HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #16-12A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Reduction of 40 acute medical/surgical beds

Project Address: 347 North Kuakini Street, Honolulu, Hawaii 96817

Hale Pulama Mau Building, 7th Floor

Applicant Facility/Organization: Kuakini Medical Center

Name of CEO or equivalent: Gary K. Kajiwara

Title: President and Chief Executive Officer

Address: 347 North Kuakini Street, Honolulu, Hawaii 96817

Phone Number: (808) 547-9231 Fax Number: (808) 547-9547

Contact Person for this Application: Gregg Oishi

Title: Senior Vice President and Chief Administrative Officer

Address: 347 North Kuakini Street, Honolulu, Hawaii 96817

Phone Number: (808) 547-9231 Fax Number: (808) 547-9547

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

October 13, 2016
Date

Gary K. Kajiwara
Name (please type or print)

President and Chief Executive Officer
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:	X
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) **Not Applicable**
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.) **Not Applicable**
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 **Attached**
   - By-Laws **Attached**
   - Partnership Agreements **Not Applicable**
   - Tax Key Number (project's location) **TMK# 1-1-7-017-002-0000-000, location is Kuakini Medical Center, 347 North Kuakini Street, Honolulu, Hawaii 96817**

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 Medical/Surgical	265	-40	225
Critical Care	25	--	25
Acute/Long Term Swing Beds	10	--	10
TOTAL	300	-40	260

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.

Kuakini Medical Center will reduce 40 acute medical/surgical beds to allow The Queen's Medical Center to establish a 40 bed acute care unit to provide care for its waitlisted patients on the 7th floor of the Hale Pulama Mau (HPM) Building located at 347 North Kuakini Street, Honolulu, HI 96817. The HPM Building 7th floor will be leased by The Queen's Medical Center from Kuakini Medical Center. 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, **Not Applicable**
c) Dates by which financing is assured for the project, **Not Applicable**
d) Date construction will commence, **Not Applicable**
e) Length of construction period, **Not Applicable**
f) Date of completion of the project, **Not Applicable**
g) Date of commencement of operation **Not Applicable**

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.

8. **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.

Kuakini Medical Center (Kuakini) and The Queen's Medical Center (Queen's) recognize the importance of caring for our communities and have a common interest to ensure that acute care services are available to meet the needs of the communities we serve. In calendar year 2015, Queen's had an estimated 371 patients in acute care beds who were waitlisted for 10 or more days. Relocating such waitlisted patients to the 7th floor of the Hale Pulama Mau (HPM) Building will provide improved access to acute care services for Queen's patients.

The 7th floor of the HPM Building has been vacant for two decades. Previously, the HPM Building 7th floor was used to provide acute care services. Kuakini is supportive of leasing the HPM Building 7th floor to Queen's to provide care for

its waitlisted patients. The HPM Building 7th floor will house 40 acute medical/surgical beds for Queen's waitlisted patients.

Upon notification to SHPDA by both Kuakini and Queen's of the termination of the HPM Building 7th floor lease to Queen's, the 40 acute medical/surgical beds will revert back to Kuakini's SHPDA approved medical/surgical bed count.

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

The reduction of 40 acute medical/surgical beds to allow Queen's to establish a 40-bed acute care unit to provide care for its waitlisted patients meets the priorities under the State of Hawaii Health Services and Facilities Plans including the increasing cost-effective access to necessary health care services, promoting and strengthening the viability of the health care delivery system, and optimizing services to ensure that the people of Hawaii have overall access to high quality acute care services.

b) Need and Accessibility

The reduction of 40 acute medical/surgical SHPDA approved beds will not have any impact on patient access to care at Kuakini since the medical/surgical beds on the HPM Building 7th floor has not been used for patient care for over ten years. Kuakini's current licensed beds are adequate to provide access to care for patients requiring acute medical/surgical inpatient services.

c) Quality of Service/Care

Not Applicable

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

Kuakini will not incur any capital cost for the reduction of the 40 acute medical/surgical beds to allow Queen's to establish a 40-bed acute care unit for its waitlisted patients. Queen's will be funding any repairs and renovations of the HPM Building 7th floor to meet the needs of Queen's patients and to comply with state and federal regulatory requirements.

e) Relationship to the existing health care system

Kuakini's reduction of 40 acute medical/surgical beds and leasing of the HPM Building 7th floor to Queen's will have a positive impact on the existing health care system. Waitlisted patients occupying acute care beds limit the access to acute care services and results in delays for patients in the emergency room to be admitted to acute care beds, and also results in the overcrowding of the emergency room and divert of ambulances to other emergency facilities. Hawaii hospitals have been experiencing a shortage in post-acute care options in the community due to inadequate reimbursements from Medicare and Medicaid for post-acute care services.

f) Availability of Resources.

Not Applicable

9. **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.