanned readmission for any reason.				% of patients with unplanned readmission to (IP/Obs) within 30 days of discharge - exclusions/Eligible admissions- (14 readmits/total admits*100)
Elective Deliveries	0%	0%	25	*(Care Compare 0%, 22 patients 4/1/21-3/31/22)*
Percentage of mothers whose deliveries were scheduled too early *(1-2 weeks early)*, when a scheduled delivery wasn't medically necessary.				# of non-medically indicated deliveries before 39 weeks gestation / total deliveries.
Provider Quality Score (Group)	17.61	15 pts		**Scoring tabulated as a running, annual score.**
CMS Merit-Based Incentive Payment System *(MIPS)* for providers				Target to be adjusted Quarterly as appropriate
Patient Fall Rate AC	9.93	< 5	906	**# of patient falls / # patient days x 1000**
Measures the number of patient falls per 1,000 patient days				n = IP, observations and swing bed patient days. **Note:** AC had 9 falls - 4 without injury, 5 with minor injuries, 8 were same patient.
Medication Errors	0	0		
Measures the number of reported medication errors causing patient harm or death.				Reported errors classified as type E-I by the National Coordinating Council for Med Error Reporting and Prevention/CMS
Never Events	0	0		
Unexpected occurrence involving death/serious physiological or psychological injury, or the risk thereof.				

Home Health (HH)	1Q 2023	Target	n	Note
Improvement in Breathing	TBD	> 80%		
Percentage of home health quality episodes patient became less short of breath.				Pts. w/ quality episode indicating reduced shortness of breath/ Total pts. w/ quality episode ending w/ d/c during the reporting period – Exemptions.
Correct Medication Administration	TBD	> 75%		
Percentage of home health quality episodes patients improved taking oral medication correctly.				Pts. w/ quality episode indicating an improved ability to take their meds correctly. Total pts. w/ quality episode ending w/ d/c the reporting period – Exemptions.
Nursing Home	**1Q 2023**	**Target**	**n**	**Note**
Fall with Major Injury	0	< 3%		
Res. w/ look back assessment(s) that indicate 1 or more falls resulting major w/injury. *(fx/dislocation, head injury w/ altered consciousness, subdural hematoma.)*				Res. with a lookback scan assessment indicating a Major Fall/ Total pts w/ a lookback scan assessment – Exemptions
Urinary Tract Infections *(UTI)*	0	< 3%		
Residents w/ look back scan asses(s) that indicates *(UTI)* within the last 30 days.				Res. with a lookback scan assessment indicating a UTI within the last 30 days/ Total pts with a lookback scan – Exemptions.
Consumer Assessment of Healthcare Providers and Services	**1Q 2023**	**Target**	**n**	**Note: Measures as a % ranking across PG clients.**
HCAHPS Percentile	88th	75th	25	
Measures the 1-10 ranking received by inpatient client *(or family)* respondents.				Q4 -2022, n = 63 Q -2023, n = 25
HHCAHPS Percentile	99th	75th	33	***Running 12 months due to low quarterly returns**
Measures the 1-10 ranking received by Home Health Care client (or family) respondents.				Q3 -2022, 88th n = 38 Q4 -2022, 87 n = 33
Patient Satisfaction Through Press Ganey (PG)	**1Q 2023**	**Target**	**n**	**Note: % ranking across PG clients.**
Inpatient Percentile	84th	75th	25	
Measures the satisfaction of inpatient pts. respondents.				Q3 -2022: 87th, n = 49 Q4 -2022: 69th, n = 43
Outpatient Percentile	24th	75th	271	
Measures the satisfaction of outpatient pts. respondents.				Q3 -2022: 14th, n = 255 Q4 -2022: 12th, n = 252
Emergency Department Percentile	89th	75th	59	
Measures the satisfaction of emergency pts. respondents.				Q3 -2022: 83rd, n = 94 Q4 -2022: 96th, n = 43
Medical Practice Percentile	63rd	75th	358	
Measures the satisfaction of pts. respondents at SPH Clinics.				Q3 -2022: 49th, n = 466 Q4 -2022: 58th, n = 454
Ambulatory Surgery (AS) Percentile	69th	75th	75	
Measures the satisfaction of AS pts. respondents.				Q3 -2022: 20th, n = 57 Q4 -2022: 69th, n = 74
Home Health Care Percentile (HHC)	96	75th	33	***Running 12 months due to low quarterly returns**
Measures the satisfaction of HHC clients *(or family)* respondents.				Q4 -2022, n = 33 Q1 -2023, n = 33

Provider and Staff Alignment	1Q 2023	Target	n	Note
Provider Satisfaction Percentile	**74th**	**75th**		
Measures the satisfaction of physician respondents as indicated by Press Ganey physician survey results. Measured as a percentile.				Result of provider survey 2021
Employee Satisfaction Percentile	**70th**	**75th**		
Measures the satisfaction of staff respondents as indicated in Press Ganey staff survey results Measured as a percentile.				Result of employee survey 2021
Workforce	**1Q 2023**	**Target**	**n**	**Note**
Turnover: All Employees	**3.67%**	**< 5%**	**572**	
Percentage of all employees separated from the hospital for any reason				21 Terminations/ 572 Total Employees
Turnover: Voluntary All Employees	**2.62%**	**< 4.75%**	**572**	
Measures the percentage of voluntary staff separations from the hospital				15 Voluntary Terminations/ 572 Total Employees
First Year Total Turnover	**10.19%**	**< 7%**	**108**	
Measures the percentage of staff hired in the last 12 months and who separated from the hospital for any reason during the quarter.				11 New Staff Terminated in Q3/ 108 Total New Hires from - 4/1/2022-3/31/2023
Travel Nursing Utilization	**26**	**< 20**		
Measure total travel staff utilized in a previous quarter (Internal & External)				01-2023 - External: 15 / Internal: 11, Total: 26
Information System Solutions	**1Q 2023**	**Target**	**n**	**Note**
Eligible Hospital (EH) Promoting Interoperability: hospital-based measures for inpatient and observation stays.	**76**	**> 60**	**377**	**CMS score 60 and above = pass**
e-Prescribing: Electronic Prescribing *(Rx)*	**8**	**10**	377	311 of 377
Health Information Exchange: Support Electronic Referral Loops by receiving and incorporating health information	**15**	**15**	1	1 of 1
HIE: Suppt. Electronic Referral Loops by sending health info. *(Sum.of Care sent)*	**5**	**15**	179	53 of 179
Provider to patient exchange: Provide patients electronic access to their health information *(timely access via the patient portal)*	**23**	**25**	204	188 of 204
Public Health & Clinical Data Exchange	**25**	**25**	4	4 of 4
Eligible Provider (EP) - Promoting Interoperability (Group)	**N/A**	**10 pts**		**Target quarterly for annual score**
Merit Based Incentive Payment System Promoting Interoperability score *(MIPS tracking is in Athena)*				Promoting Interoperability for Providers: N/A * Athena hasn't calculated our score yet
Electronic Medical Record (EMR) Adoption Stage	**5**	**5**		
Health Information Management & Systems Society *(HIMSS)* Electronic Medical Record Adoption Model *(EMRAM)* stage.				The current US average is 2.4 out of a possible 7.0 stages. Stage 6 and 7 require site visit validation.
IT Security Awareness Training Complete Rate	**88%**	**97%**		
% of employees who have completed assigned security training				1669 videos training sent, 1469 completed.
Phishing Test Pass Rate	**99.6%**	**97%**		
% of Phishing test emails that were not failed.				**3924** test phishing emails sent out to staff. **15** of the email links were clicked, causing **15** potential security risks.

Financial Health	1Q 2023	Target	n	Note
Operating Margin	1.78%	-0.7%		
Measures the surplus (deficit) of operating income over operating expenses as a percentage of net patient service revenue for the quarter.				Target is based on budgeted operating margin for the period.
Adjusted Patient Discharges	907.12	987.09		
Measures the number of patients discharged, adjusted by inpatient revenues for the quarter divided by *(inpatient + outpatient revenues)*.				Total Discharges: # *(Acute, OB, Swing, ICU)* LTC Revenue & discharges not included
Net Revenue Growth	7.0%	14.2%		
Measures the percentage increase *(decrease)* in net patient revenue for the quarter compared to the same period in the prior year.				Target is based on budgeted net patient service revenue for the period compared to net patient service revenue for the same period in prior year.
Full Time Equivalents *(FTEs)* per Adjusted Occupied Bed	7.63	9.02		
Measures the average number of staff FTEs per adjusted occupied bed for the quarter.				Target is based on budgeted paid hours *(FTE)* divided by *(budg gross patient revenue/budg gross inpatient rev)* X budgeted average daily census for the quarter.
Net Days in Accounts Receivable	50.0	55		
Measures the rate of speed with which the hospital is paid for health care services.				
Cash on Hand	83	90		**# Represents days**
Measure the actual unrestricted cash on hand (excluding PREF and Service Area) that the hospital has to meet daily operating expenses.				Cash available for operations based average daily operating expenses during the quarter less depreciation for the quarter.
Uncompensated Care as a Percentage of Gross Revenue	2.40%	2.5-5.3%		
Measures bad debt & charity write offs as a percentage of gross patient service revenue				Target is based on industry standards & SPH Payer Mix Budgeted total is 2.9% Expected range of 2.5-3.5%
Average Age of Plant	15.9 yrs	8 yrs		
Average age of assets used to provide services				The average age of plant is calculated based on accumulated depreciation, divided by depreciation expense.
Intense Market Focus to Expand Market Share	1Q 2023	Target	n	Note
Outpatient Revenue Growth	13.9%	16%		
Measures percentage increase (decrease) in outpatient revenue for the quarter, compared to the same period in the prior year.				Target is based on budgeted outpatient revenue for the period compared to outpatient revenue for the same period in the prior year.
Surgical Case Growth	9.0%	12.2%		
Measures the increase *(decrease)* in surgical cases for the quarter compared to the same period in the prior year.				Target is based on budgeted surgeries above actual from same quarter prior year.

Item 8: SPH Policy HW-267 Quality Plan

South Peninsula Hospital	**SUBJECT:** Quality Plan	**POLICY #** HW-267 **Page 1 of 13**
SCOPE: Hospital-Wide **RESPONSIBLE DEPARTMENT:** Quality Management, Administration		**ORIGINAL DATE:** 12/2015 **REVISED:** 12/1/15; 4/2/18; 5/6/19; 10/28/2020; 5/26/2021, 05/25/2022
APPROVED BY: Quality Director, Chief Executive Officer, Medical Executive Committee, Board of Directors		**EFFECTIVE:** 5/25/2022

Table of Contents

PURPOSE:
Program components and outline for the South Peninsula Hospital (SPH) & Long Term Care (LTC) Facility Quality Plan in accordance with federal, state, and local regulatory guidelines and requirements.

DEFINITION(S):
N/A

POLICY:

I. Missions, Vision, Values:

The foundation of the SPH & LTC Facility Quality Plan is the organization's mission, vision, values, and associated behaviors:

Mission: *SPH & LTC Facility promote community health and wellness by providing personalized, high quality, locally coordinated healthcare.*

Vision: *SPH & LTC Facility is the healthcare provider of choice with a dynamic and dedicated team committed to service excellence and safety.*

Values & associated behaviors: *(See Appendix A – 'Our Values in Action' for additional details)*

- Compassion: *We provide compassionate patient and resident centered quality care, and a safe and caring environment for all individuals.*
- Respect: *We show respect for the dignity, beliefs, perspectives, and abilities of everyone.*
- Trust: *We are open, honest, fair, and trustworthy.*
- Teamwork: *We work together as a dynamic, collaborative team, embracing change, and speaking as one.*
- Commitment: *We are responsible and accountable for supporting the vision, mission, values, strategies, and processes of our organization.*

II. Patient & Resident Centered Care:

"Providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions," (Institute of Medicine, 2015). Patient and resident centered care is supported by SPH and the LTC Facility through the active involvement of patients', residents', and their designated caregivers and/or families as appropriate, in decision making about options for treatment. SPH and the LTC Facility will hereafter be referred to as "The SPH Organization."

