



HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

STANDARD APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: _____ Date of Receipt: _____
To be assigned by Agency

APPLICANT PROFILE

Project Title: _____

Project Address: _____

Applicant Facility/Organization: _____

Name of CEO or equivalent: _____

Title: _____

Address: _____

Phone Number: _____ Fax Number: _____

Contact Person for this Application: _____

Title: _____

Address: _____

Phone Number: _____ 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

Date

Name (please type or print)

Title (please type or print)

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

- Public _____
- Private _____
- Non-profit _____
- For-profit _____
- Individual _____
- Corporation _____
- 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: _____

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

| | 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 | | | | | | |
| Outpatient Facility | | | | | | |
| Private Practice | | | | | | |

5. **TOTAL CAPITAL COST:** _____

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 |
|--------------|-------------------|--------------------------------|---|
| | | | |
| | | | |
| | | | |
| | | | |
| TOTAL | | | |

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.

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

| 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: _____ | _____ | |
| TOTAL PROJECT COST: | | _____ |

B. Source and Method of Estimation

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

| C. Source of Funds | AMOUNT: | |
|-------------------------------|----------------|-------|
| 1. Cash | _____ | |
| 2. State Appropriations | _____ | |
| 3. Other Grants | _____ | |
| 4. Fund Drive | _____ | |
| 5. Debt | _____ | |
| 6. Other: _____ | _____ | |
| TOTAL SOURCE OF FUNDS: | | _____ |

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:
- a) Date of site control for the proposed project,
 - b) Dates by which other government approvals/permits will be applied for and received,
 - c) Dates by which financing is assured for the project,
 - d) Date construction will commence,
 - e) Length of construction period,
 - f) Date of completion of the project, and
 - g) Date of commencement of operation.

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.
- 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

INSTRUCTIONS TO THE APPLICANT APPLICATION NARRATIVE

General Information

Please remember that the responsibility and burden of proof for justifying a proposed project or change rests with the applicant. The application must provide information that demonstrates that a proposal meets the certificate of need criteria established under Section 323D-43 (c), Hawai'i Revised Statutes, and the Certificate of Need rules Section 11-186-15.

To assure a comprehensive and timely review, please be sure that the application is complete before submitting it to SHPDA. By statute, SHPDA shall not accept, review, or act upon an application that does not contain complete information and supporting documentation. Falsifying of information shall be grounds for denial of an application.

Section 11-186-25 of the Hawai'i Administration Rules establishes a fee for each Certificate of Need application. The filing fee, paid in full, must accompany each application.

General Instructions

In addition to the summary forms, each applicant is required to submit a narrative presenting a detailed description and justification of the proposal. The narrative for an application for Standard Review consists of six (6) sections. These sections address the certificate of need criteria as follows:

1. Relationship to State Plan Criterion
2. Need/Accessibility Criteria
3. Quality Criteria
4. Cost and Financial Criteria
5. Relationship to the Existing Health Care System Criterion
6. Availability of Resources Criterion

To assist in completing the application, instructions for each section, and statement of related criteria from the certificate of need rules, appear on the appropriate pages of the application form that follows.

SECTION A: RELATION TO THE STATE PLAN CRITERION

CRITERION. This is the criterion in Section 11-186-15 of the rules that relates to the state plan:

- (9) The relationship of the proposal to the state health services and facilities plan

INSTRUCTIONS. This section helps our reviewers understand how the proposed service fits the needs identified in the Plan. Please provide a narrative that answers the questions or provides the information requested below. To help our reviewers easily follow the application, please use the topic headings used here, number the first page A-2, and the following pages consecutively.

1. Relation to the Plan

- A. Chapter 2, Thresholds and Suboptimization.

If the proposal involves one or more of the services covered in Chapter 2 of the Plan, describe how the proposal relates to these capacity thresholds.

- B. Chapter 3, Statewide and Regional Priorities.

This chapter contains statewide and regional health care priorities. As appropriate, describe how the proposal relates to the statewide priorities as well as the regional priorities for each proposed service area.

