2014 Legislature TPS Report 60787v1

Agency: Commerce, Community and Economic Development

Grants to Named Recipients (AS 37.05.316)

Grant Recipient: Interior Alaska Hospital Foundation **Federal Tax ID:** 91-1820378

Project Title: **Project Type:** New Construction and Land Acquisition

Interior Alaska Hospital Foundation - Rural Health Care Facility

State Funding Requested: $2,000,000 **House District:** 6 / C

One-Time Need

Brief Project Description:

Design and construct a health care facility to serve Interior Alaska to be located in Delta Junction area.

Funding Plan:

Total Project Cost:	$35,000,000
Funding Already Secured:	($35,000)
FY2015 State Funding Request:	($2,000,000)
Project Deficit:	$32,965,000

Funding Details:

FY12-13 State and private funding for study and evaluation.

Detailed Project Description and Justification:

Construct a health care facility to serve Interior Alaska to be located in the Delta Junction area.

See attached PDF for feasibility analysis and construction options.

Project Timeline:

Begin design and construction once funding is secured.

Entity Responsible for the Ongoing Operation and Maintenance of this Project:

Interior Alaska Hospital Foundation

Grant Recipient Contact Information:

Name:	Mary Kaspari
Title:	President
Address:	PO Box 177
	Delta Junction, Alaska 99737
Phone Number:	(907)895-3232
Email:	marykaspari@hotmail.com

Has this project been through a public review process at the local level and is it a community priority? [X] Yes [ ] No

Contact Name: Michael Paschall
Contact Number: 907-465-5446

For use by Co-chair Staff Only:

$300,000 Approved

11:54 AM 5/13/2014

INTERIOR ALASKA HOSPITAL FOUNDATION

HEALTH FACILITY STUDY
AUGUST 2012

McClure and Associates, Inc.

LEO A DALY
PLANNING ARCHITECTURE ENGINEERING INTERIORS

Kiewit
Building Group

LANCASTER POLLARD

McClure and Associates, Inc.

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EXECUTIVE SUMMARY

Purpose: Interior Alaska Hospital Foundation (IAHF) is a private not for profit organization investigating the potential for constructing a Critical Access Hospital, Frontier Extended Stay Clinic or other potential health care models to provide health services to Interior Alaska.

Demographics

- Market designation is approximately 70, 000 square miles with 72 percent of the market with a 30 mile radius of Delta Junction.
- Total population of the primary market service area is projected in 2016 to be 6,036.
- Pediatric population is 29.8% of total projected population.
- Most age groups are seeing growth with the population over 65 growing the fastest.
- Over the last 15 year period the market has seen an increase of 15 percent.
- Interior Alaska is one of the fastest growing areas in Alaska as well as rural and frontier America.
- Total population demographics indicate a 4 percent increase from 2011 to 2016 on top an increase the previous 10 years of 11 percent.
- Income with the market has increased 45 percent from the 2000 census to the 2010 census.

Implication: Market demographics indicate that the population base will support a Critical Access Hospital, Medical Clinic Specialization Clinic and Long Term Care.

Benchmark Comparisons

Implication: Benchmarks indicate that the potential market draw will support a 10 bed Critical Access Hospital; for acute care and skilled nursing swing beds. The facility could also support up to 10 beds for long term care.

Emergency Department

- The clinic emergency department currently captures 61 percent of potential market in 2011.
- With the addition of more diagnostic equipment and access to tele medicine to larger network hospital, a significant number of individuals will not need to be transported.
- Ft. Greely is an integral part of utilizing services of the emergency department,

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- Heavy industry and visitors to the area are major users of the emergency. department.
- Remoteness of the area with the closest hospital being 125 miles means that all emergency must be stabilized before transport.

Outpatient services
Implications: Outpatient clinic visits for the market based on benchmarks would be 15,800. Even though surgical procedures would be done in a larger facility at this time, the diagnostic visits pre-op and post-op and additional follow up could be provided in Delta Junction. Local specialty clinics will save time and money eliminating the long distance to receive services.

Clinic Services: The clinic captures based on benchmarks 63 percent of the market. Outside visitors and traveling workers boost the market share. The clinic is the focal point of the future of Medical Services within the IAHF large market.
Economic Impact

Economic Impact
The economic impact of the community is significant and often times overlooked. Total impact of the Critical Access Hospital and additional jobs created in the market along with additional retail sales is projected to be $7,195,000.

Building Cost and Operational Feasibility
Due to market volume, we have chosen to focus on the CAH model with 10 acute beds and 10 long term care beds with a full service environment less the operating room. The structure would be 47,295 square feet with a total cost estimate of $39,204,700 for hard, soft and financing cost.

Several Alaska CAH's that have comparable markets and volumes have been used for a comparative analysis. In addition, we assumed that the hospital would be managed or leased by a proven professional management company or larger health system. Under proper leadership, the project can be successful.

Conclusion
The project has the potential to be successful; will need to be one of several models which all would include the need of a sponsoring larger organization, such as a regional network hospital or lease the operation to a national management group. A variety of financing options will be available determined by the operational model.

PURPOSE

Interior Alaska Hospital Foundation (IAHF) is a private not for profit organization investigating the potential for constructing a Critical Access Hospital, Frontier Extended Stay Clinic or other potential health care models to provided health services to Interior Alaska.

The intent of this study is to ultimately determine the current and future healthcare / hospital need of Interior Alaska.

SCOPE AND PROCESS
CONFIDENTIALITY
All identifiable information provided to McClure and Associates, Inc (MCA) about IAHF will be used and stored in the most confidential manner, and will not be shared with any other person(s) or organization(s) without the expressed, written consent of a duly authorized representative(s) of IAHF. Should a representative of MCA become aware of any personal health information, it will be treated with the utmost care in compliance with HIPAA confidentiality mandates.

IAHF may photocopy the written report provided by MCA for internal purposes of IAHF, or to submit to a duly authorized representative(s) of IAHF oversight governing body.

PROJECT DELIVERABLES
The project development team provides the expertise and process to guide Interior Alaska Foundation through the Facility Assessment and Planning Process. We provide a team that has worked and guided hospital administrations and boards on similar projects throughout the United States. Our step-by-step process begins with an experienced team that can investigate, organize and formulate a to guide the decision making process through master planning. This is especially important in a dynamic environment where each service line (hospital, clinic, and senior function) option has it's own specialized needs and space requirements

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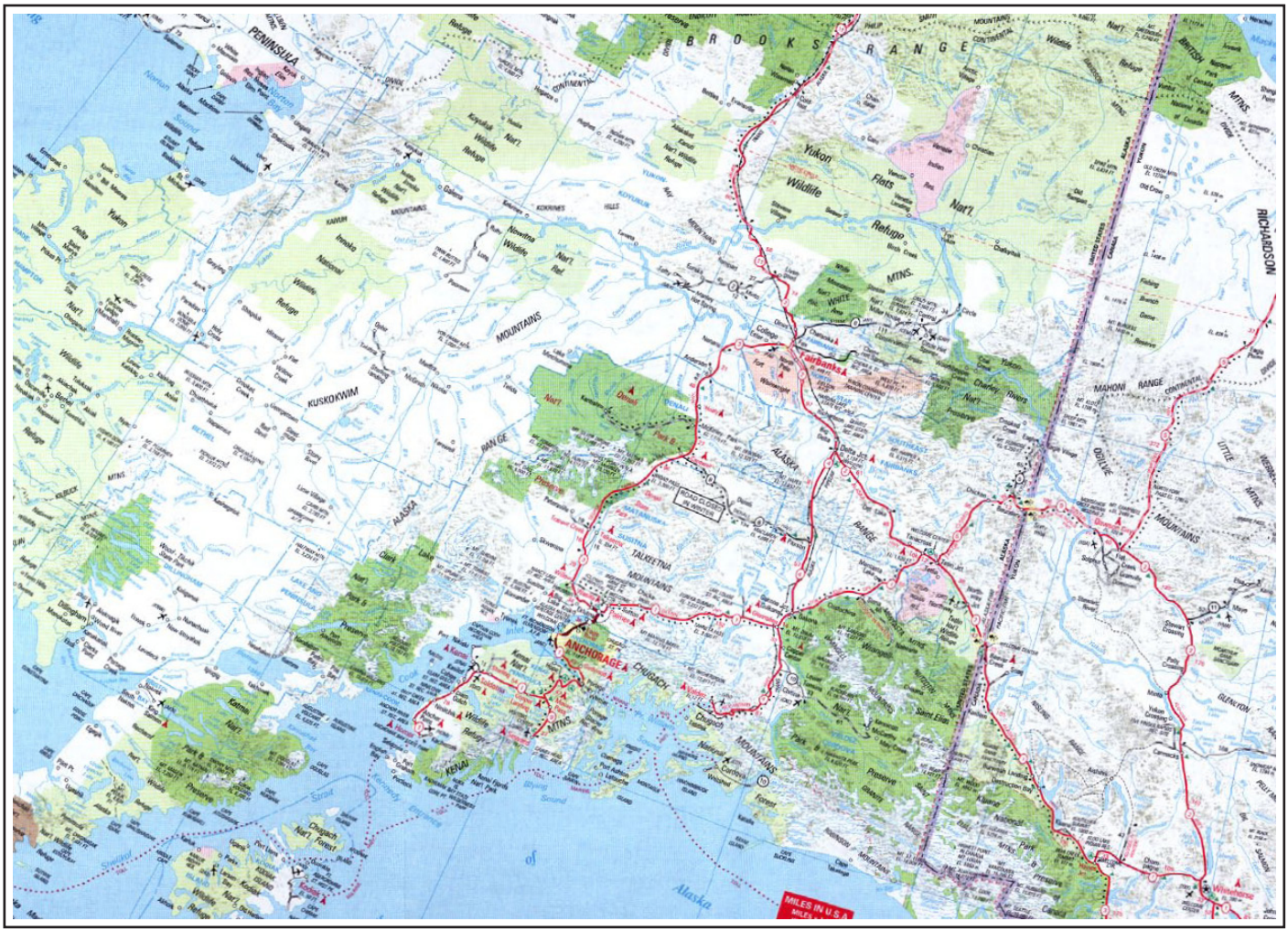
RFP 1: Need and Demand for Healthcare Service
Market Designation and Demographics

Market Service Area Map
Interior Alaska Hospital Foundation
Delta Junction, Alaska



Market Designation

Market designation is approximately 70,000 square miles with 72 percent of the market within a 30 mile radius of Delta Junction. The box outline on the map, the previous page, indicates the market . The market identified is where 80 percent of the potential business comes from. The market represents patient draws at the current clinic in Delta Junction. Census track information was pulled via GPS tracking system from Claritas/Nielson Company.

Market Demographics – Conclusions 2016

As indicated in charts I, II, III as shown in the appendix

- Total population of the primary market service area (PSA) is projected in 2016 to be 6,036.
- Pediatric population is 1,799 (29.8%) of total projected population.
- OB age population is 1,080 (17%) of total projected population for the PSA.
- The 0 to 17 age cohort group has a slight projected increase by 2016.
- The 25 to 34 age cohort group has a projected growth of 17 percent by 2016, which would indicate a significant increase in this segment of the market.
- The 55 to 64 age cohort group has a projected growth of 8 percent by 2016, which would indicate a significant increase in this segment of the market.
- The 65 to 74 age cohort group has a projected growth of 26 percent by 2016, which would indicate a good increase in this segment of the market.
- The population 65 and over shows an increase of 35 percent by 2016 of is significant growth.
- The population 75 plus has increased by 45 percent; this number is a significant increase.
- Ft. Greely population is in the population base.
- The total population demographics indicate a 4 percent increase from 2011 to 2016 on top of an increase the previous 10 years of 11percent. This is significant in that over a 15 year period the market has seen an increase of 15 percent. Interior Alaska is one of the fastest growing areas in Alaska as well as rural and frontier America.
- Income within the market has had significant increases from the 2000 census to the 2010 census. There was an increase of 45 percent over the 2000 census. The median income is $61,872 compared to the national median of $50,022.