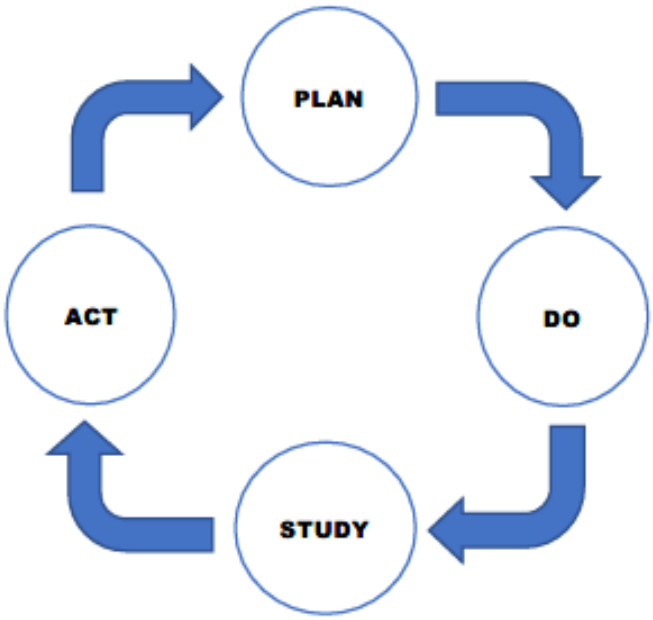
A. Patient and Resident Centered Care is provided:
   - In accordance with the SPH Organization values & behaviors
   - In a safe, timely, and cost effective manner
   - Consistent with achievable goals
   - With proper documentation to facilitate continuous evaluation and improvement
   - Adhering to evidence based, effective practices

B. Patient and Resident Centered Care is delivered:
   - By qualified and/or licensed personnel who are lawfully vetted
   - Utilizing clear channels of supervision
   - By effectively supervised personnel fostering patient and resident care

III. Quality Foundation:

1. *Quality Plan:* The Quality Plan serves as the foundation of commitment the SPH Organization has to reduce harm while continuously improving the quality and safety of the treatment and services provided.
2. *Hospital Board of Trustees Balanced Scorecard Report (BSC):* The SPH BSC provides an overview of specifically selected indicators to monitor the organizations quality and financial health. The BSC is updated quarterly and communicated monthly to the BOD and MEC, and quarterly to the Patient Centered Care Quality Committee (PCCQC).
3. *Quality Improvement Change Model:* The Quality Improvement Change Model "Plan-Do-Study-Act" (PDSA) will be used to communicate, track and trend specific department quality improvement activities as well as for those indicators falling below the established target on the SPH BSC.

PDSA Cycle for Improvement



A. Plan: Identify a problem or process to improve and determine the objective or goal
B. Do: Carry out the plan. Collect data and begin to analyze the data
C. Study: Complete the analysis of the collected data and summarize what was learned
D. Act: Determine next steps. Adopt, abandon, or modify the plan. Prepare the plan for the next PDSA is needed. If the plan was successful and adopted, plan for periodic review to assure the plan is effective.

4. *Measurement/Monitoring and Data Analysis:* Quality monitoring is intended to allow ongoing surveillance of important activities through sampling measures. Data, once collected, will be analyzed for opportunities of performance improvement. Quality and safety monitors and measures include but are not limited to the following:
   - Hospital Board of Trustees Balanced Scorecard Report (BSC)
   - Adverse Drug Events
   - Trends identified through occurrence reports, grievances, or complains received
   - Infection Prevention surveillance
   - National Patient Safety Goals
   - CMS Hospital Compare and Nursing Home Compare
   - Reported Patient/resident and/or staff concerns
   - Patient Satisfaction survey data/responses
   - Failure Modes and Effects Analysis (FMEA), Root-Cause-Analysis and/or Sentinel Event Alerts
   - Identified quality improvement opportunities
   - CMS Core Measures or other nationally accepted measures
   - Statewide quality improvement opportunities through the Hospital Engagement Network (HEN), Telligen Hospital Quality Improvement Contractor (HCIQ) or Medicare Beneficiary Quality Improvement Project (MBQIP)
5. *Employee Engagement:* Employees on all levels of the organization are expected to contribute to quality improvement initiatives and risk identification to improve care provided to the customers of the SPH Organization. Employees are able to contribute to quality improvement and risk reduction through the Patient Centered Care Quality Committee (PCCQC), Process Enhancement Teams, Rapid Cycle Quality Improvement Process, occurrence report system, employee suggestion box

system, internal departmental communication, and employee satisfaction surveys. Individuals or departments will be recognized for their quality improvement efforts.

6. *Services:* The SPH Organization will deliver service to preserve and advance the quality of patient and resident care, promote patient and resident centered care, enhance appropriate utilization of resources, deliver care utilizing evidence-based best-practice principles and reduce or eliminate unnecessary risks and hazards within the facility. The Organization will integrate the use of Trauma Informed Principles into patient and resident care to support patient and resident engagement, reduce re-traumatization and provide a safe and welcoming environment for all. Each patient's and resident's need for care, intervention, or treatment is assessed by qualified individuals (as defined by credentialing procedures, licensing, and hospital-approved job descriptions) and continues throughout the patient's or residents contact with SPH, LTC Facility, and/or Home-Based Health Services.

IV. Roles and Responsibilities:

Leadership of SPH and LTC Facility includes the Operating Board of Directors (BOD), Medical Executive Committee (MEC), Senior Leadership Team, Quality Management Department, Patient Centered Care Quality Committee, Safety/Hospital Incident Management Team (HIMT) Committees, and SPH staff.

Active leadership participation and contribution fosters quality improvement and safety initiatives consistent with our mission, vision, and values.

1. *Operating Board of Directors (BOD):* The SPH BOD shall review and evaluate overall quality activities to promote improvement and efficiencies to patient and resident care. The BOD will provide support and guidance of quality improvement activities, dedicate appropriate resources necessary to support the quality improvement process from the planning and development phase through the implementation of measures, actions, or changes which improve patient and resident care and facilitate safety and satisfaction. While maintaining overall responsibility, the Board delegates an oversight role to the Patient Centered Care Quality Committee and operational authority to the Senior Leadership Team and Medical Staff represented by the MEC. The Board will maintain responsibility for, review, evaluate, and approve the Quality Plan annually. The Board will:
   - Actively participate in and co-chair the Patient Centered Care Quality Committee
   - Receive and review periodic quality improvement performance reports on findings, conclusions, recommendations, actions, and results of plan activities
   - Assess the plan's effectiveness and efficacy and require modification in organizational structure and systems where necessary to improve Plan performance
   - Verify the overall goal of patient and resident centered care is being achieved
   - Require a process designed to ensure all individuals responsible for the assessment, treatment, or care of patients and residents are competent
   - Commit to and support the organization's values
2. *Medical Executive Committee (MEC):* The MEC is the primary governance committee for the medical staff and is accountable to the Board of Directors for oversight, monitoring, and evaluation of medical services. The MEC, with input from the medical staff will:
   - Play a significant role in performance improvement and assessment of each provider's clinical competence and professional behavior, through the Medical Staff Bylaws/Rules & Regulations, credentialing, ongoing and focused professional practice evaluation, and/or medical staff committees
   - Make key leadership decisions related to medical staff policies, procedures, and rules with an emphasis on patient and resident quality and improvement initiatives
   - Work collaboratively with nursing and other patient/resident care departments to develop policies and procedures necessary to provide safe and effective care
   - Participate in quality improvement activities and monitoring to facilitate patient safety and standard of care
   - Oversee the quality of patient care, treatment, and services provided by practitioners privileged

through the Medical Staff credentialing process
- Commit to and uphold the organization's values

3. *Senior Leadership Team (SLT):* The SLT works collaboratively with the BOD, Management team, Quality Management Department and SPH staff to support quality improvement activities and facilitate excellent clinical care that aligns with best practice. The SLT will:
   - Embody a culture of patient/resident centered care
   - Ensure sufficient resources and personnel are provided to support patient and resident safety and quality improvement activities
   - Assure staff are provided adequate time to participate in quality improvement and patient and resident safety activities
   - Establish a culture of communication to encourage appropriate interaction between and among patients, residents, families & caregivers, and members working within and utilizing the services of SPH
   - Support Quality Improvement initiatives by encouraging Departmental Managers/Directors to engage in unit specific quality and safety monitoring
   - Support and actively engage in improvement opportunities for quality indicators identified on the SPH BSC
   - Embrace and demonstrate the organization's values and behaviors
4. *Quality Management:* Quality Improvement and risk reduction activities for the SPH organization are led by the Director of Quality Management (QM). The Director of Quality Management, along with the assistance of the QM team, is responsible to facilitate quality improvement and safety initiatives to reduce risk throughout the organization. The quality improvement and safety initiatives are to reflect evidenced-based practice and promote improved care to our patients, residents, and customers. The Director of QM along with the QM team will:
   - Oversee quality improvement, safety initiatives and risk management activities for SPH and LTC
   - Facilitate completion of quarterly Hospital Board of Trustees Balanced Scorecard Report and support departmental improvement activities, including development of PDSA's to meet established targets
   - Communicate BSC updates and PDSA's along with risk and/or safety concerns to BOD monthly
   - Be responsible for ensuring appropriate quality actions are implemented, and within established time frames, as directed by the PCCQC, for quality and safety matters
   - Provide orientation and training on quality improvement and risk functions
   - Report known changes in regulations, laws, and certifications/accreditation standards to the staff
   - Ensure data retrieval functions are completed for ongoing quality improvement to meet best practice standards utilizing: National Patient Safety Goals & quality indicators, Patient satisfaction data through Press Ganey, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Hospital Engagement Network (HEN), Medicare Beneficiary Quality Improvement Program (MBQIP), Telligen Hospital Quality Improvement Contractor (HQIC) and Core Measure CMS reporting
   - Aggregate quality data findings for presentation to the Board, Medical Staff, SPH & LTC staff, SLT, Departmental Managers/Directors and Patient Centered Care Quality Committee
   - Conduct data analysis for data collected falling outside statistical norms
   - Assist Departmental Managers/Directors with systemic occurrence review
   - Conduct and/or participate in a timely root cause analysis for sentinel or serious safety events or to facilitate improvement related to specific process-driven events
   - Assist departments with identifying opportunities for improvement, planning & implementing changes, and departmental Quality dashboard/PDSA reporting
   - Engage with SPH Trauma Informed Care Committee as a Risk Mitigation strategy
   - Chair and facilitate the SPH Hospital-Wide Policy Committee and assist with policy writing, review and work to ensure SPH policies meet State, Federal and regulatory requirements

- Actively and enthusiastically promote the organization's values

5. *Patient Centered Care Quality Committee:* The Patient Centered Care Quality Committee provides ongoing operational leadership of continuous quality improvement activities at SPH & LTC. The PCCQC is composed of at least two Board members, member(s) of SLT with the Director of QM as co-chair, Department Managers/Directors and staff, a designated physician from patient or resident care/service area. The PCCQC will meet quarterly. Functions of the committee include:
   - Providing input and recommending approval of the Quality Plan to the BOD
   - Suggesting and supporting priority indicators of quality for the BSC
   - Assessing information based on the indicators, taking action as evidenced through the quality improvement initiatives to solve problems and pursue opportunities to improve quality
   - Establishing and supporting specific quality improvement and safety initiatives
   - Reporting to the Board through committee minutes or Director of Quality Management, CNO, or CEO on quality improvement activities on a regular basis
6. *Safety/Hospital Incident Management Team (HIMT) Committees:* The Safety/HIMT Committees are responsible to provide an update to the PCCQC at least quarterly on the committee's active quality improvement and safety initiatives.
7. *Staff:* All employees of the organization are expected to engage and contribute with improving the quality of care provided to the customers of SPH. Importance of organizational quality improvement is conveyed during initial hospital orientation and through individual departments by the department managers/directors.

V. Quality Plan

A. SPH is dedicated to the ongoing improvement of the quality and safety of care our patients and residents receive as evidenced by the outcomes of that care. The goal of this plan is to strive for and achieve system-wide quality and safety best practices to improve patient experiences, outcomes, and also provide accountability for reaching the highest possible quality and value for healthcare provided.

B. *Quality Statement:* The SPH Organization has adopted the six Domains of Healthcare Quality proposed by the Agency for Healthcare Research and Quality (AHRQ): Quality – care delivered in a safe, effective, patient-centered, timely, efficient, and equitable fashion.

C. *Safety Statement:* The SPH Organization contends safety is the foundation upon which all other aspects of quality care are built.

