HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: # 12-22A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title:	**Acquisition of Robotic Surgical System**
Project Address:	**98-1079 Moanalua Road, Aiea, HI 96701**
Applicant Facility/Organization:	**Pali Momi Medical Center**
Name of CEO or equivalent:	**Jen Chahanovich**
Title:	**Chief Operating Officer (COO)**
Address:	**98-1079 Moanalua Road, Aiea, HI 96701**

Phone Number: **(808) 485-4434** Fax Number: **(808) 485-4400**

Contact Person for this Application:	**Michael Robinson**
Title:	**Executive Director, Government Affairs**
Address:	**55 Merchant Street, 26th Floor, Honolulu, HI 96813**

Phone Number: **(808) 535-7124** Fax Number: **(808) 535-7111**

CERTIFICATION BY APPLICANT

I hereby attest that I reviewed the application and have knowledge of the content and the information contained herein. I declare that the project described and each statement amount and supporting documentation included is true and correct to the best of my knowledge and belief.

Signature — Date: 8/29/12

Ray Vara — **President & CEO of Operations**

Name (please type or print) — Title (please type or print)

1. **TYPE OF ORGANIZATION**: (Please check all applicable)

Public	____
Private	X
Non-profit	X
For-profit	____
Individual	____
Corporation	X
Partnership	____
Limited Liability Corporation (LLC)	____
Limited Liability Partnership (LLP)	____
Other: _____	____

2. **PROJECT LOCATION INFORMATION**

A. Primary Service Area(s) of Project: (please check all applicable)

Statewide:	____
O`ahu-wide:	____
Honolulu:	X
Windward O`ahu:	____
West O`ahu:	X
Maui County:	____
Kaua`i County:	____
Hawai`i County:	____

3. **DOCUMENTATION** (Please attach the following to your application form):

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent)

- [not required – project located onsite at Pali Momi Medical Center]

B. A listing of all other permits or approvals from other government bodies (federal, state, county) that will be required before this proposal can be implemented (such as building permit, land use permit, etc.).

-Certificate of Need, State Health Planning & Development Agency

C. Your governing body: list by names, titles and address/phone numbers

-See Attachment A

D. If you have filed a Certificate of Need Application this current calendar year, you may skip the four items listed below. All others, please provide the following:
- Articles of Incorporation: **See Attachment B**
- By-Laws: **See Attachment B**
- Partnership Agreements: **Not Applicable**
- Tax Key Number: **1-9-8-16:57**

4. **TYPE OF PROJECT.** This section helps our reviewers understand what type of project you are proposing. Please place an "x" in the appropriate box.

	Used Medical Equipment (over $400,000)	New/Upgraded Medical Equip. (over $1 million)	Other Capital Project (over $4 million)	Change in Service	Change in Beds
Inpatient Facility		(X)			
Outpatient Facility					
Private Practice					

5. **BED CHANGES.** Please complete this chart only if your project deals with a change in your bed count and/or licensed types. Again, this chart is intended to help our reviewers understand at a glance what your project would like to accomplish. Under the heading "Type of Bed," please use only the categories listed in the certificate of need rules.

Type of Bed	Total	Proposed Beds for your Project	Total Combined Beds if your Project is Approved
Medical/Surgical			
Critical Care			
Obstetric			
Pediatric			
Neonatal ICU			
TOTAL	N/A	N/A	N/A

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	N/A
2.	Construction Contract	$ 0
3.	Fixed Equipment	$ 1,800,000
4.	Movable Equipment	$ 184,500
5.	Financing Costs	_____
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	_____
7.	Other:	$ 0
	TOTAL PROJECT COST:	**$ 1,984,500**

B. Source of Funds

1.	Cash	$ 1,984,500
2.	State Appropriations	_____
3.	Other Grants	_____
4.	Fund Drive	_____
5.	Debt	_____
6.	Other: _____	_____
	TOTAL SOURCE OF FUNDS:	**$ 1,984,500**

7. **CHANGE OF SERVICE: If you are proposing a change in service, then please briefly list what services will be added/modified. Be sure to include the establishment of a new service or the addition of a new location of an existing service. Please reference the Certificate of Need Rules Section 11-186-5 for the categories of services. If you are unable to determine which category best describes your project, please consult with agency staff.**

This project does not involve the establishment of a new service or a new location of an existing service. The project does exceed the $1,000,000 capital cost threshold related to the purchase of new equipment.