Market Demographics – Implications 2016

- The population increase is significant not only within the Alaskan market but also in the United States.
- The pediatric population age (0-17) has remained stable and is a high percentage of the total population.
- According to the Henry Kaiser Family Foundation the Alaska birth rate per

1000 population in 2010 was 16.7 which indicate that the market area would have 101 births.

- The cohort age group 55 to 74 indicates strong growth. These two age groups have a high utilization of health care services. In addition this group will be looking for independent living that is designed for aging in place. Need and use calculation indicate that a potential exists for 35 independent living units. The cohort age group 75 and over has had a significant increase. This group is the largest user of health care services including clinic, outpatient, inpatient, home health, nursing home care and skilled nursing care. Skilled nursing home and nursing home potential need is projected to be 30 beds. A conservative, projected capture rate of 1/3rd would be 10 beds.

Implication: Market demographics indicate that the population base will support a Critical Access Hospital, Frontier Extended Care Clinic, Medical Clinic, Specialization Clinic, Skilled Nursing Facility, Long Term Care Facility, Aging in Place Independent Living Units, and Assisted Living.

Potential Utilization Based on of the Following Areas
Chart IV Inpatient Admission Potential
Benchmark Market Service Area

Age		Hospital Admissions 2000	2011	2016
		Market Population		
Under 18 Years		1,749	1,797	1,799
18 - 44 Years		1,894	1,920	2,240
45 - 64 Years		1,265	1,563	1,562
65 Years and Over		320	540	729
	Total	5,228	5,820	6,330
		Number of Visits Per One Thousand		
Persons				
Under 18 Years		44	44	44
18 - 44 Years		88	88	88
45 - 64 Years		126	126	126
65 Years and Over		384	384	384
		Market Target		
Under 18 Years		77	79	79
18 - 44 Years		167	169	197
45 - 64 Years		159	197	197
65 Years and Over		123	207	280
Total	526	652		753
		Actual Usage		
Total		0	0	
Inpatient Admissions		0	0	0
		Inpatient Admissions		
		2000	2011	2016
Market Capture Percentage		0%	0%	0%
Average Stay Days		3	3	3
	1,578	1,957		2,259
Average Daly Census	4.32	5.36		6.19

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Chart V
Skilled Nursing and Long-Term Care
Benchmark
Market Service Area

Preliminary Unadjusted Target Market	242
Apply market capture rate primary 10%	24.2
Apply secondary capture rate 20% primary	6
Adjusted Calculations	
Existing and planned units	0
Preliminary Unit Potential	30

Chart VI
Current Alaska Utilization Rates
Market Projections

Hospitals 2009	Alaska	All U.S.	Market Population	Market Utilization
Hospital Beds Per 1000 Population *	2.2	2.6	6036	13
Hospital Admissions Per 1000 Population *	82	116	6036	492
Hospital ER Visits per 1000 Population *	425	415	6036	2,550
Hospital Days per 1000 Population *	485	628	6036	2,910
Hospital Outpatient Visits per 1000 *	2530	2091	6036	15,180
Note 3 Kaiser Family Foundation State Health Facts				

Inpatient Admissions Benchmark
Conclusions 2016

Benchmark Comparison
Interior Alaska Hospital Foundation
Patient Conclusion:

Charts IV, V and VI indicate the following:

- Potential inpatient admissions have increased by 379 between 2000 and 2011.
- Potential inpatient admissions projections indicate an increase of 302 by 2016.
- 45 year olds and up have the largest number of admissions. Those 65 and over will comprise 60 percent of all inpatient admissions.
- Based on strictly Alaska benchmarks as presented in Chart VI, market utilization shows a need of 13 beds per day, all facilities.
- Total bed need would be based on an average census of 6.19 with a high census of 8 with a plus buffer of 25 percent to handle a disaster which brings.

- Total bed need for Nursing Care Facility is projected at 30 with an assumption of capturing 1/3 of the market or 10 beds.

Implication: Benchmarks indicate that the potential market draw will support a 10 bed Critical Access Hospital for acute care and skilled nursing swing beds. The facility could also support up to 10 beds for long term care.

Furthermore, the same statistics indicate that a Frontier Extended Care Clinic would be supported. This could work as a phased project to accommodate financial considerations. The Clinic would have the ability to collect proper charges from insurance programs.

Chart VII
Operated by Family Medical Center
Benchmark
Emergency Department
Market Service Area

		Emergency Department		
Age		2000	2011	2016
		Market Population		
Under 18 Years		1,749	1,797	1,799
18 - 44 Years		1,894	1,920	1,946
45 - 64 Years		1,265	1,563	1,562
65 Years and Over		320	540	729
	Total	5,228	5,820	6,036
		Number of Visits Per One Hundred Persons		
Under 18 Years		36	36	36
18 - 44 Years		42	42	42
45 - 64 Years		30	30	30
65 Years and Over		90	90	90
		Market Target		
Under 18 Years		630	647	648
18 - 44 Years		795	806	817
45 - 64 Years		380	469	469
65 Years and Over		288	486	656
Total		2,093	2,408	2,590
		Actual Usage		
Total		0	1810	2072
ED Encounters		0	1810	2072
		Actual ED Encounters		
		2000	2011	2016
Market Capture Percentage		0%	75%	80%

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Statement of Clarification: Emergency Department Operated by Family Medical Center

- The emergency services available at the clinic 24/7 are provided independently by the clinic.
- Emergency stabilization for critical care is required before transportation can be arranged and provided. The closest ED is 125 miles, which is at a distance that without stabilization the patient would be in a more dangerous situation.
- Since the clinic ED is not part of a Hospital or Frontier Extended Care clinic they receive a fraction of the cost of services.
- For the 25 years, the clinic has provided this service to the betterment of region at a tremendous cost without reimbursement.
- With the addition of a Critical Access Hospital or Frontier Extended Care Clinic the cost of services would be covered.
- EMS services reimbursement rate for services paid by Medicare and third party insurers would approximately double helping offset the cost of EMS services in the region to all providers of Emergency Transport.
- The clinic maintains the staff certifications, equipment and supplies to meet the standards of a level 4 Trauma Center while not being certified due to the requirement of being a hospital or extended care clinic.
- The cost of these extended services is absorbed by the Family Medical Center.

Emergency Department Benchmark – Conclusions 2015
Benchmark Comparison – Delta Junction Family Medical Center Department Conclusion:

Charts VI and VII indicate the following:

- Emergency Department currently capturing 61percent of potential market in 2011, and projected potential market of 80 percent in 2016, (based on benchmark, rural market trends and CDC). Typically the minimal capture rate would be 50 percent or greater within a critical access hospital market which in the lower 48 are much closer together and closer to larger market. Typically a frontier market would be in excess of 70 percent due to remoteness and need for stabilization.
- With the addition of more diagnostic equipment and access to tele medicine to larger network hospitals, a significant number of individuals will not need to be transported.
- 1,490 emergency department visits per year in this market would be reasonable within a Critical Access Hospital. The projected benchmark for the year 2016 is 2059.
- Ft. Greely is an integral part of utilizing services of the emergency department.
- Heavy industry in the market is also a major factor for the significant utilization of the Emergency Department.
- With roughly 30,000 visitors (according to the visitors bureau) traveling to and through Delta Junction the need for emergency services is paramount.
- Emergency visits provided 24/7 were 1,490 in the clinic. The benchmark comparison of potential ED visits for the market was 2,408.

Implications: Emergency services are critical to the market in a variety of areas including national security with the presence of Fort Greely, just a few short miles from Delta Junction, and several heavy industrial operations including the Trans-Alaska Pipeline and Pogo Mine. Medical services are currently available to the base with leased clinic space. In addition, the current facilities at the clinic handle after hours calls for emergency department, radiological and laboratory services.

The remoteness of the community is represented by the vast size of the service area which includes approximately 70,000 square miles of territory. Delta Junction and Tok are the largest communities, both having private medical clinics. The closest hospital to Delta Junction is Fairbanks which is 125 miles away. Tok is a greater distance as is much of the area and in a even much more precarious position.

Delta Rescue, Tok Rescue along with Fort Greely provides the backbone for rescue in the market area which can be very challenging with the remoteness and severe weather conditions that are prevalent. All emergency patients must be stabilized in the clinic's emergency department 24/7. Needed transportation is then arranged which can vary from ground transportation to fixed wing. All fixed wing missions arrive and depart from Fort Greely airfield. Destinations, depending on type of situations, can be Fairbanks, Anchorage or Seattle.

The addition of a full service emergency department with the proper diagnostic equipment such as CT, Sonogram, X-Ray, and laboratory services that are connected to a network hospital, to help oversee emergency trauma services, will provide the market area with a timely, high level service and advanced diagnostics for those being transported. A significant number of patients would be able to have specialized testing completed, eliminating unnecessary transfers causing less stress on the statewide emergency system.

Outpatient Services

Chart VIII
Inpatient and Outpatient Procedures MALE
Benchmark
Market Service Area

	Market Target		
	Ambulatory		*Inpatient*
Male	**2011**	**2016**	**2016**
Under 15 Years			
Myringotomy with insertion of tube	6.9	6.4	0.2
Tonsillectomy, with or without andenoldectomy	2.7	3.2	0.2
Reduction of Fracture	0.8	0.9	0.2
16 - 44 Years			
Cardiac catheterization	0.6	0.7	0.0
Endoscopy of small or large intestine	6.1	6.7	0.0
Cholecystecomy	0.2	0.6	1.3
Reduction of fracture	1.2	1.6	1.8
Arthroscopy of the knee	4.1	3.9	0.5
Excision or destruction of interverebrai disc		0.3	2.5
Angio-cardiography with contrast material	0.1	0.7	1.9
	22.7	25.2	8.6
45 - 64 Years			
Coronary angioplasty	0.0	0.0	4.6
Coronary artery bypass graft		0.0	1.1
Cardiac catheterization	2.7	4.2	9.2
Endoscopy of small or large intestine	16.3	17.0	4.8
Cholecystecomy	0.4	0.9	1.3
Prostatectomy	0.0	0.0	1.3
Reduction of fracture	0.5	0.6	1.5
Arthroscopy of the knee	3.0	3.4	0.0
Excision or destruction of interverebrai disc	0.0	0.0	1.8
Angio-cardiography with contrast material	3.7	5.0	11.9
	26.6	31.1	37.5

Chart VIII
Inpatient and Outpatient Procedures MALE Continued
Benchmark
Market Service Area

