HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION – CERTIFICATE OF NEED PROGRAM

Application Number 02-21A

Applicant: Gastroenterology Associates, Inc.

Project Title: Change in ownership (addition of shareholder) of The Endoscopy Center

Project Address: 134 Puuhonu Way
Hilo, Hawaii

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

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

2. PROJECT LOCATION INFORMATION

A. Project will be located in:

State Senate District Number: 1

State House District Number: 2

County Council District Number: 2

Neighborhood Board District Number (O`ahu only): N/A

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

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

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

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

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.) N/A

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

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
- By-Laws
- Partnership Agreements
- Tax Key Number (project's location)

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.

[X] CHANGE IN OWNERSHIP

	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					
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	Current Bed Total	Proposed Beds for your Project	Total Combined Beds if your Project is Approved
TOTAL			

6. PROJECT COSTS AND SOURCES OF FUNDS N/A

A. List All Project Costs:	AMOUNT:
1. Land Acquisition	
2. Construction Contract	
3. Fixed Equipment	
4. Movable Equipment	
5. Financing Costs	
6. Fair Market Value of assets acquired by lease, rent, donation, etc.	
7. Other: Fair market Value of Shares being bought	125,492.00
TOTAL PROJECT COST:	125492.00

B. Source of Funds ~~N/A~~

1. Cash	125,492.00
2. State Appropriations	
3. Other Grants	
4. Fund Drive	
5. Debt	
6. Other: _____	
TOTAL SOURCE OF FUNDS:	125492.00

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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.

N/A

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: N/A

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

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.

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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.

a) Relationship to the Hawai`i Health Performance Plan (H2P2), also known as the State of Hawai`i Health Services and Facilities Plan.
b) Need and Accessibility
c) Quality of Service/Care
d) Cost and Finances (include revenue/cost projections for the first and third year of operation)
e) Relationship to the existing health care system
f) Availability of Resources.

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Gastroenterology Associates, Inc.

William A. Hartman, M.D. Timothy C. Jahraus, M.D. Edwin M. Montell, M.D.

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EXECUTIVE SUMMARY REGARDING CHANGE IN OWNERSHIP OF THE ENDOSCOPY CENTER

In brief, this project is simply the addition of a third physician owner. The acceptance of The Endoscopy Center by the patients and physicians of the island of Hawaii in the last eight years has necessitated the addition of another physician to Gastroenterology Associates, Inc. We have increased from approximately 90 cases per month when the initial Certificate of Need was issued to 300 cases a month. This overwhelmed the capacity of Dr. Jahraus and Dr. Montell to provide high-quality service and required us to seek a third physician. We were fortunate to attract a senior gastroenterologist from Oahu, Dr. William Hartman. In order to make his relocation acceptable, we offered him equal partnership in all our enterprises.

Therefore, as outlined below, only a third physician/owner has changed. All other items remain the same or superior to our original application.

a) Relationship to H2P2

This project was already deemed consistent with H2P2 at the approval of our original application. See attached page D-2 from that application. These factors remain the same.

b) Need and Accessibility

Need has been demonstrated by the provider and public acceptance of our facility as demonstrated by the rise in case load from 90 per month to 300 per month since our opening. We remain fully compliant with all ADA regulations for accessibility. We also provide services 7:00 a.m. to 5:00 p.m. six days a week which is far superior to most health care facilities. We also provide access to patients throughout the island although our primary catchment area is East Hawaii.

c) Quality of Service/Care

We have demonstrated quality of service and care by our continued licensure and Medicare certification. In addition, we have voluntarily become accredited by JCAHO. We are the only free-standing endoscopy center in the state to comply with this superior level of accreditation.

d) Cost and Finances

There will be no cost to patients. The physician buying in will buy one-third of the assets.

e) Relationship to the existing health care system

We have appropriate transfer arrangements with the only hospital in the region. We continue to support that hospital by using it for patients who are not appropriate for an outpatient endoscopy center.

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f) Availability of Resources

There are no additional resources required for this project other than those brought by Dr. Hartman who has sufficient financial resources to make this purchase.

The proposed ASC will meet the State Health Services and Facilities Plan by providing appropriate care, accessible without discrimination at a lower cost than the current service available at Hilo Hospital. Appropriate transfer agreements will be arranged with Hilo Hospital prior to initiation of services. Patients who prefer evaluation or treatment in Hilo Hospital's outpatient facility or are felt by the physician to require the additional services of anesthesia will continue to be served through Hilo Hospital.

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.

__X__ 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.