HAWAI`I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #15-19A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Add 2 Acute/Long Term Swing AND Delete 2 SNF/ICF

Project Address: 56-117 Pualalea Street
Kahuku, HI 96731

Applicant Facility/Organization: Kahuku Medical Center

Name of CEO or equivalent: Stephany Vaioleti

Title: President/Chief Executive Officer

Address: 56-117 Pualalea Street, Kahuku, HI 96731

Phone Number: (808) 293-9221 Fax Number: (808) 293-2262

Contact Person for this Application: Jonathan Pantenburg

Title: Chief Financial & Operating Officer

Address: 56-117 Pualalea Street, Kahuku, HI 96731

Phone Number: (808) 293-9221 Fax Number: (808) 293-1574

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

9/16/15
Date

Jonathan Pantenburg
Name (please type or print)

VP/CFOO
Title (please type or print)

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: _____	____

2. **PROJECT LOCATION INFORMATION**

A. Primary Service Area(s) of Project: (please check all applicable)

Statewide:	____
O`ahu-wide:	____
Honolulu:	____
Windward O`ahu:	x
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)
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
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)

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
Acute/Long Term Swing	13	+2	15
SNF/ICF	8	-2	6
TOTAL	21	0	21

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.

Change of service will involve converting two (2) SNF/ICF beds to 2 Acute/Long Term Swing.

The beds being converted are identical in configuration and the respective rooms are contiguous.

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,
b) Dates by which other government approvals/permits will be applied for and received,
c) Dates by which financing is assured for the project,
d) Date construction will commence,
e) Length of construction period,
f) Date of completion of the project,
g) Date of commencement of operation

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.

KAHUKU MEDICAL CENTER

Kahuku Medical Center
56-117 Pualalea Street
Kahuku, HI 96731

Hawaii State Health Planning and Development Agency
Certificate of Need Program

Section 3: Documentation

a) Not Applicable
b) OHCA License and Medicare Certification (if applicable)
c) Governing Body

Barbara Kahana	– Chair / Director
Creighton Mattoon	– Vice Chair / Director
Paul Nielson	– Secretary / Director
William Wood	– Director
Robert Akoi	– Director
Sarah Cadiz	– Director
Dee Dee Letts	– Director
Lance Segawa	– Director
Stephany Vaioleti	– President / CEO
Jonathan Pantenburg	– Vice President / CFO / Treasurer

d) Articles of Incorporation (2nd Application this Calendar Year)
By-Laws (2nd Application this Calendar Year)
Partnership Agreements – Not applicable
Tax Key Number: 01-05-06-0006-0013-0000

Section 8: Implementation Schedule

a) Not Applicable
b) Application for appropriate SNF/ICF bed license change through the Hawaii Department of Health. Within 15 days after approval from SHPDA.
c) Not Applicable
d) Not Applicable
e) Not Applicable
f) Not Applicable
g) Upon license approval; see 8(b) above.

Section 9: Executive Summary

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

This Administrative Certificate of Need Application for converting 2 SNF/ICF beds to 2 Acute/Long Term Swing beds is in alignment with the Hawaii Services and Facilities Plan. Key Hawaii goals and objectives for realizing its vision are consistent with the Kahuku Medical Center Administrative Certificate of Need Application:

- Focus on increasing cost-effective access to necessary health care services;
- Promote financial viability of the health care delivery system;
- Encourage optimization of services…by ensuring that supply meets the need and costs are reasonable; and
- Promote regionalization of services where appropriate.

b) **Need and Accessibility**

Kahuku Medical Center is in the Windward Oahu Sub Area Health Planning Region for the State of Hawaii. The hospital is the only primary service provider in the broad rural area of north Oahu known as Ko`olauloa. The hospital also services residents living as far away as Waialua and Kaaawa. Situate in the town of Kahuku, the center of the service area, Kahuku Medical Center serves as north Oahu's only safety net. The nearest hospitals are an hour drive in either direction.

The Ko`olauloa service rea of Oahu is home to over 22,500 residents. The population is comprised of a diverse cultural blend of native Hawaiians, Polynesians, Caucasians, and Asians. Native Hawaiians account for roughly 25% of the population of the Ko`olauloa area.

Approval of this application would allow the residents of the Ko`olauloa area of Oahu more accessibility for Acute/SNF/ICF services within the community. Currently, patients have to receive services outside the service area due to the limited number of beds. Kahuku Medical Center is the only provider in this service area with Acute/SNF/ICF beds.

Deleting the 2 SNF/ICF beds will have no substantial long term impact on the community or hospital. Adding 2 Acute/Long Term Swing beds will allow the hospital to more effectively serve the patients in the demographic area. In addition, the 2 Acute/Long Term Swing beds will allow the hospital more flexibility in providing care to patients.

Kahuku Medical Center is a 501(c)3 tax exempt general acute care hospital and has a policy of being accessible to all residents in the service area.

c) Quality of Service/Care

Kahuku Medical Center is licensed by the State of Hawaii and certified for Medicare/Medicaid programs as surveyed by the State Department of Health (copies of acute and SNF licenses attached).

Patients remain more accessible to their family and friends as well as personal care physician when remaining in their own community. This helps in the patients healing process as well as provides time for the staff to interact with the families and encourage their participation as indicated.

d) Cost and Finances

It is estimated that converting the bed from SNF/ICF to Acute/SNF/ICF will improve annual revenues by approximately $400,000 per year, depending on the mix of patients. Revenue increases would remain the same for year 1 and 3.

e) Relationship to existing health care system

Availability and accessibility to Acute/Long Term Swing care levels will be improved and more patients will be able to be appropriately cared for within the Kahuku area. Because Kahuku Medical Center is the only hospital within the Ko'olauloa community, any impact on other providers in the health planning area is minimal.

f) Availability of Resources

This bed designation will utilize existing hospital staff. Staffing needs will be assessed on a continuous basis and additional staff will be recruited if needed. As indicated in section 6(a), no capital resources will be needed for this proposal.