Office of Health Care Access
Certificate of Need

Final Decision

Applicant:	**Ridgefield Surgical Center, LLC**
Docket Number:	**04-30383-CON**
Project Title:	**Establishment of an Ambulatory Surgical Center**
Statutory Reference:	**Sections 19a-638 and 19a-639, Connecticut General Statutes**
Hearing Date:	**August 11, 2005**
Presiding Officer:	**Commissioner Cristine A. Vogel**
Filing Date:	**June 29, 2005**
Decision Date:	**September 27, 2005**
Default Date:	**September 27, 2005**
Staff:	**Laurie Greci**

Project Description: Ridgefield Surgical Center, LLC ("Applicant") proposes to establish and operate an ambulatory surgery center to be located at 901 Ethan Allen Highway, Ridgefield, Connecticut, at an associated capital expenditure of $7,227,182.

Nature of Proceeding: On June 29, 2005, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application of Ridgefield Surgical Center, LLC ("Applicant") to establish and operate an ambulatory surgery center to be located at 901 Ethan Allen Highway, Ridgefield, Connecticut, at an associated capital expenditure of $7,227,182.

Ridgefield Surgical Center, LLC is a health care facility or institution as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning OHCA's receipt of the Applicants' Letter of Intent was published on October 16, 2004, in *The News Times* (Danbury). OHCA received no responses from the public concerning the Applicants' proposal.

A public hearing regarding the CON application was held on August 11, 2005. The Applicant was notified of the date, time and place of the hearing, and a notice to the public was published in *The News Times* on July 17, 2005. Commissioner Cristine A. Vogel served as Presiding Officer for this case. The public hearing was 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 Applicant and, 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.

Findings of Fact

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

1. Ridgefield Surgical Center, LLC ("Applicant" or "RSC") is a limited liability company whose members are Danbury Health System, Inc. ("DHS") and physicians who practice in the greater Danbury, Connecticut area. *(February 4, 2005, Initial CON Submission, page 3)*

2. DHS, the parent corporation of Danbury Hospital ("Hospital") owns 70% of the RSC; the physician-members own 30%. The Applicant intends to sell additional membership interests to other physicians. At no time will DHS own less than 51% of the membership interest in the RSC and at no time shall the physicians own more than 49%. *(February 4, 2005, Initial CON Submission, page 3)*

3. Each of the physician-members of RSC is a surgeon on the medical staff of the Hospital. The physicians' specialties include: ear, nose and throat; urology; orthopedics; gastroenterology; general surgery, including pediatric surgery; and plastic surgery. Eighteen of the physicians currently have offices within the town of Ridgefield; eleven of them will be relocating from their current location in Ridgefield to within the same building as the RSC. *(February 4, 2005, Initial CON Submission, page 54, and August 4, 2005, Response to Interrogatories, page 12))*

4. The Applicant proposes to establish an ambulatory surgery center ("Surgical Center") at 901 Ethan Allen Highway, Ridgefield, Connecticut. The Applicant's proposal to includes three (3) operating rooms, one (1) endoscopy room, and one shelled operating room. *(June 29, 2005, Second Completeness Response, page 1)*

5. The Applicant used the discharge data obtained from CHIME and the Hospital Association of New York State to conduct an analysis of the discharges from the Hospital for all surgical procedures to define the primary and secondary service areas that accounted for 97% of the Hospital's surgical discharges in calendar year 2003. Service areas were further defined by the number of surgical cases and market share. *(February 4, 2005, Initial CON Submission, page 7)*

6. The Applicant's primary service area includes the following Connecticut towns: Bethel; Brookfield; Danbury; New Fairfield; Newtown; Redding; and Ridgefield. The Applicant's secondary service area includes the following Connecticut towns: Bridgewater; New Milford; Roxbury; Sherman; Southbury; and Woodbury. The Applicant's secondary service area also includes the following New York towns: Brewster; Carmel; Patterson; and Pawling. *(February 4, 2005, Initial CON Submission, pages 7 and 8)*

7. The existing providers of ambulatory surgery services in the proposed service area are the Hospital's Duracell Center and HealthSouth Surgery Center ("HealthSouth") in Danbury and Wilton Surgical Center in Wilton. *(February 4, 2005, Initial CON Submission, page 15)*

8. Nineteen of the investors in RSC have privileges at HealthSouth. The Applicant stated that the surgeons only use HealthSouth occasionally and therefore the volume loss at HealthSouth will not be a significant portion of HealthSouth's surgical caseload. *(August 11, 2005, Hearing Testimony of Dr. Richard Lipton)*

9. The Applicant based the need for the Surgery Center on:
    - The growth and aging of population in the proposed service area;
    - Increase in surgical volume at the Hospital;
    - The number of physicians that already have offices in Ridgefield;
    - The Hospital's recruitment of physicians;
    - The wait times for surgery at the Hospital and the Duracell Center; and
    - The demand of patients to receive ambulatory surgical services close to home in a freestanding ambulatory setting.

