



## HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

### ADMINISTRATIVE APPLICATION – CERTIFICATE OF NEED PROGRAM

Application Number 03-03A

Applicant: The ARC of Maui  
95 Mahalani Street, #17  
Wailuku, Maui  
Phone: 808-242-5781

Project Title: Increase the total number of beds to 5 Intermediate Care  
Facility/Mental Retardation (ICF/MR) beds

Project Address: 450-B Kanaloa Avenue,  
Kahului, Maui

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

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

**2. PROJECT LOCATION INFORMATION**

A. Project will be located in:

State Senate District Number:     4      
State House District Number:     8      
County Council District Number:   NA    
Neighborhood Board District Number (O`ahu only):   NA  

B. Primary Service Area(s) of Project: (please check all applicable)

Statewide: \_\_\_\_\_  
O`ahu-wide: \_\_\_\_\_  
Honolulu: \_\_\_\_\_  
Windward O`ahu: \_\_\_\_\_  
West O`ahu: \_\_\_\_\_  
Maui County:   X    
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)
- 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.)
- 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)

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					4 to 5
Outpatient Facility					
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
Intermediate Care Facility for mentally ret.	4	5	5
<b>TOTAL</b>	4	5	5

**6. PROJECT COSTS AND SOURCES OF FUNDS**

**A. List All Project Costs:**

**AMOUNT:**

1. Land Acquisition	NA
2. Construction Contract	NA
3. Fixed Equipment	NA
4. Movable Equipment	NA
5. Financing Costs	NA
6. Fair Market Value of assets acquired by lease, rent, donation, etc.	0
7. Other: _____	NA

**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:** \* \*

No capitol funds are required.  
Lease payments are funded through  
Federal and State funds.

RECEIVED  
03 FEB 10 2:53  
ST. HELENA  
& ELV. CONC.

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.

Change of service is based upon the need for severely  
impaired individuals to reside within the community, as

State Institution closed July 2000. Increase of one bed  
is requested - from four to five.

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,
- b) Dates by which other government approvals/permits will be applied for and received,
- c) Dates by which financing is assured for the project,
- d) Date construction will commence,
- e) Length of construction period,
- f) Date of completion of the project,
- g) Date of commencement of operation

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 Hawai'i Health Performance Plan (H2P2), also known as 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.

**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.
- The applicant believes it will not have a significant impact on the health care system.

## **8. Implementation Schedule:**

- A. Site Control has been in existence that was obtained through HUD in 1989
- B. No other approvals / permits are required
- C. Additional finances for this project are assured upon approval by SHPDA with Medicaid funds currently in existence for current operation.
- D. Construction is not required
- E. Not applicable – building exists
- F. Completion of increase beds will be upon approval by SHPDA (on increased beds)
- G. Commencement of operation will be by early spring or sooner. We remain in agreement with your CON implementation policy.

## **9. Executive Summary:**

The ARC of Maui submits herewith a request to increase our beds at Hale Kanaloa, an Intermediate Care Facility for the mentally retarded within the community (ICF / MR-C), from four (4) to five (5) beds.

Our request is based upon need for individuals who are developmentally disabled in need of twenty-four hour active treatment long-term care.

Further, the other resource, namely, the State School and Hospital at Wamanolo closed in July 2000.

The program will concentrate on severely impaired individuals who require 24-hour active treatment. This treatment begins with an Individualized Service Plan (ISP), coupled with resources such as nursing-psychologist-psychiatrically-nutrition-social work-recreation-therapeutic activities value the aegis of certified personnel.

Our past record of outside evaluations have shown a dramatic improvement in client's health i.e., loss of weight, dental services, up from wheelchair to ambulation, etc.

These evaluations have proved our efforts to serve. The cost will remain in force with the established rates by HMSA.

### **A. Relationship to Hawaii State Facilities Plan (HSFP):**

The existing Hawaii State Facilities Plan (HSFP) does not specifically address ICF/MR facilities. We have participated within the Hawaii State Facilities Plan. However, the focus seems to be on Mental Health. Developmental Disabilities while recognized, has not been a major factor listed.

**B. Need:**

**There is a vital need for an ICF/MR program. The ARC of Maui proposes to request one additional bed to the four (4) beds at Kanaloa ICF/MR level of care.**

The location is 450-B Kanaloa Ave., Kahului. The present clients now served in this facility require the higher-level ICF/MR service.

This more intense level of care is appropriate for the mental and physical limitations or impairments for the residents. As it supports both Federal and State Department of Health policies, which favors developmentally disabled person to remain in their community. The issues are:

- 1) The proposed service population is made up of developmentally disabled individuals of low income. With HUD regulations, individuals with chronic disabilities require support services or continuum of care to prevent homelessness.
- 2) The ARC of Maui is capable to provide personnel management and operational expertise without additional burdens to the Maui community. The services proposed are consistent with the Code of Federal Regulation 42: Section 440.180 which advocates Home and Community Based services as described in Section 441.300.
- 3) Recent Federal legal action continues to support community programs for individuals who are eligible to receive Medicaid services (ICF/MR).

