HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #24-04A
To be assigned by Agency

Date of Receipt: ST HLTH PLNG & DEV. AGENCY

APPLICANT PROFILE

Project Title: Acquisition of SNF/ICF Services

Project Address: 91-1204 Kealanani Ave

Kapolei, HI 96707

Applicant Facility/Organization: Hawaii Health Systems Corporation – Oahu Region

Name of CEO or equivalent: Derek Akiyoshi

Title: CEO

Address: 3675 Kilauea Ave, Honolulu, HI 96816

Phone Number: (808) 733-7922 Fax Number: (808) 733-7914

Contact Person for this Application: Derek Akiyoshi

Title: CEO

Address: 3675 Kilauea Ave, Honolulu, HI 96816

Phone Number: (808) 733-7922 Fax Number: (808) 733-7914

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]
Signature

04/12/2024
Date

Derek Akiyoshi
Name (please type or print)

CEO
Title (please type or print)

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

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

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)
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, CMS Medicare Certification, VA survey
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
   - By-Laws
   - Partnership Agreements
   - Tax Key Number (project's location)

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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.

	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
N/A			
TOTAL			

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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: FMV of acquired service	11,733,388
	TOTAL PROJECT COST:	11,733,388

B. Source of Funds

1.	Cash	
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other: FMV of acquired service	11,733,388
	TOTAL SOURCE OF FUNDS:	11,733,388

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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.

_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,
   - December 6, 2023

b) Dates by which other government approvals/permits will be applied for and received,
   - Licensure applied for – 10/30/24; estimated date of receipt 12/13/24

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
   - Estimated first admission 12/14/24

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

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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.

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EXECUTIVE SUMMARY

Hawaii Health Systems Corporation – Oahu Region (HHSC OR) will acquire the assets of the Daniel K. Akaka State Veterans Home (DKA SVH). The DKA SVH was constructed under the State of Hawaii, Department of Defense (DOD), Office of Veterans Services (OVS). Upon completion of construction, the assets will transfer from one Hawaii state government department to another Hawaii state government entity.

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

The importance of this facility to the State Health Services and Facilities Plan (HSFP) was set forth in CON Application #20-21. The acquisition of the facility by HHSC OR will not affect the project's relationship to the HSFP. Moreover, the acquisition will further the long term financial viability of the project by moving it to HHSC OR which already operates two nursing facilities – Leahi Hospital and Maluhia. This will therefore be the third nursing facility under HHSC OR.

b) Need and Accessibility

The need for and accessibility of the DKA SVH was addressed in CON Application #20-21. The facility is needed to address the needs of the veterans, their spouses and Gold Star parents on Oahu. The facility and services will continue to be accessible to serve 1) the veteran population needing a long term stay facility and 2) the veteran population needing a short term stay /rehabilitative facility.

c) Quality of Service/Care

The facility will comply with all applicable federal and state statutes and regulations governing the delivery of care and maintenance of facility and equipment. The facility will be licensed by OHCA and certified by the Centers for Medicare and Medicaid Services (CMS) as well as the VA Recognition Survey. HHSC OR provides high quality services to its patients as evidenced by the fact that Maluhia and Leahi Hospital are each five star facilities under the CMS rating system for nursing homes.

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

The facility is in the final stages of construction. The Three Year Proforma that was submitted with CON #20-21 is still applicable. Revenue for the Home will be provided through VA funded Service Connection per diem reimbursement, Medicare, Medicaid and self-pay, where appropriate.

Revenue is estimated to be:

Year 1 (ending 6/30/25) $3,367,015
Year 2 (ending 6/30/26) $14,225,786

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Year 3 (ending 6/30/27) $19,632,084

The facility is intended to be a self-supporting project. The first year of operations is estimated to have a loss of $778k – which will be funded by HHSC OR temporarily, as the facility is estimated to have net income of $4.16M in year 2 and $6.7M in year 3.

e) Relationship to the Existing Healthcare System

The proposed acquisition of the assets by HHSC OR is not expected to have an impact on the existing health care system. The need for this facility was provided in CON #20-21.

f) Availability of Resources

The availability of resources was provided in CON #20-21. The acquisition of assets will not affect the availability of resources.