Male	Market Target Ambulatory 2011	Ambulatory 2016	Inpatient 2016
65 - 74 Years			
Coronary angioplasty	0.0	0.0	2.5
Extraction of lens	6.5	9.6	0.0
Insertion of prosthetic lens	5.3	7.7	0.0
Coronary artery bypass graft	0.0	0.0	2.8
Cardiac catheterization	1.2	2.7	4.6
Pacemaker insertion or replacement	0.0	0.0	0.9
Carotid endarterectomy	0.0	0.0	0.6
Endoscopy of small or large intestine	8.7	11.2	3.4
Cholecystecomy	0.0	0.0	0.8
Prostatectomy	0.0	0.0	1.8
Reduction of fracture	0.0	0.0	0.6
Total hip replacement	0.0	0.0	0.6
Angio-cardiography with contrast material	1.8	3.5	5.7
75 - Years and over			
Coronary angioplasty	0.0	0.0	0.8
Extraction of lens	4.6	7.6	0.0
Insertion of prosthetic lens	3.5	5.7	0.0
Coronary artery bypass graft	0.0	0.0	0.9
Cardiac catheterization	0.3	0.5	1.6
Pacemaker insertion or replacement	0.0	0.0	1.1
Carotid endarterectomy	0.0	0.0	0.3
Endoscopy of small or large intestine	3.2	4.6	2.4
Cholecystecomy	0.0	0.0	0.3
Prostatectomy	0.2	0.2	0.8
Reduction of fracture	0.0	0.0	0.5
Total hip replacement	0.0	0.0	0.1
Angio-cardiography with contrast material	0.3	0.6	2.0

Chart IX
Inpatient and Outpatient Procedures FEMALE
Benchmark
Market Service Area

		Market Target	
	Ambulatory		*Inpatient*
Female	**2011**	**2016**	**2016**
Under 15 Years			
Myringotomy with insertion of tube	4.8	4.1	0.0
Tonsillectomy, with or without andenoldectomy	3.5	3.4	0.0
Reduction of Fracture	0.4	0.6	0.1
	8.7	8.0	0.1
16 - 44 Years			
Cardiac catheterization	0.0	0.2	0.1
Endoscopy of small or large intestine	7.0	8.0	1.8
Cholecystectomy	1.5	2.1	2.0
Bilateral destruction or occlusion of fallopian tubes	5.9	6.9	6.1
Hysterectomy	0.0	0.0	6.1
Cesarean section	0.0	0.0	15.9
Repair of current obstetrical laceration	0.0	0.0	20.8
Reduction of fracture	0.4	0.5	1.0
Arthroscopy of the knee	1.9	2.2	0.0
Excision or destruction of interverebrai disc	0.0	0.0	1.0
Lumpectomy	2.7	2.2	0.2
Mastectomy	0.0	0.0	0.0
45 - 64 Years			
Coronary angioplasty	0.0	0.0	1.6
Coronary artery bypass graft	0.0	0.0	1.1
Cardiac catheterization	1.7	1.9	4.1
Endoscopy of small or large intestine	16.7	17.9	4.1
Cholecystectomy	1.4	2.6	1.9
Hysterectomy	0.0	0.0	6.0
Reduction of fracture	0.5	0.6	1.6
Arthroscopy of the knee	2.1	2.7	0.0
Excision or destruction of interverebrai disc	0.0	0.0	1.4
Lumpectomy	3.7	3.6	0.3
Mastectomy	0.0	0.3	0.8
Angio-cardiography with contrast material	2.3	2.6	5.7

Chart iX
Inpatient and Outpatient Procedures FEMALE Continued
Benchmark
Market Service Area

Female	Market Target *Ambulatory* 2011	Market Target *Ambulatory* 2016	Market Target *Inpatient* 2016
65 - 74 Years			
Coronary angioplasty	0.0	0.0	1.0
Extraction of lens	6.9	10.8	0.0
Insertion of prosthetic lens	3.2	4.9	0.0
Coronary artery bypass graft	0.0	0.0	0.0
Cardiac catheterization	0.5	1.2	2.2
Pacemaker insertion or replacement	0.0	0.0	0.6
Carotid endarterectomy	0.0	0.0	0.3
Endoscopy of small or large intestine	6.4	10.3	3.0
Cholecystecomy	0.2	0.5	0.0
Hysterectomy	0.0	0.0	0.6
Reduction of fracture	0.0	0.0	0.8
Total hip replacement	0.0	0.0	0.4
Lumpectomy	0.7	1.1	0.1
Mastectomy	0.0	0.0	0.4
Angio-cardiography with contrast material	0.8	1.6	2.9
75 - Years and over			
Coronary angioplasty	*	*	0.6
Extraction of lens	6.8	11.2	0.0
Insertion of prosthetic lens	5.3	8.4	0.0
Coronary artery bypass graft	*	*	0.4
Cardiac catheterization	0.1	0.5	1.3
Pacemaker insertion or replacement	*	0.1	1.0
Carotid endarterectomy	*	*	0.2
Endoscopy of small or large intestine	3.3	5.2	3.5
Cholecystecomy	*	0.2	0.4
Hysterectomy	0.2	0.0	0.2
Reduction of fracture	*	*	1.4
Total hip replacement	*	*	0.3
Lumpectomy	0.3	0.4	0.1
Mastectomy	*	*	0.2
Angio-cardiography with contrast material	0.2	0.7	1.7

Chart X
Orthopedic Outpatient
Benchmark
Market Service Area

Orthopedic Surgeons Modality	All Population Per 100 Persons	Market Population	Market Utilization
Orthopedic Surgeons Visi	14.5	6036	870

Chart XI
Utilization of Imaging
Benchmark
Market Service Area

Based population projection 2016 Modality	All Population Per 1000 Persons	Market Population	Market Utilization
CT	287	6036	1,722
MR	86	6036	516
Ultrasound	522	6036	3,132
Interventional	131	6036	786
Nuclear Medicine	135	6036	810
PET	8	6036	48
X-ray, total including Mammography	1091	6036	6,546
All Diagnostic Radiology	2259	6036	13,560
Radiation Oncology	123	6036	738

Chart XII
Top 10 Speciality Clinics
Market Service Area

	Clinics	%
1	Surgery	9.0%
2	Orthopedics	8.8%
3	ENT	8.5%
4	OB-GYN	8.3%
5	Ophthalmology	8.2%
6	Dermatology	7.3%
7	Mental Health	6.8%
8	Cardiology	6.2%
9	Nutrition	5.7%
10	Urology	4.8%
	Total	73.6%

Inpatient and Outpatient Procedures Benchmark – Conclusions 2016
Benchmark Comparison – Interior Alaska Hospital Foundation Market Potential Conclusion: This is not an inclusive list of procedures and does not limit specialty services to these alone. A number of other specialties may be defined throughout the report and recommendations.

Charts VI, VIII through XII indicate the following:

Outpatient procedures

- Pediatric procedures (19) such as Myringotomy with insertion of tube, tonsillectomy, reduction of fracture.
- Cardiac procedures (106) such as Cardiac cauterization, angiocardiography with contrast material, coronary angioplasty, Coronary artery by-pass graff, Carotid endarterectomy, Pacemaker insertion or replacement.
- Gastrointestinal (122) such as Endoscopy of small or large intestine, Cholecystectomy.
- Women's health (172) OB Delivery, C-Section, Bilateral destruction or occlusion fallopian tube, Hysterectomy, Repair of current obstetrical laceration, Lumpectomy, Mastectomy.
- Orthopedic procedures (34) such as reduction of fracture, Arthroscopic knee, Total Hip replacement.
- Ophthalmic procedures (68) such as Extraction of lens, Insertion prosthetic lens.

Implications: The number of procedures during the review was limited in scope. There are many more procedures that would be generated within the market. Of more importance is what this means to outpatient clinics that could and should be provided in Delta Junction. As indicated in chart VI outpatient visits in specialty clinics for the area would be 15,800. Even though surgical procedures would be done in a larger facility at this time, the diagnostic visits pre-op and post-op and additional follow up could be provided in Delta Junction.

In the case of orthopedic services, an estimated 870 visits per year would be reasonable. This coupled to physical and occupational therapy provided within the CAH would be significant to the area. This would be a tremendous benefit to Fort Greely and area employers as it relates to less time off work and eliminates long travel distance to receive services.

You will note in chart XII the top ten specialty clinics; of these there is no reason that arrangements could not be made with a larger system network hospital to

provide for the clinics. In addition many of the specialty services could be provided via video conferencing reducing the need of the specialties to physically be at the facility. Providing local staff to assist with the video conferencing such as LPN, RN and if necessary mid-level practitioner's to assist with the examination.

Chart XIII
Delta Junction Family Care Center
Benchmark
Market Service Area

Age	Physician Office 2000	Physician Office 2011	Physician Office 2016
Under 18 Years	1,749	1,797	1,799
18 - 44 Years	1,894	1,920	1,946
45 -54 Years	817	856	798
55 - 64 Years	448	707	764
65 - 74 Years	209	369	487
75 Years and Over	111	171	242
Total	5,228	5,820	6,036
		Number of Visits Per 100 Population	
Under 18 Years	271	271	271
18 - 44 Years	203	203	203
45 -54 Years	286	286	286
55 - 64 Years	343	343	343
65 - 74 Years	494	494	494
75 Years and Over	588	588	588
Under 18 Years	4,740	4,870	4875
18 - 44 Years	3,845	3,898	3950
45 -54 Years	2,337	2,448	2282
55 - 64 Years	1,537	2,425	2621
65 - 74 Years	1,032	1,823	2406
75 Years and Over	653	1,005	1423
Total	14,143	16,469	17,557
Delta Junction Clinic	0	16,891	0
Market Capture	-	1.03	

Delta Junction Family Medical Center Benchmark – Conclusions 2016
Benchmark Comparison –

Conclusion:

- The clinic is capturing 63 percent of the market potential or 10,439 patient visits per year ending January 2011 and projected at 13,167 for year 2016.
- In addition to the Delta Junction Clinic, the Tok Clinic has an additional 4,000 patient visits per year.
- Current clinic visits include 18% of the total visits from individuals outside the market. For example,

those working in the area who are not full time residents and tourist. Delta Junction had 30,000 visitors go through the area last year.

- Laboratory procedures performed at the clinic were 11,636.
- Radiology procedures performed at the clinic were 1,422.
- 264 surgical procedures were performed in the clinic.
- 258 surgical procedures were performed in the emergency room.
- The clinic serves many dependents from Fort Greely.
- The population projections do not take into consideration the number of employees that are working within the industrial employment spending several weeks on and traveling home.
- The clinic has in excess of 7,500 active charts in Delta Junction. This does not take into consideration the Tok clinic.
- The clinic currently has a history over the past 25 years of providing medical professionals such as OD, MD, NP, RN, LPN, certified aides, certified technicians in radiology and laboratory.
- The clinic is only one of a very few that is privately owned and operated.

Implications: The Family Medical Center is the focal point of the future of Medical Services within the IAHF large market. During the investigation process we verified the market draw of the clinic. This draw is significant and is more natural than casual meaning, geographically with natural borders the clinic naturally became the focal point of the provision of service. When you look at what could be similar markets, not only in Alaska, but some of the Western States in the lower 48 you would not find the organization of medical services to the extent of the Delta Junction Clinic!

After lengthy investigation, several community meetings, individual conversations in person and numerous phone interviews, there seems to be a significant lack of understanding of the magnitude of services by the Health Professionals at The Family Medical Center. The services offered by the 24/7 Emergency Department are not compensated appropriately since it is not a hospital and the clinic absorbs the losses.

Working within a new model with Interior Alaska Hospital Foundation providing for the development of a Critical Access Hospital, the function of the clinic would become part of the Hospital operation and would be controlled by the Hospital entity. The clinic is the main back bone of the proposed hospital. It currently has a history of significant volumes and has been taken for granted within the community.

The clinic has not only provided a great service to Interior Alaska but also to the whole state due to the private responsibility of The Family Care Center.

