HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #24-06A
To be assigned by Agency

Date of Receipt: ST HLTH PLNG & DEV. AGENCY

APPLICANT PROFILE

Project Title: Addition of Cardiac Surgical Procedures

Project Address: 1401 S. Beretania Street, Suite 600, Honolulu, HI 96814

Applicant Facility/Organization: Specialty Surgical Suites, LLC

Name of CEO or equivalent: Art Gladstone

Title: Manager

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	Date
Art Gladstone	Manager
Name (please type or print)	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:	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.)

- **N/A**

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: **N/A**
  - Partnership Agreements: **N/A**
  - Tax Key Number (project's location): 240050510000

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:	_____
	TOTAL PROJECT COST:	**$0**

B. Source of Funds

1.	Cash	_____
2.	State Appropriations	_____
3.	Other Grants	_____
4.	Fund Drive	_____
5.	Debt	_____
6.	Other: _____	_____
	TOTAL SOURCE OF FUNDS:	**$0**

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.**

Specialty Surgical Suites, LLC ("SSS") dba Minimally Invasive Services ("MIS") is seeking to add cardiac services to its current ASC operations located at 1401 South Beretania St, Suite 600, Honolulu, HI 96814.

The application involves the addition of cardiac and vascular procedures including, but not limited to: percutaneous cardiac ablation; rhythm management via primary pacemaker placement, ICD system implant and associated changes; transluminal angioplasty. MIS will continue to provide specialized orthopedic procedures at its current location.

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:** N/A
b) **Dates by which other government approvals/permits will be applied for and received:** N/A
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:** June 30, 2024
g) **Date of commencement of operation:** August 1, 2024

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. 11-16 approved on November 17, 2011.

The addition on cardiac services will strengthen the project's relationship to the HSFP's Statewide Health Coordinating Care (SHCC) priorities to (1) promote and support the long-term viability of the health care delivery system; (2) ensure that any proposed service will at least maintain overall access to quality health care at a reasonable cost; and (3) strive for equitable access to health care services.

The addition of cardiac services will also strengthen the Subarea Health Planning Council Priorities for Honolulu County to control escalating costs in the senior care industry and other needed services through the provision of services available at an existing ambulatory surgical center.

b) Need and Accessibility

The acquisition will not have an impact on the need or accessibility of this service. The need and accessibility of the ambulatory surgery center was addressed in the original certificate of need (No. 11-16) approved on November 17, 2011.

The proposed project is a response medical need resulting from changing demographic trends in Hawai'i's population and changing healthcare workforce marketplace dynamics. More specifically: (1) Hawai'i's continuously growing aging population with diagnosed cardiac and peripheral vascular disease require care, including those from our neighboring islands; (2) Physician shortages related to retirement leading to a large number of patients with previously implanted rhythm management devices requiring battery/generator change; and (3) Lack of access to operating room suites in hospitals due to the severe current shortage in anesthesiologists locally. These three major trends have contributed to the rising need for additional sites of service for these types of cardiac procedures to be performed in an outpatient setting.

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

MIS 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 addition of cardiac services at this location will not result in any lowering of the quality of care and service provided by MIS.

To ensure quality all physicians who will be performing cardiac procedures will be specialty trained Cardiologists/peripheral vascular specialists with extensive experience. We will also have a designated Cardiologist train our circulating and recovery room personnel, oversee all credentialing applications for new providers, assist with set up and maintenance of all equipment and sets required for these procedures as well as facilitate regular peer review of cardiac and vascular cases.

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

The addition of cardiac services will result in the ASC achieving positive financial margin from Year 1 and through Year 3. **[See Attachment D]**

e) Relationship to the existing health care system

The proposed addition of cardiac service will improve the existing health care access to cardiac services while reducing health care delivery costs. The change will not alter the staff or service at SSS, which will continue to maintain operations of the ASC.

f) Availability of Resources

The proposed project will utilize existing equipment and resources on-site, including the current staff. A cardiac surgical specialist has been identified and will be brought on board to provide this service. SSS has sufficient financial resources to fund the acquisition 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.