SECTION B: NEED AND ACCESSIBILITY

CRITERIA. These criteria in Section 11-186-15 of the rules that relate to Need and Accessibility:

- (1) The need that the population served or to be served has for the services proposed to be offered or expanded, and the extent to which all residents of the area, and in particular low income persons, racial and ethnic minorities, women, people with disabilities, and other underserved groups, and the elderly, are likely to have access to those services;
- (2) In the case of a reduction or elimination of a service, including the relocation of a facility or service:
 - a. The need that the population presently served has for the service;
 - b. The extent to which that need will be met adequately by the proposed relocation or by alternative arrangements; and
 - c. The effect of the reduction, elimination, or relocation of the service on the ability of low-income persons, racial and ethnic minorities, women, people with disabilities, and other underserved groups, and the elderly, to obtain needed health care.

INSTRUCTIONS. This section helps our reviewers understand the community's need for your proposal, and how it will be accessible to those in need in the proposed service area, including those who traditionally may have had difficulty accessing services. Please provide a narrative, which answers the questions or provides the information requested below. To help our reviewers easily follow the application, please use the topic headings used below, number the first page B-3 and the following pages consecutively.

1. Description of the Service Area

- A. Description of the service area, such as island, district, census tract and special geographic features, which restrict or enhance access to services.
- B. Describe the specific target population affected by the proposed project as precisely as possible.

2. Estimates of Need, Demand and Supply

Define the need and demand for the beds or services proposed to be added, modified, or deleted. Be specific about the unit of service (e.g. bed-day, outpatient visit, CT scan procedure). In addition, identify the extent of the resources available in the service area to meet the demand and determine the rate at which the population utilizes those resources. Also, clearly present the methodology used for deriving the estimates. The following should be included:

- A. Estimates of area wide need and demand. (Describe the methodologies used)
- B. Estimates for supply and utilization. (Describe the methodologies used)
- C. Deficits or surpluses between need/demand and supply.
- D. Utilization at applicant facility.

3. Projects of Future Utilization

For new beds or services, estimate the future utilization in the target year. Please clearly present the methodology used for deriving the projection. Projections for outpatient and ancillary service utilization should be in the units of measure such as clinic visits, number of procedures performed, number of individuals served, etc.

4. Accessibility

Describe how new beds or services will be accessible to all the residents of the community, in particular low income persons, racial and ethnic minorities, women, people with disabilities, other underserved groups, and the elderly. Identify the barriers to accessibility and describe how these will be overcome. Barriers include such things as geographic, transportation, financial, and cultural barriers.

5. Types of Patients and Sources of Funds

A. Submit a table similar to the one below showing past (if pertinent) and projected utilization of this proposed service by source of payment. If the proposal is for bed services, the unit of service will be bed-days. If the proposal is for non-bed services, indicate the unit of services, e.g. procedures, visits, etc.

| SOURCE OF PAYMENT | MOST RECENT YEAR (indicate time period) | | FIRST YEAR OF OPERATION _____ | | SECOND YEAR OF OPERATION _____ | |
|----------------------|--|---------|-------------------------------|---------|--------------------------------|---------|
| | Units of Service | | Units of Service | | Units of Service | |
| | Number | Percent | Number | Percent | Number | Percent |
| Medicare | | | | | | |
| Medicaid | | | | | | |
| Commercial Insurance | | | | | | |
| Private Pay | | | | | | |
| Other _____ | | | | | | |
| TOTAL | | 100% | | 100% | | 100% |

B. Submit a table similar to the one below showing past (if pertinent) and projected operating revenues of this proposed service by source of payment.

| SOURCE OF PAYMENT | MOST RECENT YEAR (indicate time period) | | FIRST YEAR OF OPERATION _____ | | SECOND YEAR OF OPERATION _____ | |
|----------------------|--|---------|-------------------------------|---------|--------------------------------|---------|
| | Amount of Revenue | Percent | Amount of Revenue | Percent | Amount of Revenue | Percent |
| | Medicare | | | | | |
| Medicaid | | | | | | |
| Commercial Insurance | | | | | | |
| Private Pay | | | | | | |
| Other _____ | | | | | | |
| TOTAL | | 100% | | 100% | | 100% |

SECTION C: QUALITY CRITERIA

CRITERIA. These are the criteria in Section 11-186-15 of the rules that relate to quality:

- (6) The applicant's compliance with federal and state licensure requirements;
- (7) The quality of the health care services proposed;
- (8) In the case of existing health services or facilities, the quality of care provided by those facilities in the past.