General Statistical Information

Chart XIV

Health Statistics per 100,000 Populations
Market Service Area

Health Statistics per 100,000 Population	Alaska	All U.S.
Age-Adjusted Invasive Cancer Incidence Rate	411	465
Number of Deaths Due to Diseases of the Heart Per 100,000	145.4	186.5
Number of Deaths Due to Suicide	24.2	11.6
Deaths Caused by Stroke	42.9	40.7

Implications: As we look at the information in Chart XIV we could draw several different conclusions from the comparison of Alaska as compared to all of the United States. Fewer instances of cancer could be factual or could also be due to the remoteness of some areas and cancer is under diagnosed. This does not preclude the local need for services. For example, with a Critical Access Hospital specialty clinics could be set up and ongoing Infusion Therapy could be done locally.

The number of Deaths Due to Diseases of the Heart is also significantly lower than the national average. Again, this could be explained in the same manner as the low cancer rates or could also be due to the overall better physical health, fitness and local diet. The community will still be served very well with the addition of Cardiac Specialty Clinics.

Deaths due to suicide are significantly higher in Alaska than the rest of the Nation and would indicate a need for a variety of mental health services. This will be addressed in the recommendations at the conclusion.

Deaths caused by stroke in Alaska similar to the rest of the nation. This area will be addressed in the recommendation at the conclusion.

Chart XV
Health Status
Market Service Area

Health Status	Alaska	All U.S.
Infant Mortality Rate per 1,000 Live Births	6.5	6.8
Teen Death Rate per 100,000 population	87	58
AIDS Diagnosis Rate per 100,000 population	5.3	10.8
Overweight or Obese Children	33.0%	31.0%
Adults who Visited the Dentist Clinic	69.4%	69.7%
Adults with Disabilities	12.0%	10%
Prenatal Care in the First Trimester	81.1%	83.2%
Percentage of Adults Reporting Poor Mental Health	31.9%	34.0%
Percent of Adults Been Told by Doctor Have Diabetes	5.3%	8.7%

Chart XV has several areas that stand out. The most startling is the Teen Death Rate which is 30 percent greater than the rest of the nation. The number of adults reporting poor mental health is lower than the rest of the nation. This will be discussed in the conclusion.

Diabetes is significantly lower in Alaska than the rest of the nation. However, discussions with clinic staff would indicate that it is not lower and may be under reported. Nationally 26.9 percent of the population over the age of 65 has diabetes. Thirty-five percent of the adults over the age of 20 based on a fasting blood sugar have pre diabetes. In addition 50% of those over the age of 65 have pre diabetes. This will be addressed in the conclusions.

Chart XVI
Health Cost
Market Service Area

Health Costs & Budgets	Alaska	All U.S.
Uninsured Population	18.0%	16.0%
Uninsured Children	12.0%	10.0%
Medicaid Beneficiaries	17.0%	20.0%
Medicare Beneficiaries	9.0%	15.0%

Implications: Chart XVI indicates that Alaska has a 2 percent greater uninsured population with uninsured children having the same rate as compare to national utilization. Medicaid utilization is 3 percent less and Medicare is 6 percent less than the national utilization. However, the population of Alaska is starting to see the impact of the boomer population with projections for those over the age of 65 increasing by 3 percent for the Interior Alaska catchment area by 2016 which will increase the demand on the health system significantly.

The Economic Impact of the Health Sector on Delta Junction, Alaska

Medical facilities have a tremendous medical and economic impact on the community in which they are located. This is especially true with health care facilities, such as hospitals and nursing homes. These facilities not only employ a large number of people and have a significant payroll, but they also draw a large number of people from rural areas that need medical services.

National Trends in Health Care

The health care sector is an extremely fast growing sector Based on the current demographics, there is every reason to expect this trend to continue. Data in Chart XVII provides selected expenditure and employment data for the United States. Several highlights from the national data are:

S**OURCES: Bureau of Labor Statistics; Bureau of Economic Analysis; Centers for Medicare & Medicaid Services**

- In 1970, health care services as a share of the national gross domestic product (GDP) were 7.2 percent. This increased to 16.0 percent in 2005;
- Per capita health expenditures increased from $356 in 1970 to $6,697 in 2005; and
- Employment in the health sector increased 250 percent from 1970 to 2002.

Chart XVII
United States Health Expenditures and Employment Data
2000, 2005 Projected 2012, 2016

Year	Total Health Expenditures ($$Billions)	Per Capita Health Expenditures ($$)	Health as % of GDP (%)
2000	1,353	4,790	13.8
2005	1,988	6,697	16
Projections			
2012	3,173	9,148	17.9
2016	4,137	12,320	19.6

In addition, the Center for Medicare and Medicaid Services National Health Expenditures, projects substantial increases in health care expenditures from 2005 through 2016. In fact, it is predicted that health care expenditures will account for 17.9 percent of GDP by 2012 and increase up to 19.6 percent of GDP in 2016. Per capita health care expenditures are projected to increase to almost $9,148 in 2012 and up to $12,320 in 2016. Total health expenditures are projected to increase to over $4 trillion in 2016. Of the 16.0 percent of GDP or $2.0 trillion spent on health care in 2005, 31 percent of the expenditures were for hospital care and another 21 percent were for physician services.

The Direct Economic Activities

The health sector creates employment and payroll impacts, which are important direct economic activities for the Delta Junction market area. The health sector is divided into the following four components:

- Hospital
- Physicians, Dentists, and Other Medical Professionals
- Nursing and Protective Care
- Other Medical and Health Services (includes massage therapists and a pharmacy)

The health sector in the Delta Junction market service area we are addressing will feature and address the Critical Access Hospital. The inpatient, outpatient, medical clinic and specialty clinic projected employment with either of the 10 acute and 10 SNF is 65 FTE employees and has an estimated payroll of $4,500,000.

The health sector is vitally important as both a community employer and a source of income to the community's economy. The health sector employs a large number of residents. These residents, along with businesses in the health sector, purchase a large amount of goods and services from businesses in the Delta Junction Medical Market Area. These impacts are referred to as secondary impacts or benefits to the economy. Before the secondary impacts of the health sector are discussed, the basic concepts of community economics will be reviewed.

At this juncture we have not included current dental, optical, home health or senior services.

Chart XVIII
Delta Junction Hospital Sector
Impact on Employment and Income and Retail Sales

Health Sector	Employment			Income			Retail
	Employed	Multiplier	Impact	Income	Ratio	Impact	Sales
Hospital	65	1.32	85.8	$ 5,000,000	1.17	$ 5,850,000	$ 1,345,500

Secondary Impacts of the Health Sector on the Economy of Delta Junction Hospital Sector
Employment and income multipliers for the area have been calculated by use of the IMPLAN mode. It was developed by the U.S Forest Service and is a model that allows for the development of multipliers for various sectors of an economy. The employment multipliers for the componets of the health sector are shown in **Chart XVII**I, column 3. The employment multiplier of the Hospital component is 1.32. This indicates that for each job in that component, an additional 0.32 jobs are created throughout the area due to business (indirect) and household (induced) spending. The income multiplier for the Hospital component is 1.17 (**Chart XVIII**, column 6). This indicates that for each dollar in that component, an additional 0.17 dollars are created throughout the area due to business (indirect) and household (induced) spending. The income multipliers for the other health sector components are also shown in **Chart XVIII**, column 6.

Applying the employment multipliers to the number of employees for each component yields an estimate of the impact on the economy (**Chart XVIII**, columns 2, 3, and 4). For example the hospital has a direct employment of 65 FTE employees; applying the employment multiplier of 1.32 to the employment number of 65 brings the total employment impact of the hospital to 86 employees (55x1.32=50). Applying the income multipliers to the income (payroll including benefits)) for each of the health sector components yields an estimate of each component's income impact on the Delta Junction market area (**Chart XVIII 2**, columns 5, 6, and 7). The hospital has a total payroll of $5,000,000; applying the income multiplier of 1.17 brings the total hospital income impact to $5,850,000.

Income also has an impact on retail sales, and the health sector has its own distinct effect on retail sales. The local retail sales capture ratio is used to estimate the effect of the health sector on retail sales. This ratio indicates the percentage of personal income spent locally on items that generate local retail sales. This ratio is estimated to be 23% which would generate retail sales of $1,354,000 annually and increase accordingly with inflation over a period of time. The bottom line is the health sector not only contributes greatly to the medical health of the community, but also to the economic health of the community.

The economic impact of the health sector on the economy of Delta Junction and a new Critical Access

Hospital is tremendous. The health sector employs a large number of residents, similar to a large industrial firm. The secondary impact occurring in the community is extremely large and is a testament to the importance of the health sector. If the health sector increases or decreased in size, the medical health of the community, as well as the economic health of the community is really affected. For the attraction on industrial firms, businesses, and retirees, it is crucial that the area have a quality health sector. The fact that a prosperous health sector also contributes to the economic health of the community is often overlooked. This review did not include other parts of the health sector such as dental, eye care or chiropractic services.

Demographics and Economy	% Alaska	$ Alaska	% All U.S.	$ All U.S.
Population Living in Poverty	21%		21%	
Median annual Income		$ 61,872		$ 50,022
Participants in Food Stamps, Dec 2011	13.3%		15.2%	
Unemployment Rate, Dec 2011	7.3%		8.5%	

Implications: The economic impact on the community is significant and often times overlooked. Typically health care businesses will be in the top five for providing employment. In addition, the multiplying factor of jobs created and money spent are not noticed. As discussed above health care is a major factor in the local community health.

For communities to grow and bring in new business and support current business several factors are necessary. Number one is the availability of health care and emergency services to provide for day to day wellbeing. Number two on the list are good schools. Families looking to move to the community and work in the area are concerned for their families health and education needs.

Citical Access Hospital's
Frontier Extended Care Clinics Definitions

Critical Access Hospital (CAH)

Access to health care in rural America has been a persistent challenge. After World War Two, the availability of federal Hill Burton funds enabled rural communities across the country to build community hospitals. These hospitals became the source of critical emergency care, primary health services, and even secondary types of surgery. The hospitals also became important to the local economy, and were a vital source of jobs and economic development.

During the 1980s the federal government adopted a prospective payment system (PPS) for hospitals and physicians that threatened the future of rural hospitals across the country. Given the hospitals' fixed costs and limited volume, rural hospitals began to lose money year after year. During the period of the 1980s, hundreds of hospitals closed.

In the 1990s, a new type of hospital was developed in a special demonstration project in Montana. This new model limited the size and scope of the hospitals but provided cost-based reimbursement, which allowed the hospitals to succeed financially. This model was expanded nation-wide in the 1997's Balanced Budget Act, which created a new Critical Access Hospital (CAH) type and enabled cost-based reimbursement for both Medicare and Medicaid patients.

Critical Access Hospitals, as defined by the 1997 legislation and subsequent modifications , are small—no more than 25 beds— remote—at least 35 miles away from any other hospital--and limited in the number of days they can house a patient—no more than an average of 4 days. In return for the size and distance limitations, CAHs are reimbursed for Medicare and Medicaid patients at 101 per cent of actual cost of service, including capital funding and depreciation. By receiving payments for actual costs, most CAHs can create positive financial margins and provide services to the entire population in their service areas.

Today, there are more than 1320 critical access hospitals that have been designated in 45 states. In addition to the designation process, each state, with critical access hospitals, is given a grant (called the Medicare Rural Hospital Flexibility Grant) to support the critical access hospitals in their state. In Alaska the grant goes through the Alaska Department of Health. National technical assistance and resources are also available through the Technical Assistance and Services Center (TASC) which is federally funded through the National Rural Health Resource Center.

