Office of Health Care Access
Certificate of Need

Final Decision

Applicants:	**University of Connecticut Health Center Finance Corporation, on behalf of John Dempsey Hospital, and Health Resources International, d/b/a Farmington Surgery Center, LLC**
Docket Number:	**01-535**
Project Title:	**Ambulatory Surgery Center Joint Venture**
Statutory Reference:	**Section 19a-638 and 19a-639, Connecticut General Statutes**
Filing Date:	**February 1, 2002**
Hearing Dates:	**March 15, 2002, March 26, 2002, April 9, 2002, and May 9, 2002**
Decision Date:	**June 10, 2002**
Default Date:	**June 16, 2002**
Staff:	**Susan Cole** **Laurie Greci** **Tillman Foster**

Project Description: The University of Connecticut Health Center Finance Corporation, on behalf of John Dempsey Hospital, and Health Resources International ("Applicants"), in a joint venture to do business as the Farmington Surgery Center, LLC, are proposing to establish an ambulatory surgery center with an associated capital cost of $5,662,471.

Nature of Proceeding: On February 1, 2002, the Office of Health Care Access ("OHCA") received the University of Connecticut Health Center Finance Corporation's, on behalf of John Dempsey Hospital, and Health Resources International's ("Applicants") Certificate of Need ("CON") application seeking authorization to establish an ambulatory surgery center in a joint

venture doing business as the Farmington Surgery Center, LLC, at a capital cost of $5,662,471. John Dempsey Hospital is a health care facility or institution as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

Public hearings were held on March 15, 2002, March 26, 2002, and April 5, 2002, and May 9, 2002. The Applicants were notified of the dates, times and place of the hearings, and a notice to the public was published prior to the hearing in *The Hartford Courant*, *The Herald* of New Britain, and *The Northeast Minority News.* Commissioner Raymond J. Gorman served as presiding officer for this case. The public hearings were conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Sections 19a-638 and 19a-639, C.G.S.

The Presiding Officer heard testimony from the Applicants. Commissioner Gorman, in rendering this decision, considered the entire record of the proceeding. OHCA's authority to review and approve, modify or deny this proposal is established by Sections 19a-638 and 19a-639, C.G.S. The provisions of these sections, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were considered by OHCA in its review.

On November 27, 2001, the Applicants requested an extension of the Letter of Intent's current status for 30 days. On November 29, 2001, OHCA extended the LOI current status to December 30, 2001. An incomplete application was submitted to OHCA on December 21, 2002. With the submission of additional information the application was deemed complete on February 1, 2002. On April 10, 2002, the Applicants requested an extension of OHCA's application review period from May 2, 2002, to May 17, 2002; OHCA granted the request on April 17, 2002. Due to the untimely filing of necessary information from the Applicants, on May 13, 2002, OHCA extended the review period 30 days from May 17, 2002, to June 16, 2002.

Findings of Fact

Clear Public Need
Impact on the Applicant's Current Utilization Statistics on Delivery in the Region
Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services
Contribution of the Proposal to the Quality and Accessibility of Health Care Delivery in the Region

1. The University of Connecticut Health Center ("UCHC"), located in Farmington, Connecticut, is composed of John Dempsey Hospital, the School of Medicine, School of Dental Medicine, the UConn Medical Group, UConn Health Partners and University Dentists. *(January 28, 2002, www.uchc.edu/hc/info.html)*

2. John Dempsey Hospital ("JDH") is an acute care hospital currently licensed for 204 beds. It is the teaching hospital for the UCHC. *(January 28, 2002, www.uchc.edu/hc/info.html)*

3. The University of Connecticut Health Center Finance Corporation ("UCHCFC") was created by public act to promote maximum flexibility for John Dempsey Hospital and Uncas-on-Thames Hospital to continue to serve effectively as the teaching hospitals of The University of Connecticut and to provide lower cost health care to benefit the people of the state of Connecticut. *(C.G.S. Chapter 187c, Section 10a-251)*

4. The UConn Medical Group ("UMG") is the multi-specialty group practice of the University Schools of Medicine and Dental Medicine. More than 200 physicians, dentists and other health care professionals within the group provide a complete range of programs in more than 50 specialties. *(http://health.uchc.edu/welcomedesk/index.htm)*

5. Health Resources International ("HRI") was formed in 1998 as a privately held limited liability company engaged in developing ambulatory surgery centers and provider-associated management consulting services. HRI is owned by Bernard A. Kershner, Allen D. Hecht and Beth S. Derby, who formerly served as the respective Chairman, Executive Vice President and Chief Operating Office, and Senior Vice President of ASC Network Corporation, a privately held company that owned and operated ambulatory surgery centers in the United States. *(February 1, 2002, Completeness Responses, pages 7 and 8 and March 8, 2002, Interrogatories, page 4)*

6. UCHCFC, on behalf of JDH, and HRI through a joint venture propose to establish a freestanding ambulatory surgery center on the campus of the UCHC. *(February 1, 2002, CON Application, pages 2 and 10)*

7. The Articles of Organization for the Farmington Surgery Center, LLC ("FSC") were filed with the Connecticut Secretary of State on October 19, 2001. *(February 1, 2002, CON Application, page 214)*

8. The UCHCFC, on behalf of the UMG, and HRI entered into a Memorandum of Understanding on March 8, 2002, concerning the joint venture that will coordinate the ownership and operation of the building that will house the FSC. *(March 8, Interrogatories, page 18)*

9. The Articles of Organization for the Medical Arts & Research Building of Farmington, LLC ("MARB") were filed with the Connecticut Secretary of State on April 26, 2002. The MARB is the company that will own and develop the building in which the FSC will be located. *((February 1, 2002, Completeness Responses, page 8 and May 7, Late File 4, page 60)*

10. The Applicants propose to locate the FSC in 18,020 square feet of leased space in a still-to-be-built building on the UCHC campus. *(February 1, 2002, CON Application, page 22)*

11. The FSC is a for-profit company. *(February 1, 2002, Completeness Responses, page 3)*

12. The UCHCFC, on behalf of JDH, and HRI will initially each have a 50% Membership Interest in the FSC. *(March 22, 2002, Interrogatories-B, page 11)*

13. The Applicants stated that the Net Profits of FSC are to be allocated on the basis of a preferred distribution percentage interest. *(March 22, 2002, Interrogatories-B, page 11)*

14. The non-cash contribution of JDH, i.e., the value of the ambulatory cases that will migrate to the FSC, relative to the cash and non-cash contributions of HRI, will determine the percentage of JDH's preferred distribution interest. *(March 8, Interrogatories, page 6)*

15. UCHCFC and HRI stated that they expect to offer up to 30% interest to physicians through an equal divestiture of their respective membership interest. However, at no time shall HRI or any other member hold an interest in the FSC that exceeds the interest held by UCHCFC. *(February 1, 2002, CON Application, pages 20 and 209)*

