HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION – CERTIFICATE OF NEED PROGRAM

Application Number 05-02A

Applicant: Life Care Services of Hawaii dba Hale Ola Kino
1314 Kalakaua Avenue, 2nd floor
Honolulu, HI 96826
Phone: 808-983-4450

Project Title: Change of 32 SNF beds to SNF/ICF beds

Project Address: same

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

Public	____
Private	__X__
Non-profit	____
For-profit	__X__
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:	____
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)-**See Exhibit 1**

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 Exhibit 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-**Exhibit 3**
- By-Laws-**Exhibit 4**
- Partnership Agreements-**Not Applicable**
- Tax Key Number (project's location)-**421410435**

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				X	X
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
SNF	**32**	**-32**	**0**
SNF/ICF	**0**	**+32**	**32**
TOTAL	**32**	**0**	**32**

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.

Per the recommendation of the Office of Health Care Assurance, State of Hawaii Department of Health, Hale Ola Kino is requesting that its *Certificate of Need be changed from an SNF designation to an SNF/ICF* designation for 32 beds.

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,-**Not Applicable**
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**
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-**Not Applicable**

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 Executive Summary, Exhibit 5**

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.

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