Properly led and efficiently operated, critical access hospitals have been shown to provide vital services and life-saving care to citizens in rural areas throughout the country, while also maintaining a positive bottom line. They have provided a core set of services that often includes the following:

- Primary medical care
- Chronic disease management
- Stabilization and transfer of the most acutely ill/injured patients
- Diagnostic services
- Specialty services, either on site or through telemedicine
- Emergency services
- A range of therapies, including physical and occupational therapies
- Workman's comp testing
- Wellness and preventative services
- Cardiac rehab and other rehab services
- Community health education
- Health information

In short, a critical access hospital can usually provide a full range of out-patient and in-patient services, and, where additional specialty care is required, can transfer patients to appropriate specialty centers.

In that regard, many CAHs have become part of larger health systems, thereby gaining access to additional expertise, capital and services.

Several studies have shown that the financial impact of a rural hospital on the local community and the region is substantial. Even the smallest of CAHs generate millions of dollars of revenue for the local economy, and are responsible for the creation of a hundred or more additional jobs. As a vital economic force, the CAH also attracts new businesses to the community and contributes to the attractiveness of the area for tourists and retirees.
Critical access hospitals are currently the backbone of rural America's health care delivery system. They are a vital part of this country's safety net, and are an important contributor to rural economies.

Frontier Extended Stay Clinics (FESC)

In 2006, Congress established the Frontier Extended Stay Clinic (FESC) Demonstration Project under the Medicare Modernization Act. The FESC model is designed to meet the needs of critically ill patients in remote wilderness areas

who, due to adverse weather or lack of transportation and cannot immediately be transferred to acute care referral centers. The model can also be used for patients in wilderness settings who need monitoring or observation for a limited period of time.

The request for the FESC model came out of Alaska, where inclement weather hindered the transfer of seriously ill or injured patients to medical centers. The clinic in Dutch Harbor, Alaska, for example, was often compelled to treat patients overnight, sometimes for days, before they could be safely transferred to Anchorage. Since there was no mechanism for paying for these overnight services, and since additional capabilities like access to oxygen were needed, the FESC model was forged to meet this wilderness need. Early models have been successfully implemented in Klawock, Dutch Harbor, Haines and Glennallen in Alaska, and in Friday Harbor in the state of Washington.

In the FESC model, Medicare will reimburse clinics for overnight treatment and associated services. To be eligible for FESC designation, clinics must be 75 miles or more from the nearest hospital or be inaccessible by public roads. On-site physician coverage is not required, but medical consultation must be available at all times. In addition, an RN must be immediately available in the FESC. FESC clinics are required to have appropriate equipment and oxygen available, and must be able to offer lab, and radiology services on site. FESCs must also have transfer agreements to larger medical centers in place, must provide for appropriate record keeping and must have ample space for ambulatory health care. In addition, FESC patient stays are limited to no more than 48 hours, either because the patient has improved or because the patient was transferred. This overnight capability saves money and lives, and can prevent expensive and inconvenient transport.

The relatively new Frontier Extended Stay Clinic Program has provided wilderness communities with another important option for health services and has expanded those services eligible for Medicare reimbursement. The FESC can be used for the traditional primary care services, chronic illness management, emergency medical services, diagnostic services, wellness and nutritional education, and overnight observation and treatment. It has provided Alaska communities with medical capabilities and services over and above those found in typical primary care clinics. In a sense, it has become a hybrid of the small hospital and the rural health clinic, providing limited overnight care when necessary and still not having to meet the extensive staffing and facility requirements of a hospital. And, FESC has provided a mechanism for isolated rural clinics to be paid for services and over-night observations. These were often compelled to perform for free, because of extreme weather and other wilderness barriers.

Despite the initial FESC successes, early models have reported difficulties in meeting and maintaining nursing staff requirements. Other key staffing positions have also been reported as difficult to fill, reflecting Alaska's documented shortage of health care professionals. Recent attempts have been made to convince the Center for Medicare Services (CMS) to relax the nursing staff requirements and to enable FESCs to substitute paramedics and other qualified nursing and EMS personnel, but these changes have not been made to date.

Implications: As we look at the two potential concepts for the health care model for Interior Alaska we must consider the current market conditions and utilization in the area. First, utilization of the Family Medical Care Center of Delta Junction currently captures 103 percent of the target market. In addition, the Tok clinic generates another 25 percent market capture. Together the capture rate is 128 percent within the market. Keep in mind that Delta Junction has 18 percent of patient visits from outside the market, and Tok would most likely follow the same pattern. Tourism and temporary workers make up this expanded market. A significant number of workers for large industrial operations do not show up in the census.

When we look at this total utilization and the number of medical practitioners located at the clinic in Delta Junction and Tok, the numbers drive our process toward the Critical Access Hospital model. Current clinic business, emergency department, laboratory, radiology and several specialty clinics provide for sufficient volume for the CAH model.

The market is more significant by way of utilization than what could be provided within a free standing Frontier Extended Care Clinic. In addition the demand for specialty services is significant and would be accommodated by the CAH model. The expanded availability of physical therapy and more advanced diagnostic equipment and potential for tele health make the CAH model the most practical.

The potential for utilization of the FECC model does exist on a short term basis once it moved from a trial program to a program approved by CMS. There will be a period of time needed to develop a CAH project and during this time the existing clinic (Family Medical Care Center) could function in that capacity. The advantage would be in collecting reimbursement more commiserate with the service provided for the emergency department, and would provide for short term observation and treatment of less than 48 hours.

Option One Space Programs and Source and Use of Funds
Option One 10 Acute 10 NCF Full Service Less OR

Introduction:

This facility program summarizes programming information based on demand analysis by McClure and Associates. The Interior Alaska Hospital Foundation is a new organization located in Delta Junction, Alaska to serve the market of Interior Alaska comprising approximately 70,000 square miles. Phone interviews with key clinic personnel have been employed in addition CEO's of Critical Access Hospitals in Alaska have been interviewed. Demographics and benchmarking have been utilized to size the market and medical need. Comparisons to other Critical Access Hospitals have been utilized. Projections for new space needs are the best assessment of the programmer using input from available sources in concert with experience and guidelines for norms in terms of square feet per function. All space has been reviewed clinically by Alicia K. McClure, BSN, RN and Renee Walburn, LPN, MHCA.

The Program is an important design tool that helps define the functioning of the hospital, the clinic and the services offered. The Program begins to define the scope of the project and communicates to architects, engineers and interior designers your ideas and ideals about what the hospital should be. It gives the Design Team a starting point for designing and serves as a check as the design progresses. The Program will change based on new insights over the course of the project development. These changes will be noted and added to the Design Team's in-house checklists. The Program also compares existing like facilities l space to space needed to accomplish the functions of IAHF. This communicates to the Design Team the general amount of space that would need to be designed for a new hospital; staffing, adjacencies and efficiencies are also considered. The approximate total square footage to be constructed assists the Team in developing early parameter budgets.

Immediately following is a summary of the Program with activity areas and rooms named and sized, departments identified and adjacencies noted. Please note that the nature of architectural design – and of budgets – is that not every desire is achievable. Compromise is part of the process. Communication allows all of the Design Team, including the Owner, to participate in determining those compromises. Foremost in all of our hearts and minds needs to be the importance of constantly asking, "what is best for those we serve?" and "what is best for those who provide our services?" as well as "what does this decision mean in terms of both short-term and long-term costs?"

Interior Alaska Hospital Foundation

Facility Program Facility Wide Issues

Location:

- The facility will be located in Delta Junction, Alaska approximately 125 miles south of Fairbanks, Alaska. A sight has not been chosen yet.

Site:

- A number of potential location are available in Delta Junction, a number of issues will need to be addressed.
- Extreme weather conditions, climate is cold arid with low temperatures down to 60 degrees Fahrenheit below zero.
- Utilities will have to be identified at a later date.

Miscellaneous:

- HIPAA compliance
- Handicap accessibility
- Flexibility/expandability
- Systems infrastructure that enables future growth and that can support digital radiography and telemetry.
- Mechanical/electrical systems that address code issues and are sized for future expansion
- Consider local vendors and trades in determining construction materials in design
- Address patient flow not only internally, but also in regard to pick-up, drop-off in such a way that is both efficient and that reinforces patient dignity.
- Segregate delivery traffic from all other

Summary by Department

Proposed	Total NSF	Grossing Factor	Total Departmental Gross SF
Pharmacy	740	1.25	925
Med-Surg	7,865	1.45	11404
Surg-PACU-SPD	0	0.00	0
Emergency	2,792	1.45	4048
Radiology	1,649	1.45	2391
CT	500	1.45	725
MRI	500	1.45	725
Clinical Lab/Path	1,255	1.30	1632
Respiratory Therapy	100	1.25	125
Physical Therapy	1,190	1.25	1488
Clinics	3,770	1.35	5090
Administration	1,360	1.30	1768
MIS/Information Stystem	660	1.25	825
Education	380	1.15	437
Medical Records	635	1.25	794
Medical Staff	440	1.25	550
Nutritional Services	1,370	1.25	1713
Material Mangement	1,060	1.15	1219
Laundry	0	0.00	0
Enviromental Services	790	1.15	909
Central Plant	2,300	1.15	2645
	28,616	39,411	
Building Gross Square Footage		1.20	47,293
Total Building Square Footage			86,704

Chart XIX
Option One 10 Acute 10 NCF Full Service Less OR
Source and Use of Funds

	Option One	47,295 Square feet	
	Source of Funds		
1	Equity Investors 10%	$ 3,319,711	10% of project cost line 28
2	Land from City	$ 280,000	
3	Cash From Loans	$ 35,604,990	
		$ 39,204,700	
	Use of Funds	**Amount**	
	Project Costs		
4	Land Cost Acquisition	$ 280,000	Donated by city
5	Other		
6	Total Architect & Eng.	$ 2,066,370	7.5% Lines 7, 8, 9, 10, 11
7	Fees and Permits	$ 10,000	Local
8	Landscaping	$ 50,000	Allowance
9	Site Survey	$ 35,500	
10	Site Work/	$ 5,154,937	
11	Hard Construction Cost	$ 22,133,124	20 bed minus OR
12	Soil Investigation	$ 100,000	
13	Materials Testing	$ 78,045	
14	Furniture, movable equipment	$ 750,000	
15	Med Equipment RAD, CT ECT.	$ 2,000,000	
16	On-Site Project Manager	$ -	
17	Contingency/Owner 2%	$ 647,560	2% Lines 6 through 16
18	Project Counsel	$ 15,000	Local organizational counsel
19	Other Counsel	$ 5,000	Consulting council
20	Marketing	$ 50,000	Pre opening education
21	Market Feasibility and CON	$ 150,000	Cost associated with CON
22	Financial Feasibility	$ 30,000	Required for CON
23	Development Fees	$ 499,133	1.50% of lines 6 through 23
24	Travel Reimbursement	$ 20,000	Organizational
25	Organization/Administration Cost	$ 50,000	
26	Capitalized Int-	$ -	
27	Development Loan	$ -	
28	**Total Project Cost**		$ 33,197,109

McClure and Associates, Inc.