16. FSC proposes to provide the ambulatory surgery needs of patients who now seek care from a physician member of the UMG and community physicians associated with JDH. JDH proposes to continue to provide ambulatory surgery services in cases where the acuity or co-morbidity warrants surgery in an acute care setting. *(February 1, 2002, CON Application, pages 2 and 3)*

17. JDH states that shifting the patients seeking ambulatory surgeries to FSC will allow it to focus its operating room program around inpatient surgical services and renovate and retool the operating room facilities. *(February 1, 2002, CON Application, pages 5 and 12)*

18. The Applicants state that technological advancement and volume growth has created a need at JDH for additional space, equipment, and systems for its inpatient and ambulatory surgery programs. *(February 1, 2002, CON Application, page 2)*

19. JDH states that it is constrained by the available space in its existing operating room suite. The suite, originally constructed in 1972, was not designed to meet the demands of today's technology and regulatory requirements. The existing operating rooms are small relative to current American Institute of Architects guidelines; equipment is stored outside the rooms and brought in as needed. *(February 1, 2002, CON Application, pages 5 and 6)*

20. JDH reports that two operating rooms are currently dedicated to inpatient surgery; the other operating rooms are used for both inpatient and ambulatory surgery throughout the day. *(February 1, 2002, CON Application, page 5)*

21. JDH states that efficient scheduling is impaired as inpatient and ambulatory operations compete for rooms, equipment and staff. *(February 1, 2002, CON Application, pages 5 and 6)*

22. Emergency surgeries, inpatient and "add-on" cases are accommodated in the evenings and on weekends. However, disruptions in the ambulatory surgery schedule often occur. *(February 1, 2002, CON Application, pages 6 and 11)*

23. The number of hospital-based ambulatory surgery cases statewide has been increasing due to the growth in population. Large increases in the age groups of 45-65 and 65 and older, which have the highest use rate of ambulatory surgery, also contribute to the demand. *(February 1, 2002, CON Application, pages 10 and 114)*

24. The numbers of ambulatory surgical cases performed in the last three years for the Applicant's primary service area (PSA) and statewide and the percent increase from the previous year is shown in the table below:

Ambulatory Surgery Volume

	1998		1999		2000	
	Cases	*% Increase*	*Cases*	*% Increase*	*Cases*	*% Increase*
Avon	983	8.4%	1,100	11.9%	1,301	18.3%
Burlington	563	12.8%	636	13.0%	686	7.9%
Canton	562	9.3%	672	19.6%	697	3.7%
Farmington	1,602	7.9%	1,753	9.4%	1,973	12.5%
Simsbury	1,332	12.4%	1,522	14.3%	1,727	13.5%
West Hartford	4,123	4.2%	4,189	1.6%	4,599	9.8%
PSA Total	**9,165**	**7.2%**	**9,872**	**7.7%**	**10,983**	**11.3%**
Statewide Total	**239,003**	**8.9%**	**260,358**	**8.9%**	**280,606**	**7.8%**

(February 1, 2002, CON Application, page 102)

25. JDH stated that it has seen a steady increase in its ambulatory surgery cases from the Farmington Valley and West Hartford, growing by 14.6% and 20.8% over the two most recent years.

Ambulatory Surgery Growth for JDH

	1998		1999		2000	
	Cases	*% Increase*	*Cases*	*% Increase*	*Cases*	*% Increase*
Avon	158	14.5%	168	6.3%	186	10.7%
Burlington	46	-19.3%	55	19.6%	66	20.0%
Canton	85	7.6%	80	-5.9%	107	33.8%
Farmington	319	10.0%	404	26.6%	427	5.7%
Simsbury	144	7.5%	252	75.0%	302	19.8%
West Hartford	376	7.7%	334	-11.2%	474	41.9%
PSA Total	**1,128**	**7.7%**	**1,293**	**14.6%**	**1,562**	**20.8%**
Statewide Total	**4,247**	**-0.5%**	**4,612**	**8.6%**	**5,463**	**18.5%**

(*(February 1, 2002, CON Application, page 110)*

26. JDH reported that the majority of ambulatory surgery patients originate from a wide array of towns as the UMG subspecialty mix drives a broader than usual geographic base. *(February 1, 2002, CON Application, pages 8 and 12)*

27. JDH reported that 25% of its ambulatory surgery cases come from the following towns: Berlin, Bloomfield, Bristol, East Granby, Granby, Hartford, New Britain, New Hartford, Newington, Plainville, and Wethersfield. *(February 1, 2002, CON Application, page 8)*

28. JDH's share of all ambulatory surgery cases statewide is less than 2%; its share of the Farmington Valley and West Hartford is 14.2%. *(February 1, 2002, CON Application, pages 8 and 110)*

29. There are no other providers within JDH's proposed service area. However, Hartford Hospital, St. Francis Hospital and Medical Center, New Britain General Hospital, and Bristol Hospital each have a share of the area's ambulatory surgery market. In addition, two free-standing ambulatory surgery centers, Hartford Surgical Center and HealthSouth Connecticut Surgery Center provide services to area residents. *(February 1, 2002, CON Application, page 13)*

30. UMG physicians accounted for 81% of JDH ambulatory surgery procedures in the most recent 12-month period. *(February 1, 2002, CON Application, page12)*

31. The Applicants state that the University of Connecticut is committed to "UCHC delivering an educational curriculum that integrates basic research with innovative clinical programs*". (March 8, 202, Dr. Peter Deckers, Prefiled Testimony)*

32. The UCHC has adopted a strategic plan that will allow the Health Center to develop four "Centers of Excellence" – Connecticut Health, Brain and Human Behavior, Cancer and Musculoskeletal. The UCHCFC believes that the proposed FSC will contribute most significantly to the development of the Musculoskeletal Institute. *(February 1, 2002, CON Application, page 3)*

33. It is proposed to locate the FSC and the Musculoskeletal Institute in the same building. (*February 1, 2002, CON Application, page 4)*

34. JDH states that the education programs of the UCHC, the School of Allied Health and the School of Health Care Management at UConn-Storrs, and potentially other UConn, state and private universities and colleges will be afforded access to the FSC for training of students in an "environment of excellence". (*February 1, 2002, CON Application, page 4)*

35. The Applicants state that the development of a freestanding ambulatory surgery center will:

    - Provide state-of-the-art clinical facilities for students and residents.
    - Increase the attractiveness of the program to patients and physicians.
    - Enhance opportunities for clinical research.
    - Make it substantially easier to develop and utilize shared resources.
    - Create an exemplary practice site and a "laboratory" for technology transfer and clinical research.
    - Assist in attracting, recruiting and retaining faculty for the medical school.
    - Lower delivery of service costs and enhance customer satisfaction.

