HAWAIʻI STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: # 21-10A Date of Receipt:
To be assigned by Agency

APPLICANT PROFILE

Project Title: **Addition of 21 SNF/ICF beds and Deletion of 21 Med/Surg beds**

Project Address: 128 Lehua St.
Wahiawa, HI 96786
Applicant Facility/Organization: Wahiawa General Hospital

Name of CEO or equivalent: Brian Cunningham

Title: CEO

Address: 128 Lehua St. Wahiawa, HI 96786

Phone Number: 808-621-8411 Fax Number: 808-621-4451

Contact Person for this Application: Brian Cunningham

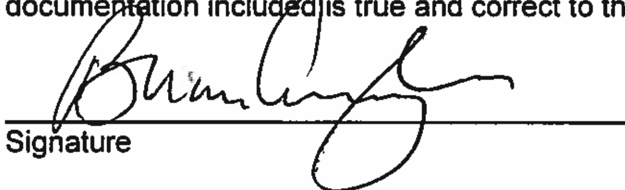
Title: CEO

Address: 128 Lehua St. Wahiawa, HI 96786

Phone Number: 808-621-4210 Fax Number: 808-621-4451

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 5/3/21
Date

_ Brian Cunningham _______ CEO _______
Name (please type or print) 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:	__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) **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.) **OHCA License**

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

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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 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
Med/Surg	37	-21	16
SNF/ICF	115	+21	136
Critical Care	5	0	5
TOTAL	**157**		**157**

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	____NA____
2.	Construction Contract	____NA____
3.	Fixed Equipment	____NA____
4.	Movable Equipment (Beds, chairs, etc.)	$45K
5.	Financing Costs	____NA____
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	____NA___
7.	Other:	
	TOTAL PROJECT COST:	**$45K**

B. Source of Funds

1.	Cash	$45K
2.	State Appropriations	__________
3.	Other Grants	__________
4.	Fund Drive	__________
5.	Debt	__________
6.	Other: ____________________	__________
	TOTAL SOURCE OF FUNDS:	**$45K**

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 <u>or</u> 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. **NA**

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, **NA**
b) Dates by which other government approvals/permits will be applied for and received, **NA**
c) Dates by which financing is assured for the project, **NA**
d) Date construction will commence **NA**
e) Length of construction period, **NA**
f) Date of completion of the project, **NA**
g) Date of commencement of operation – **7/1/21**

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Please remember that the Agency does monitor the implementation of Certificates approved. Non-implementatio 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.

This project is related to a partnership between Wahiawa General Hospital (WGH) and Queen's Health System (QHS). WGH is partnering with QHS for the purpose of WGH accepting SNF/ICF residents from QHS's Acute waitlisted patient population. The additionally licensed beds will be reserved for the transfer of waitlisted QHS acute care patients to WGH for post-acute SNF/ICF care.

a) Relationship to the State of Hawai`i Health Services and Facilities Plan – **This project is consistent with the goals and objectives of SHPDA's Health Services Facilities Plan (HSFP) along with a number of other State assessments that consistently highlight the need for addition SNF/ICF Beds on Oahu and in the state.**
Statewide Health Coordinating Council (SHCC) Priorities indicate under "General Principles & Specific Health Areas of Concern:"
Ensure capacity and access to a continuum of long-term care services
HONOLULU COUNTY (HONSAC) priorities also include:
Increase the availability of long-term care services and other supportive services, including nursing homes, assisted living facilities, skilled nursing facilities, home and community-based services and hospice services.

b) Need and Accessibility – **The need for additional SNF/ICF beds in the state along with a more expedited process for the transition of Acute Care patients to Post-Acute Care is well documented and this project creates ease of accessibility with transferring QHS waitlisted patients to WGH for post-acute care. QHS has reported to WGH an annual average of approximately 40 waitlisted patients housed at Punchbowl on any given day, which should fill up the 21**

beds allocated for this project quickly. All residents of the area will have access to this program through the QHS patient transition process including the elderly, low income, racial and ethnic minorities, women, persons with disabilities, and other underserved groups.

c) Quality of Service/Care – **The additional ICF/SNF beds will fall under our existing Wahiawa Nursing and Rehabilitation Center, and receive the same commitment and attention to quality of service as our other residents, and will be surveyed based on the same CMS guidelines. In addition, it will be licensed by OHCA.**

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

Year 1 Financial Estimates		Year 3 Financial Estimates	
Total Revenue	$ 2,266,625	Total Revenue	$ 2,862,810
Total Expenses	$ 1,673,225	Total Expenses	$ 2,186,105
Net Revenue	$ 593,400	Net Revenue	$ 676,705

e) Relationship to the existing health care system – **This project links two key elements of the continuum of care within the existing healthcare system, specifically, the acute care to post-acute care transition between two key healthcare organizations (WGH and QHS).**

f) Availability of Resources – **Most of the resources for this project will be addressed from within WGH's & QHS's current infrastructure, however, a small number of additional nursing and support staff will be hired for this service. We plan to recruit the additional staff from current on-island and in-state resources as availability of clinical staff has actually increased slightly since the COVID Pandemic.**

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.

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