HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #14-15A
To be assigned by Agency

Date of Receipt:

RECEIVED
'14 DEC -8 P1:12
ST. HLTH. PLAN. & DEV. AGENCY

APPLICANT PROFILE

Project Title: Deletion of 12-Special Treatment Facility beds

Project Address: 73-4697 Hina Lani

Kailua-Kona, HI 96740

Applicant Facility/Organization: Hawaii Island Recovery, LLC

Name of CEO or equivalent: John A. Hibscher, Ph.D.

Title: Owner and CEO

Address: 75-170 Hualalai Road, Ste. C311, Kailua-Kona, HI 96740

Phone Number: 808-329-1281 Fax Number: 808-329-1281

Contact Person for this Application: Eliza Wille

Title: Program Director

Address: 75-170 Hualalai Road, Ste. C311, Kailua-Kona, HI 96740

Phone Number: 808-938-8707 Fax Number: 808-329-1281

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

John A. Hibscher, Ph.D.
Name (please type or print)

CEO
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:	____
Honolulu:	____
Windward O`ahu:	____
West O`ahu:	____
Maui County:	____
Kaua`i County:	____
Hawai`i County:	__X__

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 Attachment A**
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

Ownership Information

Corporate Information

Name	Hawaii Island Recovery LLC
Type	Member Managed
Address	P.O. Box 785, Kailua-Kona, HI 96745
Phone	808-329-1281
Fax	866-922-0689

Member Manager

Name	Dr. John A. Hibscher
Address	75-170 Hualalai Road, Ste. C311A Kailua-Kona, HI 96740
Phone	808-329-1281
Fax	866-922-0689

Member

Name	Ludmilla Hibscher
Address	75-170 Hualalai Road, Ste. C311A Kailua-Kona, HI 96740
Phone	808-329-1281
Fax	866-922-0689

Member

Name	Jan Seifert
Address	75-170 Hualalai Road, Ste. C311A Kailua-Kona, HI 96740
Phone	808-329-1281
Fax	866-922-0689

Member

Name	Leos Holub
Address	Dobrodruzna 758, Liberec 25, Czech Republic 46312
Phone	420602492161
Fax	n/a

Board of Directors: None

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 B**
   - By-Laws **See Attachment B**
   - Partnership Agreements **N/A**
   - Tax Key Number (project's location): **7-3-047-032**

5. **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					

6. **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
STF	20	-12	8
TOTAL	20	-12	8

8. **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**

1.	Cash	_____
2.	State Appropriations	_____
3.	Other Grants	_____
4.	Fund Drive	_____
5.	Debt	_____
6.	Other:	_____

TOTAL SOURCE OF FUNDS: **$ 0**

9. **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

10. **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, **7/25/2014**
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 **NA**

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.

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 BELOW

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.

12. **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.

9. EXECUTIVE SUMMARY

a) Relation to the State Plan Criteria

The project's relation to the State Plan was demonstrated in Certificate of Need Approval no. 13-01. The deletion of 12 beds will not change the project's relationship to the State Plan.

b) Need and Accessibility

Certificate of Need Approval No. 13-01 demonstrated the need for at least 20 beds. We believe that there is still a need for at least 20 beds. However, Hawaii Island Recovery (HIR) was not able to continue at the former location and have had to move to a new location that has only 8 beds. It is HIR's intention is to increase back to 20 beds as soon as they are able.

c) Quality of Service/Care

The project's relation to the State Plan was demonstrated in Certificate of Need Approval no. 13-01. The deletion of 12 beds will not change the project's Quality of Service/Care.

d) Cost and Finances

The project's relation to the State Plan was demonstrated in Certificate of Need Approval no. 13-01. The deletion of 12 beds will not change the project's relative cost and finances.

HIR projects the following sales and costs over a 3-year period:

	2015	2017 (after STF accreditation)
Sales:	$ 520,000	$1,800,000
Costs:	$ 485,000	$1,020,000
Profit:	$ 35,000	$ 780,000
	6.73%	43.33%

Treatment of alcohol and drug abuse will reduce chronic overutilization of hospital emergency room services and an extensive array of related health issues caused by alcohol and drug abuse.

HIR will continue to help to fill the gap between supply and demand for substance abuse treatment on the Big Island and State of Hawaii and hence will be a positive shared addition to already existing treatment programs in Hawaii.

Certification of HIR as an STF will allow for third party reimbursement and thereby will make services available to all in need of treatment for alcohol and drug abuse treatment. Physical accessibility to Hawaii residents will reduce the added cost and inconvenience of travel to the mainland for treatment.

Treatment for alcohol and drug abuse will reduce chronic overutilization of hospital emergency room and a myriad of other health services necessitated due to alcohol and drug abuse and dependence.

e) Relationship to the existing healthcare system

The project's relation to the State Plan was demonstrated in Certificate of Need Approval no. 13-01. The deletion of 12 beds will not change the project's relationship to the existing healthcare system.

f) Availability of Resources

The project's relation to the State Plan was demonstrated in Certificate of Need Approval no. 13-01. The deletion of 12 beds will not change the project's availability of resources.