   1. Empowerment of Stakeholders: To achieve the greatest level of success in our quality improvement efforts, we include all involved stakeholders in patient and resident care. The SPH Organization's goal is collaboration of leadership and stakeholders in all aspects of quality improvement so all are empowered to guide its success. This will be achieved by:
      a. Employee Disclosure: The SPH Organization expects employees to speak-up and speak-out by identifying improvement and process opportunities, reporting occurrences, sentinel or serious safety events, near misses, the existence of hazardous conditions, and related opportunities for improvement as a means to identify systems and behavior changes needed to avoid future adverse events. It is acknowledged that errors must be identified before they can be corrected.
      b. Patient Disclosure: Hospital or Facility Representative at SPH and LTC will notify patients and residents or their family and/or significant other/designated caregiver when an unanticipated medical risk, hazard or error occurs in a patient or resident's care and will explain the unexpected outcome to the patient or resident, and/or family if the patient or resident is not able to understand. Hospital or Facility Representative will also coordinate with the attending physician, when appropriate.
      c. Fair, Equitable and Just Culture: The SPH Organization operates within a fair, equitable and just culture where the organization's values and behaviors are actively promoted. Front-line staff or others are not punished for actions, omissions or decisions which are commensurate with their experience and training. The Decision Tree for Determining the

Culpability of Unsafe Acts and the Incident Decision Tree along with Just Culture principles will be used for follow-up to concerns, errors or near misses.

d. Patient and Family Engagement: The SPH Organization recognizes each patient or resident is an individual with unique health care needs and to the best of our ability will provide considerate, respectful care focusing on those needs. It is recognized the patient or resident has the right to be involved in making decisions regarding their care. Patients and their families are afforded the right and opportunity to have any complaints, suggestions or concerns heard, investigated promptly and resolved.

e. Culture of Safety: The SPH Organization is committed to minimizing adverse events. We maintain a commitment to safety for all staff. This commitment establishes a "culture of safety" that encompasses these key features:
   i. acknowledgment of the high-risk nature of the organization's activities and the determination to achieve consistently safe operations
   ii. a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
   iii. encouragement of collaboration among departments and disciplines to seek solutions to patient safety problems
   iv. organizational commitment of resources to address quality and safety concerns
   v. improving the culture of safety within our organization is an essential component of preventing or reducing errors and improving health care quality to our customers.

2. Identification of Risks, Hazards and Errors: Prospective, Concurrent and Retrospective review of patient/resident care is utilized to identify quality improvement opportunities and to assess for risks, hazards, and errors.
   a. Prospective Identification: Prospective identification occurs prior to patient interaction. This review involves identifying risks, hazards and error potential before occurrences happen.
   b. Concurrent Review: Concurrent Quality Improvement (QI) review begins when quality and safety measures or initiatives are evaluated at the point of care.
   c. Retrospective Review: Retrospective review includes after-care appraisal to evaluate and/or measure performance.
3. Goal Setting: The SLT and Departmental Managers/Directors will be responsible for determining organizational priorities and goals identified on the BSC. The BOD will review and may provide input for yearly quality and safety indicators, and organizational goals on the BSC. Department Managers/Directors will document quality accomplishments and establish quality improvement goals in the annual Critical Access Program Evaluation with BOD review and approval. The PCCQC will assist with providing specifics on how to meet and achieve organizational quality and safety goals.
   a. The goal setting philosophy of The SPH Organization is prioritizing goals most important to our patient and resident population and achieving zero harm or 100% compliance in quality and safety indicators.
   b. The SPH Organization will utilize state and/or national patient/resident outcome quality and safety database reports (including CMS reports) to compare the hospital's performance with other facilities which is used to identify areas for quality improvement.
4. Measurement & Assessment: Categorical and/or Continuous Data will be captured, assessed, analyzed, and communicated through facility and departmental Quality Department Dashboards and BSC. Department Dashboard analytic data may be communicated through visual displays such as Run Charts, Pareto Charts, Histograms, etc. Continuous quality improvement requires adjustments to processes and/or procedures based on data analysis and the opportunities for performance improvement identified.
   a. Classification Systems: The SPH Organization will utilize the SPH Risk Classification Grid for assessment and classification of the severity of the identified risks and occurrence reports. For medication events, the National Coordinating Council for Medication Error Reporting and Prevention Index for categorizing medication errors will be used for classification and determination of patient/resident harm. These tools are the foundation for

patient and resident safety and risk measurement for South Peninsula Hospital and LTC Facility:

	South Peninsula Hospital Identified Risk Classification Grid			
		No Injury, Potential or Unknown Harm:	Moderate - Minor Harm:	Great Harm or Substantial Potential for Great Harm: (Never/Sentinel Events
PROBABILITY, LOW → HIGH	Great Likelihood of Risk, Hazard or Error Recurrence: Daily or hourly Probability almost certain or likely	**2C**	**2A**	**1A**
	Moderate Likelihood of Risk, Hazard or Error Recurrence: Monthly or weekly Probability possible ***Use if probability is unknown	**3B**	**2B**	**1B**
	Little Probability of Risk, Hazard or Error Recurrence: Quarterly or Annually Probability Unlikely or Rare	**3C**	**3A**	**1C**
	LEVEL OF HARM, LOW → HIGH			
Incidents with the potential of Great Harm-Never/Sentinel Events will be shared with the Board of Directors and PCCQ as appropriate following completion of a Root-Cause-Analysis (RCA). The reporting format will be the Plan-Do-Study-Act (PDSA).				

Definitions:

- A near miss: An unexpected occurrence in which there was no adverse outcome to the patient/resident, but which had the potential to cause serious injury or harm to the patient/resident.
- Never Event: Errors in medical care that are clearly identifiable, preventable and serious in their consequences as defined by CMS and National Quality Forum (NFQ).
- Sentinel event: An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof, i.e. loss of patient/resident life, limb, or function. The National Quality Forum (NQF) Never Events are also considered Sentinel Events.

  b. Assessment: Measurement and assessment procedures include:
  - Identify problems and opportunities to improve the performance of processes
  - Assess the outcome of the care provided
  - Assess whether a new or improved process meets performance expectations
  - Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level
  - Assess and analyze data gathered through State/Federal quality reporting and internal quality improvement departmental and facility initiatives

  c. Risk Mitigation: The SPH Organization strives to design effective processes to achieve excellent outcomes. Staff report occurrences relating to patients, residents, visitors, employees, property, systems and devices related to unusual or adverse events along with actual or potential injuries. The goal of this system is to identify opportunities for improvement, risk prevention, reduction

and/or resolution and monitored for trends. The Director of QM and QM team reviews all reports, evaluates them for possible risk prevention, reduction or resolution and forwards to the appropriate Director/Manager for follow-up, process improvement and/or risk reduction.
d. Audits: Process review and improvement is conducted by various audits including random sampling, specific stratified sampling, department rounding, etc.
e. Feedback: Opportunities for quality, safety and process improvement. Feedback and data from Press-Ganey satisfaction surveys, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), SPH Quality email, occurrence and grievance reports is used to inform practice and measure results. Grievances and complaints are documented, monitored for trends, with grievances communicated at the executive session of PCCQC and with the BOD as requested by PCCQC BOD members.

5. Optimization of Performance: Once the performance of a selected process has been measured, assessed and analyzed, the data gathered is used to identify the quality improvement initiative to be undertaken.
   - Elevation of Sentinel, Never & Near Miss Events: Should a sentinel event occur, the Director of QM, with guidance from SLT as needed, will work with those involved to review the incident and conduct a root-cause analysis (RCA) to determine if there was either:
     - Special cause variation - human error, or
     - Common cause variation - underlying system or process issue

     Once the root-cause analysis has been conducted, the RCA team will develop an appropriate action plan to address any variations identified and establish measures for any changes made which will be documented in the PDSA format and shared with the PCCQ Committee and the Board at the next scheduled meeting. Quarterly updates of PDSA Reports will be shared with the Committee until the issue is determined to be resolved. Once resolved, QI indicators may be continued to ensure the problem remains corrected.
   - Root Cause Analysis or Investigation: Occurrences are evaluated by Investigation or Root Cause Analysis in a fair and equitable manner.
     - Investigation: Departmental Managers/Directors investigate occurrences with guidance provided by the Quality Management Department. After investigation is completed, the occurrence report with all pertinent findings is sent back to the Director of QM for review of the findings, determination if additional steps are needed, and/or accepted as complete. Occurrence investigation may lead to a root cause analysis.
   - Performance Enhancement Teams (PETs): A Performance Enhancement Team is developed when a process in need of improvement has been identified. The team is a group of people who work together on the improvement process/initiative and has a team leader, facilitator and subject expert members. The QM Department is a resource and will assist with facilitation, tracking and trending of goals and outcomes as needed.
   - Standardization of Work: Standardized work leads to increased patient safety, faster care and better quality outcomes. The SPH Organization strives to reduce harm and increase patient, resident, and staff satisfaction through standardization of work processes and care decisions.
   - Evidence Based Practice: The SPH Organization provides healthcare using the best, research-proven assessments and treatments in our day-to-day customer care and service delivery. Each clinician is expected to stay in touch with the research literature and to use it as a part of their clinical decision making.
   - Deployment of Lessons Learned: A "lesson learned" (in the context of evaluations) is defined as a generalization based on an experience (e.g., projects, policies, or programs) which was evaluated. Our organization retains and applies this knowledge to future practice and clinical decision making to enhance overall quality and safety.
6. Support to Ensure Quality Plan Effectiveness:
   - Communication: communication may take place through the following methods:

- Balanced Scorecard, PDSA's, Departmental Quality Dashboards, story boards, graphs and posters displayed in common areas, on the Staff Information Site (SIS) and/or SPH website
- Members participating in the PCCQ Committee report information back to their departments
- Newsletters and/or handouts

- Education: Managers, clinicians, and staff will be educated in the principles and practices of quality improvement. The SPH Organization offers continuing education in-house, and off campus and supports new or higher education for improved clinical competency.
- Training for improved education/competence: Various methods for staff education include:
  - Computer based programs such as Up-To-Date and eLippincott
  - Healthstream
  - Skills Fairs/Labs
  - Alaska State Hospital and Nursing Home Association webinars, in-services and conferences
  - Quality Improvement educational offerings and conferences for individuals with leadership roles and responsibilities to enhance and develop quality improvement efforts
  - Quality Improvement/Risk reduction webinars and Bite-sized Learning offerings through Optima Healthcare Insurance.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. Attachment A – "Our Values In Action"
2. Attachment B - Performance Management Decision Guide
3. Duquette, CLeadership and management; Q solutions: Essential resources for the healthcare quality professional. *National Association for Healthcare quality. Third edition*. (2012)
4. National Coordinating Council for Medication Error Reporting and Prevention. *Index for Categorizing Medication Errors.* 2001
5. Six Domains of Health Case Quality. Retrieved from *https://www.ahrq.gov/talkingquality/measures/six-domains.html*
6. The Incident Decision Tree. Retrieved from https://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf
7. Patient-Centered Care. Institute of Medicine. Crossing the chasm: A new health system for the 21st century. Retrieved from http://www.oneviewhealthcare.com/the-eight-principles-of-patient-centered-care/
8. Key Ingredients for Successful Trauma-Informed Care Implementation. Menschner, C. and Maul, A.; Center for Health Care Strategies. (April, 2016).

9. Plan Incorporation:
   A. The following policies are incorporated by reference in this plan:
      1. ED-001 Nursing Continuing Education Administrative Support
      2. EMP-03 Disruptive Conduct & Abusive Behavior
      3. HW-007 Employee Suggestion System
      4. HW-014 Occurrence Reports
      5. HW-068 Patient and Resident Rights
      6. HW-144 Patient Grievance Process
      7. HW-147 Disclosure of Medical Errors
      8. HW-151 HIPAA
      9. HW-160 Sentinel Events

Item 9: SPH Policy HW-160 Sentinel Events

South Peninsula Hospital	**SUBJECT:** SENTINEL EVENTS	**POLICY # HW-160**
		PAGE: 1 **OF:** 2
SCOPE: HOSPITAL WIDE **RESPONSIBLE DEPARTMENT: QUALITY MANAGEMENT**		**ORIGINAL DATE: 10/13/2008** **REVISED: 10/17/2019**
APPROVED BY: ADMINISTRATION		**EFFECTIVE:10/23/2019**

POLICY

South Peninsula Hospital is committed to patient safety. A Sentinel or Near Miss Event will necessitate notification to the Chief Executive Officer (CEO) and/or Director of Quality Management (QM) who will work with those involved and associated Directors/Managers to review the incident.A root-cause analysis (RCA) will be completed to determine cause.

DEFINITIONS

Sentinel Event: An unexpected patient safety event reaching a patient resulting in death, permanent harm or severe temporary harm and intervention required to sustain life (The Joint Commission, 2019).

Near Miss: An unexpected occurrence in which there was no adverse outcome to the patient, but which had the potential to cause serious injury or harm to the patient.

PROCEDURE

1. If a sentinel event occurs, notify the Director of QM who will be responsible for notifying the CEO or designee. Should a sentinel event occur after hours, notification is to be made directly to the CEO. Staff discovering or involved in the event are to complete an Occurrence report as soon as practicable but before clocking out. .

2. The attending Physician or surgeon along with the CEO and/or Director of QM or designee(s) will explain the unexpected outcome to the patient, and/or family if the patient is not able to understand. See HW-147, Disclosure of Medical Errors.