    (February 4, 2005, Initial CON Submission, page 2 and June 29, 2005, Second Completeness Response, pages 2 and 14)

10. The following table provides the population[1] in the proposed primary service area of the Under 55 and the 55 and Older age groups:

Table 1: Estimated Population of Under 55 and 55 and Older Age Groups in the Primary Service Area

Primary Service Area	Total Population		Percent of Population		Population Change 2001-2006
	2001	2006	2001	2006	
0-54	148,128	151,925	80.4%	78.3%	2.5%
55 +	35,998	42,169	19.6%	21.7%	**14.6%**
Total	**184,126**	**194,094**			**5.1%**

(February 4, 2005, Initial CON Submission, pages 8 to 11)

11. Persons aged 55 and older will make up the largest population growth. The Applicant stated that the aging of the population and the increase in population will result in increased utilization of surgical services. *(February 4, 2005, Initial CON Submission, pages 8 and 9)*

12. The Applicant reported the following growth in the Hospital's inpatient surgical cases from FY 2000 to FY 2004:

Inpatient Service Type	Cases for Fiscal Year				
	2000	2001	2002	2003	2004
Orthopedic	1,005	1,033	1,042	1,096	1,083
General	1,163	1,130	1,347	1,493	1,399
Gynecology	470	437	452	426	435
Urology	349	265	309	316	319
Ear, Nose, and Throat	78	93	98	61	89
Neurology	449	463	456	526	585
Plastic	145	164	150	115	110
Vascular/Thoracic	316	438	398	430	419
Other*	238	254	276	244	340
Inpatient Total Increase	**4,094**	**4,150**	**4,390**	**4,585**	**4,609**
Inpatient Increase, Percent		1.4%	5.8%	4.4%	0.05%

* Includes ophthalmology, podiatry, dental/oral, and other non-defined procedures that require an OR team assignment.

(February 4, 2005, Initial CON Submission, page 17)

[1] The Applicant's source for population was ESRI, Inc., whose information is proprietary.

13. The Applicant reported the following growth in the Hospital's outpatient surgical cases from FY 2000 to FY 2004:

	Cases for Fiscal Year				
Outpatient Service Type	**2000**	**2001**	**2002**	**2003**	**2004**
Orthopedic	2,593	2,604	2,453	2,456	2,445
General	1715	1,886	1,984	2,112	2,171
Gynecology	959	849	934	1,008	994
Urology	685	758	921	850	924
Ear, Nose, and Throat	1,072	1,045	1,134	1,120	1,152
Neurology	11	17	13	25	28
Plastic	654	726	674	580	525
Vascular/Thoracic	96	127	158	253	305
Other*	1,038	966	1,140	1,357	1,822
Outpatient Total Increase	8,823	8,978	9,411	9,761	10,366
Outpatient Increase, Percent		1.6%	5.1%	3.9%	4.4%

* Includes ophthalmology, podiatry, dental/oral, and other non-defined procedures that require an OR team assignment.

(February 4, 2005, Initial CON Submission, page 17)

14. Mr. Hovan, the Hospital's Chief Operating Officer, stated that the expected decrease in surgical volume at the Hospital due to the Surgical Center will be replaced with surgeries performed by the growth in surgical cases due to the aging and growth of the population and the recruitment of physicians to the area. Many of the physicians being recruited to the area will be performing longer, more difficult inpatient surgical procedures. These surgeries will utilize additional operating room capacity and limit the number of ambulatory surgeries that can be performed at the Hospital. With the introduction of cardiac services at the Hospital, additional inpatient procedures will occur. *(August 11, 2005, Hearing Testimony of Keith Hovan)*

15. Between FY 2004 and FY 2005, the number of inpatient surgeries performed at the Hospital increased by 0.05%. Mr. Hovan stated that the small increase in volume was due to lack of capacity that affected the ambulatory surgery volume and the inability to schedule general and orthopedic surgical cases with shorter lead time and the lack of growth in the inpatient case volume as a result of new physicians coming into the community at the same time that some physicians were retiring or leaving their practices. FY 2005 projected volumes are expected to go back up with the additional practitioners in the community. *(February 4, 2005, Initial CON Submission, page 17 and August 11, 2005, Hearing Testimony of Keith Hovan)*

16. The Duracell Center is wholly owned by, and part of, the Hospital. It functions as a hospital based ambulatory surgery center. The Duracell Center provides surgery which is entirely ambulatory, as well as surgery that requires an inpatient admission. *(May 12, 2005, Completeness Response, page 3)*

17. The Applicant reported the following operating room capacity of the Hospital and the Duracell Center:

Table 2: Operating Room Capacity at the Hospital and Duracell Center

Provider Name	Number of Operating Rooms				Estimated Maximum Capacity in Case per OR	Current Utilization as Average per Room
	Avail-Able	Util-ized	Not Util-ized	Equipped		
Danbury Hospital, inpatient and outpatient Main Operating Rooms	10 *	7*	3	9*	1,200	1,177
Duracell Center	7	7	0	7	1,200	1,124
Duracell Center, gastro-enterology procedures	6	6	0	6	1,500	1,430
Total Number of Operating Rooms	**23***	**20***	**3**	**22***		

