HAWAI`I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

STANDARD APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #11-15 Date of Receipt:
To be assigned by Agency

APPLICANT PROFILE

Project Title: Establishment of Surface Ambulance Service

Project Address: 87-154 Farrington Highway

Waianae, Hawaii 96792

Applicant Facility/Organization: Hawaii Medical Response Inc. ("HMR")

Name of CEO or equivalent: Arthur Martirosian, M.B.A.

Title: President

Address: 86-213 Kuwale Road, Waianae, Hawaii 96792

Phone Number: 808-330-5364 Fax Number: 808-394-6962

Contact Person for this Application: Ani Martirosian, J.D.

Title: Counsel and Marketing Director

Address: 980 Kaahue Street, Honolulu, Hawaii 96825

Phone Number: 808-429-4490 Fax Number: 808-394-6962

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

July 11, 2011
Date

Arthur Martirosian
Name (please type or print)

President of HMR
Title (please type or print)

1. **TYPE OR 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. Primary Service Area(s) of Project: (Please check all applicable)

Statewide:	
O`ahu-wide:	
Honolulu:	
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)
Lease Agreement attached as Attachment AI-1

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.)
DOH Ambulance Service License.

C. Your governing body: list by names, titles and address/phone numbers
See Attachment 1.

D. If you have filed a Certification 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 2.
- By-Laws See Attachment 3.
- Partnership Agreements Not Applicable.
- Tax Key Number (project's location) 870110030000

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 ownership	Change in service/ establish new service/facility	Change in Beds
Inpatient Facility						
Outpatient Facility					X	
Private Practice						

5. **TOTAL CAPITAL COST:** $450,000.00

6. **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. Not Applicable.

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

7. **CHANGE IN 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 consult 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 proposal establishes a surface ambulance service, pursuant to the definition enumerated in CON Rules Section 11-186-5.

8. PROJECT COSTS AND SOURCES OF FUNDS (For Capital Items Only)

A. List All Project Costs:		AMOUNT:
1.	Land Acquisition	150,000.00
2.	Construction Contract	75,000.00
3.	Fixed Equipment	45,000.00
4.	Movable Equipment	160,000.00
5.	Financing Costs	20,000.00
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	NA
7.	Other: _____	NA
	TOTAL PROJECT COST:	$450,000.00

B. Source and Method of Estimation

Describe how the cost estimates in Item "A" were made, including information and methods used:

Please see Attachment 4.

C. Source of Funds		AMOUNT:
1.	Cash	200,000.00
2.	State Appropriations	NA
3.	Other Grants	NA
4.	Fund Drive	NA
5.	Debt	0
6. (A)	Other: Credit Line/Real Estate	250,000.00
	TOTAL SOURCE OF FUNDS:	$450,000.00

9. **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, Lease in effect immediately following approval of CON; conditioned on approval.
b) Dates by which other government approvals/permits will be applied for and received, See below 'g)'
c) Dates by which financing is assured for the project, Pending approval of CON.
d) Date construction will commence, Immediately following approval of CON.
e) Length of construction period, 45-60 days.
f) Date of completion of the project, and Sixty days following approval of CON.
g) Date of commencement of operation. Immediately following approval of CON.

b) Applied for: Immediately following approval of CON; Received: Within 30 days of submission.

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.

10. **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 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

See Attachment 5.

Attachment

5

Hawaii Medical Response Inc.

Certificate of Need Application

Attachment 5

EXECUTIVE SUMMARY

A) Hawaii Medical Response Inc. ("HMR") seeks to establish a new surface ambulance service within the Island of Oahu, with primary focus on the underserviced region of West Oahu. According to Section 11-186-3 of the Hawaii Administrative Rules, a surface ambulance service includes "transportation of a patient in any motor vehicle . . . specifically equipped, designed or constructed, and maintained or operated for the purpose of accommodating the medical needs of patients." HMR plans to establish a non-emergency, basic life support ("BLS") surface ambulance service that will respond to patients that need supervisory and managed care during transport to health care facilities, health plans, and government entities in West Oahu.