3. Within three business days, a team will perform a Root Cause Analysis (RCA) to identify the possible cause of the sentinel event/near miss. The team will include the Director of QM or designee, along with those SPH staff and physicians closest to the issue. The department manager/director is to be included in the process. The Director of QM will serve as a resource to provide help in applying the tools of RCA.

- The RCA Team will meet as frequently as necessary and will keep minutes of the meeting(s). Progress reports will be communicated to the CEO no less than weekly. It is the responsibility of each member of the RCA Team to maintain confidentiality of the process.
- The RCA Team will sort and analyze the cause list and construct a cause and effect diagram (also known as a Fishbone or Ishikawa Diagram).
- If a common cause or systems problem is identified, those with the most knowledge and/or closest to the situation should be involved in the design of the solution.
- Improvements to correct the root cause should be initiated as soon as practicable to reduce the risk for reoccurrence.
- The RCA Team will be empowered to redesign systems or processes as necessary to eliminate the root cause. This may involve changes in training, policies or procedures, forms, equipment, etc.
- The RCA Team will develop an action plan, complete with timelines for completion or evaluationand will utilize the change model Plan-Do-Study-Act.
- Any processes or systems which are redesigned will have QI monitor indicators developed to ensure that the change is maintained.

4. The CEO and Director of QM or designees, will be responsible for determining if the event requires reporting to any regulatory agency within 5 days of discovery of the incident.

5. All findings and recommendations from the RCA of the sentinel event/near miss investigation will be reported to the CEO, Director of QM, Medical Executive Committee and the Board of Directors, as appropriate.

6. South Peninsula Hospital will use the Incident Review policy principles for review principles/purposes to determine post RCA actions, which considers assessment of systems, processes and human behavior. This safety-supportive system of shared accountability where health care organizations are accountable for the facilities values, systems they have designed and for responding to the behaviors of their staff in fair and just manners. Staff, in turn, is accountable for the quality of their choices and behaviors and for reporting both their errors and system vulnerabilities

DISCLOSURE OF THE MEDICAL ERROR

1. Reviewable sentinel events as defined in this policy shall be disclosed.
2. Disclosure of reviewable sentinel events shall be made to the affected patient, and when appropriate, their family. If the patient is deemed incapable of understanding a discussion of this nature, then the patient's representative shall be informed.
3. Disclosure of reviewable sentinel events shall take place as soon as practically possible after the reviewable sentinel event has been identified.
4. Disclosing reviewable sentinel events is generally the responsibility of the attending physician or surgeon, as appropriate, with the CEO and/or Director of QM or designee(s) present.
5. In certain cases, the reviewable sentinel events/near miss may be associated with non-physician staff, such as Nursing or other health care professionals. In such cases, the duty of disclosure will rest with the CEO or appropriate member(s) of the Senior Leadership Team.
6. The CEO, Director of QM or appropriate designee may disclose information regarding reviewable sentinel events/near misses to a patient if the physician cannot or does not inform the patient prior to discharge.

COMPLIANCE

Compliance with this policy will be the responsibility of the employee identifying a sentinel event/near miss, Director of QM, Administration, the Medical Staff, and all Department Managers. Implementation of this policy will be the responsibility of the Director of QM with assistance from Administration, the Medical Staff and Department Managers.

Administration and Director of QM will have the following additional responsibilities:

1. Secure and protect all records and evidence in a timely manner.
2. Determine appropriate public relations response to external inquiries relative to the incident.
3. Notify the hospital's insurance company of the probable compensatory claim(s).
4. Report the sentinel event/near miss to the Medical Executive Committee, and Board of Directors.

REVIEWABLE SENTINEL EVENTS

The following sentinel events and/or near miss require(s) a Root Cause Analysis and intensive review by Director QI/RM, Administration, and Medical Executive Committee:

1. Suicide of any patient receiving care, treatment, or services in a staffed round-the-clock setting or within 72 hours of discharge
2. Unanticipated death of an in-house full-term infant
3. Abduction of any patient receiving care, treatment, or services
4. Discharge of an infant to the wrong family.

5. Rape within the facility.
6. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
7. Unintended retention of a foreign object in a patient after surgery or other procedure
8. Severe neonatal hyperbilirubinemia (bilirubin > 30 milligrams/deciliter)
9. Prolonged fluoroscopy with cumulative dose > 1500 rads to a single field or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose.
10. Surgery on wrong patient, wrong site/body part, wrong side of patient.

SPECIAL CONSIDERATIONS

- An adverse outcome directly related to the natural course of the patient's illness or underlying condition, for example, terminal illness presents at the time of presentation, is not considered for intensive review except for suicide in, or following elopement from, a 24-hour care setting.
- The root cause analysis and action plan are not to include the patient's name or the name of the caregivers involved in the sentinel event/near miss. RCA Team members and/or responsible persons should be designated by position and title only.
-
- Critical Incident Stress Debriefing (CISD) may be convened as necessary.
  - Refer to HW-229, Incident Review
-

REFERENCES

- Agency for Healthcare Research and Quality Patient Safety Network (AHRQ PSNET), https://pnet.ahrq.gov/, September 2019.
- Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs), https://www.cms.cov/
- Conditions of Participation: Critical Access Hospitals (CAHs)
- State Operations Manual, Appendix W – Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs June 30, 2015
- Centers for Medicare & Medicaid Services, https://www.cms.gov
  - The Joint Commission: https://www.thejointcommission.org, 08-08-2019
  - Health Care Quality Improvement Act of 1986
  - Alaska State Statute AS 18.80.220
  - HW-147, Disclosure of Medical Errors

CONTRIBUTORS

Director of Quality Managment

Item 10: Brochure

SIEMENS

SYMBIA Pro.specta Q3, X3 AND X7

TYPICAL ROOM PLAN

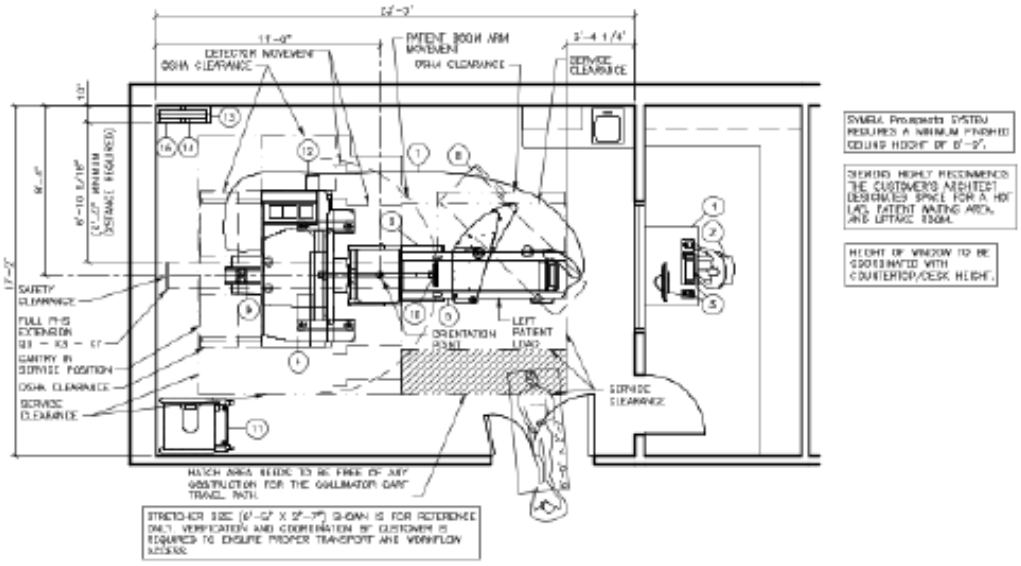
The intended use for this Cut Sheet is to communicate the spatial requirements as well as the basic architectural, electrical, structural, and mechanical requirements for this piece of imaging equipment. The information provided in this document is for reference only, during the pre-planning stage, and therefore does not contain any site specific detailed requirements. This information is subject to change without notice. Federal, state and/or local requirements may impact the final placement of the components. It is the customer's responsibility to ensure that the final layout and placement of the equipment complies with all applicable requirements.

SIEMENS

FOR REFERENCE ONLY,
NOT FOR CONSTRUCTION.

SYMBIA Pro.specta Q3, X3 AND X7

TYPICAL ROOM PLAN



TYPICAL PLAN SCALE: 1/8" = 1'-0"

SIEMENS

FOR REFERENCE ONLY,
NOT FOR CONSTRUCTION.