LEO A DALY
PLANNING ARCHITECTURE ENGINEERING INTERIORS

Kiewit Building Group

LANCASTER POLLARD

Chart XIX Continued

Option One 10 Acute 10 NCF Full Service Less OR
Source and Use of Funds

	Option One	47,295 Square Feet		
	Cost of Financing			
29	Printing of Bonds/Official Statement	$ 5,000		
30	Underwriters Discount	$ 445,063		
31	Trustee Fees	$ 2,000		
32	Title and Recording	$ 27,500		
33	Real Estate Property Transfer Tax	$ -		
34	Mortgage Registration Tax	$ -		
35	Accounting	$ -		
36	Construction loan interest	$ -		
37	Issuer Fees	$ 35,605		
38	Miscellaneous Cost of Issuance	$ 252,824		
39	**Total Cost of Financing**		$	767,991
	Reserve Accounts:			
40	Bond Debt Service Reserves	$ 2,760,300		
41	Working Capital Reserve	$ -		
42	Capitalized Interest	$ 2,479,300		
43	Negative Arbitrage	$ -		
44	Capitalized Interest - Dev. Loan	$ -		
45	Capital Replacement Reserve	$ -		
46	**Total Reserve Accounts**		$5,239,600.00	
	Credit Enhancement/Tiff etc..			
	Fees			
47	Mortgage Insurance Premium Res.	$ -		
48	Application Fees	$ -		
49	Certification & Inspection	$ -		
50	Letter of Credit Origination Fee	$ -		
51	**Total Credit Enhancement Tiff**		$	-
52	**Total All Cost**		$ 39,204,700	

Option Two Space Programs and Source and Use of Funds
Option Two 6 Acute Full Service Less OR

Space Programs and Source and Use of Funds

Introduction:

This facility program summarizes programming information based on demand analysis by McClure and Associates. The Interior Alaska Hospital Foundation is a new organization located in Delta Junction, Alaska to serve the market of Interior Alaska comprising approximately 70,000 square miles. Phone interviews with key clinic personnel have been employed in addition CEO's of Critical Access Hospitals in Alaska have been interviewed. Demographics and benchmarking have been utilized to size the market and medical need. Comparisons to other Critical Access Hospitals have been utilized. Projections for new space needs are the best assessment of the programmer using input from available sources in concert with experience and guidelines for norms in terms of square feet per function. All space has been reviewed clinically by Alicia K. McClure, BSN, RN and Renee Walburn, LPN, MHCA.

The Program is an important design tool that helps define the functioning of the hospital, the clinic and the services offered. The Program begins to define the scope of the project and communicates to architects, engineers and interior designers your ideas and ideals about what the hospital should be. It gives the Design Team a starting point for designing and serves as a check as the design progresses. The Program will change based on new insights over the course of the project development. These changes will be noted and added to the Design Team's in-house checklists. The Program also compares existing like facilities l space to space needed to accomplish the functions of IAHF. This communicates to the Design Team the general amount of space that would need to be designed for new hospital; staffing, adjacencies and efficiencies are also considered. The approximate total square footage to be constructed assist the Team in developing early parameter budgets.

Immediately following is a summary of the Program with activity areas and rooms named and sized, departments identified and adjacencies noted. Please note that the nature of architectural design – and of budgets – is that not every desire is achievable. Compromise is part of the process. Communication allows all of the Design Team, including the Owner, to participate in determining those compromises. Foremost in all of our hearts and minds needs to be the importance of constantly asking, "what is best for those we serve?" and "what is best for those who provide our services?" as well as "what does this decision mean in terms of both short-term and long-term costs?"

Interior Alaska Hospital Foundation

Facility Program Facility Wide Issues

Location:

- The facility will be located in Delta Junction, Alaska approximately 125 miles south of Fairbanks, Alaska. A sight has not been chosen yet.

Site:

- A number of potential location are available in Delta Junction, a number of issues will need to be addressed
- Extreme weather conditions, climate is cold arid with low temperatures down to 60 degrees Fahrenheit below zero.
- Utilities will have to be identified at a later date.

Miscellaneous:

- HIPAA compliance
- Handicap accessibility
- Flexibility/expandability
- Systems infrastructure that enables future growth and that can support digital radiography and telemetry
- Mechanical/electrical systems that address code issues and are sized for future expansion
- Consider local vendors and trades in determining construction materials in design
- Address patient flow not only internally, but also in regard to pick-up, drop-off in such a way that is both efficient and that reinforces patient dignity.
- Segregate delivery traffic from all other

Summary by Department

Proposed	Total NSF	Grossing Factor	Total Depart GSF
Pharmacy	740	1.25	925
Med-Surg	3,984	1.45	5777
Surg-PACU-SPD	0	0.00	0
Emergency	2,792	1.45	4048
Radiology	1,649	1.45	2391
CT	500	1.45	725
MRI	500	1.45	725
Clinical Lab/Path	1,255	1.30	1632
Respiratory Therapy	100	1.25	125
Physical Therapy	1,190	1.25	1488
Clinics	3,770	1.35	5090
Administration	1,360	1.30	1768
MIS/Information Stystem	660	1.25	825
Education	380	1.15	437
Medical Records	635	1.25	794
Medical Staff	440	1.25	550
Nutritional Services	1,370	1.25	1713
Material Mangement	1,060	1.15	1219
Laundry	0	0.00	0
Enviromental Services	790	1.15	909
Central Plant	2,300	1.15	2645
	24,735		33,784
Building Gross Square Footage		1.20	40,540
Total Building Square Footage			74,324

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LANCASTER POLLARD

Chart XX
Option Two 6 Acute With Out OR
Source and Use of Funds
Interior Alaska Hospital Foundation

	Option Two Source of Funds	40,540 Square Feet	
1	Equity Investors 10%	$ 3,421,993	
2	Land from City	$ 280,000	
3	Cash From Loans	$ 30,517,938	
		$ 34,219,931	
	Use of Funds	**Amount**	
	Project Costs		
4	Land Cost Acquisition	$ 280,000	
5	Other		
6	Total Architect & Eng.	$ 1,774,134	7.5% Lines 7, 8, 9, 10, 11
7	Fees and Permits	$ 10,000	
8	Landscaping	$ 50,000	
9	Site Survey	$ 35,500	
10	Site Work/	$ 4,418,860	
11	Hard Construction Cost	$ 18,972,720	20 bed minus OR
12	Soil Investigation	$ 100,000	
13	Materials Testing	$ 78,045	
14	Furniture, movable equipment	$ 750,000	
15	Med Equipment RAD, CT ECT.	$ 2,000,000	
16	On-Site Project Manager	$ -	
17	Contingency/Owner 2%	$ 563,785	2% Lines 6 through 16
18	Project Counsel	$ 15,000	
19	Other Counsel	$ 5,000	
20	Marketing	$ 50,000	
21	Market Feasibility and CON	$ 150,000	
22	Financial Feasibility	$ 30,000	
23	Development Fees	$ 435,046	1.50% of lines 6 through 23
24	Travel Reimbursement	$ 20,000	
	Organization/Administration	$	

Chart XX Continued
Option Two 6 Acute With Out OR
Source and Use of Funds
Interior Alaska Hospital Foundation

	Cost of Financing			
28	Printing of Bonds/Official Statement	$	5,000	
29	Underwriters Discount	$	388,063	
30	Trustee Fees	$	2,000	
31	Title and Recording	$	27,500	
32	Real Estate Property Transfer Tax	$	-	
33	Mortgage Registration Tax	$	-	
34	Accounting	$	-	
35	Construction loan interest	$	-	
36	Issuer Fees	$	31,045	
37	Miscellaneous Cost of Issuance	$	253,369	
	Total Cost of Financing			$ 706,976
	Option One	**47,293 Square Ft.**		
	Reserve Accounts:			
38	Bond Debt Service Reserves	$	2,406,900	
39	Working Capital Reserve	$	-	
40	Capitalized Interest	$	2,161,750	
41	Negative Arbitrage	$	-	
42	Capitalized Interest - Dev. Loan	$	-	
43	Capital Replacement Reserve	$	-	
	Total Reserve Accounts			$ 4,568,650.00
	Credit Enhancement/Tiff etc..			
	Fees			
44	Mortgage Insurance Premium Res.	$	-	
45	Application Fees	$	-	
46	Certification & Inspection	$	-	
47	Letter of Credit Origination Fee	$	-	
48	**Total Credit Enhancement Tiff**			$ -
49	**Total All Cost**			$ 34,219,931

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Option Three Space Programs and Source and Use of Funds
Option Three 10 Acute 10 NCF Full Service OR

Introduction:

This facility program summarizes programming information based on demand analysis by McClure and Associates. The Interior Alaska Hospital Foundation is a new organization located in Delta Junction, Alaska to serve the market of Interior Alaska comprising approximately 70,000 square miles. Phone interviews with key clinic personnel have been employed in addition CEO's of Critical Access Hospitals in Alaska have been interviewed. Demographics and benchmarking have been utilized to size the market and medical need. Comparisons to other Critical Access Hospitals have been utilized. Projections for new space needs are the best assessment of the programmer using input from available sources in concert with experience and guidelines for norms in terms of square feet per function. All space has been reviewed clinically by Alicia K. McClure, BSN, RN and Renee Walburn, LPN, MHCA.

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Immediately following is a summary of the Program with activity areas and rooms named and sized, departments identified and adjacencies noted. Please note that the nature of architectural design – and of budgets – is that not every desire is achievable. Compromise is part of the process. Communication allows all of the Design Team, including the Owner, to participate in determining those compromises. Foremost in all of our hearts and minds needs to be the importance of constantly asking, "what is best for those we serve?" and "what is best for those who provide our services?" as well as "what does this decision mean in terms of both short-term and long-term costs?"

Interior Alaska Hospital Foundation

Facility Program Facility Wide Issues

Location:

- The facility will be located in Delta Junction, Alaska approximately 125 miles south of Fairbanks, Alaska. A sight has not been chosen yet.

Site:

- A number of potential location are available in Delta Junction, a number of issues will need to be addressed.
- Extreme weather conditions, climate is cold arid with low temperatures down to 60 degrees Fahrenheit below zero.
- Utilities will have to be identified at a later date.

Miscellaneous:

- HIPAA compliance
- Handicap accessibility
- Flexibility/expandability
- Systems infrastructure that enables future growth and that can support digital radiography and telemetry.
- Mechanical/electrical systems that address code issues and are sized for future expansion
- Consider local vendors and trades in determining construction materials in design
- Address patient flow not only internally, but also in regard to pick-up, drop-off in such a way that is both efficient and that reinforces patient dignity.
- Segregate delivery traffic from all other

Summary by Department

Proposed	Total NSF	Grossing Factor	Total Departmental Gross SF
Pharmacy	740	1.25	925
Med-Surg	7,865	1.45	11404
Surg-PACU-SPD	3,007	1.45	4360
Emergency	2,792	1.45	4048
Radiology	1,649	1.45	2391
CT	500	1.45	725
MRI	500	1.45	725
Clinical Lab/Path	1,255	1.30	1632
Respiratory Therapy	100	1.25	125
Physical Therapy	1,190	1.25	1488
Clinics	3,770	1.35	5090
Administration	1,360	1.30	1768
MIS/Information Stystem	660	1.25	825
Education	380	1.15	437
Medical Records	635	1.25	794
Medical Staff	440	1.25	550
Nutritional Services	3,386	1.45	4910
Material Mangement	1,060	1.15	1219
Laundry	680	1.15	782
Enviromental Services	790	1.15	909
Central Plant	2,300	1.15	2645
	34,319		47,750
Building Gross Square Footage		1.20	57,300

Chart XXI
Option Three 10 Acute 10 NCF Full Service With OR
Source and Use of Funds