The Hawaii Health Services and Facilities Plan ("Plan"), consistent with SHPDA, focuses on increasing cost effective access to necessary health services, promoting regionalization of services when appropriate, and encouraging optimization of services by ensuring that supply meets need, and costs are reasonable. HMR's proposed services are aligned with the goals enumerated in the Plan. HMR will provide prompt and efficient supervisory transfers, delivering safe, reliable, efficient, timely, and much needed services to the community at large at a reasonable price.

B) There is currently a need for HMR's proposal, specifically in West Oahu, because only one other company is providing similar services. According to the U.S. Department of Justice and Hawaii`s anti-trust laws, free and open competition benefits consumers by lowering prices and increasing quality of care to consumers. HMR will offer significantly lower rates for transfers while delivering high quality, indiscriminate care to its patients. Specifically, HMR estimates to charge eighty-four dollars less than its competitor that currently charges three-hundred-nineteen dollars per transfer. The discount that ensues from HMR's reasonable price will lower health care costs for patients, healthcare providers, and insurance carriers alike.

C) HMR will be located in a central location in West Oahu, ready to dispatch culturally-sensitive emergency medical technicians and well-equipped ambulances upon notice to

Waianae, Nanakuli, Makakilo, Waipahu, Waipio and Wahiawa. Currently, the west-most station on Oahu is located in Waipio. HMR projects its central West Oahu location, reliable and timely services, professional staff, and low costs for patients will greatly benefit the quality of care delivered to those in need and will improve the existing health care system. HMR will also ensure that its staff continues education, its equipment is maintained at an optimum level, and dispatching services are efficient and timely.

D) The financial feasibility of HMR's proposal is sound. HMR projects its total project cost to be $450,000, with the same amount of financing available to cover its total projected cost. HMR estimates its net revenue to total $959,290 during its first year of service, with an increase to $1,109,480 during its third year. Similarly, operating expenses for the first year are estimated to total $994,420, with an increase to $1,037,315 during the third year. HMR projects each unit of service to cost $241 during the first year, with an increase to $246.99 during its third year of service, and proposes to charge approximately $294 for each transfer for the first two years with an operational increase to $302 on the third year. As of current, similar non-emergency BLS transfer services in Hawaii charge $319 for each transfer. HMR's proposal benefits the community by making transfer services more affordable, reasonably priced, and available to all those in need.

E) According to the Plan, the health care system is currently burned with geographic challenges, a growing and aging population, rising costs, and quality concerns. HMR's proposal aims to alleviate these issues and concerns. HMR's non-emergency, BLS, supervisory transport services will be available to the community at large, and particularly to low income persons, racial and ethnic minorities, people with disabilities, the elderly, and other underserved groups. HMR will be geographically located in the heart of West Oahu, equipped and ready to service health care establishments and the community. HMR will work closely with multiple insurance companies on Oahu, including Medicare and Medicaid, to ensure indiscriminate, cost-effective transport. HMR will deliver fast, reliable, professional, and reasonably priced services. Other health care services will in turn benefit from HMR's overall performance. Furthermore, HMR will optimize the health system by enabling emergency responders to respond to pressing matters rather than focus on non-emergency transfers. Finally, HMR's proposal

will aide in health care facility congestion by transferring patients in a timely, supervised, and efficient manner.

F) HMR has sufficient financial resources and availability to personnel to carry out its proposed project. As of current, HMR has a stable and available source of funds available upon approval of this application. An estimated amount of $200,000 of this funding is available cash, and $250,000 is available on credit line. Similarly, HMR has availability to other credit lines that may provide shelter and back up funding for its proposed project. HMR has estimated its need of personnel to carry out this project and is confident that it will procure the necessary personnel to carry out its proposal. Specifically, HMR intends and is ready to hire local EMT-B and personnel.