SYMBIA Pro.specta Q3, X3 AND X7
SPECIFICATIONS

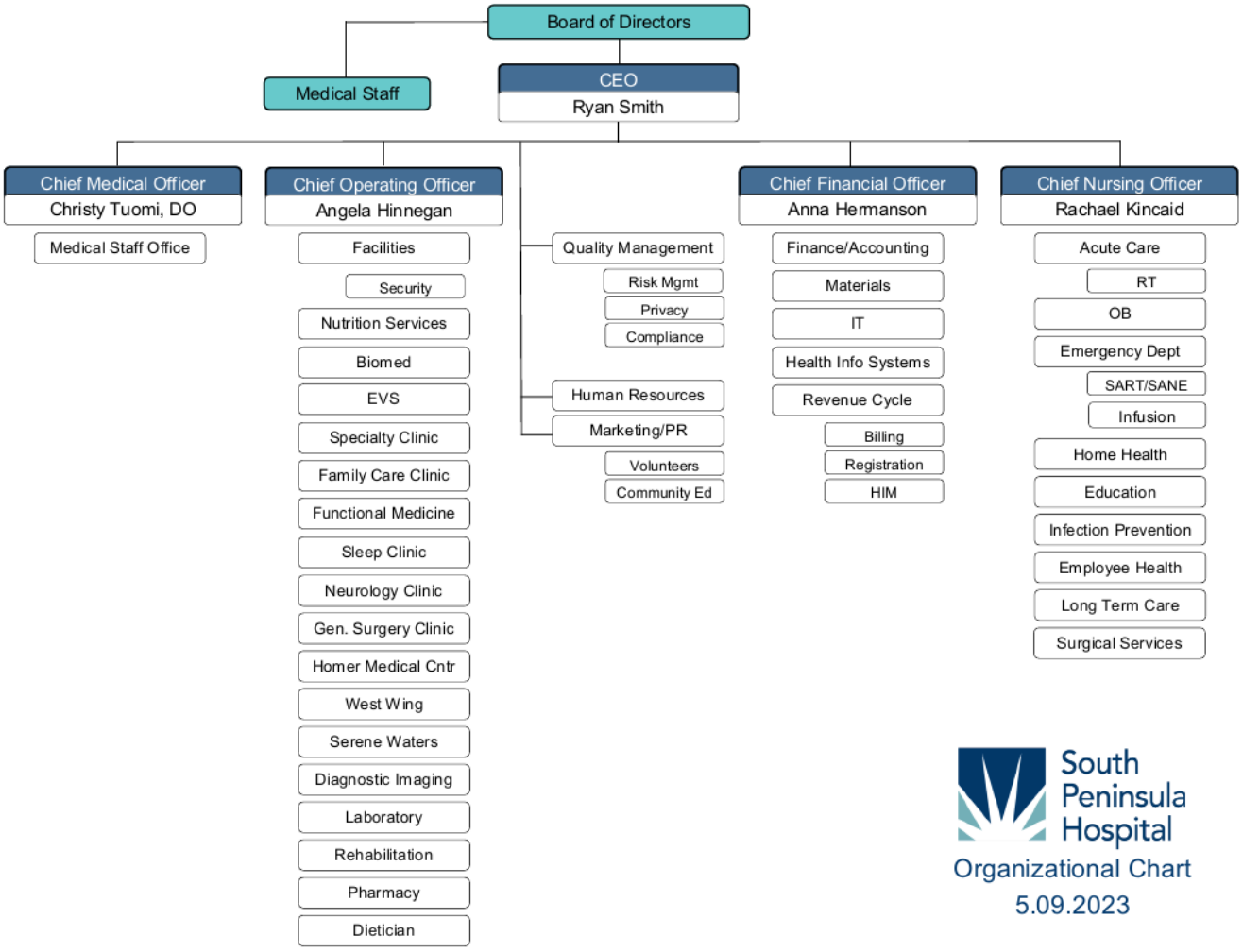
EQUIPMENT LEGEND

NO	DESCRIPTION	SMS SYM	WEIGHT (LBS)	BTU/HR TO NR	DIMENSIONS (INCHES) W	D	H	REMARKS
1	COMPUTER TABLE (OPTION)		86	–	47 3/16	31 1/2	28 3/8	ON FLOOR
2	SWIVEL TILT CHAIR		35	–	21 1/2	18 1/2	36	ON FLOOR MAXIMUM HEIGHT 38 1/2"
3	23" FLAT SCREEN MONITOR, KEYBOARD AND CONTROL DEVICE		20	–	22 1/2	9 1/4	19 3/8	ON TOP OF WORKPLACE AREA
4	SYMBIA Pro.specta Q3 W/COLLIMATORS (OPTION)		8,690	21,155	92 3/4	76 3/4	88 3/4	WORST CASE WEIGHT 8,690 LBS. WITH (2) HIGH ENERGY COLLIMATORS AT 275 LBS. EACH
4	SYMBIA Pro.specta X3 W/COLLIMATORS (OPTION)		8,730	21,155	92 3/4	76 3/4	88 3/4	WORST CASE WEIGHT 8,731 LBS. WITH (2) HIGH ENERGY COLLIMATORS AT 275 LBS. EACH
4	SYMBIA Pro.specta X7 W/COLLIMATORS (OPTION)		8,731	26,616	92 3/4	76 3/4	88 3/4	WORST CASE WEIGHT 8,731 LBS. WITH (2) HIGH ENERGY COLLIMATORS AT 275 LBS. EACH
5	FRONT PHS		1,846	–	32 1/2	96 1/4	21 1/4	MAXIMUM HEIGHT 46.3"
6	AUTOMATIC COLLIMATOR CHANGER – ACC WITH AQC – PRODUCTIVITY PACKAGE (OPTION)		769	–	33	24 1/2	24 1/2	WEIGHT CALCULATED WITH 1 SET LOW AND MEDIUM ENERGY COLLIMATORS.
7	OVER FLOOR CABLE HYBRID– PHS CABLE ON FLOOR (OPTION)		–	–	–	–	–	40' CABLE EXPOSED ON THE FLOOR
8	PHS EXTENDED 45 DEGREE PIVOT (OPTION)		–	–	–	–	–	EXTENDED PIVOT – 45 DEGREES
9	REAR PHS		403.3	–	19 5/8	45	30 1/2	ON FLOOR.
10	PATIENT BOOM SWING ARM		–	–	–	–	–	MOUNTED ON TOP OF GANTRY
11	COLLIMATOR CART (EMPTY) (OPTION)		400	–	43	32 1/2	40	WORST CASE 1330 LBS WITH 1 SET HE AND 1 SET ME
12	EXTERNAL ECG (OPTION)		–	–	–	–	–	MOUNTED ON THE SIDE OF GANTRY
13	INTEGRATED ELECTRICAL CABINET (OPTION)		428	612	32	9 3/4	48	WALL MOUNTED
14	UNINTERRUPTIBLE POWER SUPPLY – UPS (OPTION)		106	1,366	28 1/2	5 1/8	17 1/4	PLACED IN UPS CABINET
15	UPS CABINET (OPTION)		78.6	–	32	10	25	MOUNTED ON THE FLOOR OR WALL

FOR MORE INFORMATION

FOR MORE DETAILED PLANNING REQUIREMENTS FOR THIS SYSTEM, SEE THE TYPICAL FINAL DRAWING SET NUMBER: TYPICAL #22087

Item 11: SPH Organizational Chart 05/09/2023



Item 12: SPH Board of Directors Roster as of January 2023

South Peninsula Hospital

Board of Directors
January 2023

NAME	TITLE/INFO.	TERM EXPIRES
Bernadette Wilson Homer, AK 99603	Director Appointed 11/2006 Occupation: Retired RN & Records Management	12/23
Julie Woodworth Homer, AK 99603	Secretary Appointed 03/2009 Occupation: Senior VP & Lending Manager	12/23
Matthew Hambrick Homer, AK 99603	Director Appointed 01/2010 Occupation: General Contractor	12/24
Kelly Cooper Homer, AK 99603	President Appointed 01/2021 Occupation: Business Owner	12/25
Aaron Weisser Homer, AK 99603	Vice President Appointed 01/2022 Occupation: Pastor	12/24
Beth Wythe Homer, AK 99603	Director Appointed 01/2020 Occupation: Retired Human Resources/Administration	12/25
Keri-Ann Baker Homer, AK 99603	Director Appointed 03/2018 Occupation: Membership Director	12/23
Walter Partridge Homer, AK 99603	Treasurer Appointed 06/2018 Occupation: Retired Telecommunications	12/25
Melissa Jacobsen Homer, AK 99603	Director Appointed 01/2019 Occupation: City Clerk	12/24
Todd Boling, DO Homer, AK 99603	Director – Physician Seat Appointed 02/2020 Occupation: Surgeon	12/24
Edson Knapp, MD Homer, AK 99603	Director – Physician Seat Appointed 03/2020 Occupation: Radiologist	12/25

Committee Chairs / Liaisons:

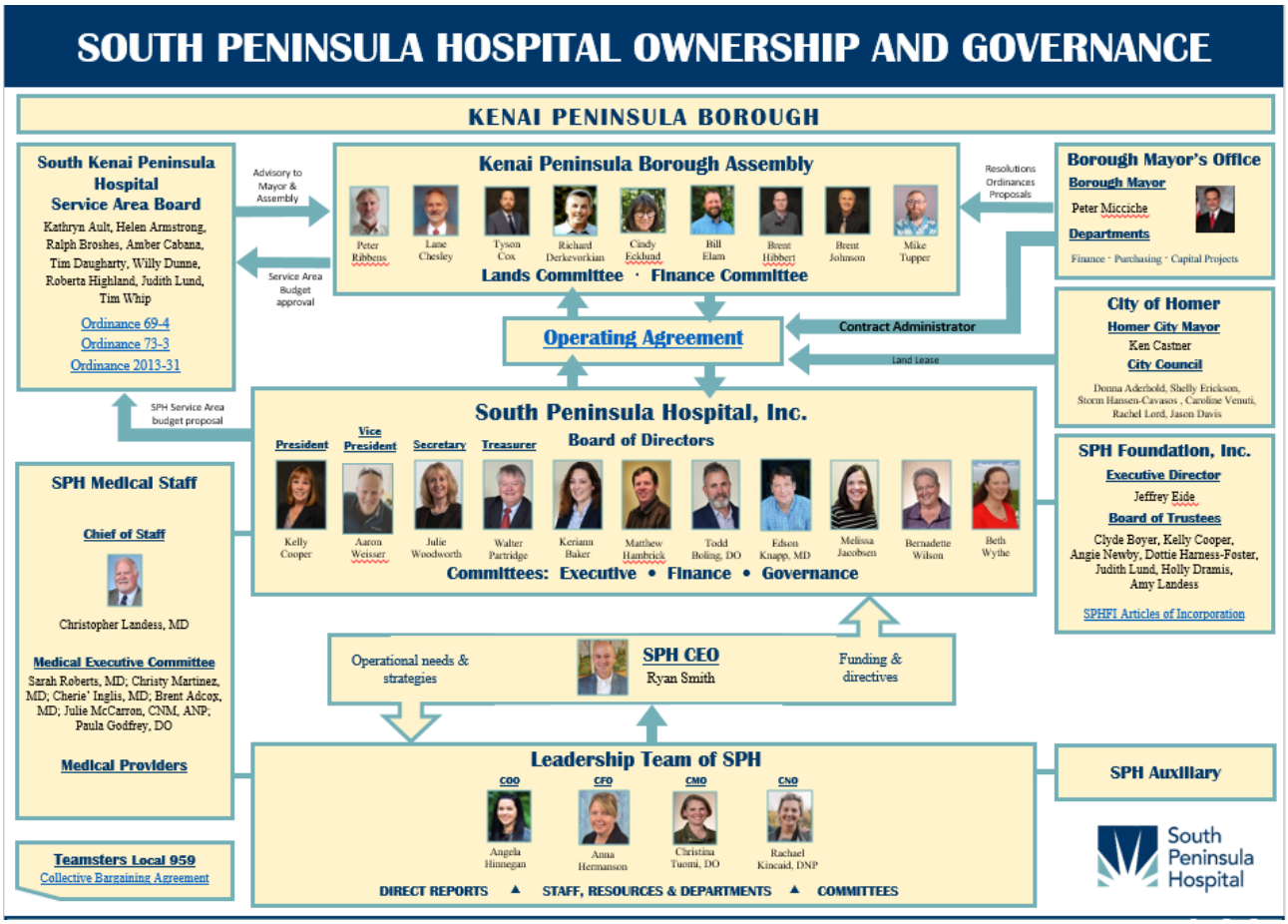
Finance Committee: Walter Partridge
Pension Committee: Walter Partridge
Education Committee: Melissa Jacobsen
Governance Committee: Aaron Weisser
Credentials Committee: Kelly Cooper

SPH Foundation: Kelly Cooper
PCCQ Committee: Bernadette Wilson/Beth Wythe

Medical Executive Committee: Todd Boling, DO / Edson Knapp, MD

Board members may be reached by emailing: sphbod@sphosp.org

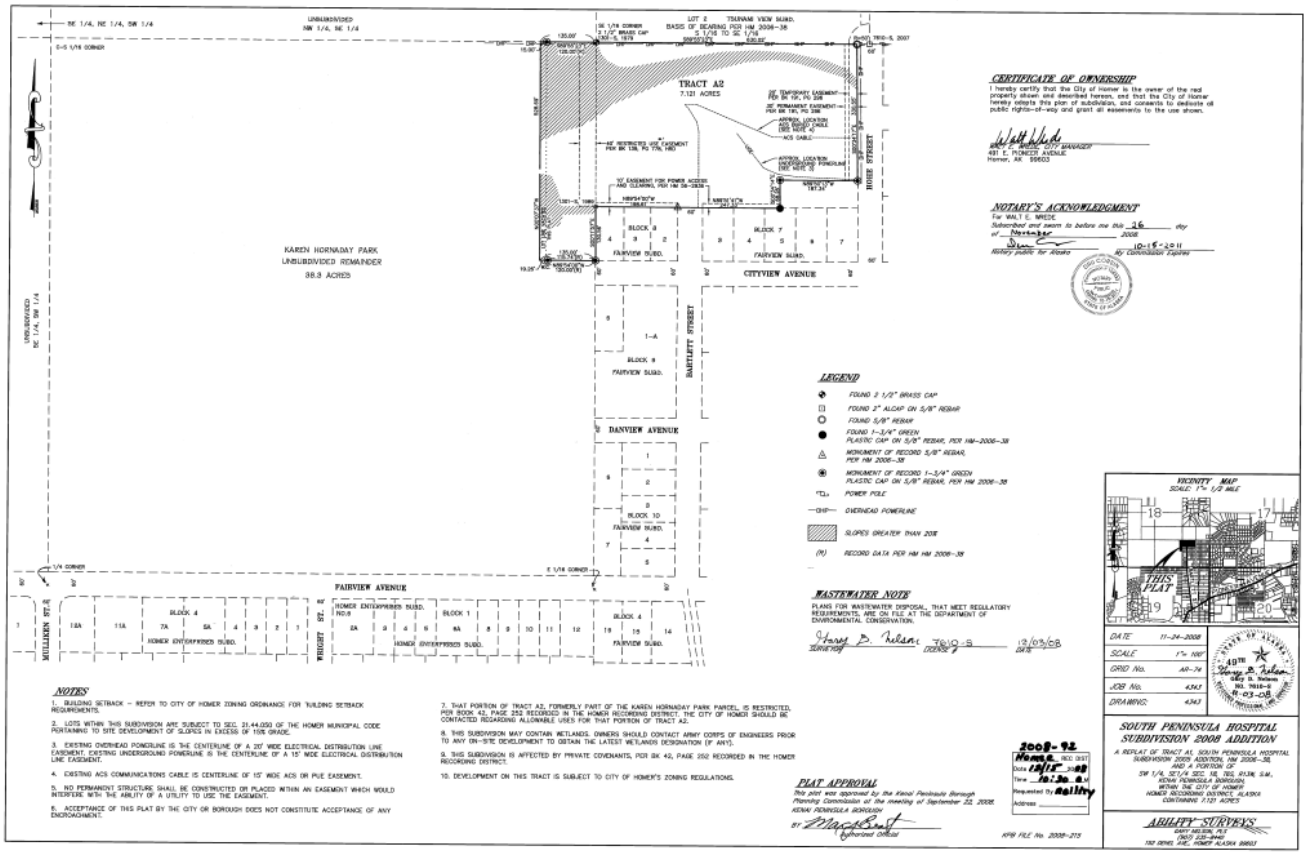
Item 13: SPH Ownership and Governance Structure



