HAWAI`I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #10-16a (To be assigned by Agency) Date of Receipt:

APPLICANT PROFILE

Project Title: **Change of Ownership and deletion of 15 Skilled Nursing Facility / Intermediate Care Facility beds**

Project Address: **2787 Winam Ave, Honolulu, HI**

Applicant Facility/Organization: **SYS East, LLC**

Name of CEO or equivalent: **Sandra Shim**

Title: **Manager**

Address: **2220 McKinley Street, Honolulu, HI 96822**

Phone Number: **(808)943-8767** Fax Number: **(808)356-0808**

Contact Person for this Application: **Rory Loughran**

Title: **Project Manager**

Address: **2042 Linohau Way, Honolulu, HI 96822**

Phone Number: **(808)447-7679** Fax Number: **(808)356-0808**

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 Date 11-20-2010

Sandra Shim Name (please type or print)

Manager, SYS East LLC Title (please type or print)

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

Public	_____
Private	__x__
Non-profit	_____
For-profit	__x__
Individual	_____
Corporation	_____
Partnership	_____
Limited Liability Corporation (LLC)	__x__
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 attached Letter of Intent and Lease Agreement**

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.) **No other approvals or permits are required to make the proposed changes.**

C. Your governing body: list by names, titles and address/phone numbers **Sandra Shim, Manager, SYS East, LLC, 2220 McKinley Street, Honolulu. 808-943-8767**

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 **See Attachment**
- By-Laws **N/A**
- Partnership Agreements **N/A**
- Tax Key Number (project's location) **2-7-35: 52**

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/ICF	**42**	**-15**	**27**
TOTAL	**42**	**-15**	**27**

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.	100,000
7.	Other: _____	
	TOTAL PROJECT COST:	$100,000

B. Source of Funds		
1.	Cash	
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other: FMV of assets acquired by transfer	$100,000
	TOTAL SOURCE OF FUNDS:	$100,000

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.

The proposed project includes transferring ownership of the Certificate of Need from SYS Land Corp to SYS East, LLC a w holly owned subsidiary of SYS Land Corp managed by Sandra Shim. The change in service is a proposed deletion of 15 skilled nursing / intermediate care 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, **Oct 15, 2010**
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, **12/1/2010 or upon approval by SHPDA**
g) Date of commencement of operation, **8/1/2010 or upon licensing by the State Dept of Health**

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.

The proposed project includes 1) a change in ownership of the to-be-built business and 2) the deletion of 15 skilled nursing/intermediate care beds.

1) **The proposed change of ownership of the CON will be from SYS Land Corp (current owner) to SYS East, LLC (proposed owner), a wholly owned subsidiary of SYS Land Corporation. Business operations will be conducted by SYS East, LLC. The property will be owned by Sandra Yee Shim Revocable Living Trust and leased to SYS East, LLC.**

2) **The applicant was originally approved for 42 SNF/ICF beds. In prior correspondence SHPDA had approved the facility to be built in two phases; 27 beds for phase one and 15 more beds for phase two. However, the lender has indicated that they will commit only to building phase one and therefore require the deletion of the phase two beds (15 beds) as a condition for project funding. The applicant would still like to build phase two of the project, however, lender restrictions require removal of phase two from the plan in order to prevent future non-compliance should phase two prove economically unfeasible.**

a) Relationship to the State of Hawai`i Health Services and Facilities Plan.

The previous project was consistent with the previous Health Services and Facilities Plan and this project will be consistent with the new Health Services and Facilities Plan. Because there are no new beds being proposed the utilization thresholds are not applicable. This project is consistent with Chapter 3 of the new plan. It is supportive of Statewide Health Coordinating Council (SHCC) Priorities because its approval will help to ensure capacity and access to a continuum of long-term care services. Additionally it is in line with the Honolulu Sub-Area Council Priorities because it will increase the availability of long-term care services.

b) Need and Accessibility

The need and accessibility for the project was established in application 09-03 and the needs still continues for skilled nursing / intermediate care beds. There will be no changes to the accessibility of the project that was established in the prior application. The lending institution financing the construction of the facility has required the deletion of 15 beds as a condition for financing. If the need exists for a 42 bed nursing facility then the need must also exist for a 27 bed facility. Although a 42 bed nursing facility would better fill the need than a 27 bed facility, disapproval of the proposed bed deletion would seriously jeopardize the project financing and therefore inhibit construction of the facility. Since there is a high need for long-term care beds, construction of a 27 bed facility is a better option than no facility being constructed at all. Therefore approval of the proposed bed deletion is consistent with meeting the needs for long-term care beds.

c) Quality of Service/Care

The Quality of Care criteria were met in application 09-03. Manoa Cottage has a strong track record for providing high quality service. The change of ownership from one entity to another related entity will have no effect on the quality of care or service provided. The reduction of the total number of beds from 42 to 27 will have no impact on the quality of care and service that we provide.

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

	1st year fiscal yr. start 9/1/2011	3rd year fiscal yr. start 9/1/2013
Income		
Gross Revenue (27 SNF/ICF beds)	2416720	2706000
Expenses		
Wages	820000	902000
Mortgage	384000	384000
Leased equipment	120000	120000
Other expenses	327500	356621
Total Expenses	1651500	1762621

The proposed changes will have no impact on costs of healthcare service provided to the community. At 27 beds the project is still financially feasible as indicated by the income/expense chart above.

e) Relationship to the existing health care system

The change of ownership will have no impact on the existing healthcare system. Although the deletion of 15 beds would have a negative impact on the healthcare system as seen on paper, it is necessary for the construction of the facility and therefore will have a net positive impact on the healthcare system by providing an additional 27 SNF/ICF beds to residents of the community.

f) Availability of Resources.

No financial resources are necessary for the change of ownership and there is no money changing hands between the new entity and previous entity. The new entity, SYS East, LLC (as business operator and lessee), in conjunction with Sandra Yee Shim Revocable Living Trust (as property owner/lessor) have been approved for conditional financing through the lender requiring the bed deletion.
Resources available to staff the 42 bed facility were included in application 09-03 and nothing has changed. It will actually be easier to staff the 27 bed facility verses the 42 bed facility.

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.

__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.