	Option Three	57,300 Square FT.	
	Source of Funds		
1	Equity Investors 10%	$ 3,925,766	10% of project cost line 28
2	Land from City	$ 280,000	
3	Cash From Loans	$ 42,067,765	
		$ 46,273,531	
	Use of Funds	**Amount**	
	Project Costs		
4	Land Cost Acquisition	$ 280,000	Donated by city
5	Other		
6	Total Architect & Eng.	$ 2,494,628	7.5% Lines 7, 8, 9, 10, 11
7	Fees and Permits	$ 10,000	Local
8	Landscaping	$ 50,000	Allowance
9	Site Survey/Soil Invest.	$ 35,000	
10	Site Work/	$ 6,245,700	
11	Hard Construction Cost	$ 26,931,000	20 bed minus OR
12	Soil Investigation	$ 100,000	
13	Materials Testing	$ 78,045	
14	Furniture ,movable equipment	$ 1,000,000	
15	Med Equipment RAD, CT ECT.	$ 1,500,000	
16	On-Site Project Manager	$ -	
17	Contingency/Owner 2%	$ 768,887	2% Lines 6 through 16
18	Project Counsel	$ 15,000	Local organizational counsel
19	Other Counsel	$ 5,000	Consulting council
20	Marketing	$ 50,000	Pre opening education
21	Market Feasibility and CON	$ 150,000	Cost associated with CON
22	Financial Feasibility	$ 30,000	Required for CON
23	Development Fees	$ 493,291	1.50% of lines 6 through 23
24	Travel Reimbursement	$ 20,000	Organizational
25	Organization/Administration Cost	$ 50,000	
26	Capitalized Int-	$ -	
27	Development Loan		
28	**Total Project Cost**		$ 39,257,663

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LANCASTER POLLARD

Chart XXI Continued
Option Three 10 Acute 10 NCF Full Service With OR
Source and Use of Funds

	Option Three Source of Funds	57,300 Square FT.		
	Cost of Financing			
29	Printing of Bonds/Official Statement	$ 5,000		
30	Underwriters Discount	$ 523,688		
31	Trustee Fees	$ 2,000		
32	Title and Recording	$ 27,500		
33	Real Estate Property Transfer Tax	$ -		
		$		
34	Mortgage Registration Tax	-		
35	Accounting	$ -		
36	Construction loan interest	$ -		
37	Issuer Fees	$ 41,895		
38	Miscellaneous Cost of Issuance	$ 251,936		
39	**Total Cost of Financing**		$	852,018
	Reserve Accounts:			
40	Bond Debt Service Reserves	$ 3,246,600		
41	Working Capital Reserve	$ -		
42	Capitalized Interest	$ 2,917,250		
43	Negative Arbitrage	$ -		
44	Capitalized Interest - Dev. Loan	$ -		
45	Capital Replacement Reserve	$ -		
46	**Total Reserve Accounts**		$ 6,163,850.00	
	Credit Enhancement/Tiff etc..			
	Fees			
47	Mortgage Insurance Premium Res.	$ -		
48	Application Fees	$ -		
49	Certification & Inspection	$ -		
50	Letter of Credit Origination Fee	$ -		
51	**Total Credit Enhancement Tiff**		$	-
52	**Total All Cost**		$ 46,273,531	

Space Plan and Source and Use of Funds Implications: We have planned and prepared estimates three options. All the options have a number of areas that are the same. All would have the same clinic space, emergency department, radiology, laboratory, physical therapy and support areas such as food service, administration and business office are all the same.

Option One has a configuration of 10 acute rooms all private, 10 nursing care facility rooms all private and no operating room or associated function spaces. This plan has 47,293 square feet with a total estimated cost including all hard, soft and financing as explained in the source and use of funds of $39,204,700.

Option Two has 6 acute rooms all private, does not have an operating room and associated function spaces. This plan has 40,540 square feet with a total estimated cost including all hard, soft and financing as explained in the source and use of funds of $34,219,931.

Option Three has 10 acute rooms all private, 10 nursing care facility rooms all private and a full service operating room and associated function spaces. In addition this model has a full service nutrition center and laundry. This plan has 57,300 square feet with a total estimated cost including all hard, soft and financing as explained in the source and use of funds of $46,273,531.

As we were planning space and taking into consideration the high cost of construction due to remoteness and extreme weather, we looked at ways to reduce the total square footage. Options one and two have adapted to a food service using re-therm technology of specialized contracted meals thus reducing the space requirements for kitchen and bulk storage. Laundry would be contracted commercially to again reduce the amount of square footage.

Two of the options have no operating room (OR) however any of the hospital models will have planned expansion space available for handling future growth.

At this stage there are several contingency funds built into the project, the list of items not covered under construction cost in some cases may be in the budget such as material testing, surveys, furnishings, medical equipment among others. At this point the exercise is to be at a reasonable number that would become more quantified if and when the process continues. It is the intention to be high at this point however due to the unknown of projecting in the future and the potential of a volatile market these are strictly estimates.

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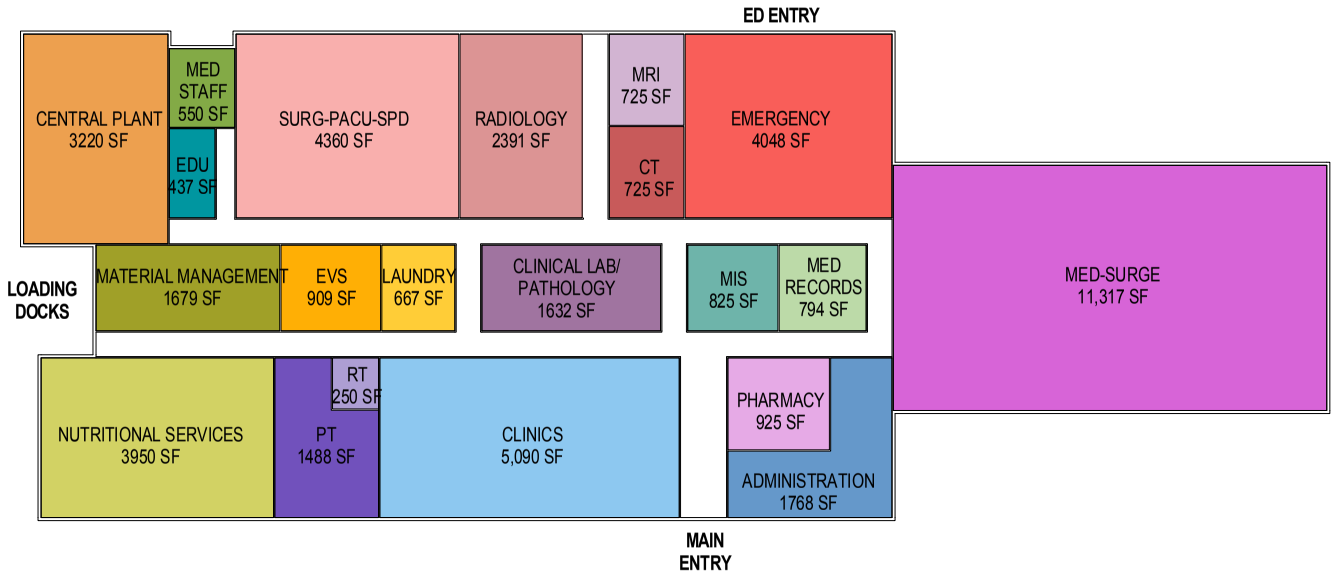

CONCEPTUAL BLOCK PLAN

SCALE: 1" = 50'-0"

CONCEPTUAL BLOCK PLAN

04/17/12

DELTA JUNCTION ALASKA
CRITICAL ACCESS HOSPITAL AND CLINIC

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RFP Item 3: Evaluate financial feasibility as to construction and operation of a full service hospital; and potential conversion to Critical Access Hospital.

A Critical Access Hospital is a full service hospital with a special designation for reimbursement purposes under the Medicare program. This program is essential for successful operation in rural and remote areas; the CAH model has been described in detail earlier in this section. The other option is the Frontier Extended Care Clinic model which was also described in detail in this section. Do to market volumes we have chosen to focus on the CAH model with 10 acute beds and 10 long term care beds within a full service environment less the operating room.

Volumes are described in detail in Block 1. Volumes have a historic basis with clinic operations.

Chart XXIII

Estimated Statement of Income and Expense
CAH Model 10 Acute 10 Long Term Care Full Service No OR

Based on Projected Volumes
Comparable to two
Alaska CAH

Income Statement	**First Year**
Inpatient Revenue	$7,200,000
Outpatient Revenue	$9,800,000
Total Patient Revenue	$17,000,000
Contractual Allowance (Discounts)	$1,360,000
Net Patient Revenues	$15,640,000
Total Operating Expense	$14,700,000
Operating Income	$940,000
Other Income	$ -
Income From Investments	$100,000
Governmental Appropriations	$ -
Miscellaneous Non-Patient Revenue	$100,000
Total Non-Patient Revenue	$200,000
Total Other Expenses	$ -
Net Income or (Loss)	$1,140,000
Depreciation Expense (Included above)	$1,750,000
Funds Available for Debt Service and Reserves NOI and Depreciation	$2,890,000

First Year includes inflation two years out

The CAH cost based reimbursement system allows for capital cost and depreciation for all business associated with Medicare. Additional revenue for capital is through positive margins, potential other income, contributions, sponsors support, governmental support.

Using several Alaska CAH that have comparable markets and volumes were used for a comparative analysis. In addition we assumed that the hospital would be managed or leased by a proven professional management company or larger health system. Under proper leadership the project can be successful.

Financing Avenues

RFP Item 5: Investigate and report on possible avenues of financing (both public and private) for pre-construction and construction phases of a building project.

The source and use of funds section on financing was completed by Lancaster Pollard. The pre-construction and construction phases of the project have been included in this part including capitalization of interest during construction. Expenditures that occur before loan proceeds are acquired can be paid back to the foundation. A resolution will need to be passed when the foundation completes their legal corporate registrations.

There will be available a variety of financing options available depending on the legal entity that ownership will be in. If it is owned by a sub-division of government then it will be a General Obligation Bond, USDA or HUD 242.

If it is owed by a not-for-profit then Revenue Bonds, USDA, HUD242 and or combinations of all three sources would be used. Final determination on types of foundation would be made during the Certificate of Need Stage.

RFP Item 6: Make recommendations summary as to proceeding with the project and submitting Certificate of Need to the State Of Alaska.

RECOMMENDATIONS SUMMARY

The following recommendations are made on the assumptions derived from the above documentation. The information represents a variety of demographic and statistical information from a variety of sources. Sources for data and assumptions are included in the appendix of this document. Sizing of the project has been based on the data collected; in addition comparisons have been made to several current Critical Access Hospitals in Alaska with similar markets. Financially at this time looking at like size market and utilization of current Alaska CAH's, the facility would most likely cash flow. The development of complete operational budgets and presented to a CPA firm specializing in CAH cost reports for CMS would take place in the next piece which would be the Certificate of Need assessment.

- Population within the defined market is sufficient to support a CAH.
- Current clinic statistical information on utilization is greater than those in many current CAH markets
- Established physicians and mid-level staff are currently providing service in the area.
- The local area has other health professionals such as RN, LPN, and Certified Medical Technicians and currently the Family Medical Center staff meet the requirements for a level 4 trauma center even though they cannot be certified because they are not a hospital.

At this time it would not be appropriate to have a surgery center in the operation, however, planning should encompass the addition if and when surgery would be practical. The distance to Fairbanks and Anchorage and low volumes would not be practical.

1. The Interior Alaska Hospital Foundation (IAHF) would be the catalyst of the development of a Critical Access Hospital.
   a. The foundation could be the owner of the project as a 501 c3 corporation. Several alternatives exist, they could raise the equity required for financing, and financing would be accomplished with tax exempt bonds or USDA loans. The foundation would need to hire a well-recognized management group that understands the different circumstances of the market.
   b. The same option as above but partnering with a larger hospital organization that would be willing to make some guarantee on the loan. In this case the partnering organization would likely be the management of the facility and would have an interest in developing a close relationship to capture the outpatient market of which they would be able to provide onsite specialty clinics, tele-medicine specialty clinics and providing the backbone to all diagnostic services and surgical business.
   c. The foundation could lease the CAH to a sponsoring organization that was willing to make guarantees of the loan and provide for all operations including all expenses and loan payment guarantees.
   d. After discussion with a significant private foundation, and sharing some data on need and remoteness there is a strong believe that significant potential exist to secure grant monies from multiple foundations.