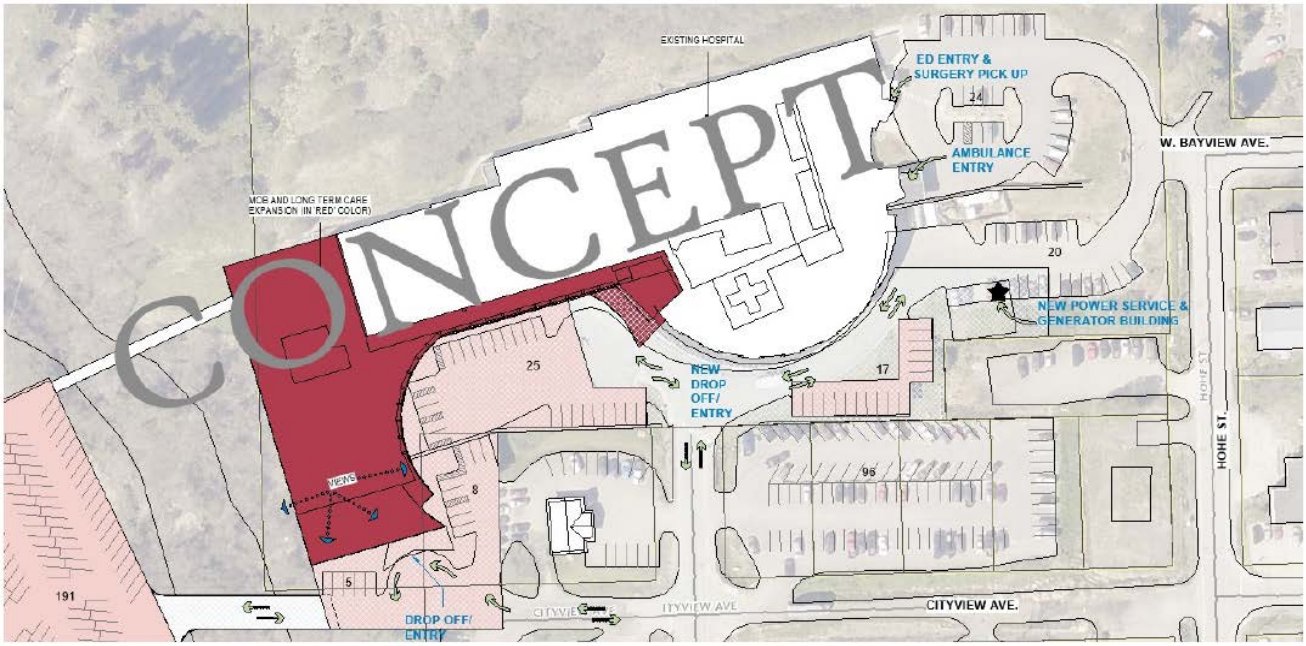
Item 14: MAPP Steering Committee Members

Name	Organization	Email
Rick Abboud	City of Homer	**rabboud@ci.homer.ak.us**
Lorne Carroll	Homer Public Health Center	**lorne.carroll@alaska.gov**
Lisa Marie Talbott	Homer United Methodist Church	**lisamarietalbott@gmail.com**
Brian Partridge	Kachemak Bay Campus (Kenai Peninsula College)	**bcpartridge@alaska.edu**
Judy Kamara	Sprout Family Services	**judy@sproutalaska.org**
Emma Schumann	SVT Health & Wellness	**eschumann@svt.org**
Jay Bechtol	South Peninsula Behavioral Health Services	**jbechtol@spbhs.org**
Ronnie Leach	South Peninsula Haven House	**ronnie@havenhousealaska.org**
Asia Freeman	Bunnell Street Arts Center	**asia@bunnellarts.org**
Derotha Ferraro	South Peninsula Hospital	**dbf@sphosp.org**
Kyra Wagner	Sustainable Homer	**kyra@sustainablehomer.org**
Claudia Haines	Kachemak Bay Family Planning Clinic	**claudia@kbfpc.org**
Hannah Gustafson	MAPP Coordinator	**mappofskp@gmail.com**

Item 15: South Peninsula Hospital Subdivision 2008 Addition, Plat Map

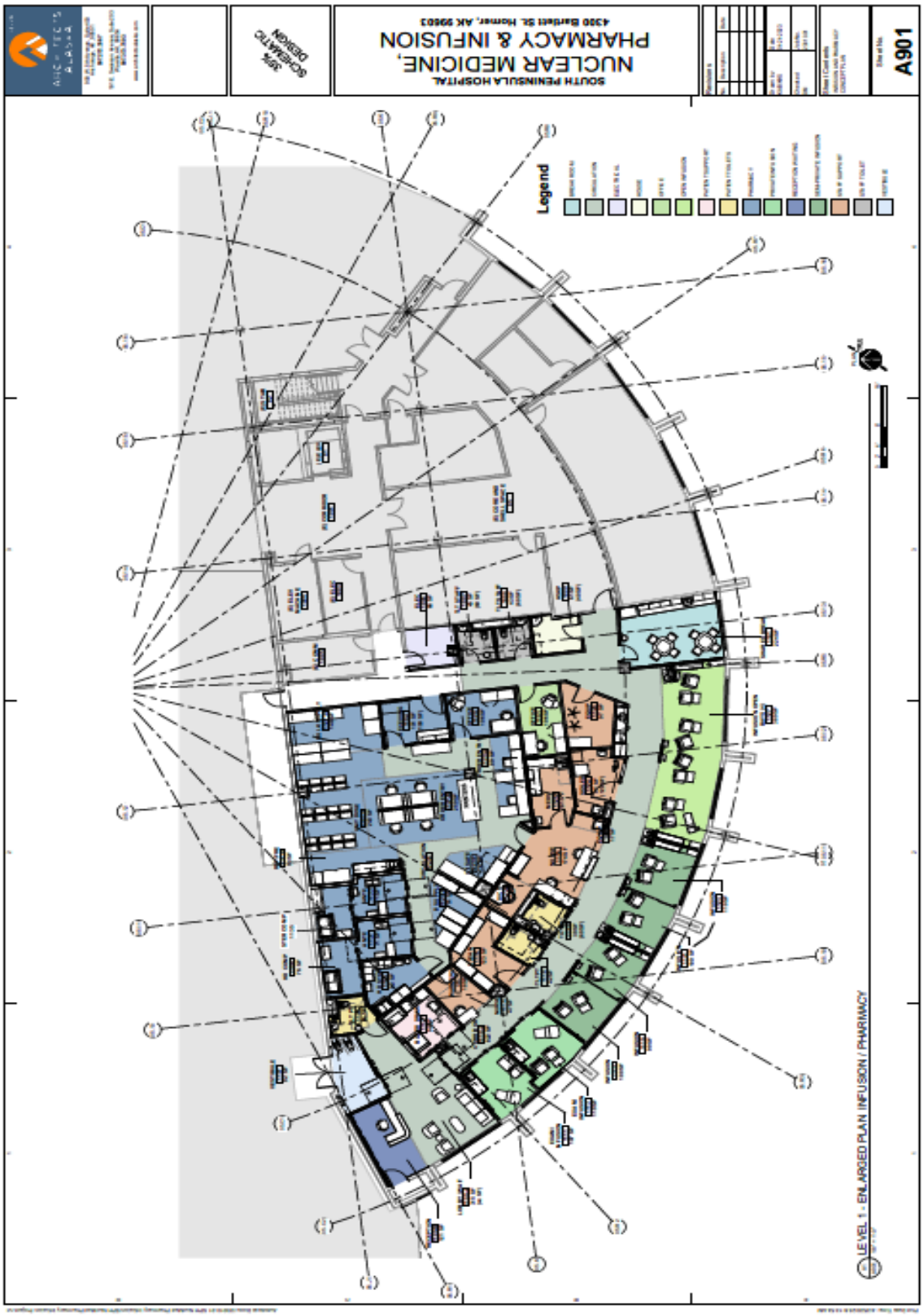


Item 16: SPH conceptual master plan (2D) including long-range concept and development of total facility (Source: April 12, 2023 SPH Facilities Master Plan Report)



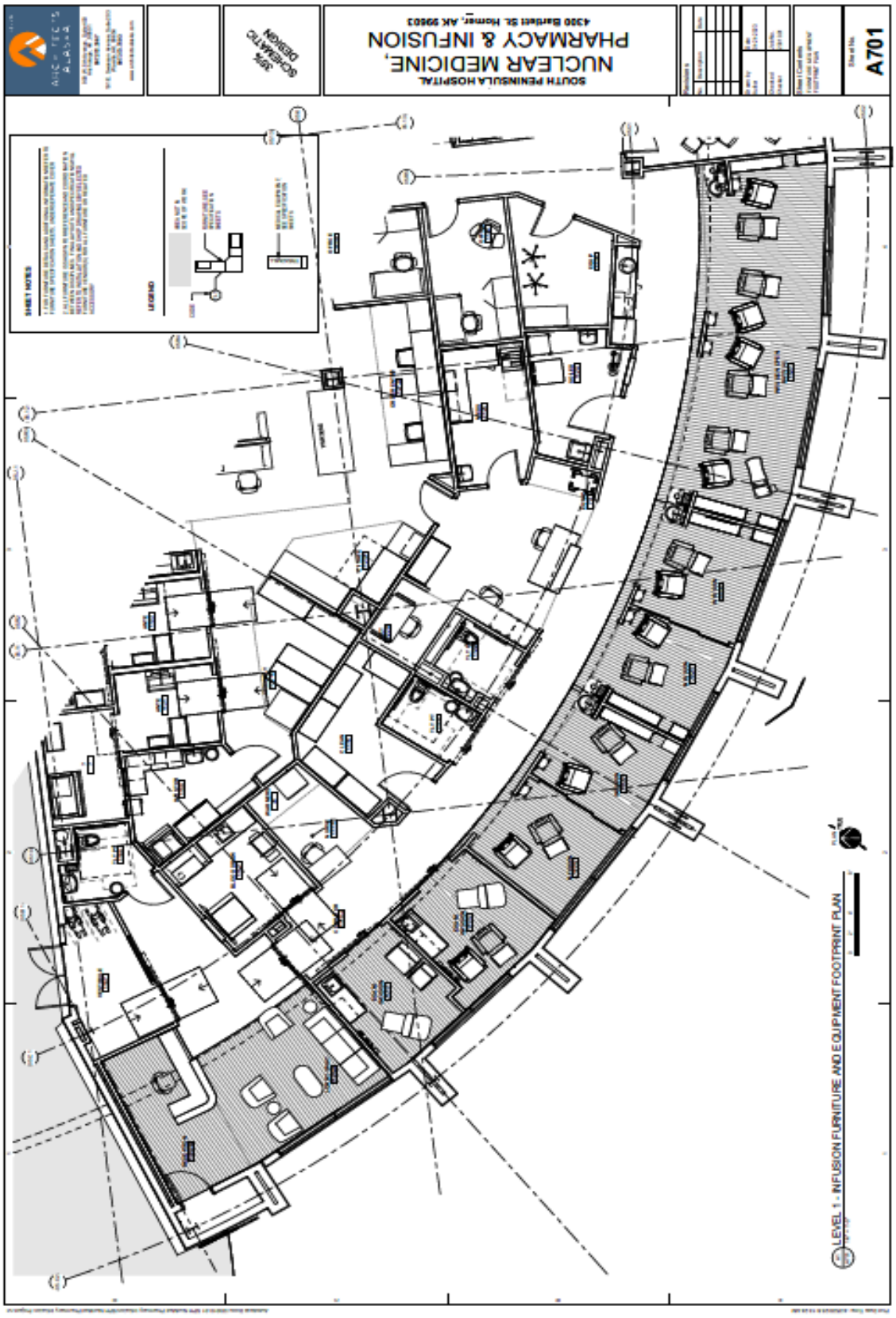
Item 17: SPH conceptual master plan (3D) including long-range concept and development of total facility (Source: April 12, 2023 SPH Facilities Master Plan Report)

Item 18: SPH First Floor Schematic Design for Oncology / Infusion expansion and Pharmacy Upgrade

