

HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

| ADMINISTRATIVE A | PPLICATION - CERTIFICATI | E OF NEED PROGRAM |
|--------------------------------|---|---|
| | # II - ITA to be assigned by Agency | |
| | APPLICA | NT PROFILE |
| Project Title: <u>Establ</u> i | shment of Ambulatory Surgery C | Center Limited to Plastic Surgery Procedures |
| Project Address: | 1401 S. Beretania Street, 8th Flo | oor, Honolulu, Hawaii 96814 |
| - | | |
| Applicant Facility/Or | ganization: <u>Asia Pacific Plasti</u> | c Surgery, Inc. |
| | | |
| | | |
| | | Honolulu, Hawaii 96813 |
| | | umber: |
| | | 1.D. |
| | | |
| | | u, Hawaii 96813 |
| Friorie Number:5 | <u>35-8855</u> Fa | ax Number: |
| | CERTIFICATION | N BY APPLICANT |
| contained nerein. | nat I reviewed the application an I declare that the project desided is true and correct to the bes | ad have knowledge of the content and the information cribed and each statement amount and supporting at of my knowledge and belief. |
| Signature | | Date |
| Shim Ching | | President |

Certificate of Need Administrative Application July 2009 1374556.V1

Name (please type or print)

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Title (please type or print)



| 1. | TYPE OF ORGANIZATION: (Please check all applicable) | | | |
|----|---|-------------|--|--|
| | Public Private X 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: | | | |
| 3. | DOCUMENTATION (Please attach the following to your application form): | | | |
| | A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement letter of intent) | ent | | |
| | See Attachment 1. Note that only 2085 square feet of the leased space will used for the Proposed ASC. The remainder of the leased space will be used Dr. Ching's professional office. (See the floor plan included as Attachment 5.) | fo | | |
| | B. A listing of all other permits or approvals from other government bodies (fede state, county) that will be required before this proposal can be implement (such as building permit, land use permit, etc.) | ral itec | | |
| | Building Permit – City & County of Honolulu License – State of Hawaii, Department of Health Medicare Certification – State of Hawaii, Department of Health | | | |
| | C. Your governing body: list by names, titles and address/phone numbers | | | |
| | See Attachment 2 | | | |
| | D. If you have filed a Certificate of Need Application this current calendar year, year may skip the four items listed below. All others, please provide the following: Articles of Incorporation: See Attachment 3 By-Laws: None | you | | |

- Partnership Agreements: Not Applicable
- Tax Key Number (project's location) (1) 2-4-5-26 (portion of)
- **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 | | | | Х | |
| 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 |
|-------------|----------------------|--------------------------------|---|
| | | | |
| | | | |
| | | | |
| | | i | |
| | | | |
| TOTAL | | | |

6. PROJECT COSTS AND SOURCES OF FUNDS

| A. List | All Project Costs: | AMOUNT: |
|---------|---|------------------------------|
| 1. | Land Acquisition | |
| 2. | Construction Contract | \$469,125.00 |
| 3. | Fixed Equipment | |
| 4. | Movable Equipment | \$117,260.00 |
| 5. | Financing Costs | \$8,200.00 |
| 6. | Fair Market Value of assets acquired by lease, rent, donation, etc. | <u>\$493,186.00</u> |
| 7. | Other: | |
| | | ******** |
| | TOTAL PROJECT COST: | <u>\$1,087,771.00</u> |
| B. Sou | rce of Funds | |
| 1. | Cash | \$142,442.00 |
| 2. | State Appropriations | |
| 3. | Other Grants | |
| 4. | Fund Drive | |
| 5. | Debt | \$138,393.00 |
| 6. | Other: <u>lease payments</u> <u>Tenant Improvement Allowance</u> | \$496,186.00 \$312,750.00 |
| | TOTAL SOURCE OF FUNDS: | <u>\$1,087,771.00</u> |

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.

Implementation of ambulatory surgery services limited to plastic surgery in

Honolulu. Reference HAR § 11-186-5(3)(C)

- 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: August 2011
 - b) Dates by which other government approvals/permits will be applied for and received:

Building Permit applied for: September 2011 Building Permit received: November 2011

- c) Dates by which financing is assured for the project: September 2011
- d) Date construction will commence: November 2011
- e) Length of construction period: 3 months
- f) Date of completion of the project: January 2012
- g) Date of commencement of operation: January 2012

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
 - 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.

Executive Summary

Asia Pacific Plastic Surgery, Inc. ("Asia Pacific"), a professional corporation owned and operated by Shim Ching, M.D., seeks to establish an ambulatory surgery center that will specialize in plastic surgery of the face, body and breasts (the "Proposed ASC") at the Hale Pawa`a Professional Services Building, located at 1401 South Beretania Street in Honolulu. A map showing the location is included as Attachment 4. The facility will be adjacent to Dr. Ching's professional office and will consist of one procedure rooms and a pre-operative/ recovery area. A floor plan is included in Attachment 5.