2. The Interior Alaska Hospital Foundation (IAHF) would decide the next step of development which would be identification of potential partnering larger hospitals, in addition starting a dialog with the State of Alaska on what participation they may be willing to pursue to provide health services to the vast area of interior Alaska. There is a comprehensive need to assure that the area be able to sustain a reasonable safe living environment with the large military presence and the importance of the industrial base such as mining and the oil pipe-line. The area strategically is of high interest in the area of National Security, and in reality should be on the radar screen nationally.

3. Once identification and partnering strategies have been determined the need would be to complete the certificate need process of which a significant piece is completed. How this would play out would be determined on who

would be the members of the team and maintaining local control to assure the local interest but at the same time bring in the expertise to move forward with a successful project.

4. At some point during developing partnering strategies, serious discussions need to be developed with the health care contractors from Fort Greely. The base already leases space from the clinic and will continue to have the need. In addition they will be a significant user of imaging diagnostic, laboratory and a desire to have active physical therapy available for the solders instead of the long distance they currently travel for service.

5. Development of local stakeholders will be a key element for attracting potential partners for development. They will want to see local commitment before they will be willing to make large investments in the venture. In addition if the State of Alaska decides to provide assistance I am sure they will also want to see the depth of local commitment.

6. A separate document will be developed outlining the Certificate of Need process and time lines.

Interior Alaska Hospital Foundation Function

The function of the foundation is greater than securing a hospital for the community. It encompasses a number of other areas that are crucial to the wellbeing of the citizens of Interior Alaska. As has been mentioned throughout the report there are other areas of concern that need to be addressed. Some of these will eventually become rolled into the Critical Access Hospital. At this time several areas need to be addressed which I will list below.

- Community education of what the foundation is trying to do in the community. Many do not understand the need and why the medical community needs expansion to better meet the needs of Interior Alaska. As part of the education process enlarging the membership should be one of the main objectives.
- Bringing in outside resources will require local support and leadership to assure whoever it may be that there is commitment not only of time but also financial support.
- There is a need to look at the issues of mental health with the high level of suicide and teen deaths. Local identification of concerns with mental health is paramount for a healthy community.
- Development of a wellness and nutrition program in conjunction with local organizations such as the school system and senior service providers.
- Development of health screening testing for diabetes, heart disease, stroke prevention, and other areas that would identify issues with those that are not at this time actively maintaining good health practices.
- Development of chronic disease management system that will allow the public to have accountability and improve their medical conditions.
- Identifying other aspects of health delivery to better serve the community.
- This document represents the finding of a variety of facts and assumptions and in no way completely represents all aspects of the market and further more does not offer any guarantees either specified or implied.

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Chart I
Demographics
Market Service Area
Population by Age

Description	2000 Census	Percent	2011 Estimate	Percent	2016 Projection	Percent
	5,228		5,820		6,036	
Age 0 - 4	386	7.38%	510	8.76%	527	8.73%
Age 5 - 9	473	9.05%	520	8.93%	525	8.70%
Age 10 - 14	577	11.04%	449	7.71%	453	7.50%
Age 15 - 17	313	5.99%	318	5.46%	294	4.87%
Age 18 - 20	191	3.65%	206	3.54%	210	3.48%
Age 21 - 24	220	4.21%	340	5.84%	389	6.44%
Age 25 - 34	613	11.73%	635	10.91%	687	11.38%
Age 35 - 44	870	16.64%	739	12.70%	660	10.93%
Age 45 - 54	817	15.63%	85(	14.71%	798	13.22%
Age 55 - 64	448	8.57%	707	12.15%	764	12.66%
Age 65 - 74	209	4.00%	369	6.34%	487	8.07%
Age 75 - 84	93	1.78%	142	2.44%	196	3.25%
Age 85 and over	18	0.34%	29	0.50%	46	0.76%
Age 16 and over	3,669	70.18%	4,220	72.51%	4,416	73.16%
Age 18 and over	3,479	66.55%	4,023	69.12%	4,237	70.20%
Age 21 and over	3,288	62.89%	3,817	65.58%	4,027	66.72%
Age 65 and over	320	6.12%	540	9.28%	729	12.08%

Chart II
Demographics
Market Service Area
Male Population

Description	2000 Census	Percent	2011 Estimate	Percent	2016 Projection	Percent
	2,708		3,020		3,088	
Age 0 - 4	198	7.31%	255	8.44%	262	8.48%
Age 5 - 9	244	9.01%	276	9.14%	281	9.10%
Age 10 - 14	265	9.79%	227	7.52%	238	7.71%
Age 15 - 17	172	6.35%	171	5.66%	153	4.95%
Age 18 - 20	98	3.62%	106	3.51%	102	3.30%
Age 21 - 24	128	4.73%	171	5.66%	201	6.51%
Age 25 - 34	306	11.30%	348	11.52%	353	11.43%
Age 35 - 44	438	16.17%	380	12.58%	351	11.37%
Age 45 - 54	441	16.29%	429	14.21%	391	12.66%
Age 55 - 64	255	9.42%	378	12.52%	389	12.60%
Age 65 - 74	104	3.84%	205	6.79%	261	8.45%
Age 75 - 84	50	1.85%	59	1.95%	89	2.88%
Age 85 and over	9	0.33%	15	0.50%	17	0.55%
Age 16 and over	1,936	71.49%	2,201	72.88%	2,251	72.90%
Age 18 and over	1,829	67.54%	2,091	69.24%	2,154	69.75%
Age 21 and over	1,731	63.92%	1,985	65.73%	2,052	66.45%
Age 65 and over	163	6.02%	279	9.24%	367	11.88%

Chart III
Demographics
Market Service Area
Female Population

Description	2000 Census	Percent	2011 Estimate	Percent	2016 Projection	Percent
	2,520		2,800		2,948	
Age 0 - 4	188	7.46%	255	9.11%	265	8.99%
Age 5 - 9	229	9.09%	244	8.71%	244	8.28%
Age 10 - 14	312	12.38%	222	7.93%	215	7.29%
Age 15 - 17	141	5.60%	147	5.25%	141	4.78%
Age 18 - 20	93	3.69%	100	3.57%	108	3.66%
Age 21 - 24	92	3.65%	169	6.04%	188	6.38%
Age 25 - 34	307	12.18%	287	10.25%	334	11.33%
Age 35 - 44	432	17.14%	359	12.82%	309	10.48%
Age 45 - 54	376	14.92%	427	15.25%	407	13.81%
Age 55 - 64	193	7.66%	329	11.75%	375	12.72%
Age 65 - 74	105	4.17%	164	5.86%	226	7.67%
Age 75 - 84	43	1.71%	83	2.96%	107	3.63%
Age 85 and over	9	0.36%	14	0.50%	29	0.98%
Age 16 and over	1,733	68.77%	2,019	72.11%	2,165	73.44%
Age 18 and over	1,650	65.48%	1,932	69.00%	2,083	70.66%
Age 21 and over	1,557	61.79%	1,832	65.43%	1,975	66.99%
Age 65 and over	157	6.23%	261	9.32%	362	12.28%

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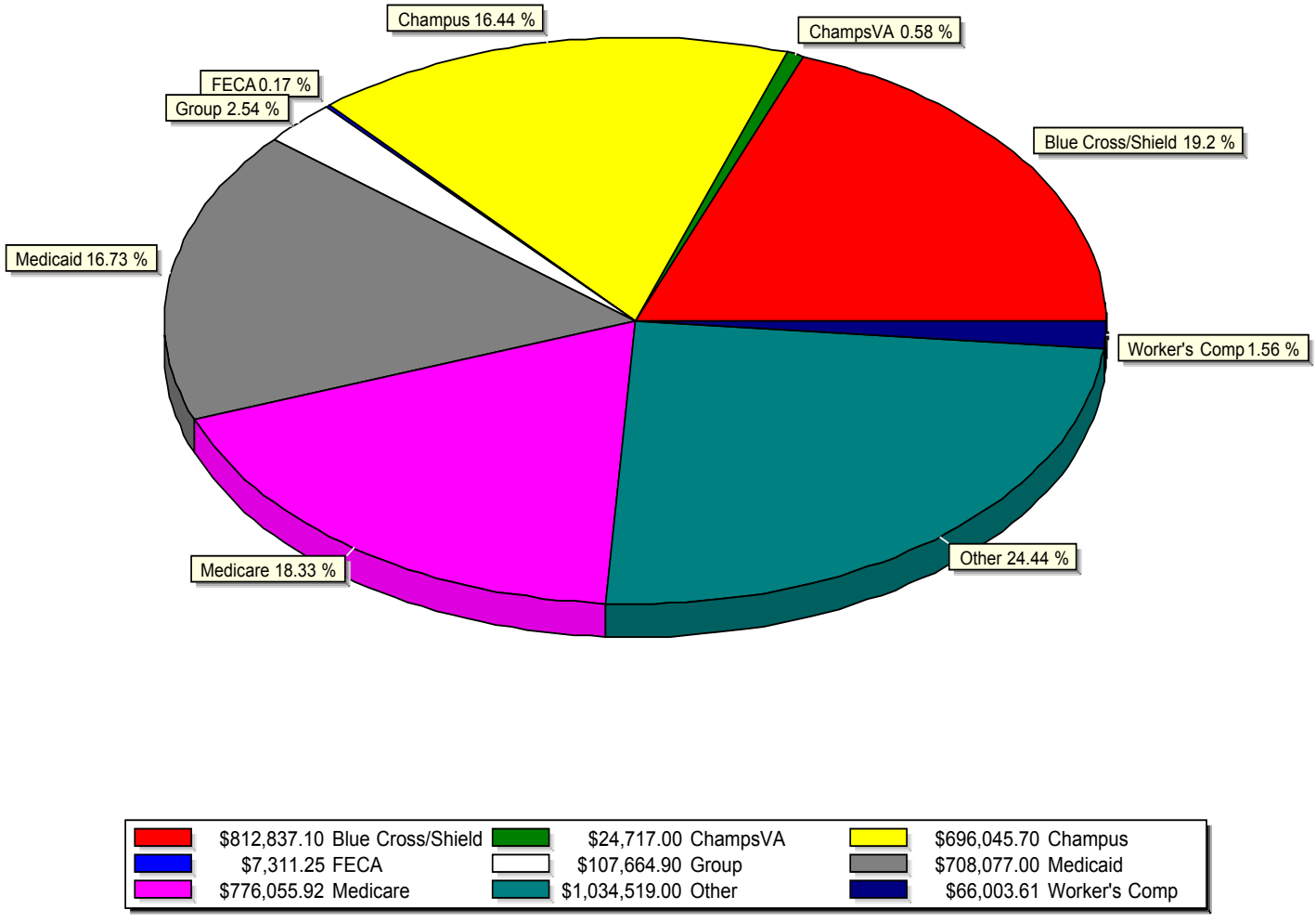
Charges by Insurance Type

Family Medical Center

Show all data where the Date From is between 10/1/2010, 9/30/2011



Study Sources

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U.S. Department of Health and Human Services

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National Institute of Diabetes and Digestive and Kidney Disease

National Institutes of Health

Centers for Medicare & Medicaid Services

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