INSTRUCTIONS. SHPDA is committed to high quality services. This section helps our reviewers understand how the applicant will maintain quality health care services. Please use the format below to provide us with a summary that answers the questions or provides the information requested below in reference to quality care. To help our reviewers easily follow the application, please use the topic headings used here, number the first page C-2, and the following pages consecutively.

1. Quality Of Care

- A. Describe how the proposal will improve the quality of care being delivered to the target group.
- B. Describe the internal policies and procedures that will be used to monitor and evaluate the quality of care. If there are written policies and procedures, attach them as exhibits.
- C. If the applicant is an existing facility, or has operated facilities in other places, discuss the quality of care provided by those facilities in the past.

2. Staffing

- A. Describe patient care staff in FTEs by kind of staff, and the staff to patient ratio by kind of staff.
- B. Describe any special qualifications of the staff as they relate to quality.
- C. Describe all continuing education efforts that impact quality of care.

3. Licensures And Certificates

What licenses or certificates are required for this proposal? What certificates or accreditations will be sought, even though they are not required?

4. Memberships And Affiliations

List memberships in, affiliations with, or accreditations by local or national organizations. If there are accreditation reports, submit them as exhibits to this section.

5. Medicare Reports

If Medicare certifies the facility, submit the last two "Statement of Deficiency and Plan of Correction" reports.

SECTION D: COST AND FINANCIAL CRITERIA

CRITERIA. These are the criteria in Section 11-186-15 of the rules that relate to cost and finances:

- (3) The probable impact of the proposal on the overall costs of the health services to the community;
- (4) The probable impact of the proposal on the costs of and charges for providing the health services by the applicant;
- (5) The immediate and long-term financial feasibility of the proposal.
- (11) The availability of less costly or more effective alternative methods of providing service.

SPECIAL PROVISION OF THE LAW. HRS 323D-43(b)(2) prohibits the Agency from issuing a certificate of need unless it has determined that "the cost of the facility or service will not be unreasonable in the light of the benefits it will provide and its impact on health care costs."

INSTRUCTIONS. This section helps our reviewers understand the cost and finances of the applicant, the proposed project and its impact on the community, please provide a narrative that answers the questions or provides the information requested below. To help our reviewers easily follow the application, use the topic headings used here. number the first page D-3, and the following pages consecutively.

1. Description of the Institution's Financial Base.

The purpose of this section is to document the applicant's current financial base.

- A. Attach as Exhibit D-1 audited financial statements for the last two years. If unavailable, submit internally generated statements. The statements must include (with accompanying Auditor's notes):
 - (1) Balance Sheet
 - (2) Statement of Revenue and Expense
 - (3) Source and Application of Funds
- B. If a Formal Financial Feasibility Report was obtained, include as an attachment.
- C. If available, formal planning, utilization, and space programming studies should be included.

2. Financial Feasibility of the Proposed Project.

- A. Describe the project cost and financing and show that resources exist to successfully implement and operate the project.
- B. Attach as Exhibit D-2 a three-year projection of revenues and expenses for the proposed services. You may use the format attached as Exhibit D-2 or you may use your own format showing revenue and expense detail.
- C. Attach as Exhibit D-3 a facility operation information worksheet.
- D. If the proposal will involve new debt, complete and attach Exhibit D-4, "Financing Information Related to Project."
- E. If the proposal will involve new equipment, attach an equipment list.

3. Staffing Requirements

Present the FTE staffing pattern for the facility or service, together with personnel costs.

4. Impact of Project on Cost of Health Care

- A. Discuss the effect this project will have on health care costs. Include a discussion of the projected total annual revenues and costs.
- B. Describe the per unit charges for the proposed services, and the per unit cost to the applicant. Describe how these costs and charges compare with similar services in the community, and how they compare to the applicant's costs and charges before the project is implemented.

5. Alternatives

Describe other (any) alternatives for the project considered and found not to be as desirable as the proposed project. If applicable, indicate why any less cost alternatives for the project were found not to be as desirable as the proposed project.