**Accessibility:**

ICF/MR services shall be made available to any individual eligible by the Department of Health. An Interdisciplinary Team (IDT) indicates in the Individual Service Plan (ISP) that ICF level services are appropriate as the least restrictive alternative. Physician certifies a need for ICF/MR Placement.

This home (Kanaloa), was built to ADA standards for handicap accessibility, including entrances without stairs, wide bathroom doors, roll-in-shower stalls, grab handles and more.

Kanaloa represents a multi-cultural setting in which culturally appropriate customs and preferences are respected.



**C. Quality of Service / Care:**

- 1) The ARC of Maui currently operates 3 ICF / MR-C facilities, we have demonstrated a fine record of providing quality care.
- 2) The quality of service / care is based on an individual program plan (IPP) which identifies client needs and monitors client outcomes. A team of professional consultants (nurse, dietician, pharmacist, psychologist and recreation therapist) design and monitor treatment plans. Trained direct care staff implements the individual's program plan. The ratio of direct care staff to clients is approximately 1:2 in the ICF / MR Program based on high client needs. A case manager coordinates and manages the overall client's program. The ICF / MR Program includes a quality assurance review and utilization review which is completed by non-agency related professionals.
- 3) As with our three (3) existing facilities, this request to increase a bed will meet Licensure and Certification requirements.

**D. Cost Finances**

	FISCAL ANALYSIS		
	KANALOA ICF/MR	10/01/99-06/30/02	
	10/01/99-06/30/00	07/01/00-06/30/01	07/01/01-06/30/02
<b>INCOME</b>			
ICF/MR Inpatient Room & Care	236,428.92	316,104.60	325,587.74
<b>TOTAL INCOME</b>	<b>\$236,428.92</b>	<b>\$316,104.60</b>	<b>\$325,587.74</b>
<b>EXPENDITURES</b>			
SALARIES	170,756.25	227,675.00	234,505.25
FICA	13,062.85	17,417.14	17,939.65
SUTA	3,842.02	5,122.69	5,276.37
WORKER'S COMP	4,610.42	6,147.23	6,331.64
TDI	717.18	956.24	984.92
HEALTH CARE	10,124.46	14,365.31	14,796.27
TELEPHONE	360.00	480.00	494.40
BANK SERVICE CHARGES	45.00	60.00	61.80
ELECTRICITY	900.00	1,200.00	1,236.00
SEWER	202.50	270.00	278.10
WATER	675.00	900.00	927.00
STAFF TRAINING	918.00	1,224.00	1,260.72
PROGRAM ACTIVITIES	750.00	1,000.00	1,030.00
VEHICLE REPAIR	900.00	1,200.00	1,236.00
GAS & MILEAGE	1,350.00	1,800.00	1,854.00
PROP & PROF LIABILITY INS	900.00	1,200.00	1,236.00
AUTO INSURANCE	1,256.25	1,675.00	1,725.25
HOUSEHOLD ALLOWANCE	11,700.00	15,600.00	16,068.00
PROFESSIONAL CONSULTANTS	3,780.00	5,040.00	5,191.20
PROGRAM SUPPLIES	1,800.00	2,400.00	2,472.00
OFFICE SUPPLIES	450.00	600.00	618.00
AUDIT	877.50	1,170.00	1,205.10
CLIENT RENT	3,204.00	4,272.00	4,400.16
CLIENT ALLOWANCE	1,080.00	1,440.00	1,483.20
OFFICE RENT	2,167.50	2,890.00	2,976.70
<b>TOTAL EXPENDITURES</b>	<b>\$236,428.92</b>	<b>\$316,104.60</b>	<b>\$325,587.74</b>
<b>EXCESS (DEFICIT) FROM OPERATION</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**E. Relationship to Existing Health Care System:**

The proposed increased bed will relate well to the existing health care system that it will meet the need on Maui for high quality ICF / MR services.

*Relationship to the existing health care system exists with:*

- 1) Department of Health for referrals to the ICF / MR
- 2) Department of Human Services for Licensure and Certification of the ICF / MR Facility and Program.

**F. Availability of Resources:**

The financial resources remain available through Federal and State reimbursement funds. The QMRP (Qualified Mental Retardation Professionals) already exist.

The ARC of Maui continues to search to locate resources both fiscal and programmatic. The following items serve as examples:

- Foundations
- Department of Health
- Department of Human Services
- Local Civic Groups
- Churches
- Families
- Fund Raising Efforts
- Public Relations – Market our efforts – new website developed

Our Board of Directors represents a cross section of the community. It includes parent, community leaders, business and county government representation. Their strong, viable ties enable The ARC of Maui to continue our services with support.