    (February 1, 2002, CON Application, pages 3 and 4)

36. The UCHC contends that there are no alternate locations within JDH that may be used to relocate surgical services on a permanent, or even temporary, basis. Rooms cannot be taken out of service for renovations without diverting cases. *(February 1, 2002, CON Application, page 6)*

37. JDH explored several options for renovations and new construction to ease its shortage of surgical space:

- Option 1 - Construct a three-room ambulatory surgery addition adjacent to the existing operating room suite.
- Option 2 - Renovate space adjacent to the existing operating rooms.
- Option 3 - Renovate an existing on-campus building.
- Option 4 – Enter into a joint venture with HRI to establish the FSC.

(February 1, 2002, Completeness Responses, page 1)

38. JDH determined that the main advantage of Option 1 was speed and minimal disruption. The eliminating disadvantage was the lack of space for related support services, such as waiting and recovery areas. Cost estimates were not provided. *(February 1, 2002, Completeness Responses, page 1)*

39. JDH contends that Option 2 was not feasible due to construction issues: a loading dock could not be relocated; adjacent space was designed solely for offices; and access to the existing operating suite would be problematic. Cost estimates were not provided. *(February 1, 2002, Completeness Responses, page 1)*

40. According to JDH, the primary advantage of Option 3 was that the location was ideal for a freestanding facility in terms of patient access. The disadvantages were that the building was not designed to house clinical services and extensive renovations would have been required. Additionally, the administration offices would have required relocation. It was apparent to JDH that the costs would be prohibitive. Cost estimates were not provided. *(February 1, 2002, Completeness Responses, page 1)*

41. JDH management considered the need for capital expenditure for the proposal in relation to other needs of the hospital. Due to limited space and capital, they stated that the FSC was attractive for the following reasons:

- No capital expenditure was required from JDH.
- The proposed FSC would be in an entirely new building that would also house programs and services related to the development of the UCHC's Musculoskeletal Signature Program.
- The expertise that HRI would bring to the development and operation of the ambulatory surgery centers would allow JDH and UCHC to derive the benefit of a state-of-the-art ambulatory care facility.
- The creation of the FSC would allow JDH to dedicate its operating rooms to inpatient surgery and high intensity outpatient surgery, allowing growth of both programs.

(February 1, 2002, Completeness Responses, page 2)

42. The FSC is the first phase of JDH's plan to address the space shortage in the surgical suite. The Applicants stated that moving the majority of outpatient surgeries to the FSC would provide JDH the ability to undertake renovations to existing surgical rooms without interruption of services to patients. *(February 1, 2002, CON Application, pages 5 and 12)*

43. FSC's projected volume is expected to come primarily from increase in demand for ambulatory surgery services in the proposed service area. *(February 1, 2002, CON Application, page 13)*
44. Utilization projections by specialty mix for the FSC are as follows:

Utilization Projections by Specialty Mix for FSC

		Number of Cases		
Specialty	% of Total Cases	Year 1	Year 2	Year 3
Orthopedics	45%	1,845	2,115	2,385
General Surgery	18%	738	846	954
Ophthalmology	8%	328	376	424
Gynecology	7%	287	329	371
Other	22%	902	1,034	1,166
Total	**100%**	**4,100**	**4,700**	**5,300**

(February 1, 2002, CON Application, pages 5 and 12)

45. JDH currently has nine operating rooms. Projected surgical demand by 2003 will require that JDH have 11 operating rooms. *(February 1, 2002, CON Application, page 5 and 98)*

JDH Operating Room Volume

Fiscal Year	Number of Cases	Change in No. of Cases	Required Number of Operating Rooms
1998	**5,261**	**-**	**7**
1999	**5,487**	**4.3%**	**8**
2000	**6,270**	**14.3%**	**9**
2001	**6,822**	**8.8%**	**9**
Projected 2002	**7,351**	**7.8%**	**10**
Projected 2003	**7,930**	**7.9%**	**11**

(February 1, 2002, CON Application, page 98)

46. The proposed number of five operating rooms required at the FSC is based on:

- 254 days/year, 8 hours/day.
- Minutes per room/year = 254 days x 8hrs x 60 minutes = 121,920.
- 103,632 total minutes at a Utilization Rate of 85%.
- Average minutes/case = 60 minutes with 15 minute turnover between cases.

Year	No. of Cases	Minutes *(60+15)*No. of Cases*	Minutes/103,632	Rooms Required
1	4,100	307,500	2.97	**3**
2	4,700	352,500	3.40	**4**
3	5,300	397,500	3.84	**4**

(January 9, 2002, Revised Exhibit F4)

47. The proposed hours of operation for the FSC will be Monday through Friday, 6:30 a.m. to 5:00 p.m. *(February 1, 2002, CON Application, page 13)*

48. The Applicants propose to seek licensure for the FSC as an outpatient ambulatory surgery center. *(February 1, 2002, CON Application, page 19)*

49. The FSC proposes to have a comprehensive Quality Assurance program that reviews and evaluates the quality of care provided by all surgeons, podiatrist, dentists, anesthesia care givers, allied health providers and nursing personnel. The Medical Director, Director of Nursing, Administrative Director and at least two other staff members as well as no less than one additional physician will form a Quality Assurance Committee that will review the quality of care to patients by meeting at least six times a year. *(February 1, 2002, CON Application, page 204)*

50. The Memorandum of Understanding signed by the Applicants on December 21, 2001, states that the FSC is governed by a Board of Managers, three from JDH and three from HRI. It also states that the FSC will be operated on a day-to-day basis pursuant to a Management Agreement between the FSC and HRI. *(February 1, 2002, CON Application, pages 209 and 210)*

51. The Management Agreement was submitted to OHCA as Exhibit B of the late filing accepted into the Table of Record at the hearing held on May 6, 2002. Representatives of HRI and FSC signed the Management Agreement on May 6, 2002. *(May 6, 2002, Late File 4, page 34)*

52. The Management Agreement stated, in part, that HRI will:

- Provide day-to-day management services to and for the FSC.
- Assure that the FSC meets the standards of the Accreditation Association of Ambulatory Healthcare Facilities.
- Establish an Annual Plan for the FSC.
- Be an independent contractor undertaking its duties for the FSC.
- Act as the agent of the FSC.
- Operate the FSC at all times in the manner that furthers the purposes of the UCHC and JDH.
- Manage the FSC for an initial term of ten (10) years with automatic renewal for two (2) successive five (5) year terms.
- Be paid management fees quarterly at a rate of 5% of net revenues for the first three years and then 6% thereafter.

(May 6, 2002, Late File 4)

53. FSC and HRI also entered into a Development Agreement. HRI will serve as the consultant for the design and the development of the FSC. The Development Agreement was submitted to OHCA as Exhibit A of the late filing accepted into the Table of Record at the hearing held on May 6, 2002. Representatives of HRI and FSC signed the Development Agreement on May 6, 2002. *(May 6, 2002, Late File 4, page 14)*

54. The Applicants submitted an incomplete draft of the Operating Agreement for the FSC on March 15, 2002. On March 22, 2002, a complete version of the document was submitted.