STATEMENT OF REVENUE AND EXPENSES

BASE YEAR: _____ YEAR 1: _____ YEAR 2: _____ YEAR 3: _____

Patient Service Revenue

Inpatient Room and Care
Inpatient Other Nursing Services
Inpatient Ancillary Services
Outpatient Services
Gross Patient Services Revenue

Deduction from Patient Services Revenue

Contractual Adjustments
Charity Care and Administrative Allowances
Allowance for Uncollectibles
Total Deductions

Net Patient Services Revenue
Other Operating Revenue
Total Operating Revenue

Operating Expenses

Salaries and Wages
Expenses
Depreciation
Interest
Total Expenses

Net Income (Loss) from Operations

Add: Depreciation
Interest

Funds from Operations

Debt Financing

Principal
Interest
Total Debt Financing

Excess (Deficit) Funds from Operations

FACILITY OPERATION INFORMATION WORKSHEET

BASE YEAR: _____ YEAR 1: _____ YEAR 2: _____ YEAR 3: _____

Statistics

Admissions
Average Length of Stay
Patient Days
Total Licensed Beds
Average Occupancy
Outpatient Visits

Rates

Average Room Charge
 1. By Type of Service
 2. By Room of Service
Average Ancillary Department
 1. By Ancillary Department
Average Outpatient Charges
 1. By Clinic
 2. By Ancillary Department

Payroll

Staffing (FTEs)
Projected Hours
Projected Average Hourly Wage

Salaries and Other Expenses

Aggregate Rate Per Unit of Service

FINANCING INFORMATION RELATED TO PROJECT (Include additional pages if necessary)

| NEW DEBT | Source 1 | Source 2 | Source 3 |
|---------------------|-----------------|-----------------|-----------------|
| Name of Lender | | | |
| Address | | | |
| Phone | | | |
| Contact | | | |
| Amount | | | |
| Interest Rate | | | |
| Term of Loan | | | |
| Annual Debt Service | | | |
| Total Debt Service | | | |

Prepayment Restrictions (by source):

Restrictions on Additional Debt (by source):

EXISTING DEBT

1. Not to be Refinanced as Part of this Project:

- A. Holder of Debt _____
- B. Amount of Debt Remaining _____
- C. Date Debt if to be Retired _____
- D. Interest Rate _____
- E. Prepayment Restrictions Remaining _____

2. To be Refinanced as Part of this Project:

- A. Holder of Debt _____
- B. Amount of Debt Remaining _____
- C. Date Debt is to be Retired _____
- D. Interest Rate _____
- E. Prepayment Restrictions Remaining _____

SECTION E: RELATION TO THE EXISTING HEALTH CARE SYSTEM CRITERION

CRITERION. This is the criterion in Section 11-186-15 of the rules that relates to the existing health care system.

(10) The relationship of the proposal to the existing health care system of the area.

INSTRUCTIONS. This section helps our reviewers understand the relationship of the proposal to the existing health care system. Please provide a narrative that answers the questions or provides the information requested below. To help our reviewers easily follow the application, please use the topic headings used here, number the first page E-2, and the following pages consecutively.

1. Improvement to the Existing Health Care System

Summarize briefly how the proposal will improve the existing health care system.

- A. If applicable, show how the project will fill a gap in health care delivery pattern.
- B. Show how the project will improve the availability of health care in the community.
- C. Show how the project will improve accessibility to health care in the community.

2. Effect on Other Health Care Providers

Describe the effect of the project on other institutions or groups.

- A. Describe how the proposed project will affect other health care services in the community and what impact it will have on their utilization.
- B. Describe services that will be shared with another institution or consolidated as a result of the project.

SECTION F: AVAILABILITY OF RESOURCES CRITERION

CRITERION. This is the criterion in Section 11-186-15 of the rules that relates to the availability of resources:

(12) The availability of resources (including health personnel, management personnel, and funds for capital and operating needs) for the provision of services proposed to be provided and the need for alternative uses of these resources as identified by the state health services and facilities plan (a.k.a. H2P2) or the annual implementation plan.

INSTRUCTIONS. This section helps our reviews understand whether you have sufficient personnel and financial resources to carry out the project you are proposing. Please include a narrative that answers the questions or provides the information requested below. To help our reviewers easily follow the application, please number the first page F-2 and the following pages consecutively.

This criterion is addressed in previous sections. If you have additional information to add about human resources and/or financial resources, please insert here.