



HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM # 19-09A

Application Number: # 19-09A
To be assigned by Agency

Date of Receipt: 6-28-19
STATE HEALTH PLANNING & DEV. AGENCY

APPLICANT PROFILE

Project Title: Kahuku Medical Center; Addition of 6 Acute/Long Term Swing Beds and Deletion of 6 SNF/ICF Beds

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

Applicant Facility/Organization: Kahuku Medical Center

Name of CEO or equivalent: Alan MacPhee
Title: Chief Executive Officer

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

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

Contact Person for this Application: Diane Hale

Title: Chief Nursing Officer

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

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

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.

Alan MacPhee, CEO
Signature

6-28-19
Date

Alan MacPhee
Name (please type or print)

CEO
Title (please type or print)

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

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- Public _____
- Private _____
- Non-profit _____
- For-profit _____
- Individual _____
- Corporation _____
- Partnership _____
- Limited Liability Corporation (LLC) _____
- Limited Liability Partnership (LLP) _____
- Other: _____

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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: _____

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

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent)

N/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.)

**Medicare Certificate of Approval
Office of Health Care Assurance Waiver**

C. Your governing body: list by names, titles and address/phone numbers

See attached documentation

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)

See attached documentation

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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.

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	Used Medical Equipment (over \$400,000)	New/Upgraded Medical Equip. (over \$1 million)	Other Capital Project (over \$4 million)	Change in Services	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/Swing	15	+6	21
SNF/ICF	6	-6	0
21 TOTAL	21	0	21

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6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

- 1. Land Acquisition N/A_____
- 2. Construction Contract N/A_____
- 3. Fixed Equipment N/A_____
- 4. Movable Equipment N/A_____
- 5. Financing Costs N/A_____
- 6. Fair Market Value of assets acquired by lease, rent, donation, etc. N/A_____
- 7. Other: _____

TOTAL PROJECT COST: 0_____

B. Source of Funds

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

TOTAL SOURCE OF FUNDS: 0_____

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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 6 dual certified beds to Acute/Long-Term Swing Beds. The beds to be converted are identical in configuration.

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)

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- _____ 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. **19 JUL -1 AIO 38**
- _____ 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. **STATE PLANS & DEV. AGENCY**
- _____ 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.



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Kahuku Medical Center SHPDA Administrative Certificate Application Updated June 13, 2019

9. IMPLEMENTATION SCHEDULE:

Conversion of the 6 SNF/ICF beds at Kahuku Medical Center converted to Acute/Long Term/Swing Beds as of July 1, 2019.

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Kahuku Medical Center is currently licensed as both a Hospital and Nursing Facility (License Number 12-H and 77-N respectively). Upon approval from SHPDA the Office of Healthcare Assurance shall be notified of Kahuku Medical Center's intent to retire our Nursing Facility license as of July 1, 2019 and a CMS 855A form will be completed to reflect the change in licensure.

This project involves no construction or special financing.

10. EXECUTIVE SUMMARY:

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

This Administrative Certificate of Need Application for converting 6 SNF/ICF beds to 6 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 including:

Statewide Health Coordinating Council (SHCC) Priorities and Specific Health Areas of Concern

- Ensure that any proposed service will at least maintain overall access to quality health care at a reasonable cost
- Promote and support the long-term viability of the health care delivery system
- Ensure capacity and access to a continuum of long-term care services
- Ensure capacity and access to primary care services

Windward SAC Priorities

- Improve bed availability through timely transfer of ready patients to appropriate levels of care. Examples include the transfer of an acute care patient to a long term care facility or for specialized continued treatment.

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 Ka'a'awa. Situated 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 area 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



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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 6 SNF/ICF beds will have no substantial long term impact on the community or hospital. Adding 6 Acute/Long Term/ Swing beds will allow the hospital more flexibility in providing care to patients, by allowing for the admission of Acute or Observation patients from our Emergency Department, or patients from the acute facilities who require Long Term or Swing admissions.

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Kahuku Medical Center is a 501©3 tax exempt general acute care hospital and has policy of being accessible to all residents in our 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. 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.

Quality health care will not be compromised because Federal Regulations of Swing Bed Patients mirror many of the quality related regulations under Long-term Care. 42 CFR 485.645 (d) (1-9) still requires substantial compliance with regulations related to resident rights. Admission, transfer and discharge rights, freedom from abuse, neglect, patient activities, social services, comprehensive assessments, care and discharge planning etc.

D. Cost and Finance

It is believed that this bed change will not result in any change to the revenue or expenses of Kahuku Medical Center during the 1st and 3rd year of operation.

E. Relationship to existing Healthcare System

Having all of the beds in Kahuku Medical Center designated as Swing Beds will improve the existing health care system by enabling our hospital to be more responsive to community need whether it is for Long-term, Skilled, or Acute Care, and especially our Ko'olauloa community. It provides the potential to provide some relief to the problem of patients that are waitlisted in the acute beds, particularly at larger facilities on island such as Queen's Medical Center and Castle Medical Center as well as to those Kahuku residents who may be waiting for placement into Long-term care.

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.