REPLACEMENT PAGE

HAWAI`I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #11-19A Date of Receipt:
To be assigned by Agency

APPLICANT PROFILE

Project Title: Acquisition of Proposed ASC limited to plastic surgery to be located at 1401 S. Beretania Street, 8th Floor Honolulu, Hawaii 96814

Project Address: 1401 S. Beretania Street, 8th Floor, Honolulu, Hawaii 96814

Applicant Facility/Organization: Asia Pacific Surgery, LLC

Name of CEO or equivalent: Shim Ching, M.D.

Title: Member

Address: 550 South Beretania Street, Suite 603, Honolulu, Hawaii 96813

Phone Number: 585-8855 Fax Number:

Contact Person for this Application: Shim Ching, M.D.

Title: Member

Address: 550 South Beretania, Suite 603, Honolulu, Hawaii 96813

Phone Number: 585-8855 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

Shim Ching
Name (please type or print)

Member
Title (please type or print)

1. **TYPE OF 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:	X
Honolulu:	X
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)

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.)

Not applicable

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, you may skip the four items listed below. All others, please provide the following:
   - Articles of Organization: See Attachment 3
   - By-Laws: Not applicable
   - Partnership Agreements: None
   - Tax Key Number (project's location) (1) 2-4-5-26 (portion of)

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				X	
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: _____	$0
	TOTAL PROJECT COST:	**$0**

B. Source of Funds

1.	Cash	
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other: N/A (acquisition of proposed ASC – no value)	$0
	TOTAL SOURCE OF FUNDS:	**$0**

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.

Acquisition of proposed ASC limited to plastic surgery by affiliated limited liability company. 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: November 18, 2011

b) Dates by which other government approvals/permits will be applied for and received: Not applicable

c) Dates by which financing is assured for the project: Not applicable

d) Date construction will commence: Not applicable

e) Length of construction period: Not applicable

f) Date of completion of the project: Not applicable

g) Date of commencement of operation: Not applicable

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., obtained Certificate of Need No. 11-17A for the establishment an ambulatory surgery center at 1401 South Beretania Street, 8th floor, Honolulu, Hawaii 96814 (the "ASC") on October 28, 2011. This application is for the acquisition of the proposed ASC by Asia Pacific Surgery, LLC, a separate entity established by Dr. Ching to facilitate compliance with Medicare certification requirements. The project will remain precisely as described in Application No. 11-17A

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

Established by Certificate of Need No. 11-17A and no changes will be made.

b) Need and Accessibility

Established by Certificate of Need No. 11-17A and no changes will be made.

c) Quality of Service/Care

Established by Certificate of Need No. 11-17A and no changes will be made.

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

Established by Certificate of Need No. 11-17A and no changes will be made.

e) Relationship to the Existing Health Care System

Established by Certificate of Need No. 11-17A and no changes will be made.

f) Availability of Resources

Established by Certificate of Need No. 11-17A and no changes will be made.

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.