HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #16-07A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Acquisition of a Membership Interest in The Cancer Center of Hawaii, LLC

Project Address: 2226 Liliha Street, #B2, Honolulu, Hawaii 96817

91-2135 Fort Weaver Road, #B-120, Ewa Beach, Hawaii 96706

Applicant Facility/Organization: Castle Medical Center

Name of CEO or equivalent: Kathryn Raethel

Title: President/Chief Executive Officer

Address: 640 Ulukahiki Street, Kailua, Hawaii 96734

Phone Number: (808) 263-5142 Fax Number: (808) 263-5143

Contact Person for this Application: J. George Hetherington

Title: Attorney

Address: 700 Bishop Street, 15th Floor, Honolulu, Hawaii 96813

Phone Number: (808) 523-6000 Fax Number: (808) 523-6001

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

Date

Kathryn Raethel
Name (please type or print)

President/Chief Executive Officer
Title (please type or print)

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

Public	____
Private	X
Non-profit	X
For-profit	____
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:	X
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)

See Attachment 1 (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.)

Not applicable.

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

See Attachment 2.

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* Attachment 3.
- By-Laws: *See* Attachment 4.
- Partnership Agreements: Not applicable.
- Tax Key Number (project's location): (1) 1-8-018:025 and (1) 9-1-017:085

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	
5.	Financing Costs	
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	
7.	Other: Fair market value of LLC interest purchased and sold	$5,946,318.00
	TOTAL PROJECT COST:	**$5,946,318.00**

B. Source of Funds

1.	Cash	$5,946,318.00
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other: _____	
	TOTAL SOURCE OF FUNDS:	**$5,946,318.00**

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.

This application is for the acquisition of a 25% membership interest in The Cancer Center of Hawaii, LLC. The category is HAR § 11-186-5(4)(G). No new locations or expansions are proposed.

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: February 10, 2016.
b) Dates by which other government approvals/permits will be applied for and received: Not applicable.
c) Dates by which financing is assured for the project: Not applicable. This is a cash transaction.
d) Date construction will commence: Not applicable.
e) Length of construction period: Not applicable.
f) Date of completion of the project: Not applicable.
g) Date of commencement of operation: Upon closing of the purchase and sale transaction.

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

The Cancer Center of Hawaii, LLC ("TCCH") owns and operates two radiation treatment facilities, located in Liliha and Ewa Beach, on the Island of Oahu (the "TCCH Facilities"). TCCH is currently owned by Hawaii Pacific Health Partners, Inc., St. Francis Healthcare Enterprises, Inc., SFHE, Inc., and P.R.O. Associates, LLC. Castle Medical Center ("CMC") seeks to acquire a 25% interest in TCCH (the "Proposed Transaction").

The Proposed Transaction is not intended to change the scope of services provided at the TCCH Facilities. TCCH intends to maintain the same services described in CON #93-25, which was approved for the Liliha facility on May 10, 1994, and CON #94-27, which was approved for the Ewa Beach facility on January 5, 1995.

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

The facilties' relationship to the state health plan was established in CON #93-25 and CON #94-27, respectively, and this change in ownership will not change that relationship.

Radiation treatment facilities are not subject to any of the utilization thresholds set forth in Chapter 2 of the Health Services and Facilities Plan.

By diversifying the ownership of TCCH, the Proposed Transaction advances the following Statewide Health Coordinating Council priorities:

- Promoting and supporting the long-term-viability of the health care delivery system; and
- Ensuring that access to quality radiation therapy for cancer treatment is maintained at a reasonable cost.

The proposed transaction will also address the priorities of the West Oahu Subarea Council ("SAC") by ensuring continued access to specialty care.

b) Need and Accessibility

The need for TCCH's services was established in CON #93-25 and CON #94-27. Access to radiation oncology procedures in the current service areas will be maintained at existing levels. After the Proposed Transaction, TCCH will continue to serve all Hawaii residents, including low income persons, racial and ethnic minorities, persons with disabilities, the elderly, and other underserved groups, regardless of payor source.

c) Quality of Service/Care

TCCH will continue to ensure continuity and quality of care by observing the same protocols described in CON #93-25 and CON #94-27. The Proposed Transaction is not intended to alter the scope of services provided by TCCH. The Center will continue to be licensed by the Radiation Section of the Hawaii Department of Health and comply with all applicable federal and state regulations. The transition will be seamless and have no effect on the care provided to TCCH's patients.

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

The facilities original CON applications, CON #93-25 and CON #94-27, respectively, showed that they satisfied the Cost and Finances Criteria. This change in ownership will have no effect on their satisfaction of that criteria.

CMC will pay $5,946,318 for a 25% interest in TCCH.

TCCH's estimated revenue and operating costs for the first and third full years of operation following the transaction are shown in the table below:

	Projected 1st Full Year Operations	Projected 3rd Full Year Operations
Total Operating Revenue	**$14,332,555**	**$14,993,067**
Operating Expenses		
Salaries, Wages, Benefits	3,524,238	3,781,809
Other Expenses	6,433,855	6,478,027
Depreciation	1,526,185	2,343,980
Total Expenses	11,484,278	12,603,816
Net Income (Loss) from Operations	**2,848,277**	**2,389,251**
Add Back: Depreciation	**1,526,185**	**2,343,980**
Excess (Deficit) Fund from Operations	**4,374,462**	**4,733,231**

e) Relationship to the existing health care system

The Proposed Transaction is not expected to have any negative effect on other health care providers or impair the public's access to services. The Proposed Transaction will not require any additional staffing as the same services will continue to be provided. Accordingly, it should have no negative impact on the number of trained health care professionals available to meet the staffing needs of other providers. In summary, the Proposed Transaction should have minimal, if any, impact on the existing health care system.

f) Availability of Resources.

There are few financial obstacles to the Proposed Transaction. CMC will pay for its membership interest in TCCH with cash. The Proposed Transaction is not intended to result in any changes to the staff currently employed by TCCH. Accordingly, no additional employees will be required as a result of the Proposed Transaction.

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.