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

The proposed ASC will enter into the required collaborative agreement with Kapi`olani Medical Center for Women and Children ("Kapi'olani") and, in the event that one of its patients requires hospitalization, the center's personnel will coordinate the patient's transfer to Kapi olani.

The Proposed ASC will be O`ahu's only outpatient surgery center dedicated to reconstructive and cosmetic surgery. It will advance the Statewide Health Coordinating Council's ("SHCC") priority to promote and support the long term viability of the health care delivery system by providing a less costly alternative to outpatient plastic surgery in hospital-based facilities and free up such facilities for procedures that truly need hospital based care. For more detail, see Section A, which follows.

b) Need and Accessibility

Asia Pacific's service area includes all of O`ahu. It will be located on the eighth floor of the Hale Pawa'a Professional Services Building at 1401 South Beretania Street in Honolulu, which is easily accessible via public transportation and has ample handicap accessible parking in the adjacent eight-story, 400-stall parking structure.

A substantial number of the procedures performed at the facility will be breast reconstruction surgery following a mastectomy for treatment of breast cancer. Women requiring such surgery are typically between the ages of 35 and 65. The Proposed ASC will also provide cosmetic procedures to men and women of all ages. The Asia Pacific will be accessible to all residents of O'ahu, including low income persons, racial and ethnic minorities, women, people with disabilities, the elderly and the medically underserved. It is conveniently located on public transportation routes and has ample handicapped accessible parking. The proposed ASC will provide services to patients covered by Medicare and Medicaid and will dedicate a portion of its operating revenues for charity care. For more detail, see Section B which follows.

c) Quality of Service/Care

Asia Pacific will comply with State and Federal regulations for the delivery of care, maintenance of equipment and maintenance of the clinical environment. It will seek accreditation from the Accreditation Association of Ambulatory Health Care, be licensed by the Department of Health, and be certified by Medicare.

Dr. Ching is certified by the American Board of Plastic Surgery and licensed by the Hawaii Medical Board. He is on the staff of several O'ahu hospitals. The Proposed ASC will have a transfer agreement with Kapi`olani in the event of a medical emergency that requires more extensive care than can be offered at the Proposed ASC.

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Dr. Ching will be assisted by registered nurses and a qualified operating room technician. Staff competency will be maintained by regular in-service education. A written quality assessment and improvement plan will be in place. The Proposed ASC will conduct ongoing quality review.

As O`ahu's only ambulatory surgery center dedicated to reconstructive and cosmetic surgery, the Proposed ASC will provide a less intimidating and threatening environment for reconstructive and cosmetic surgery patients who are often self-conscious about their conditions. These patients will benefit by having their procedures performed in a familiar setting by health care professionals with whom they have developed a supportive therapeutic relationship. For more detail, see Section C which follows.

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

As documented on page 4 of 8 of this Application form, the project is estimated to cost \$1,087,771. Build out of the facility will be paid for, in part, with a tenant improvement allowance of \$312,750. Additional funds for the project will come from cash contributions from Dr. Ching and a commercial loan. The site, which is valued at \$493,186, will be acquired by lease and will be paid for by means of monthly rent payments over the five-year term of the lease.

The operating revenue for the first year of operation is projected at \$541,961, and operating expenses for the same period are protected at \$424,332, resulting in a net operating profit of \$117,629. By the third year of operation, revenue is expected to increase to \$597,512, with total expenses for year three projected at \$487,717, resulting in an operating profit of \$109,795. For more detail, see Section D which follows.

e) Relationship to the Existing Health Care System

The Proposed ASC's staff will largely be drawn from Dr. Ching's current pool of employees. Because the ASC will operate in conjunction with Dr. Ching's current office practice, it is expected to have minimal, if any, impact on other health care providers and the existing health care system. For more detail, see Section E which follows.

f) Availability of Resources

Asia Pacific expects to employ persons who are already members of Dr. Ching's staff. It does not anticipate the need for additional personnel.

There are minimal financial obstacles to this project. The site will be leased. Build out of the facility will be paid for, in part, by the tenant improvement allowance of \$312,750. Additional funds for the project will come from cash contributions from Dr. Ching and a commercial loan. The site, which is valued at \$493,186, will be acquired by lease and will be paid for by means of monthly rent payments over the five-year term of the lease. For more detail, see Section F which follows.

| 10. | Eligibility to file for Administrative Review. This project is eligible to file 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. | |
| | <u>X</u> | The applicant believes it will not have a significant impact on the health care system. | |