



HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: # 10-06A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Change of Ownership of diagnostic radiology services (x-ray and dexa operations located at 1029 Kapahulu Avenue, Suite 500, Honolulu, Hawaii)

Project Address: 1029 Kapahulu Avenue, Suite 500, Honolulu, Hawaii 96813

Applicant Facility/Organization: Hawaii PET Imaging, L.L.C.

Name of CEO or equivalent: Scott Halliday

Title: President, National Medical Development, Inc., Owner, Hawaii PET Imaging, L.L.C.

Address: 101 Elliot Avenue West, Suite 500, Seattle, WA 98119

Phone Number: 206-272-3580 Fax Number: 206-272-3588

Contact Person for this Application: same as above

Title: _____

Address: _____

Phone Number: _____ Fax Number: _____

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

4-20-10
Date

Scott Halliday
Name (please type or print)

PHY. NINDT, OWNER, HPI
Title (please type or print)

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

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

2. PROJECT LOCATION INFORMATION

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

Statewide: _____
O`ahu-wide: X
Honolulu: _____
Windward O`ahu: _____
West O`ahu: _____
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)- Exhibit C
- 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.)- none needed
- C. Your governing body: list by names, titles and address/phone numbers -Exhibit D
- 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 Exhibit A
 - By-Laws -NA
 - Partnership Agreements – See Exhibit B
 - Tax Key Number (project's location) – 3-2-007-019 (portion of)

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					
Outpatient Facility				XXX	
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

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.	\$75,000
7. Other: _____	_____
TOTAL PROJECT COST:	\$75,000

B. Source of Funds	
1. Cash	_____
2. State Appropriations	_____
3. Other Grants	_____
4. Fund Drive	_____
5. Debt	_____
6. Other: FMV of Leased Assets incl. space lease	\$75,000
TOTAL SOURCE OF FUNDS:	\$75,000

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 is a change in ownership of the existing x-ray and dexta service located at 1029 Kapahulu Avenue, Suite 500, Honolulu, Hawaii

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, -May 1, 2010
- b) Dates by which other government approvals/permits will be applied for and received, - none needed
- c) Dates by which financing is assured for the project,-na
- d) Date construction will commence,-na
- e) Length of construction period, - na
- f) Date of completion of the project,-na
- g) Date of commencement of operation-upon CON approval

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.

Hawaii PET Imaging, L.L.C. ("HPI") is proposing to acquire the dexta and x-ray services from Maui Diagnostic Imaging, L.L.C. ("MDI"). Both MDI and HPI are wholly owned by National Medical Development, Inc.

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

The relationship to the SHHSFP was established in certificate 10-03A. There is no change in the projects relationship to the State Health Plan since that approval.

b) Need and Accessibility

The need for the services was established in app 06-25A and there have been no changes to the projects relationship to these criteria since the approval.

The imaging services will be available to all on a non-discriminatory basis consistent with our policy of imaging all patients with a physician's order without regard to ability to pay, including low income people, racial and ethnic minorities, women, people with disabilities, the elderly and other underserved.

c) Quality of Service/Care

HPI is one of the few companies in Hawaii that is accredited by the American College of Radiology. HPI is licensed by the State of Hawaii. The HPI staff Radiologists are certified by the American Board of Radiology and are licensed physicians in Hawaii. They are members of a wide variety of professional organizations. The HPI technologists are certified by the American Registry of Radiologic Technologists, and licensed by the State of Hawaii. HPI physicians and technologists are continually expected to meet or exceed all state and national registry requirements for continuing medical education ("CME"). Currently, radiologists are required to obtain 50 CME credits annually and technologists are required to obtain 12 CME credits annually.

The facility will operate in accordance with all applicable state and federal guidelines and the standards of the accrediting body, and will have the HPI policies and procedures to insure the quality and safety of patient care. The facility's patient care staff currently includes 2.0 FTE Radiology/Dexascan Technicians.

The staff-to-patient ratio will be 1:1. The technician will be with each patient at all times while a procedure is being performed.

HPI has over 6 years of experience of providing radiology services on Oahu to Hawaii residents. HPI is recognized as a quality provider that continually upgrades and enhances its services and facilities to the local population.

HPI is the current acting manager of this site (acting for Maui Diagnostic Imaging, L.L.C.), the technicians and staffing are in place, and will not change from the prior application.

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

HPI will assume the space and equipment lease. The total project costs are 75k. No other capital expenditures are required and any needed capital will be provided by existing HPI.

The net operating revenue for the first year of operation is projected at \$261,312 and operating expenses for the same period are projected at \$371,876, resulting in net operating loss of \$110,564. By the third year of operation, net operating revenue is expected to increase to \$469,521, with total expenses projected at \$423,408, resulting in net profit of \$46,113.

The facility's proposed charges will be within the range of charges for similar procedures billed by other providers on Oahu.

e) Relationship to the existing health care system

The relationship was established in application 10-03A and there are not changes from that prior application.

f) Availability of Resources.

HPI will be starting a new facility lease, the facility will be managed thru HPI established and existing management, and will utilize HPI existing internal capital and reserves.

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.

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