Representatives of the UCHCFC, acting on behalf of JDH, and HRI signed the FSC Operating Agreement on March 15, 2002. *(March 15, 2002, Applicant Exhibit 3)*

55. The FSC Operating Agreement stated, in part, that:

- The FSC was formed for the purpose of operating a freestanding ambulatory surgery center and to arrange for the delivery of clinical services ancillary to such surgical services.
- The FSC shall operate at all times in a manner that furthers the purposes of the UCHC and the JDH.
- The purposes of the formation of the FSC shall not be subverted to its operation solely for the financial benefits of its members.
- The UCHCFC is not required to make an initial cash capital contribution to the FSC.
- The preferred distribution interest of the UCHCFC, on behalf of JDH, is 76%.

(March 22, 2002, FSC Operating Agreement)

56. The Operating Agreement for the MARB was submitted to OHCA as Exhibit O of the late filing accepted into the Table of Record at the hearing held on May 6, 2002. Representatives of the UCHCFC, acting on behalf of the UMG, and HRI signed the MARB Operating Agreement on May 6, 2002. *(May 6, 2002,Late File 4)*

57. The MARB Operating Agreement stated, in part, that:

- The MARB was formed for the purpose of owning and operating a certain building and other improvements situated on the campus of the UCHC.
- A portion of the building shall be leased to an Affiliate of the Members for the purpose of operating a freestanding ambulatory surgery center.
- MARB will operate at all time in a manner that furthers the purposes of the UCHC.
- The building will be approximately 99,246 square feet and 5 stories.
- The UCHCFC will be afforded a right of first opportunity on behalf of itself and any of its affiliates to lease or allocate any particular space in the building other than that allocated to the FSC or the provision of any clinical services in the building.
- The initial capital contribution of the UCHCFC was determined to be $2,500,000. The amount is based on a report[1] by CB Richard Ellis – NE Partners, LP that established the fair market value of land to be used for the building at $2,500,000.
- The initial capital contribution of HRI is $2,500,000 in cash.
- UCHCFC and HRI each have a 50% interest in the MARB.
- The land will be leased by or on behalf of the UCHCFC pursuant to a 99-year lease.

(May 6, Late File 4, Page 5)

58. Site plans submitted on May 6, 2002, indicated that the location of the building was changed since the submission date of the CON application. The Applicants state that the new site will meet the needs of the patients who will be served, accommodate the physical needs of the building, and enhance the UCHC campus. Consultants for the UCHC identified the alternate location that met, in part, the following criteria:

[1] See Finding of Fact 79.

- Fit within the context of Master Plan campus "zones";
- Visibility;
- Proximity of existing and future clinical facilities;
- Vehicular access and adequate parking; and
- Impact on wetlands.
- Construction Costs

(May 6, 2002, Late File 4, pages 1 and 2)

59. The Applicants state that no additional regulatory approval will be required for the construction of the new building as:

- The building will be sized at less than 100,000 square feet.
- No wetlands or wooded areas are impacted and no existing buildings will need to be demolished.
- Previous construction indicates that the soil will provide adequate bearing capacity and drainage.
- Surface parking will be available next to the building and access to additional parking lots is served by a shuttle system.

(May 6, 2002, Late File 4, pages 2,3 and 4)

60. The Applicants state that the ambulatory surgery center will be located on the first floor of the building. The floor plan was designed to:

- Meet regulatory requirements and current guidelines.
- Provide ideal patient flow.
- Provide patients with privacy and comfort.
- Ensure safety and optimum clinical oversight.
- Accommodate the newest technology and equipment.

(May 6, 2002, Late File 4, page 3)

61. Dr. Peter Deckers, Dean of the University of Connecticut School of Medicine and Executive Vice President for Health Affairs at the UCHC, stated that the principals of HRI are experienced managers of ambulatory surgery centers with a proven track record of success. *(March 15, 2002, Dr. Deckers' Prefiled Testimony, page 8)*

62. Mr. Bernard Kerschner, Chairman of HRI, testified that he and Mr. Allen Hecht, President of HRI, introduced the concept of ambulatory surgery centers to the state of Connecticut almost 28 years ago with the opening of the Hartford Surgical Center. An additional six centers were developed and operated by them; three were joint ventures with Connecticut hospitals. *(March 15, 2002, Mr. Bernard Kerschner's Testimony)*

63. The Applicants submitted the following schedule as a revision to that proposed in the original CON application:

Description	Date
Commence Building Construction	December 2002
Complete Building/ Shell Construction	December 2003
Commence FSC fit-out	November 2003
Complete FSC fit-out	February 2004
FSC Occupancy	March 2004
FSC Licensure	April 2004

(May 6, 2002, Late File 4, Page 5)

Financial Feasibility of the Proposal and its Impact on the Applicant's Rates and Financial Condition

64. The proposal has a capital expenditure of $5,662,471 as follows:

Capital Expenditure Breakdown

Project Component	Capital Expenditure
Fixed Equipment (Purchase)	0
Fixed Equipment (Lease (FMV))	$1,066,387
Movable Equipment (Purchase)	0
Movable Equipment (Lease (FMV))	$1,126,917
Construction (Fit-out of Leased Space)	$2,777,500
Contingency & Start-up Expenses	691,667
Total Capital Expenditure	**$5,662,471**

(February 1, 2002, CON Application, page 22)

65. The proposed FSC project will be funded with $1,200,000 of equity. A conventional loan will be obtained in the amount of $2,269,167. Lease financing will be $2,193,304. *(February 1, 2002, CON Application, pages 22-24)*

66. A CHEFA loan was not considered because UCHC administration determined that adequate reserves to secure a loan and meet CHEFA's eligibility requirements were not available. (*(March 22, 2002, Interrogatories-B, page 11)*

67. The Applicants did not consider funding by the State Bonding Commission, as they believe such "funds would not be made available for the clinical activities of UCHC" and that "the process can be lengthy and the outcome of the process uncertain". *(March 22, 2002, Interrogatories-B, page 11)*

68. Capitalized financing costs are not included in the proposed capital expenditure. For informational purposes only, the interest on borrowings is projected to be $227,012 per year for ten years. *(March 8, Interrogatories, pages 10 and 29)*

69. Leasehold improvements will be required. The breakdown of the construction costs are:

Construction Cost Breakdown

Construction Component	Cost
Total Building Work	$2,252,500
Architectural & Engineering	$ 200,000
Development	$ 325,000
Total Capital Construction Cost	**$2,777,500**

(February 1, 2002, CON Application, page 23)

70. The leasing costs were based on preliminary planning prior to the designing of the building in which the FSC will be located. *(February 1, 2002, CON Application, page 25)*

71. The rental expense for the FSC was calculated on a basis of $20 per square foot, or $360,400. *(February 1, 2002, Completeness Responses, page 8)*