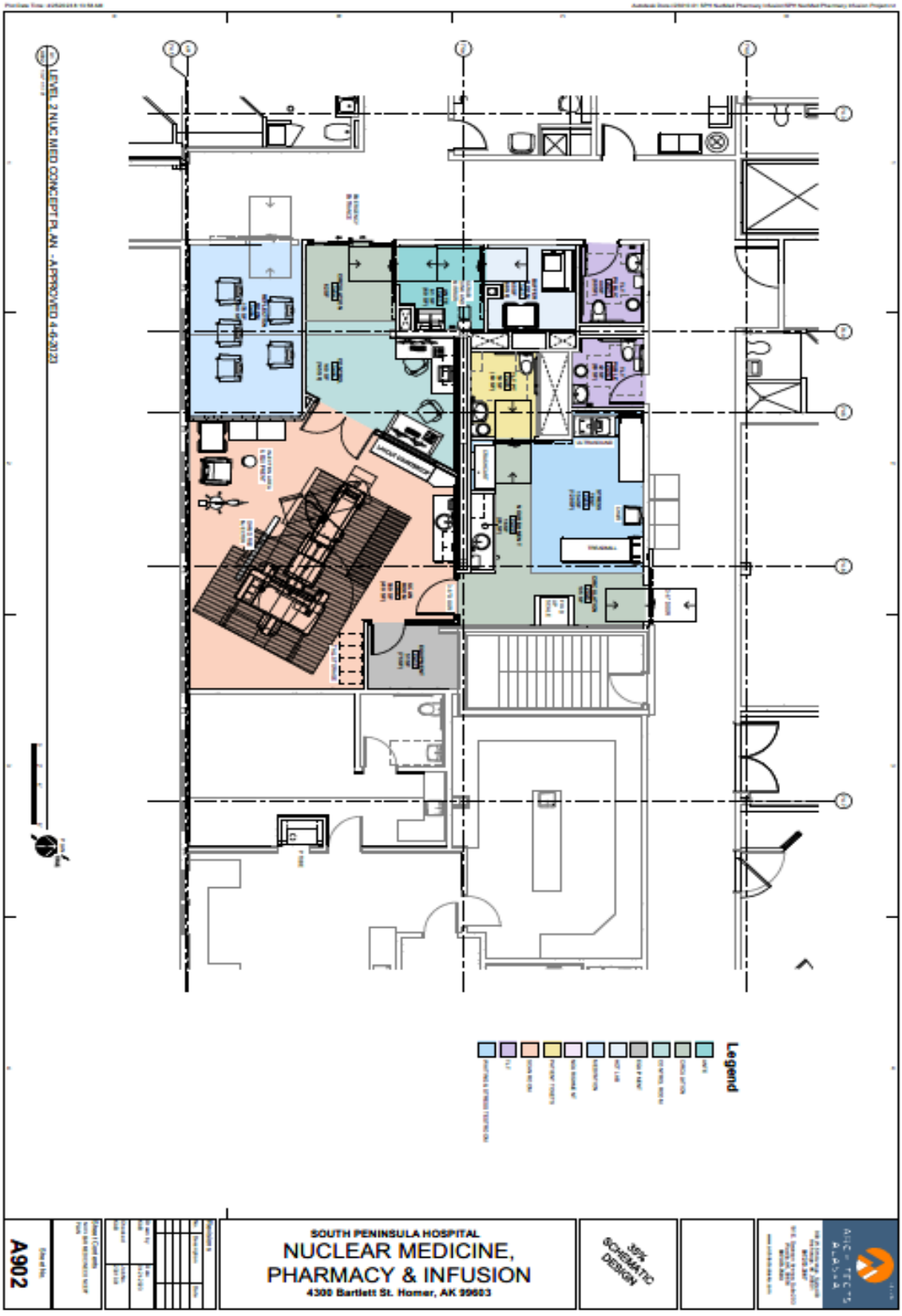


Item 19: SPH First Floor Schematic Design for Pharmacy Upgrade

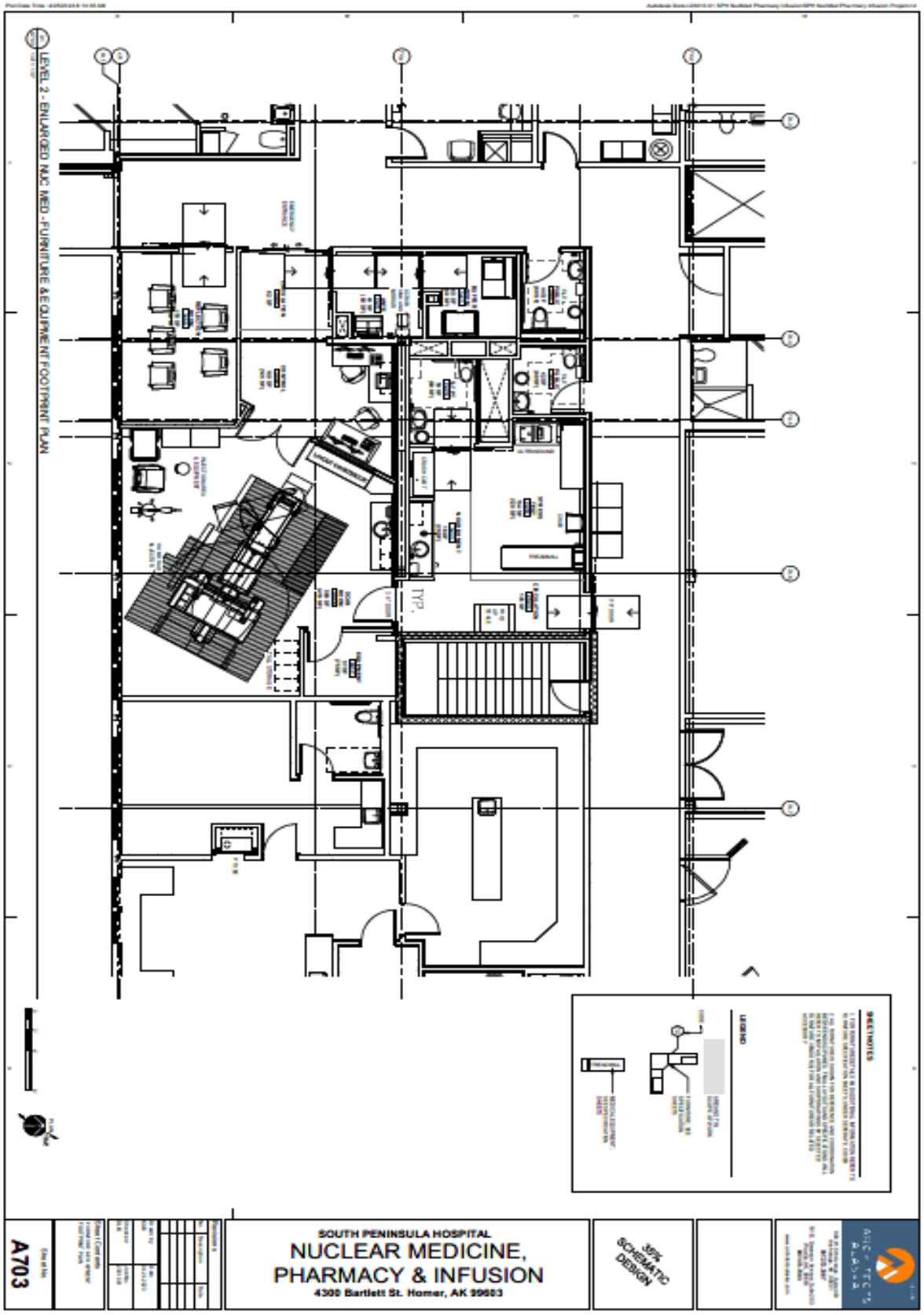
Item 20: SPH First Floor Schematic Design for Oncology / Infusion Expansion



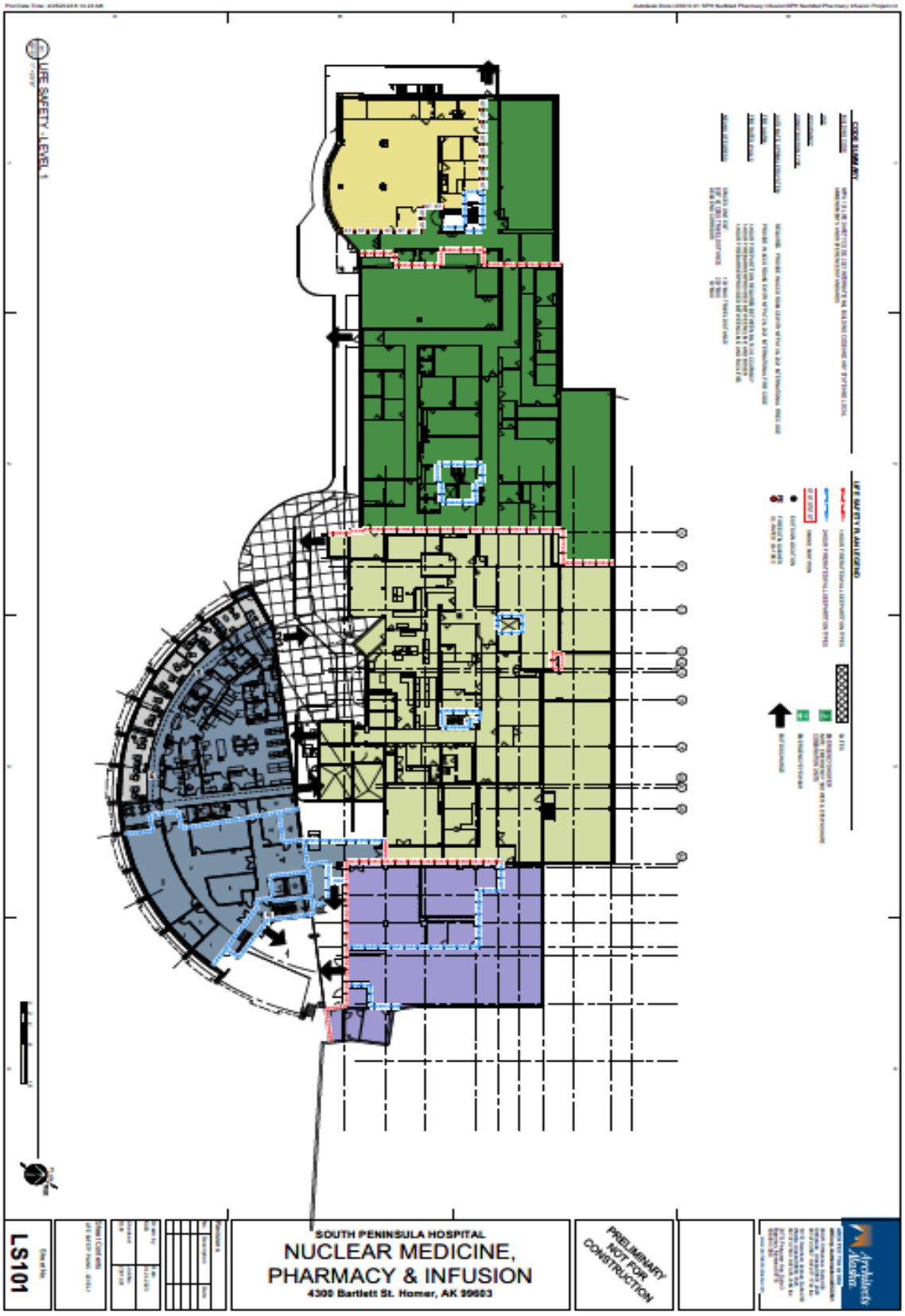
Item 21: SPH Second Floor Schematic Design for Nuclear Medicine and Ancillaries



