HAWAI`I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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**ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM**

Application Number: #21-04A Date of Receipt:
To be assigned by Agency

## APPLICANT PROFILE

Project Title: ____Change of Ownership_____

Project Address: ___395 Kilauea Ave., Unit B3_____

____Hilo,HI 96720_____

Applicant Facility/Organization: ___ Mastercare Homehealth Inc ____

Name of CEO or equivalent: ____Anwar Kazi_____

Title: ____CEO_____

Address: ___1314 S. King Street, Suite 424, Honolulu, HI 96814_____

Phone Number: _808-597-1564_____ Fax Number: ___808-597-1565_____

Contact Person for this Application: _Kathy Shields_____

Title: ____Accountant_____

Address: __1314 S. King Street, Suite 424, Honolulu, HI 96814_____

Phone Number: _808-597-1564_____Fax Number: 808-597-1565_____

## 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

06/29/2021
Date

__Anwar Kazi_____
Name (please type or print)

CEO_____
Title (please type or print)

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

| | |
|---|---|
| Public | __X__ |
| Private | _____ |
| 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: | ____ |
| Honolulu: | _____ |
| Windward O`ahu: | _____ |
| West O`ahu: | _____ |
| Maui County: | _____ |
| Kaua`i County: | _____ |
| Hawai`i County: | __X__ |

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

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent) See attached
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.) CMS Medicare approval, CHAP accreditation, DOH Home Health License
C. Your governing body: list by names, titles and address/phone numbers- See executive summary attachment
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- attachment 1
   - By-Laws- attachment 3
   - Partnership Agreements n/a
   - Tax Key Number (project's location) 3-2-2-007-001-0004

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 | | | | | |
| 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| **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: ___Shares_____ | $225,270_ |
| | **TOTAL PROJECT COST:** | **$225,720** |

### B. Source of Funds

| | | |
|---|---|---|
| 1. | Cash | $225,720 |
| 2. | State Appropriations | _____ |
| 3. | Other Grants | _____ |
| 4. | Fund Drive | _____ |
| 5. | Debt | _____ |
| 6. | Other: _____ | _____ |
| | **TOTAL SOURCE OF FUNDS:** | **$225,720** |

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.

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, November 10,2020
b) Dates by which other government approvals/permits will be applied for and received, upon CON approval
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 Medicare approval

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. – See 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.

_____ The applicant believes it will not have a significant impact on the health care system.

mastercare
Homecare & Healthcare

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## Accompanying Documentation for SHPDA Administrative Review Application

**Documentation**

A. See attached
B. N/A
C. Our governing body:
   a. Anwar Kazi – Chairman & CEO – 1314 South King St., Ste. 424, Honolulu, HI 96814
   b. Ashrafun Kazi – President - 1314 South King St., Ste. 424, Honolulu, HI 96814
   c. Irfaan Kazi – Vice-President - 1314 South King St., Ste. 424, Honolulu, HI 96814

**Executive Summary**

Mastercare Inc. is proposing to transfer $225,720 cash to Mastercare Homehealth Inc for transfer of 100% share ownership and Mastercare Inc will be the sole shareholder. There will be no change in services due to this transfer.

There is no cost to the healthcare system related to this transfer. This change will not impact the community and the transfer will not affect our client care services.

**A. Relationship to the State of Hawaii Health Services and Facilities Plan:**

The project's relationship to HSFP was met in CON 19-14A. The project will continue to be consistent with that plan after SHPDA's approval of this Administrative CON. The proposed change of ownership will not affect the relationship to HSFP.

**B. Need and Accessibility:**

The need for the proposal is established in CON 19-14A. Accessibility of our services will not be affected by the change of ownership.

**C. Quality of Service/Care:**

The quality of service was established in CON 19-14A. Our quality of care will not change as a result of this change of ownership.

**D. Cost and Finances:**

The cost and finance requirements were met in CON 19-14A. We foresee no changes in the financials of the company as a result of this change of ownership.

Year One 2021: Income $428,580
Expenses $406,310
Year Three 2024: Income $857,160
Expenses $638,121

**E. Relationship to Existing System:**

The relationship to this existing system was met in CON 19-14A. No changes will occur as a result of this change of ownership.

**F. Availability of Resources:**

This requirement was met in CON 19-14A. The assets of Mastercare Homehealth Inc., will remain the same; therefore, there are no additional cash resources that result from this application. Our staffing requirements are currently met, and we do not foresee any changes to staffing on this change of ownership.