72. The projected payer mix for the FSC's first three years of operation is as follows:

Projected Payer Mix for FSC

Payer Description	Projected
Commercial Insurers	60%
Medicare	23%
Medicaid	8%
Workers Compensation	5%
Self-Pay	2%
Uncompensated Care	2%

(February 1, 2002, CON Application, page 25)

73. The FSC is projecting the following gains from operations for the first three years of operation as follows:

FSC Gains from Operations

Fiscal Year	Gain from Operations
2004	$ 216,274
2005	$ 578,596
2006	$ 864,488

(February 1, 2002, CON Application, page 229)

74. JDH is projecting the following gains and losses from its operations for the first three years of the proposal:

JDH Gain (Loss) fromOperations

Fiscal Year	Gain (Loss) from Operations
2004	$ (400,164)
2005	$ 269,954
2006	$ 920,581

(February 1, 2002, Completeness Responses, page 12)

75. The Applicants state that JDH does not have a distinct ambulatory surgery department. Therefore, JDH contracted with Standard & Poor's Corporate Value Consulting to perform a valuation analysis of the intangible assets of JDH's outpatient surgery business to establish the value of JDH's non-cash contribution to the FSC. *(May 9, 2002, Late File 4, page 7)*

76. Financial projections provided by the Applicants to Standard & Poor's were based on an approximation of the value of JDH's ambulatory surgery business where many direct and indirect costs could not be included. *(February 1, 2002, Completeness Responses, page 5)*

77. Standard & Poor's estimated the value of the intangible assets of JDH's outpatient surgery business as of June 30, 2001, to be $5,040,000[2], the amount used for JDH's preferred distribution. The contribution ascribed to the intangible assets was established at $680,612 and the cost of capital was estimated to be 13.5%. *(April 9,2002, Late File 2, page 7)*

78. The UCHCFC, on behalf of JDH, has a 76% preferred distribution interest in the company; HRI has 24%.

Breakdown of JDH and HRI Interest In Company

	Contribution, Type	Contribution, Dollars	Preferred Distribution Percentage Interest (% of Total)
JDH	Non-Cash	$5,000,000	**76**
HRI	Cash	$1,200,000	
	Non-Cash	300,000	**24**
	Total	**$6,500,000**	**100**

(March 22, 2002, Interrogatories-B, page 11)

79. JDH expects to offset any revenue reduction from the migration of the ambulatory cases to the FSC through the profit distributions received from the FSC on the basis of its preferred distribution interest. The estimated non-operating revenues that are projected to be transferred from the FSC to JDH during the first three years of operation were reported by the Applicants as follows:

Projected Non-Operating Revenue for FSC

Fiscal Year	Non-Operating Revenue[3]
2004	$147,066
2005	$393,384
2006	$587,852

(March 8, 2002, Interrogatories, page 6 and February 1, 2002, Completeness Responses, page 12)

[2] Standard & Poor's did not perform an audit, review, or examination of the financial information used in the valuation report. *(April 9, 2002, Late File 2, page 27)*

[3] The Applicants did not provide OHCA with an updated Pro Forma to reflect the change in the preferred distribution percentage from 68% to 76%.

80. The estimated non-operating revenue reported by the Applicants in the CON applicant were based on a preferred percentage interest of 68%, and not the 76% reported in the Operating Agreement submitted on March 5, 2002. An updated Pro Forma was not provided. *(March 22, 2002, FSC Operating Agreement)*

81. HRI initially did not provide financial statements for OHCA's review. On February 1, 2002, HRI provided a self-prepared balance sheet as of February 1, 2002; the total assets of HRI were $1,502,000. *(February 1, 2002, Completeness Responses, page 19*

82. The Applicants were asked in the interrogatories to provide HRI's most recent Income Statement and Statement of Cash Flow Changes. HRI self-reported net income in 1998, 1999, and 2000 to be $80,060, $15,948, and $40,516, respectively. HRI's Income Statement for 2001 and a Statement of Cash Flow Changes were not provided. *(March 8, 2002, Responses to Interrogatories, pages 5 and 23)*

83. A Contribution Guarantee submitted to OHCA on March 26, 2002, stated that Bernard A. Kershner and Allen D. Hecht agreed to cause the sum of $2,500,000 to be contributed to HRI which would, in turn, contribute said sum to the limited liability company that would construct the building in the form of equity or subordinated debt. *(March 26,, 2002, Applicant's Exhibit 4)*

84. HRI submitted compiled financial statements to OHCA on May 6, 2002. The balance sheet was reported as of April 30, 2002, and the statements of operations and members' equity and cash flows were for four months ending on the same date.

- The balance sheet reported total assets of $4,045,080.
- The Members contributed $4,100,350 to HRI during the four-month period.
- HRI reported a $59,765 net loss during the four-month period.

(May 6, 2002, Late File 4, Pages 192-197)

85. The fair market value of the land that would be utilized to construct a building with a footprint of approximately 20,000 square feet was determined through a valuation process. CB Richard Ellis – N.E. Partners, LP performed the appraisal and prepared the report. The report, dated February 11, 2002, had the following conclusions:

- Using a sales comparison approach, the development rights to construct a 90,000 square foot medical office building on the UCHC campus as of January 31, 2002, had a fee simple market value of $23 per square foot for a total of $2,070,000.
- The contributory value of existing property improvements, such as driveway, landscaping and utility infrastructure, was estimated at $430,000.
- The total value of the development rights is $2,500,000 with an exposure time[4] of 12 months from the date of the valuation.

(May 6, 2002, Late Filing Exhibit 4, Exhibit Q)

[4] Exposure time is defined as the estimated length of time that a property was listed prior to a market value sale.

86. Section 19a-613, C.G.S., authorizes OHCA to collect patient-level outpatient data from health care facilities or institutions as defined in Section 19a-630, C.G. S.

Consideration of Other Principles and Guidelines Section 19a-637, C.G.S.

The following findings are made based upon other principles and guidelines set forth in Section 19a-637, C.G.S.:

87. There is no State Health Plan in existence at this time.

88. The Applicants have adduced evidence that this proposal is consistent with the UCHC long-range plan.

89. The Applicants stated that JDH has a continuous program for identifying cost savings and productivity enhancement. With respect to its operating rooms, JDH implemented inventory control measures that have resulted in substantial savings. JDH has programs in place that address energy efficiency and conservation, group purchasing, and technology enhancements. *(February 1, 20002, CON Applications, pages 17 and 18*

90. There are unique patient/physician mix characteristics related to this proposal. The Applicants state that the composition of the UMG, in its specialty mix, subspecialty interest, and academic focus, make it a unique provider of services. *(February 1, 2002, CON Application, page 19)*

Rationale

The University of Connecticut Health Center Finance Corporation ("UCHCFC"), on behalf of John Dempsey Hospital ("JDH") and Health Resources International, LLC ("HRI") (collectively known as "Applicants") are proposing to establish an ambulatory surgery center as a joint venture. The freestanding ambulatory surgery center to be known as the Farmington Surgery Center, LLC, ("FSC") will be located on the campus of the University of Connecticut Health Center ("UCHC").