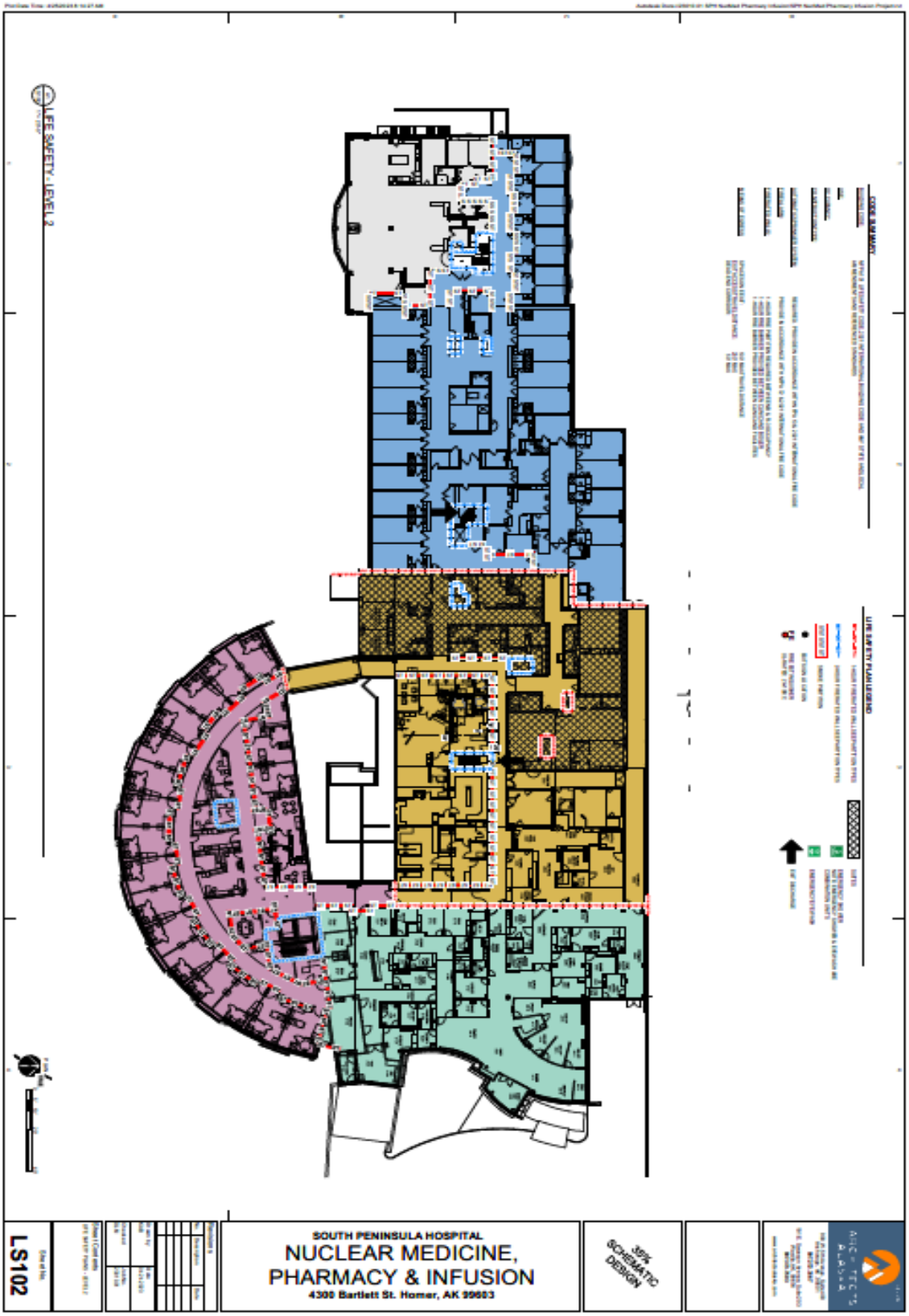
Item 22: SPH Second Floor Schematic Design for Nuclear Medicine



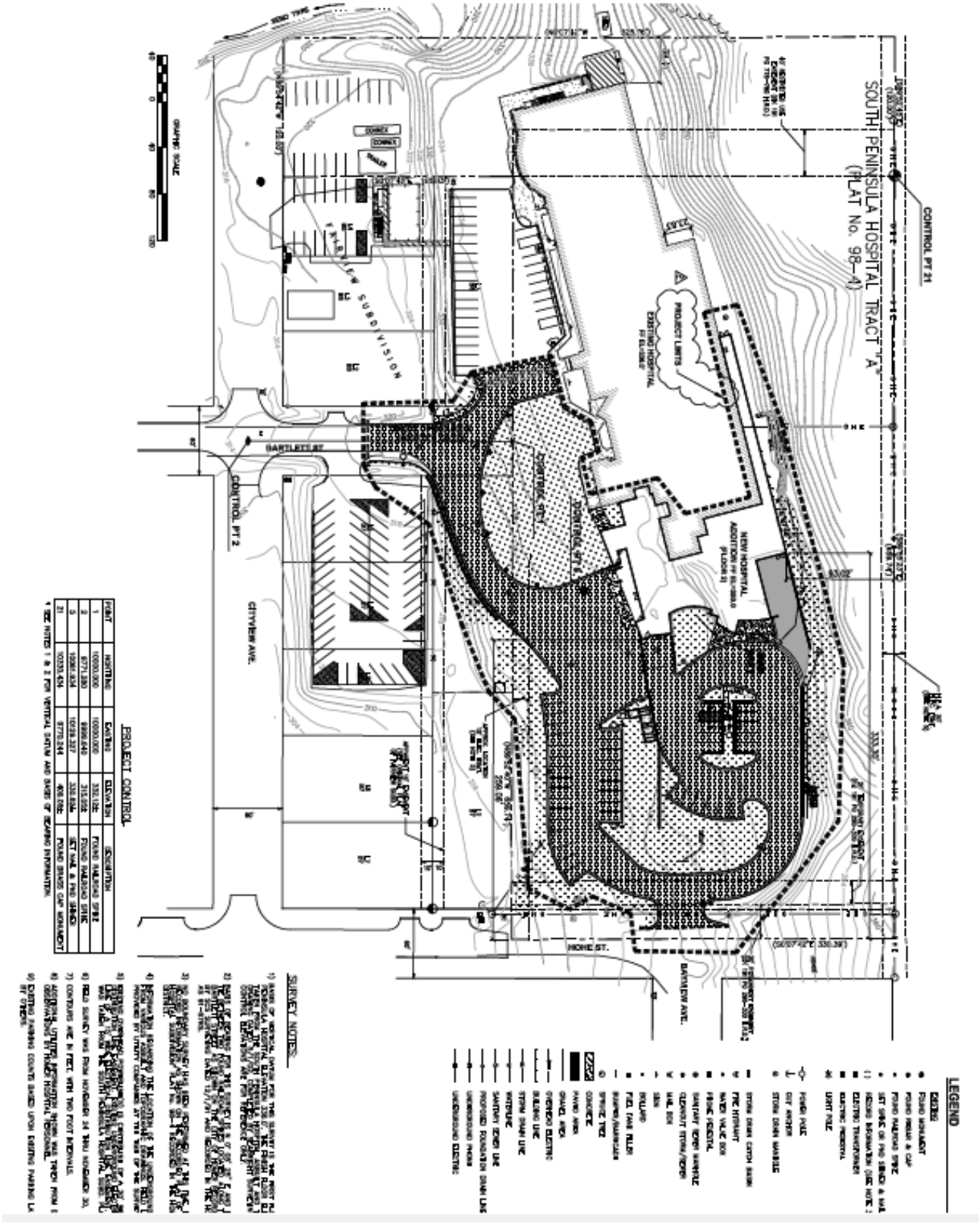
Item 23: Fire and Life Safety Drawings – First Floor



Item 24: Fire and Life Safety Drawing – Second Floor



Item 25: SPH Zone restrictions, fire protection, sewage and access diagram



Item 26: Letter of Support, South Peninsula Hospital Foundation

South Kenai Peninsula Hospital Foundation

May 12th, 2023

Alexandria Hicks, Coordinator
Department of Health and Social services
Division of Health Care Services
Office of Rate review
3601 C Street, Suite 978
Anchorage, AK 99503-5924

Dear Alexandria,

It is our pleasure to write a letter of support for South Peninsula Hospital to add the new service line of Nuclear Medicine, relocate the Pharmacy, and expand and bring back in house Infusion services.

At present, SPH's diagnostic imaging services include X-Ray, Computed Tomography (CT), Mammography, Ultrasound, and Magnetic Resonance Imaging (MRI). Although developed in the 1950s, Nuclear Medicine has been the standard of care for diagnosing illnesses and disorders related to Heart Health, Neurology, and Cancer for over 30 years. The Southern Kenai Peninsula Hospital Foundation supports bringing this vital diagnostic imaging service line to the residents of the Southern Kenai Peninsula. Bringing this service line closer to home for residents saves them traveling long distances on roads that can be dangerous at times.

In addition to bringing the Nuclear Medicine service line closer to home, the South Kenai Peninsula Hospital Foundation supports the relocation and expansion of the Pharmacy into the current shelled space within the building. The relocation will allow the Pharmacy to be compliant with new USP standards for sterile compounding and allow it to continue to provide greatly needed services to Kenai Peninsula residents.

The South Kenai Peninsula Hospital Foundation also supports bringing the Infusion services back into the main owned hospital building and out of the currently rented space just below the main hospital building. This will allow the Infusion department to be more closely located to Pharmacy and Emergency services should they be needed. This will also allow the growing Infusion department to expand services to meet the ever-increasing demand.

The SPH Foundation is grateful for your support of our Mission - "A Nonprofit dedicated to the wellbeing of the people of the Southern Kenai Peninsula and supporting the community health care mission of the South Peninsula Hospital."

Sincerely,
Angie Newby, Foundation Chair 2023

South Kenai Peninsula Hospital Foundation

Item 27: Letter of Support, South Kenai Peninsula Hospital Service Area Board

May 11, 2023

South Kenai Peninsula Hospital Service Area Board
Helen Armstrong, Chair
South Peninsula Hospital
4300 Bartlett Street
Homer, AK 99603

Alexandria Hicks, Coordinator
Alaska Department of Health and Social Services
Division of Health Care Services
Office of Rate Review
3601 C Street, Suite 978
Anchorage, AK 99503-5924

Dear Ms. Hicks,

The South Kenai Peninsula Hospital (SKPH) Service Area Board is pleased to write a letter of support for the South Peninsula Hospital (SPH) to add a new nuclear medicine service line, relocate the hospital pharmacy, and expand and bring back in-house infusion services. This letter of support was approved by the SKPH Service Area Board at its May 11, 2023, Board meeting.

At present, SPH's diagnostic imaging services include x-ray, computed tomography, mammography, ultrasound, and magnetic resonance imaging. Although developed in the 1950's, for over 30 years nuclear medicine has been the standard of care for diagnosing illnesses and disorders related to cardiology, neurology, and oncology. The SKPH Service Area Board supports bringing this vital diagnostic imaging service line to the residents of the South Kenai Peninsula. Bringing this service line closer to home for residents saves them traveling long distances on roads that can be dangerous at times.

In addition to supporting the nuclear medicine service line, the SKPH Service Area Board supports relocation and expansion of the hospital pharmacy into the current shelled space within the hospital building. Relocation will allow the pharmacy to be compliant with new United States Pharmacopeia (USP) standards for sterile compounding and allow it to continue to provide greatly needed services to South Kenai Peninsula residents.

Finally, the SKPH Service Area Board also supports bringing infusion services back into the main hospital building and out of the currently rented space just below the hospital. This will allow the SPH Infusion Center to be located closer to the hospital pharmacy and the SPH Emergency Department, should they be needed. This also allows expanding infusion services to meet ever-increasing demand.

The SKPH Service Area Board is grateful for your support of the South Peninsula Hospital mission: "South Peninsula Hospital promotes community health and wellness by providing personalized, high quality, locally coordinated healthcare."

Sincerely,

Helen Armstrong, Chair
South Kenai Peninsula Hospital Service Area Board

cc: South Kenai Peninsula Hospital Service Area Board Members
Ryan Smith, CEO, South Peninsula Hospital

Item 28: Letter of Support, South Peninsula Hospital Board of Directors

Introduced by:	Administration
Date:	May 24, 2023
Action:	Approved
Vote:	Yes - 11, No - 0, Exc - 0

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-15

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS SUPPORTING THE HOSPITAL'S REQUEST FOR A CERTIFICATE OF NEED TO ADD THE SERVICE LINE OF NUCLEAR MEDICINE TO SOUTH PENINSULA HOSPITAL, RELOCATE THE PHARMACY AND EXPAND AND RELOCATE INFUSION SERVICES

WHEREAS, South Peninsula Hospital wishes to add the new service line of Nuclear Medicine, relocate the Pharmacy and expand and bring back in-house Infusion Services ; and

WHEREAS, Nuclear Medicine has been the standard of care for diagnosing illnesses and disorders related to Heart Health, Neurology, and Cancer for over 30 years; and

WHEREAS, bringing this service line to Homer will allow patients to receive vital diagnostic services close to home which will bring access to populations who may not otherwise receive the service, resulting in better outcomes for our service area; and

WHEREAS, the relocation and expansion of the Pharmacy will bring South Peninsula Hospital into compliance with USP standards for sterile compounding and allow it to continue to provide greatly needed services to Kenai Peninsula residents; and

WHEREAS, bringing the Infusion services back into the main hospital building and will allow the Infusion department to be more closely located to Pharmacy and Emergency services should they be needed and allow the growing Infusion department to expand services to meet the ever-increasing demand; and

WHEREAS, the South Peninsula Hospital Board of Directors approved the allocation of funds towards this project in previous Board Resolution 2022-16; and

WHEREAS, this project will require a Certificate of Need per State of Alaska regulations.

WHEREAS, this resolution was discussed and recommended for approval at Finance Committee on May 18, 2023.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL:

1. That the South Peninsula Hospital Board of Directors supports the Hospital's plan to create the new service line of Nuclear Medicine, and the resulting project to construct the nuclear medicine space, as well as the relocation and expansion of the Pharmacy and Infusion Services.

2. That the South Peninsula Hospital Board of Directors instructs Hospital Administration to apply for a Certificate of Need for this project as required by State of Alaska regulations.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL AT ITS MEETING HELD ON THIS 24TH DAY OF MAY, 2023.

ATTEST:

Julie Woodworth, Board Secretary

Kelly Cooper, Board President

References

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