



HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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STANDARD APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: # 25-12 Date of Receipt:
To be assigned by Agency

APPLICANT PROFILE

Project Title: Establishment of a 12-bed Special Treatment Facility

Project Address: 22 Waimahaihai Street
Kihei, HI 96753

Applicant Facility/Organization: Mana Recovery, LLC

Name of CEO or equivalent: Owen Campbell

Title: Executive Director

Address: 1063 Lower Main Street Suite C211A, Wailuku, Hawaii 96793

Phone Number: 808-867-9268 Fax Number: 808-867-9268

Contact Person for this Application: Ernesto Noblejas

Title: Compliance Consultant

Address: 2747 S. Kihei Rd. Unit H205, Kihei, HI 96753

Phone Number: 818 584 1197 Fax Number: _____

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

Ernesto Noblejas
Name (please type or print)

5-29-2026
Date

Consultant
Title (please type or print)

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1. TYPE OR ORGANIZATION: (Please check all applicable)

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

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

- A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent)
 - a) See attachment 1
- 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.)
 - a) Land Use Designation Permit
 - b) County Building Inspection
 - c) County Fire Inspection
 - d) County Electrical Inspection
 - e) County Plumbing Inspection
- C. Your governing body: list by names, titles and address/phone numbers
 - a) See attachment 2
- D. If you have filed a Certification of Need Application this current calendar year, you may skip the four items listed below. All others, please provide the following:
 - Articles of Incorporation - see attachment 3
 - By-Laws - see attachment 4
 - Partnership Agreements - Also see attachment 4
 - Tax Key Number (project's location)
 - o Tax Key Number is 390120220000

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 ownership	Change in Service/establish new service/facility	Change in Beds
Inpatient Facility					X	
Outpatient Facility						
Private Practice						

5. **TOTAL CAPITAL COST:** \$2,176,600

6. **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
STF	0	12	12
TOTAL	0	12	12

7. **CHANGE IN 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 consult 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.

Mana recovery is seeking to establish a Specialized Treatment Facility in Kihei to support addiction recovery in the community of Maui. While we currently offer outpatient therapy in Wailuku, we've found that providing residential care before outpatient therapy significantly impacts patients and their recovery.

8. PROJECT COSTS AND SOURCES OF FUNDS (For Capital Items Only)

A. List All Project Costs:

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- | | | |
|----|---|--------------------|
| 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. | <u>\$2,176,600</u> |
| 7. | Other: _____ | _____ |

TOTAL PROJECT COST: \$2,176,600

B. Source and Method of Estimation

Describe how the cost estimates in Item "A" were made, including information and methods used:

County of Maui records department shows the total assessed value of the property to be \$2,176,600.00.

C. Source of Funds

AMOUNT:

- | | | |
|----|---|--------------------|
| 1. | Cash | _____ |
| 2. | State Appropriations | _____ |
| 3. | Other Grants | _____ |
| 4. | Fund Drive | _____ |
| 5. | Debt | _____ |
| 6. | Other: <u>FMV of leased property to be paid by monthly rent</u> | <u>\$2,176,600</u> |

TOTAL SOURCE OF FUNDS: \$2,176,600

9. 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:

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- a) Date of site control for the proposed project,
 - a. The site is already controlled and leased by Mana Recovery.
- b) Dates by which other government approvals/permits will be applied for and received,
 - a. A Certificate of Occupancy application has already been sent in with the county building department
 - b. Once we acquire the SHPDA Certificate of Need, we will immediately put our STF application in with the state's Office of Healthcare Assurance (OHCA.)
- c) Dates by which financing is assured for the project,
 - a. Building is already being leased and that lease is funded by current operating expenses from the outpatient therapy operations of Mana Recovery
- d) Date construction will commence,
 - a. NA
- e) Length of construction period,
 - a. NA
- f) Date of completion of the project, and
 - a. NA
- g) Date of commencement of operation.
 - a. Upon notification of STF license approval from OHCA

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.

10. 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.

Mana Recovery is requesting a CON for a 12 bed Specialized Treatment Facility in Kihei, Hawaii to support addiction recovery. The facility will provide the services of residential addiction recovery and rehabilitation. While we currently operate an outpatient program, we've seen great success with residential services and our patients following through on their appointments.

a) Relationship to the State of Hawai'i Health Services and Facilities Plan

The goals of the HSFP state that there is a "focus on increasing cost-effective access to necessary health care services." Mana Recovery currently works with MEDQuest to provide cost-effective addiction recovery services to the people of Maui in the most populous part of the county. There currently exists a gap in the care of addiction recovery patients, especially with regard to their living conditions and constant supervision and adherence to an addiction recovery program.

b) Need and Accessibility

The STF will be a needed addition for patients in addiction recovery in Maui. Current STF bed count in the entire county of Maui, according to the SHPDA 2023 report, is sixty-eight. 48 of those are run by Aloha House, inc. in

Makawao. By opening more STF beds on Maui, we address one of the State plan identified issues specifically for Maui by providing services of the community and for the community.

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c) Quality of Service/Care

Mana Recovery is already utilizing evidence-based practices in the addiction recovery field. With the establishment of a Specialized Treatment Facility, we will continue to expand the full spectrum and scope of services that we are already providing to the underserved population. We already have policies and procedures in place to ensure that patients' needs are met to the highest standard of care and in accordance with best practice.

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d) Cost and Finances (include revenue/cost projections for the first and third year of operation)
The revenue and cost projections are in Exhibit D-2

e) Relationship to the Existing Health Care System

We already maintain a working relationship with the other STF facilities on Maui, and we collaborate with Maui Recovery on a regular basis.

f) Availability of Resources

The building in Kihei is already leased. We're currently operating a fully staffed IOP in Wailuku. Any of the staff resources that we would need have already pledged to work with us once we start STF services, or are already part of the organization.