The Applicants have provided extensive evidence in support of the need for the proposed ambulatory surgery center. Currently, all surgeries, both inpatient and ambulatory, are performed in the JDH operating suite. JDH was constructed in 1972 and needs renovations and upgrades to meet the current standards and increasing demand. Advancements in technology and increases in volume have created a need at JDH for additional space, equipment and systems for its inpatient and ambulatory surgical programs. Two of the nine operating rooms are dedicated to inpatient surgery; the other operating rooms are used for both inpatient and ambulatory surgery throughout the day. Emergency and "add-on" cases are accommodated on the evenings and on weekends and disruptions in the ambulatory surgical schedule often occur. Efficient scheduling is impaired as impatient and ambulatory operations compete for rooms, equipment and staff. Increases in population, particularly in the age groups of 45 – 65 an 65 and older, which have the highest rate of ambulatory surgery, and the shift from inpatient to ambulatory settings for many procedures, have contributed to the demand. In calendar year 2000 JDH experienced a 20.8% increase in the number of ambulatory surgery cases from its primary service area. JDH also has experienced growth in the number of inpatient surgical cases, although the growth rate has been lower than that of ambulatory surgery. JDH anticipates that the increase in volume will continue and that by 2003 eleven operating rooms will be required to meet JDH's demand for surgical services

There are no alternative locations within JDH that may be used to relocate the surgical services on a permanent, or even temporary basis. Rooms cannot be taken out of service for renovations without diverting cases. JDH explored several options for renovations and new construction to ease its shortage of surgical space. Of the options considered, the joint venture with HRI to establish FSC appeared to make the most sense in terms of minimal disruption to existing services and the fact that JDH would not be required to make any capital expenditure for the expansion of its ambulatory surgical programs. The development of a freestanding ambulatory surgery center would allow JDH to dedicate its operating rooms to inpatient surgery and high intensity outpatient surgery, allowing growth of both programs.

The proposal is for the construction of a five-room surgery center for ambulatory procedures only. The FSC is the first phase of JDH's plan to address the space shortage in the surgical suite. By moving the majority of outpatient surgeries to FSC, JDH will have the ability to undertake renovations to the existing surgical rooms without interruption of services to its patients. FSC's projected volume is expected to come primarily from existing JDH cases and the increase in demand for ambulatory services in JDH's primary service area. The proposal will not only allow the surgical need of the Applicants to be accommodated, it will also enhance the quality of care

through the separation of services and enhance the accessibility to care through improved scheduling and availability of operating rooms.

UCHC's strategic plan and research and teaching responsibilities are also buttressed by this proposal. UCHC has adopted a strategic plan that will allow the Health Center to develop four "Centers of Excellence" – Connecticut Health, Brain and Human Behavior, Cancer, and Musculoskeletal. The UCHCFC believes that the FSC will contribute most significantly to the development of the Musculoskeletal Institute. It is proposed that the Musculoskeletal Institute will be located in the same building as the FSC. The juxtaposition of the FSC and the Musculoskeletal Institute will allow the integration of research, education, and clinical services. Students and residents will be provided with state of the art clinical facilities, opportunities for clinical research will be enhanced, and a "laboratory" for technology transfers and clinical research will be created. It is evident that the FSC would be an innovative and significant addition to the educational and research opportunities of the UCHC.

However, despite the overwhelming documentation regarding the need of the proposal to address the constraints in operation that currently exist at the JDH hospital and the enhanced opportunities of research and education, the Certificate of Need application as presented to OHCA was premature and not fully developed. Critical information regarding the relationships that exist between the Applicants regarding the ownership and management of FSC, executed management agreements between the parties, specifics regarding the financial statements of HRI, and details related to the Medical Arts & Research Building of Farmington, LLC ("MARB") that will house FSC were not available at the time of the first hearing on March 15, 2002. In fact, it was not until nearly 8 weeks later, on May 6, 2002, after several requests by OHCA that much of this information was available.

The FSC is a joint venture between UCHCFC on behalf of JDH and HRI. As such, a complex series of relationships regarding ownership, operations and development of FSC exist between the two Applicants. The relationships are set forth in a series of documents including the Articles of Organization for the FSC, Memorandum of Understanding, Operating Agreement, Management Agreement and Development Agreement. Full disclosure of these documents to OHCA is essential in order for OHCA to evaluate the financial feasibility of the proposal and the impact of the proposal on JDH. As is indicated in Table 1, even though the Letter of Intent was filed in August 2001 and the application was filed in December 2001, the Applicants did not develop and execute the critical documents until May 6, 2002.

Table 1: Timeline of Document Submission

Date of Document	Document	Description	Comment
August 1, 2001	Letter of Intent	UCHCFC, on behalf of JDH, and HRI	Date received by OHCA
October 19, 2001	Articles of Organization	Farmington Surgery Center, LLC	Date of filing with the CT Secretary of State
November 27, 2001	Letter from Applicants requesting extension of CON application filing date	Original Expiration Date of Applicants' LOI was November 29, 2001	OHCA granted extension on November 29, 2001to December 30, 2001
December 21, 2001	Memorandum of Understanding for FSC	UCHCFC, on behalf of JDH, and HRI agreement for joint venture	
December 21, 2001	CON Application	Received by OHCA	Incomplete
February 1, 2002	Completeness Responses		CON Application Complete
March 8, 2002	Memorandum of Understanding	UCHCFC, on behalf of UMG, and HRI	Joint Venture to own and operate a building on the campus of the UCHC
March 15, 2002	Operating Agreement (FSC)	UCHCFC, on behalf of JDH, and HRI	incomplete
March 22, 2002	Operating Agreement (FSC)	UCHCFC, on behalf of JDH, and HRI	complete
April 9, 2002	Letter requesting 15 day extension of OHCA's review period	UCHCFC, on behalf of JDH, and HRI	Granted by OHCA, review date extended to May 17, 2002
April 26, 2002	Articles of Organization of MARB	UCHCFC, on behalf of UMG, and HRI	Date of Filing with the CT Secretary of State
May 6, 2002	Management Agreement	FSC and HRI	
May 6, 2002	Development Agreement	UCHCFC and HRI	
May 6, 2002	Operating Agreement (MARB)	UCHCFC, on behalf of UMG, and HRI	
May 13, 2002	OHCA letter extending review period 30 days		Review Period ends on June 16, 2002

It was not until the May 6th Late File submission that the final terms of the arrangement between UCHCFC and HRI were revealed and OHCA could begin its analysis of the contractual agreements. The proposal as currently structured has the following key components:

- UCHCFC and HRI each will initially have a 50% Membership Interest in FSC.
- The net profits of the FSC will be allocated on the basis of a preferred distribution percentage and UCHCFC will have a 76% interest and HRI will have a 24% interest.
- The preferred distribution percentage is based on the value of ambulatory surgery cases that will migrate from JDH to FSC.
- UCHCFC and HRI expect to offer up to 30% interest to physicians through an equal divestiture of their respective management interest. However, at no time shall HRI or any other member hold an interest in FSC that exceeds the interest held by UCHCFC.
- A Board of Managers, 3 from JDH and 3 from HRI, will govern FSC.

