

# HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

<u>OMINISTRATIVE</u> APPLICATION - CERTIFICATE	OF NEED PROGRA	M		
oplication Number: 13-17A  To be assigned by Agency	Date of Receipt:			
APPLICAN Project Title: Addition of oculoplastic and ophthalmo	NT PROFILE logical procedures			
Project Address: Queen's Physicians Office Buildin 1329 Lusitana St. #401, Honolulu	g II HI 96813		•	
Applicant Facility/Organization: Surgical Specialties,	LLC	رم R• دم	14	곮
Name of CEO or equivalent: Marco Rizzo, MD		DEV AGENCY	JAN 23	ECEVE
Title: Member		OH HO	Р3	Á
Address: Queen's Physicians Office Building II 1329 Lusitana St. #401, Honolulu HI 9681	3	22	3 36	
Phone Number: 808-533-2900 Fax Number: 808	-531-8991			
Contact Person for this Application: Marco Rizzo, M	D			
Title: Member				
Address: Queen's Physicians Office Building II 1329 Lusitana St. #401, Honolulu HI 9681	3			
Phone Number: 808-533-2900 Fax Number: 808	-531-8991			
CERTIFICATIO	N BY APPLICANT			
I hereby attest that I reviewed the application a contained herein. I declare that the project de documentation included is true and correct to the beautiful Signature	scribed and each sta	tement and belief.	ent and amount a	the information and supporting —
Marco Rizzo, MD Name (please type or print)	Member Title (please type or	print)		-

1.	TYPE OF ORGANIZATION: (Please check all applicable)
	Public Private
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:  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
	<ul> <li>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.)</li> <li>License-State of Hawaii, Department of Health</li> <li>Medicare Certification- Pending site Inspection from AAAASF.</li> </ul>
	C. Your governing body: list by names, titles and address/phone numbers Marco Rizzo, MD Shirley Rizzo, Administrator Queen's Physicians Office Building II 1329 Lusitana St. #401, Honolulu HI 96813 Telephone: 808-533-2900
	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 A	II Project Costs:	AMOUNT:
	1.	Land Acquisition	
	2.	Construction Contract	
	3.	Fixed Equipment	
	4.	Movable Equipment	\$60,000.00
	5.	Financing Costs	
	6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	
	7.	Other:	
		TOTAL PROJECT COST:	\$60,000.00
В.	Sourc	e of Funds	
В.	Source 1.	ee of Funds Cash	\$60,000.00
В.			\$60,000.00
B.	1.	Cash	\$60,000.00
B.	1. 2.	Cash State Appropriations	\$60,000.00
В.	<ol> <li>1.</li> <li>2.</li> <li>3.</li> </ol>	Cash State Appropriations Other Grants	\$60,000.00
B.	<ol> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>	Cash State Appropriations Other Grants Fund Drive	\$60,000.00

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.

Adding Services of oculoplastic surgery and ophthalmology 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, April 2014
  - b) Dates by which other government approvals/permits will be applied for and received, March-April, 2014
  - 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 ,March-April 2014.

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.
  - i. Relationship to the State of Hawai'i Health Services and Facilities Plan.
  - ii. Need and Accessibility
  - iii. Quality of Service/Care
  - iv. Cost and Finances (include revenue/cost projections for the first and third year of operation)
  - v. Relationship to the existing health care system
  - vi. Availability of Resources.

## **Executive Summary**

Marco Rizzo, M.D surgical practice and Surgical Specialties, LLC, are located at: Physicians Office Building II, 1329 Lusitana Street Suite 401 Honolulu, HI 96813

The purpose of the ASC service change is to add oculoplastic surgery and ophthalmological procedures to the plastic and reconstruction surgery being in the same location.

Dr. McDevitt, will perform his procedures, at the ASC, as he was doing before, In his private practice.

a) Relationship to the State of Hawai'i Health Services and Facilities

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

### b) Need and Accessibility

The proposed addition of service for oculoplastic and ophthalmology services will complement our current services to ensure improved results.

Dr. Timothy McDevitt has been performing more than 200 cases 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 and people with disabilities, and other under-privileged groups will benefit from these services made available.

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

### c) Quality of Service/Care

These proposed additional services will comply with the State of Hawaii and Federal regulations in regards to delivery of care, maintenance of equipment, and clinical environment.

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

The operating revenue for the first year of operation is projected at \$ 359,965.77, While operating expenses for the same period is projected at \$ 297,201.05, resulting in a net operating profit of \$ 62,764.72. By the third year of operation,

operating revenue is expected to increase to \$ 377,923.90, with total operating expenses projected at \$ 326,934.60, resulting in an operating profit of \$ 50,989.30. (These numbers are based on reports supplied by Ophthalmologist income and expenses, which are expect it to grow to 5% by the third year; but 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 not change but will actually improve the overall delivery of care.

f) Availability of Resources

The proposed addition of services does not anticipate the need for additional personnel. In addition, a cash supply of \$60,000 is available for additional equipment that may be required for the facility.

	ile for Administrative Review. This project is eligible to file for we 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.