HAWAI`I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #11-05A Date of Receipt:
To be assigned by Agency

APPLICANT PROFILE

Project Title: Renovation Project

Project Address: 226 North Kuakini Street

Honolulu, Hawaii 96817

Applicant Facility/Organization: Rehabilitation Hospital of the Pacific

Name of CEO or equivalent: Clair Jones

Title: President & CEO

Address: 226 North Kuakini Street, Honolulu HI 96817

Phone Number: 808-566-3471 Fax Number: 808-544-3335

Contact Person for this Application: Clair Jones

Title: President & CEO

Address: 226 North Kuakini Street, Honolulu HI 96817

Phone Number: 808-566-3471 Fax Number: 808-544-3335

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.

Clair Jones

Signature

December 17, 2010
Date

Clair Jones
Name (please type or print)

President & CEO
Title (please type or print)

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:	

Primary service area is Oahu – accept patients from other islands

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

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent) – not applicable, existing site
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.) Building Permit
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 – not applicable
   - Tax Key Number (project's location) – TKM#170140420000

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		
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
TOTAL			

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	_____
2.	Construction Contract	$6,223,000
3.	Fixed Equipment	$2,888,700
4.	Movable Equipment	_____
5.	Financing Costs	_____
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	_____
7.	Other: Patient care related costs	
	TOTAL PROJECT COST:	**$9,111,700**

B. Source of Funds

1.	Cash	$8,000,000
2.	State Appropriations	_____
3.	Other Grants	_____
4.	Fund Drive	$1,111,700
5.	Debt	_____
6.	Other: _____	_____
	TOTAL SOURCE OF FUNDS:	**$9,111,700**

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.

Not applicable

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, - Building Permit – May 2011
c) Dates by which financing is assured for the project, - existing
d) Date construction will commence, - July 2011
e) Length of construction period, - 1 year 9 months
f) Date of completion of the project, - April 2013
g) Date of commencement of operation – operations ongoing throughout project duration

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 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.

Executive Summary

Project Summary:

REHAB, the only medical rehabilitation hospital in the State of Hawaii, is preparing to renovate to meet the current and future needs of patients. In this unique position as an integral part of the health care system, we need to address the needs of a growing number of elderly, the continuing increase in patient acuity and complexity and age of the building (over 50 years old). Our goals are to improve the building infrastructure, provide a healing environment and promote quality, safety and operational efficiencies. The renovation will not add any new square footage to the building. Building enhancements will include central air conditioning, hurricane resistant windows, wall suction and O2 with ceiling lifts in selected rooms and new patient room amenities to name a few.

A) Relationship to the State of Hawaii Health Services and Facilities Plan

The purpose of this application is to renovate the current facility providing a modern "state of the art" hospital for rehabilitation care. This project is consistent with and supports the State Plan health system priorities to include:

1. Maintain access to quality care at a reasonable cost for citizens with physical impairments/disabilities due to injury and or illness.
2. Strengthen REHAB's current integral role in promoting and supporting the long term viability of the health care delivery system.
3. Maintain and expand the number of professional rehabilitation physicians and clinical personnel (including rehab nursing, physical, occupational and speech therapies) vital to insure accessible, appropriate and quality based care. Serve as an educational internship site for rehab professionals in training.
4. Ensure access to a continuum of long term care services or post acute care services.
5. Promote awareness of cost effective rehabilitation programs that return patients back to home and community.

B) Need and Accessibility

During the renovation REHAB will remain open with no impact on patient access to rehabilitation services.

The renovation will provide a state of the art facility to increase the ability to handle patients with increasing medical acuity and complexity, ages 14+ including the rapidly growing increase in the elderly population and patients with chronic diseases, in our core inpatient programs for stroke, spinal cord and brain injury, amputee, complex orthopedic, medical debility and other neurological conditions.

C) Quality of Service/Care

REHAB is in compliance with federal and state licensure and certification requirements and is accredited by the Joint Commission.

The renovation project will create a transformed environment that installs wall suction/02, central air conditioning, hurricane resistant windows, and in room ceiling patient lifts to meet medical needs, patient and staff safety. This will improve our ability to meet the medical necessity needs of our patient population, enhance and expand programs/services, meet accreditation and regulatory requirements and improve our image in the community. This project will facilitate these outcomes:

1. Transfer of acute hospital patients to REHAB earlier.
2. Increase gains in mobility, self care and discharge to home and community.
3. Provide an environment for staying well and healthy by reducing falls, incontinence and skin breakdowns.
4. Increase patient and family satisfaction.
5. Improve physician and referring hospital relationships.
6. Create a center of excellence for training of rehabilitation professionals.

The renovation project will sustain and enhance the quality comprehensive services that REHAB is known for.

D) Cost and Finances

No impact to overall costs of health service to the community. Renovation costs will not increase cost to patients. Reimbursement to REHAB is determined by government fee schedules.

REHAB will use cash reserves and conduct a capital campaign to secure the total funding for this project. REHAB Hospital's Foundation has the structure, personnel and a demonstrated ability to conduct a campaign and raise the necessary funds for this project based on previous campaigns.

Revenue and cost projections for the first and third year of operation follow:

Category	First year-2014	Third year-2016
Net Revenue	$38,342,511	$42,887,446
Expenses	38,872,624	41,869,681
Operating Margin	(530,113)	1,007,765
Net Operating Margin	$ 1,067,836	$ 2,898,688

E) Relationship to the Existing Health Care System

REHAB Hospital of the Pacific is the only acute inpatient rehabilitation hospital in Hawaii. REHAB provides both inpatient and outpatient services to all referring hospitals and health care providers which will continue throughout the building renovation and beyond.

F) Availability of Resources

Resources to include health personnel, management and funding for this renovation project are available. No new staff is required to implement this project.