- FSC will be operated on a day-to-day basis pursuant to a management agreement between FSC and HRI.
- HRI will act as the consultant for the design and development of FSC.
- UCHCFC is not required to make an initial cash capital contribution to FSC.

Based on its detailed review of the proposed organizational structure and the terms of the agreements, OHCA acknowledges that the proposal presents a favorable opportunity for both Applicants. However, OHCA is concerned that UCHCFC was willing to proceed to enter into an agreement with HRI and commit its ambulatory surgical volume to FSC before the terms of the arrangement had been finalized. This does not appear to be a prudent approach to dealing with the issue of increasing surgical demand. With the submission of the additional documents on May 6th, it now seems as if UCHCFC will effectively maintain control over FSC and that there are adequate safeguards in place that will provide an effective revenue stream to JDH.

Additionally, the Applicants were reluctant to provide current financial statements for HRI. HRI was established in 1998 as a privately held limited liability company engaged in developing ambulatory surgery centers and provider-associated management consulting services. HRI's financial vitality is critical to the success of this proposal. In addition to having a 50% ownership interest in the FSC, HRI will serve as the consultant for the design and development of the FSC, will provide and be compensated for the day-to-day management services of FSC, and will be a co-owner of the Medical Arts and Research Building ("MARB") that will house the FSC. HRI has committed a minimum of $1,200,000 in capital for the development of the FSC and $2,500,000 for the development of the MARB. However, the initial financial filings did not indicate sufficient capital to support these activities. HRI self-reported net income in 1998, 1999 and 2000 were $80,060, $15,948 and $40,516, respectively. HRI's Income Statement for 2001 and a Statement of Cash Flow Changes were not provided. On February 1, 2002 in response to completeness questions HRI self-reported total assets of $1,502,000, which was not sufficient to meet the obligations outlined in the CON proposal. In response to OHCA's concerns regarding the financial viability of the proposal, on May 6, 2002 HRI filed an auditor's compilation report that indicated that as of April 30, 2002, HRI had total assets of $4,045,080. It is worthy to note that none of the financial statements provided by HRI were reviewed or audited by an independent auditor. Although HRI now appears to have sufficient funds to proceed with the proposal, OHCA is concerned at the difficulty it experienced in receiving confirmation that the proposal was financially viable.

In the same manner, the Applicants did not provide information regarding the building that would house the FSC. This building, now identified as MARB, was a hypothetical 4 or 5 story building until the submission of Late files on May 6, 2002. Prior to the submission of the Late Files, OHCA was unable to evaluate the reasonableness of the projected capital expenditure or operating expenses of the FSC because all that was provided was the schematic of an ambulatory surgery center that would have to be modified once the building plan was developed. The May 6th filing provided sufficient information to allow OHCA to evaluate the proposal and the validity of the revenue and expenses associated with FSC.

OHCA is also concerned that the Applicants are not able to break out inpatient and ambulatory surgical procedures. According to the Applicants, JDH does not have a distinct ambulatory

surgery department. JDH retained Standard & Poor's to provide an approximation of the value of JDH's outpatient surgery business and many of the direct and indirect costs could not be included. Therefore, the value of JDH's non-cash contribution is an estimate, not based on financial data. In addition, Section 19a-613, C.G.S., authorizes OHCA to collect patient-level outpatient data from health care facilities or institutions. The submission of quarterly utilization reports to OHCA by the Applicants for FSC and JDH will provide OHCA with the data necessary to monitor the quality and accessibility of care provided at the proposed facility.

It is projected that JDH will benefit financially from the proposal. Within the first three years of operation it has been projected by the Applicants that only four operating rooms will be needed to meet the demand. The FSC will have five operating rooms, allowing for growth of the ambulatory surgeries from two avenues, the UMG physicians and the community physicians, and the Musculoskeletal Institute.

JDH Financial Projections and FSC Projected Cases

Fiscal Year	JDH Gain (Loss) from Operations	JDH Non-Operating Revenue (from FSC)	FSC Number of Projected Cases	Projected Increase in Cases
2004	$ (400,164)	$147,066	4,100	-
2005	$ 269,954	$393,384	4,700	13%
2006	$ 920,581	$587,852	5,300	11%

At this time it appears that the agreements and the financial contributions will result in the development of an ambulatory surgery center that is financially viable. The FSC will alleviate the space limitations of JDH, improve the accessibility of, and the quality of care, and enhance the mission of the UCHC.

This CON application placed OHCA in the untenable position of having to repeatedly request necessary and customary information from the applicants in order to evaluate the proposal. The application that was submitted to OHCA was extempore and the proposal was hypothetical. The concept of a free-standing ambulatory surgery center is a sensible solution to JDH's need for additional space and equipment in its surgical suite. However, none of the information related to control by the UCHCFC, the impact on JDH, the continuity of care, the financial feasibility of the project itself had been developed. At the time of the application's submission, critical agreements between the Applicants had not yet been executed. While the late file submissions have alleviated some of OHCA's concerns, OHCA should not have needed to conduct 4 hearings and accept numerous late file submissions to have adequate information. Therefore, based on the foregoing Findings and Rationale, the Certificate of Need application of the University of Connecticut Health Center Finance Corporation, on behalf of the John Dempsey Hospital, and Health Resources International, LLC, d/b/a Farmington Surgery Center, LLC is hereby approved with conditions.

ORDER

University of Connecticut Health Center Finance Corporation, on behalf of John Dempsey Hospital, and Health Resources International, LLC, d/b/a Farmington Surgery Center, LLC are hereby authorized to establish an ambulatory surgery center ("facility") to be located on the campus of University of Connecticut Health Center in Farmington, Connecticut, at a total capital cost of $5,662,471. The authorization is subject to the following conditions:

1. Farmington Surgery Center, LLC will consist of five (5) operating rooms, have no more than 18,020 square feet of leased space, and be located in the Medical Arts and Research Building on the University of Connecticut Health Center campus.

2. Farmington Surgery Center, LLC will provide OHCA with utilization reports on a quarterly basis. The data elements and the format and submission requirements are described in Attachment 1.

3. John Dempsey Hospital will provide OHCA with utilization reports on a quarterly basis for its ambulatory surgery cases. The data elements and the format and submission requirements are described in Attachment 1.

4. Farmington Surgery Center, LLC will submit audited financial statements annually to OHCA. These statements shall include the calculation of John Dempsey Hospital's preferred distribution of the net profits.