8. **IMPLEMENTATION SCHEDULE:** Please present a projected time schedule for the completion of this project from start to finish. Include all of the following items that are applicable to your project:

a) Date of site control for the proposed project: **N/A**
b) Dates by which other government approvals/permits will be applied for and received: **N/A**
c) Dates by which financing is assured for the project: **N/A**
d) Date construction will commence: **N/A**
e) Length of construction period: **N/A**
f) Date of completion of the project: **October 1, 2012**
g) Date of commencement of operation: **October 15, 2012**

Please remember that the Agency does monitor the implementation of Certificates approved. Non-implementation of a project as described in your application may result in a fine and/or withdrawal of the certificate of need.

9. **EXECUTIVE SUMMARY: Please present a brief summary of your project. In addition, provide a description of how your project meets each of the certificate of need criteria listed below. If a new location is proposed, please attach an easy to read map that shows your project site.**

This application involves the purchase of a robotic surgical system which will assist our surgeons performing minimally invasive surgery.

a) Relationship to the State of Hawai'i Health Services and Facilities Plan

The proposed project meets the Statewide Health Coordinating Council (SHCC) priorities. Specifically, the proposed project meets the SHCC priority to "ensure that any proposed service will at least maintain overall access to quality health care at a reasonable cost." The addition of the surgical robot will provide greater access to higher quality specialized surgical services to all adult patients through greater access to this surgical device.

The proposed project also meets the needs of the West O'ahu SAC to improve and increase access to acute and critical care services. The enhanced surgical quality provided with the addition of this equipment will provide higher quality care closer to home for patients of West O'ahu.

b) Need and Accessibility

The proposed project will be used to enhance the quality and efficiency of general, gynecologic, urologic, bariatric and thoracic procedures performed by our surgeons. The robotic surgical system will facilitate minimally invasive surgery resulting in faster recovery times and will reduce the possibility of surgical infections for our patients. As a non-profit health care provider, Pali Momi will provide access to this service to all residents of the area, and in particular the elderly, low income persons, racial and ethnic minorities, women, persons with disabilities, and other underserved groups.

c) Quality of Service/Care

The proposed equipment purchase will ensure that superior clinical outcomes and excellence are maintained. This equipment will better enable minimally invasive procedures to be performed by our surgeons. Minimally invasive surgery is considered ideal in many types of surgical cases. This machine will improve quality by providing better dexterity, visualization, precision and control when using the robotic surgical system. Minimally invasive surgery provides faster recovery times, lower blood loss and greater patient satisfaction and outcomes compared to traditional open procedures.

Pali Momi has been recognized in "U.S News and World Report" as one of the America's Best Hospitals for the provision of care to patients with Coronary Artery Disease. Additionally, Pali Momi has also been previously awarded First Place for outstanding performance for quality by HMSA and awarded an Annual Performance Achievement Award from the American Heart Association.

d) Cost and Finances (include revenue/cost projections for the first and third year of operation)

The proposed equipment purchase will not negatively impact the operating performance of Pali Momi's surgical department (see **Attachment C**). The project is also cost-effective as it utilizes existing space and other resources within Pali Momi and will have minimal impact on the overall costs of health services in the community as it will be funded from internal resources. The proposed project will also reduce costs throughout the health care system by reducing patient surgical recovery time and reducing patient length of stay.

e) Relationship to the existing health care system

The proposed equipment purchase will strengthen the existing health care system. Pali Momi as a not-for-profit hospital has always provided care for inpatients, outpatients and emergency visits irrespective of a patients' ability to pay. Pali Momi has also been pro-active over the years in investing in the facility to bring greater benefit to patients by providing increased capacity, enhanced quality and a higher level of customer service in anticipation of the growth of the Leeward, Central and West Oahu area. The proposed equipment purchase will enhance patient quality and access to West O'ahu families.

f) Availability of Resources.

Pali Momi has sufficient trained professionals, management, systems and other resources to fully support the proposed equipment purchase. The equipment purchase may require a change in the mix of FTEs and staff may require additional training, however, these additional resources are within the organization and will be provided with minimal additional cost to the organization. The project will be funded entirely from internal cash reserves and retained earnings.

10. Eligibility to file for Administrative Review. This project is eligible to file for Administrative review because: (Check all applicable)

____ It involves bed changes, which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It involves service changes which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It is an acquisition of a health care facility or service, which will result in lower annual operating expenses for that facility, or service.

_____ It is a change of ownership, where the change is from one entity to another substantially related entity.

_____ It is an additional location of an existing service or facility.

__X__ The applicant believes it will not have a significant impact on the health care system.