HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: 10-13A Date of Receipt:
To be assigned by Agency

APPLICANT PROFILE

Project Title: **CHANGE OF OWNERSHIP**

Project Address: GENTRY PACIFIC DESIGN CENTER, 560 NORTH NIMITZ HIGHWAY, SUITE 204, HONOLULU, HI, 96817. **PLEASE SEND CORRESPONDANCE TO THE ADDRESS BELOW.**

Applicant Facility/Organization: ISLANDS HOSPICE, INC.

Name of CEO or equivalent: ROGER A. BRUHN

Title: DIRECTOR

Address: 2021 SOUTH LEWIS AVENUE, SUITE 250, TULSA, OK 74105.

Phone Number: 918.894.3487 Fax Number: 918.392.4542.

Contact Person for this Application: ROGER A. BRUHN

Title: DIRECTOR

Address: SAME

Phone Number: SAME. Fax Number: SAME.

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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]
Signature

11.29.10
Date

R. A. BRUHN
Name (please type or print)

DIRECTOR
Title (please type or print)

REPLACEMENT PAGE

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

Public	____
Private	x
Non-profit	x
For-profit	____
Individual	____
Corporation	x
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:	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 ATTACHED)**

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.)

N/A

C. Your governing body: list by names, titles and address/phone numbers

(SEE ATTACHED)

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)

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					
Private Practice					

N/A

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.

N/A

Type of Bed	Current Bed Total	Proposed Beds for your Project	Total Combined Beds if your Project is Approved
TOTAL			

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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:	**FMV at time of transfer**	**$166,263**
		TOTAL PROJECT COST:	**$166,263**

B. Source of Funds

1.	Cash		________
2.	State Appropriations		________
3.	Other Grants		________
4.	Fund Drive		________
5.	Debt		________
6.	Other:	**Asset transfer from Ministry Research Inc., to Islands Hospice, Inc.**	**$166,263**
		TOTAL SOURCE OF FUNDS:	**$166,263**

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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.

N/A

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:

N/A

a) Date of site control for the proposed project,
September 1, 2009
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,
N/A
g) Date of commencement of operation

9. **UPON CON APPROVAL OR UPON NOTIFICATION OF APPROVAL FROM SHPDA – WHICHEVER IS LATER.**

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.

10. **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 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.

(SEE ATTACHED)

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11. 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.

__x___ 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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Accompanying Documentation for
SHPDA Administrative Review Application to
PROJECTION TITLE: SUBSTANTIALLY RELATED ENTITY CHANGE OF NAME FROM MINISTRY RESEARCH, INC., DBA ISLANDS HOSPICE TO ISLANDS HOSPICE, INC.

DOCUMENTATION

1. Board of Directors Resolution dated September 1, 2009.
2. Our governing body is as follows:

   Ed Gungor, President & Director, 2021 South Lewis Avenue, Suite 250, Tulsa, OK 74133
   Gail Gungor, Vice Pres. & Director, 2021 South Lewis Avenue, Suite 250, Tulsa, OK 74133
   Roger Bruhn, Sec./Treas. & Director, 2021 South Lewis Avenue, Suite 250, Tulsa, OK 74133

3. IRS Determination letter stating our approval as a tax-exempt nonprofit corporation
4. Form SS4 – FEIN
5. Certificate of Nonprofit Corporation
6. Article of Incorporation and corporate by-laws

EXECUTIVE SUMMARY

Ministry Research, Inc., DBA Islands Hospice received its Certificate of Need from SHPDA in October, 2008. Since that time it has completed a CHAPs survey and received approval and funding as a Medicare Provider.

In September, 2009, the Board of Directors of Ministry Research, Inc., determined that it would be prudent to incorporate Islands Hospice as its own stand-alone corporation. We did so at that time (See attached documentation). And we completed the process to become a tax-exempt nonprofit organization under IRS code 501c3. The IRS Determination Letter is attached.

At the time of incorporation we were undergoing the approval process to become a Medicare Provider. We received that approval in November, 2009, and began receiving funds as a provider in the summer, 2010. Now that we have completed these state and federal approvals, we are informing both the State of Hawaii and Medicare via National Government Services, a) of our desire to be recognized as Islands Hospice, Inc., b) to use the new FEIN and c) to no longer be recognized as Ministry Research, Inc., DBA Islands Hospice. The entities are substantially related, in that:

- The Board of Directors remain the same
- The Officers remain the same
- The staff remains the same
- The location remains the same

There is no cost related to this transfer.

The transfer will not impact the community.

The transfer will not affect our continued care.

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RELATIONSHIP TO THE STATE OF HAWAII HEALTH SERVICES AND FACILITIES PLAN:
The project's relationship to HSFP was approved by CON 08-10. The project will continue to be consistent with that plan after SHPDA's approval of this Administrative CON. Nothing in this application contemplates a change in the proposal's relationship to HSFP.

NEED AND ACCESSIBILITY:
The need for the proposal is established in CON 08-10. Access to our services will remain the same. And we will continue to serve both the underserved population on Oahu, as well as some low income and unfunded patients.

QUALITY OF SERVICE / CARE:
The quality of service was established in CON 08-10. No changes in our quality of care will take place as a result of this application.

COST & FINANCES:
The cost and finance requirements were met in CON 08-10. There are no changes contemplated in this application. As stated in the application, the value of the DBA will be transferred to the new corporation.

Below are the results for year one and the projected results for year 3:

2008 Actual	**(YEAR ONE)**
Income	$26,305
Expense	$130,323

2011 PROJECTED	**(YEAR THREE)**
Income	$3,978,000
Expense	$3,381,300

We do not expect the financials of the company to change as a result of this application.

RELATIONSHIP TO EXISTING SYSTEM:
The relationship to the existing system requirement was met in CON 08-10. No changes will occur as a result of this application.

AVAILABILITY OF RESOURCES:
This requirement was met in 08-10. These are no additional cash resources that result from this application, since the assets of the DBA are being transferred to the new corporation. Our staffing requirements are currently met – and no changes to staffing are contemplated in this application.