5. Farmington Surgery Center, LLC will submit to OHCA copies of any documents related to a divestiture of membership interest prior to distribution.

6. Farmington Surgery Center, LLC will report to OHCA the name of any physicians granted a membership interest and their percentage of ownership.

7. The Applicants shall not exceed the approved total capital cost of $5,662,471. In the event that the Applicants learn of potential cost increases or expect that the final project costs will exceed those approved, the Applicants shall file with OHCA a request for approval of the revised CON project budget.

8. This authorization shall expire on December 21, 2004, unless the Applicants present evidence to OHCA that the Farmington Surgery Center has received its license from the Department of Public Health.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Office of Health Care Access

June 10, 2002
Date

Signed by:
Raymond J. Gorman
Commissioner

RJG/sce/lg
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Attachment 1

Farmington Surgery Center, LLC shall submit patient-specific data as listed and defined below for those patients that receive service, care, diagnosis or treatment at the ambulatory surgery center located in Farmington, Connecticut. This information may be extracted from either the medical abstract or billing records or both and submitted to the Office of Health Care Access (OHCA) in accordance with this Attachment.

I. The data are to be submitted in ASCII format on a computer disk or electronically.

II. Column headers to be used are listed below in parentheses after the name of each data element.

III. Data formats to be followed are listed for each data element.

IV. The disk or file should be clearly marked with the applicant's/facility's name, file name, docket number and its contents.

V. Accompanying the data submission, the applicant/facility must submit a full written description of the data submitted and its record layout.

VI. Initial data shall be submitted at the end of the first quarter in which the facility begins to provide the service it is licensed for. Subsequent data for a calendar quarter shall be filed before the end of the calendar quarter following the calendar quarter in which the encounter was recorded. This data set shall contain the data records for each individual encounter from that facility during the preceding calendar quarter. For example, the data set to be filed before June 31, 2002, shall contain the data records for each individual encounter at that facility from January 1, 2002 until March 31, 2002.

VII. All data collected by OHCA will be subject to the laws and regulations of the State of Connecticut and the Office of Health Care Access regarding its collection, use, and confidentiality.

Patient Data Elements

1. Medical Record Number (mrn) – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. **Format: string (20, zero filled to left if fewer than 20 characters)**
2. Patient Control Number (patcont) – unique number assigned by the facility to each patient's individual encounter that distinguishes the medical and billing records of the encounter. **Format: string (20, zero filled to left if fewer than 20 characters)**

3. Date of birth (dob) – the month, day, and year of birth of the patient whose encounter is being recorded. **Format: date (20, dd-mmm-yyyy hh:mm:ss)**

4. Sex (sex) – patient's sex, to be numerically coded as follows:
   a. Male = 1
   b. Female = 2
   c. Undetermined = 3

   Format: string (1)

5. If available, Race (race1, race2, race3, race4, race5, race6) – patient-identified designation(s) of one or more categories from the following list, and numerically coded as follows:
   a. White = 1
   b. Black/African American = 2
   c. American Indian/Alaska Native = 3
   d. Native Hawaiian/Other Pacific Island = 4
      (e.g., Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander.)
   e. Asian = 5
      (e.g., Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, other Asian)
   f. Some other race = 6

   Format: string (1)

6. If available, Ethnicity (pat_eth) –patient-identified cultural origin listed below, as from time to time amended, and numerically coded as follows:
   a. Hispanic/Latino = 1
      (i.e., Mexican, Puerto Rican, Cuban or other Hispanic or Latino)
   b. Non-Hispanic/Latino = 2

   Format: string (1)

7. Zip Code (patzip) - the zip code of the patient's primary residence. **Format: string (5)**

8. Date that Procedure was Scheduled (Booking Date) – means the month, day, and year on which the procedure or service was scheduled for a patient by the provider. **Format: date (20, dd-mmm-yyyy hh:mm:ss)**

9. Date of Encounter or Service (doe) – means the month, day, and year of the procedure or service for the encounter being recorded. **Format: date (20, dd-mmm-yyyy hh:mm:ss)**

10. Principal Diagnosis (dx1) – the ICD-9-CM code for the condition which is established after the study to be chiefly responsible for the encounter being recorded. **Format: String (5, do not include decimal place -- decimal place is implied)**

11. Secondary Diagnoses (dx2 through dx10) – the ICD-9-CM codes for the conditions, exclusive to the principal diagnosis, which exist at the time the patient was treated or which developed subsequently to the treatment and which affect the patient's treatment for the encounter being recorded. Diagnoses which are associated with an earlier encounter and which have no bearing on the current encounter shall not be recorded as secondary diagnoses. **Format: String (5, do not include decimal place -- decimal place is implied)**

12. E-code (ecode) – The ICD-9-CM codes for external cause of injury, poisoning or adverse effect. **Format: string (5, do not include decimal place -- decimal place is implied)**

13. Principle Procedure (px1) - the CPT-4/HCPCS code for the procedure most closely related to the principal diagnosis that is performed for the definitive treatment of the patient. **Format: string (5)**

14. Secondary Procedure (px2 through px10) – the CPT-4/HCPCS codes for other significant procedures. **Format – string (5)**

15. Modifier (mod1 through mod10) – means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. **Format: string (2)**

16. Payment sources (Primary (ppayer), Secondary (spayer) and Tertiary (tpayer)) - the major payment sources that were expected at the time the dataset was completed, from the categories listed below:

a. Self pay	=	A
b. Worker's Compensation	=	B
c. Medicare	=	C
d. Medicaid	=	D
e. Other Federal Program	=	E
f. Commercial Insurance Company	=	F
g. Blue Cross	=	G
h. CHAMPUS	=	H
i. Other	=	I
j. Title V	=	Q
k. No Charge	=	R
l. HMO	=	S
m. PPO	=	T

Format: string (1)

17. Payer Identification (payer1, payer2, payer3) – the insured's group number that identifies the payer organization from which the facility expects, at the time of the encounter, some payment for the bill. Up to three payer organizations shall be reported in the order of their expected contributions to the payment of the facility's bill. **Format: string (5, zero filled to left if fewer than 5 characters)**

18. Encounter type (etype) – indicates the priority of the encounter.
    a. Emergent = 1
    b. Urgent = 2
    c. Elective = 3
    Format: string (1)

19. Referring Physician (rphysid) -- State license number of the physician that referred the patient to the service/treatment/procedure rendered. **Format: string (6)**

20. Operating Physician (physid) – State license number identifying the provider who performed the service/treatment/procedure. **Format: string (6)**

21. Charges (chrg_tot) – Total charges for this encounter. **Format: numeric (8)**

22. Disposition (pstat) – the circumstances of the patient's discharge, categories of which are defined below and from time to time amended:
    a. Discharged home = 1
    b. Referred for medical treatment = 2
    c. Transferred to another health care facility = 3
    d. Expired = 4
    e. Other = 5
    Format: string (1)