HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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ST HLTH PLNG & DEV. AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #20-19A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Change of Ownership of Skilled Nursing Facility/Intermediate Care Facility Services

Project Address: 1814 Liliha Street, Honolulu, HI 96817.

Applicant Facility/Organization: Liliha Healthcare Center, Inc..

Name of CEO or equivalent: Edison K. Miyawaki, MD.

Title: President

Address: 809 W. 57th Street, Kansas City, MO 64113

Phone Number: 816-729-7493 Fax Number: 816-756-5306

Contact Person for this Application: Leanne Sakata

Title: Treasurer

Address: c/o New Family Health, Inc.,, 1814 Liliha Street, Honolulu, HI 96817

Phone Number: 808-595-6311 Fax Number: 808-595-6188

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

12/15/2020
Date

Edison K. Miyawaki, MD
Name (please type or print)

President
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:	____

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

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent) **Please see the attached Lease Agreement**
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.) **OHCA and CMS/Noridian**
C. Your governing body: list by names, titles and address/phone numbers **List attached**
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 **N/A**
   - Tax map number (project's location) **1-1-7-36-37**

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. N/A

	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					
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. **N/A**

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	
3.	Fixed Equipment	
4.	Movable Equipment	
5.	Financing Costs	
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	
7.	Other: Fair Market Value of Operating Assets	610,000
	TOTAL PROJECT COST:	**610,000**

B. Source of Funds

1.	Cash	10
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other: FMV of assets acquired by transfer	
	TOTAL SOURCE OF FUNDS:	**10**

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.

N/A

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, **upon approval by OHCA, SHPDA and CMS/Noridian**
   b) Dates by which other government approvals/permits will be applied for and received, **new OHCA permit applied for on Nov. 4, 2020. CMS/Noridian applied for Dec. 15, 2020**
   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 **upon approval by OHCA, SHPDA and CMS/Noridian**

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. **Attached**

   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.

__X__ 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:**

Brief Summary:

New Family Health, Inc., a Hawaii corporation, owns 100% of the stock of Family Health II, Inc., a Hawaii corporation which, currently, both (i) owns the operating assets of, and operates, the snf/icf facility the Liliha Healthcare Center at 1814 Liliha Street in Honolulu and (ii) owns the buildings and land in and upon which that facility operates.

New Family Health, Inc. also owns 100% of the outstanding stock of Liliha Healthcare Center, Inc., a newly formed Hawaii corporation.

The officers and directors of New Family Health, Inc., Family Health II, Inc., and Liliha Healthcare Center, Inc. are all the same.

Upon approval by the DOH (OHCA) and SHPDA, Family Health II, Inc. will transfer the operating assets (and liabilities) and employees of the snf/icf facility, and the trade name Liliha Healthcare Center, to Liliha Healthcare Center, Inc., which will thereafter operate the facility.

Family Health II, Inc. will retain ownership of the buildings and land in and upon which the facility operates as well as the existing mortgage on the buildings and land and the obligations which the buildings and land secure, and will lease them to Liliha Healthcare Center, Inc.

There will be no changes in location, bed numbers or services.

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

No new or additional beds or services are being proposed, so the utilization thresholds of Chapter 2, if any are otherwise applicable, do not apply. The facility's continued existence is consistent with Chapter 3's Statewide objective of insuring capacity and access to a continuum of long-term care services, and of increasing the availability of long-term care services include nursing homes, assisted living facilities, skilled nursing facilities, home and community-based services and hospice services.

b) Need and Accessibility.

No new or additional beds or services are being proposed, the need for the facility's existing beds and services was previously established, and its continued existence is consistent with the State's Health Services and Facilities Plan as indicated in the previous response. There is no change in accessibility as the facility is not moving. It will remain near downtown Honolulu, on Liliha Street, and thus accessible for patients and families from throughout urban Honolulu.

c) Quality of Service/Care.

The change in ownership with no changes in management or personnel will have no impact on the facility's quality of service and care. The facility's current ratings on www.medicare.gov's Nursing Home Compare website include Much Above Average scores for Quality Measures and Overall Rating, and an Above Average score for Staffing.

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

	1st year (2021)	3d year (2023)
Gross Revenue	10,412,653	10,777,095
Operating Expenses	8,164,857	8,328,154
Net Operating Income	2,247,796	2,448,941

The change in ownership will have no impact on the cost of healthcare services to the community.

e) Relationship to the existing healthcare system.

No new or additional beds or services are being proposed, nor are any reductions, so the facility's relationship to the existing healthcare system will not change. The facility's continued existence is consistent with Chapter 3 of the State's Health Services and Facilities Plan's objective of insuring capacity and access to a continuum of long-term care services, and of increasing the availability of long-term care services include nursing homes, assisted living facilities, skilled nursing facilities, home and community-based services and hospice services.

f) Availability of Resources

No additional financial resources are required to accomplish the change in ownership, and no staffing changes are required.