



HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION – CERTIFICATE OF NEED PROGRAM

Application Number 05-31A

Applicant: Kahala Senior Living Community, Inc.
4389 Malia Street
Honolulu, HI
Phone: (808) 218-7000

Project Title: Conversion of 16 Skilled Nursing Facility (SNF) /
Intermediate Care Facility (ICF) beds to 16 SNF beds

Project Address: same

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

- Public
- Private
- Non-profit
- For-profit:
- Individual
- Corporation
- Partnership
- Limited Liability Corporation (LLC)
- Limited Liability Partnership (LLP)
- Other: _____

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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:

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3. DOCUMENTATION (Please attach the following to your application form):

- A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, 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.) Office of Health Care Assurance License.
- C. Your governing body: list by names, titles and address/phone numbers
- 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
 - By-Laws
 - Partnership Agreements
 - Tax Key Number (project's location)

See attached materials.

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.

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	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				X	X
Outpatient Facility					
Private Practice					

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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
SNF/ICF	60	-16	44
SNF	0	+16	16
TOTAL	60	0	60

ATTACHMENT PAGE

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6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

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AMOUNT:

- 1. Land Acquisition '05 DEC -7 AM 11:26 _____
- 2. Construction Contract _____
- 3. Fixed Equipment ST. HLTH. PLNG & DEV. AGENCY _____
- 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

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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.

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Per the recommendation of the Office of Health Care Assurance, State of Hawaii Department of Health, Kahala Senior Living Community, Inc is requesting that its Certificate of Need be changed from a 60 bed SNF/ICF designation to a 16 bed SNF and 44 bed SNF/ICF. This will not change the total number of beds instead it would redesignate 16 SNF/ICF as SNF only.

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:
- Date of site control for the proposed project --March 2001
 - Dates by which other government approvals/permits will be applied for and received -- January 2006
 - Dates by which financing is assured for the project - Not Applicable
 - Date construction will commence -- Not Applicable
 - Length of construction period -- Not Applicable
 - Date of completion of the project -- Not applicable.
 - Date of commencement of operation--January 2006.

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. **See Attached Exhibit.**

- Relationship to the Hawai'i Health Performance Plan (H2P2), also known as the State of Hawai'i Health Services and Facilities Plan.
- Need and Accessibility
- Quality of Service/Care
- Cost and Finances (include revenue/cost projections for the first and third year of operation)
- Relationship to the existing health care system
- Availability of Resources.

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10. Eligibility to file for Administrative Review. This project is eligible to file for Administrative review because: (Check all applicable)

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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.

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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.

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Exhibit 1

Executive Summary

Hi'olani Care Center at Kahala Nui is a 60-bed skilled/intermediate nursing facility located in Kahala Nui, a Continuing Care Retirement Community. Hi'olani Care Center currently services people in the community in addition to the residents of Kahala Nui. Hi'olani Care Center at Kahala Nui is owned by Kahala Senior Living Community, Inc and opened in May 2005. The decision to request conversion of 16 SNF/ICF beds to 16 SNF beds is requested to allow us to provide the full continuum of care for our residents. This conversion better meets the needs of our residents in compliance with the levels of care set forth by the State of Hawaii.

9a. Relationship to H2P2 – Hi'olani Care Center at Kahala Nui's relationship with H2P2 was established in application 00-30A. The change in bed designation will continue to meet the requirements of H2P2.

9b. Need and Accessibility – The programmatic success of Hi'olani Care Center and Kahala Nui is critically dependent on the availability of an integrated continuum of care which includes a 60-bed long term care facility. As provided for in the Hawaii Health Performance Plan (H2P2), Kahala Nui, as a community, desires to enhance and foster independence through enabling residents to reside in the lowest acuity residential environment possible. The need established in application 00-30A remains the same as the need for the swing beds. As such, the 16 SNF only beds will better service the needs of residents of the Hi'olani Care Center.

9c. Quality of Service/Care – Hi'olani Care Center at Kahala Nui is a skilled/intermediate care nursing facility licensed by the State of Hawaii and is in the process of applying for Medicare/Medicaid certification. Hi'olani Care Center is dedicated to providing the highest quality care in harmony with the wishes of each resident and their family. The Care Center focuses on quality of service/care through its Quality Assessment and Assurance Committee. The conversion of 16 swing beds to 16 SNF beds will require no additional changes to meet the requirements for quality established in 00-30A. Hi'olani Care Center will continue to be among Hawaii's top nursing facilities as it relates to quality of service and care.

9d. Cost and Finances – Hi'olani Care Center at Kahala Nui continues to operate on a financially sound basis and within the parameters as set forth in its annual budget (revenues, expenses, and net operating income). This conversion will require not additional capital costs. See attached analysis.

9e. Relationship to the Existing Health Care System – Hi'olani Care Center at Kahala Nui's 60-bed SNF/ICF relationship to the local health care system will not change as a result of 16 of its beds being designated as SNF. The beds will allow us to provide the

full continuum of care within our community with no additional capital outlay and no additional staff required.

9f. Availability of Resources-A revised designation from 60 SNF/ICF beds to 44 SNF/ICF and 16 SNF beds will have no affect on the revenues and expenses for Hi'olani Care Center at Kahala Nui's operations. No additional staff is required and no capital expense will be incurred.

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