

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

MARILYN A. MATSUNAGA
ADMINISTRATOR

1177 Alakea St. #402, Honolulu, HI 96813 Phone: 587-0788 Fax: 587-0783 www.shpda.org

August 14, 2002

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Raleigh Awaya
Chief Operating Officer
St. Francis Medical Center West
2226 Liliha Street, Suite 226
Honolulu, HI 96817

Dear Mr. Awaya:

The State Health Planning and Development Agency has evaluated your application for administrative review for Certificate of Need ("Cert.") #02-18A for the renovation and expansion of your emergency room from 12 to 25 beds at St. Francis Medical Center West at a capital cost of \$5,240,000.

As provided under Section 11-186-99.1 of the Hawaii Administrative Rules (HAR), the Agency has determined that:

1. This proposal is eligible for administrative review because as it meets the criterion in Section 11-186-99.1(b)(6), i.e.: "any proposal which is determined by the agency not to have a significant impact on the health care system."
2. The applicant has proven by a preponderance of evidence that its proposal meets the Cert. criteria in Section 11-186-15, HAR:
 - a. The applicant states that its proposal supports the objectives and regional priorities of Hawaii Health Performance Plan (H2P2).
 - b. The applicant states that the utilization of its emergency room has increased by over 100% since the medical center first opened and that the current bed capacity cannot sufficiently accommodate the increase in the volume of patients.
 - c. The applicant states that it is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and complies with federal and state regulations.
 - d. The applicant projects net cash flow of \$626,000 for Year 1 of operations and \$2,010,000 for Year 3. The applicant states that there is sufficient revenue generated to fund operating expenses and adequate cash for debt servicing.

- e. The applicant states that its proposal is necessary to keep up with the current needs for emergency care in West Oahu and that it will allow the medical center to serve the needs of the community with the appropriate emergency care for this region of Oahu.
- f. The applicant states that the majority of project financing will be provided by debt financing insured through the U.S. Housing and Urban Development and that additional project costs will be funded through the St. Francis Healthcare Foundation.

There is no compelling public interest which will be served by requiring the application to go through the standard review process.

Pursuant to Section 323D-43(b), Hawaii Revised Statutes (HRS), the Agency finds that:

1. There is a public need for this proposal.
2. The cost of this proposal will not be unreasonable in light of the benefits it will provide and its impact on health care costs.

Accordingly, the State Health Planning and Development Agency hereby APPROVES and ISSUES a Certificate of Need to at St. Francis Medical Center West for the proposal described in Cert. #02-18A. The maximum capital expenditure allowed under this approval is \$5,240,000.

Please be advised that pursuant to Section 323D-47, HRS and Section 11-186-99.1(g) HAR, any person may, for good cause shown, request in writing a public hearing for reconsideration of the Agency's decision within ten working days from the date this decision. Accordingly, if no person makes such a timely request for reconsideration, this decision shall become final immediately after the deadline for making such a request has expired.

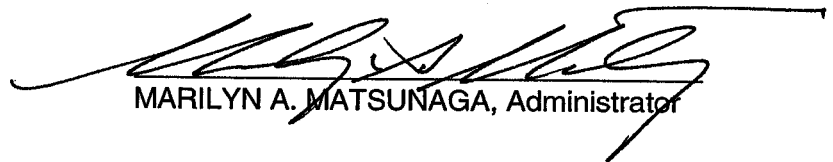

MARILYN A. MATSUNAGA
Administrator

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the attached Administrative Decision was duly served upon the applicant by sending it by certified mail, return receipt requested, in the United States Postal Service addressed as follows on August 14, 2002.

Raleigh Awaya
Chief Operating Officer
St. Francis Medical Center West
2226 Liliha Street, Suite 226
Honolulu, HI

HAWAII STATE HEALTH PLANNING
AND DEVELOPMENT AGENCY



MARILYN A. MATSUNAGA, Administrator

7001 1140 0000 1361 9086

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE

CERTIFIED MAIL



7001 1140 0000 1361 9086
7001 1140 0000 1361 9086

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

#02-18A and #02-19A DOM L USE

Postage	\$.60	Mailed 8/14/02 Postmark Here
Certified Fee	2.30	
Return Receipt Fee (Endorsement Required)	1.75	
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$ 4.65	

Sent To
Raleigh Awaya

Street, Apt. No.; or PO Box No. St. Francis Medical Center
2226 Lilihe~~XXX~~ St., #226

City, State, ZIP+4 Honolulu, HI 96817

PS Form 3800, January 2001 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to: #02-18A/#02-19A

Raleigh Awaya
Chief Operating Officer
St. Francis Medical Center
2226 Liliha Street, Suite 226
Honolulu, HI 96817

2. Article Number (Copy from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Received by (Please Print Clearly) B. Date of Delivery

C. Signature Agent
X Addressee

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes