HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #16-06A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Acquisition of Membership Interest in Pacific ASC, LLC

Project Address: 735 Iwilei Road, Suite 225, Honolulu, HI 96817

Applicant Facility/Organization: Hawai'i Pacific Health Partners, Inc.

Name of CEO or equivalent: David Okabe

Title: Chair & President

Address: 55 Merchant Street, 27th Floor, Honolulu, HI 96813

Phone Number: (808) 535-7202 Fax Number: (808) 535-7412

Contact Person for this Application: Michael Robinson

Title: Vice President, Government Relations & Community Affairs

Address: 55 Merchant Street, 27th Floor, Honolulu, HI 96813

Phone Number: (808) 535-7124 Fax Number: (808) 535-7412

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

8/8/16
Date

David Okabe
Name (please type or print)

Chair & President
Title (please type or print)

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) 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):

- Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent) **[See Attachment A]**

a) 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.)

- ASC License – Department of Health
- Provider Certification – Medicare/Medicaid Provider Status

b) Your governing body: list by names, titles and address/phone numbers

- **[See Attachment B]**

c) 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 C]**
  - By-Laws: **[See Attachment D]**
  - Partnership Agreements: **Not Applicable**
  - Tax Key Number (project's location): 150100100000 (portion thereof)

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
N/A	**N/A**	**N/A**	**N/A**

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.	
7.	Other: Fair Market Value of membership interest	$9,250,000
	TOTAL PROJECT COST:	**$9,250,000**

b) Source of Funds

1.	Cash	$9,250,000
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other: _____	
	TOTAL SOURCE OF FUNDS:	**$9,250,000**

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.**

Not Applicable.

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:** August 1, 2016
b) **Dates by which other government approvals/permits will be applied for and received:** August, 31, 2016
c) **Dates by which financing is assured for the project:** Not Applicable
d) **Date construction will commence:** Not Applicable
e) **Length of construction period:** Not Applicable
f) **Date of completion of the project:** August 31, 2016
g) **Date of commencement of operation:** September 1, 2016

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 Health Services and Facilities Plan (HSFP).

The ambulatory surgery center's relationship to the State Health Services and Facilities Plan ("HSFP") criteria was met in certificate of need No. 09-08 approved on August 24, 2009.

The acquisition of membership interest by Hawai'i Pacific Health Partners, Inc. ("HPHPI") will not affect the project's relationship to the HSFP.

b) Need and Accessibility

The need and accessibility criteria were met in certificate of need No. 09-08 approved on August 24, 2009. The acquisition of membership interest by HPHPI will not affect the facility's relationship to these criteria.

The anticipated increase in age of Hawai'i's population continues to exacerbate the need for ophthalmologic surgery procedures. The facility and services will continue to be accessible to all residents and visitors on O'ahu, including the elderly, low-income persons, racial and ethnic minorities, women, persons with disabilities, and other underserved groups.

c) Quality of Service/Care

The quality of service/care criteria were met in certificate of need No. 09-08 approved on August 24, 2009. The acquisition of membership interest by HPHPI will not affect the facility's relationship to these criteria.

Pacific ASC will continue to ensure continuity and quality of care by observing the same protocols described in CON No. 09-08.

Pacific ASC is, and will continue to be, Medicare and Medicaid certified and licensed by the Hawai'i Department of Health. The facility will continue to comply with applicable federal and state statutes and regulations governing the delivery of care and maintenance of service equipment and the clinical environment. The change in ownership will not result in any lowering of the quality of care and service provided by Pacific ASC.

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

The cost and financial criteria were met in certificate of need No. 09-08 approved on August 24, 2009. The acquisition of membership interest by HPHPI will not affect the facility's relationship to these criteria.

As set forth on Page 4 of this application, HPHPI will pay $9,250,000 in cash for its interest in the ASC. The change of ownership will have no impact on the overall cost of health services to the community or to the existing facility.

See attached statement of financial projections Year 1 to Year 3. **[See Attachment E]**

Year 1	Projected
Net Patient Revenue	$8,057494
Operating Expense	$5,488.359
Net Income	**$1,849,236**
Year 3	**Projected**
Net Patient Revenue	$8,883,387
Operating Expense	$6,050,916
Net Income	**$2,038,783**

e) Relationship to the existing health care system

The proposed acquisition of membership interest by HPHPI will not have any negative effect on the existing health care system as it is a continuation of an existing service. The change will not alter the staff or service at Pacific ASC, which will continue to maintain operations of the ASC.

f) Availability of Resources

HPHPI has the experience and resources for the proposed acquisition. The proposed project will utilize existing equipment and resources on-site, including the current staff. No additional employees are required as a result of the proposed change of ownership. HPHPI has sufficient financial resources to fund the acquisition from retained earnings and to provide operating capital.

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.