HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #15-10A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Deletion of oculoplastic and ophthalmological procedures and addition of Urology surgical procedures.

Project Address: Queen's Physicians Office Building II
1329 Lusitana St. # 401, Honolulu HI 96813

Applicant Facility/Organization: Surgical Specialties, LLC

Name of CEO or equivalent: Marco Rizzo, MD

Title: Member

Address: Queen's Physicians Office Building II
1329 Lusitana St. # 401, Honolulu HI 96813

Phone Number: 808-533-2900 Fax Number: 808-531-8991

Contact Person for this Application: Marco Rizzo, MD

Title: Member

Address: Queen's Physicians Office Building II
1329 Lusitana St. # 401, Honolulu HI 96813

Phone Number: 808-533-2900 Fax Number: 808-531-8991

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

6/25/2015
Date

MARCO RIZZO MD.
Name (please type or print)

M.D
Title (please type or print)

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

Public	_X___
Private	_____
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:	_X___
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)-Lease document-see attached

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

Marco Rizzo, MD - Medical Director
Queen's Physicians Office Building II
1329 Lusitana St. # 401, Honolulu HI 96813

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-attached
   - By-Laws: Operating agreement-attached
   - Partnership Agreements: None
   - Tax Key Number (project's location) (1) 2-1-037-002 (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				X	
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	$80,000.00
5.	Financing Costs	_____
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	_____
7.	Other: _____	_____
	TOTAL PROJECT COST:	**$80,000.00**

B. Source of Funds

1.	Cash	$80,000.00
2.	State Appropriations	_____
3.	Other Grants	_____
4.	Fund Drive	_____
5.	Debt	_____
6.	Other: _____	_____
	TOTAL SOURCE OF FUNDS:	**$80,000.00**

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.

Removing services of oculoplastic surgery and ophthalmology procedures.
Adding urology surgery procedures.

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, September 2015
b) Dates by which other government approvals/permits will be applied for and received, September 2015
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, N/A
g) Date of commencement of operation, September 2015

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.

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.

Executive Summary

Marco Rizzo, M.D surgical practice and Surgical Specialties, LLC are located at:
Queen's Physicians Office Building II,1329 Lusitana St. # 401, Honolulu HI 96813.

The purpose of the ASC service change is to delete oculoplastic and ophthalmological procedures and add Urology surgical procedures.

Dr. Garry Peers, will perform urological procedures, at the ASC, as he has been doing, in his private practice. Dr. Peers is Board certified in urology.

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

Relationship to the State of Hawaii was established with CON#12-33A.
The addition of Urology services will not change the relationship with the state plan.

b) Need and Accessibility

The aging population of the State of Hawaii is increasing, and thus will be in need of urological services.

This facility would be mostly use for shorter and simple procedures. This will alleviate the currently crowded schedule of larger healthcare facilities allowing them to schedule more complex and longer operations.

These outpatient urological procedures will be delivered in a more private, and patient-friendly environment, more acceptable by the elderly population; thus, overall will reduce the cost for those services.

Dr. Garry Peers has been performing more than 150 procedures per year in his practice. This notably shows the needs for this service.

The proposed additional services will be made available to all residents of Oahu.
In particular, the elderly, low income, ethnic racial minorities, women, people with disabilities, and other under-privileged groups will benefit from these services being made available.

This proposed addition of service will be provided to patients covered by Medicare and Medicaid. Furthermore, a portion of the operating revenue will also be donated to charity.

c) Quality of Service/Care
These proposed additions of services will comply with State of Hawaii and Federal regulations in regards to delivery of care, maintenance of equipment, and clinical environment.

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

The operating revenue for the first year of operation is projected at $339,145.97, While operating expenses for the same period is projected at $ 322,188.67, resulting in a net operating profit of $ 16,957.30. By the third year of operation,
Operating revenue is expected to increase to $ 373,060.57, with total operating expensed projected at $ 356,607.55, resulting in an operating profit of $ 16,453.02.
(These numbers are based on a report supplied by the Urologist's income and expenses, which are expected to grow by 5% to 10% by the third year: Expenses are also expected to increase 5% due to inflation).

e) Relationship to the existing health care system

Our current relationship to the existing health care system was met with CON#12-33A. The proposed addition of services will improve the system by alleviating the crowded schedule of larger health care facilities, allowing them to schedule emergency cases or more complex and lengthy procedures.

f) Availability of Resources.
The proposed addition does not anticipate the need for additional personnel. In addition, a cash supply of $ 80,000 is available for additional equipment that may be required for the facility.

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.