* Includes one (1) Open Heart Surgical Operating Room

(June 29, 2005, Second Completeness Response, page 7)

18. The Applicant stated that an operating room reaches maximum capacity at 1,500 surgeries per year. *(June 29, 2005, Second Completeness Response, page 3)*

19. The Hospital routinely utilizes seven of the nine equipped operating rooms on a daily basis. The two remaining equipped operating rooms change through the day and from day to day. The Applicant stated that this allows maximum efficiency of the surgeons and provides prompt access for urgent surgery; physicians may move to the next available operating room to perform the next cases without having to wait for the same operating room to be prepared. *(June 29, 2005, Second Completeness Response, page 9)*

20. The Applicant stated that approximately 10% of the surgery performed at the Duracell Center is performed on inpatients or patients requiring an admission to the Hospital. The equivalent of approximately 1.25 operating rooms in the Duracell Center is reserved at all times for surgery that will require an admission. Cases at the Duracell Center average approximately 1.5 hours. The reservation of the operating rooms at the Duracell Center keep the volume of surgery performed there considerably lower than a typical ambulatory surgery center. *(June 29, 2005, Second Completeness Response, page 7)*

21. The combined operating rooms of the Hospital and the Duracell Center experienced wait times during the three month period of September 1, 2004 to November 30, 2004 of 14 days to 29 days, depending on the surgical service being scheduled. *(May 12, 2005, Completeness Response, page 2)*

22. The combined number of ambulatory surgeries performed by town for the last three Fiscal Years at the Hospital and Duracell Center is reported in the following table:

Table 3: Outpatient Surgery Volume by Town and Fiscal Year

	Fiscal Year		
Service Area	**2002**	**2003**	**2004**
Primary:			
Bethel	766	813	850
Brookfield	677	660	703
Danbury	3,165	3,216	3,409
New Fairfield	611	606	626
Newtown	761	877	988
Redding	196	238	248
Ridgefield	697	731	783
Primary Total	**6,873**	**7,138**	**7,607**
CT Secondary Total	1,255	1,420	1,423
NY Secondary Total	418	440	450
Other CT and NY towns	660	762	799
Town by Town Total	**9,207**	**9,761**	**10,279**
Uncategorized Volume	204	0	87
GRAND TOTAL	**9,411**	**9,761**	**10,366**

(May 12, 2005, Completeness Response, pages 7 and 8)

23. The Applicant reported that the outpatient endoscopy volumes for FY 2002, 2003, and 2004 for the primary service area for the Hospital and the Duracell Center combined were 5,768, 6,679, and 6,549 procedures, respectively. *(May 2, 2005, Completeness Response, page 10)*

24. The Applicant projects the following units of service to be performed at the Surgical Center during the first three years of operation:

Table 4: Proposed Units of Service

Service	**FY 2007**	**FY 2008**	**FY 2009**
Surgical Cases:			
Ear, Nose, and Throat	1,145	1,300	1,478
Plastics	1,092	1,238	1,405
General, including Pediatric	565	646	739
Orthopedic	599	648	701
Urology	694	799	918
Total Surgical Cases	**4,095**	**4,630**	**5,241**
Gastroenterological (Endoscopy) Cases	1,020	1,051	1,082
Total Cases	**5,115**	**5,681**	**6,323**

(June 29, 2005, Second Completeness Response, page 43)

25. The Applicant assumed that 70% of the outpatient cases provided by the physician-members at the Duracell Center and 100% of the outpatient cases provided by the physician members at other facilities would be provided at the Surgical Center in the first year. In the second and third years, the units attributable to the Duracell Center were increased by 15% and the other cases by 3%. The projections do not include any volume for physicians who are not owners in the Surgical Center. *(February 4, 2005, Initial CON Submission, pages 21 and 22)*

26. The projected growth in surgery requiring an inpatient stay at the Hospital is provided in the following table:

Table 4: Projected Growth in Surgery Incremental to FY 2004 Actual

Type of Surgery	Type of Case	Fiscal Year				
		2006	**2007**	**2008**	**2009**	**2010**
Cardiac	Inpatient	399	514	610	610	610
Vascular (one surgeon started 7/05)	Inpatient	17	45	84	86	87
	Outpatient	2	6	12	12	12
Orthopedics (one surgeon started 8/05, others to be determined)	Inpatient	80	240	545	556	567
	Outpatient	300	420	545	556	567
Spine (two surgeons started 7/05)	Inpatient	40	200	385	393	401
	Outpatient	40	120	187	191	195
General (three new surgeons planned for 2007)	Inpatient	66	184	250	255	260
	Outpatient	180	400	496	600	618
Thoracic	Inpatient	18	50	99	100	101
	Outpatient	2	5	9	9	9
Neurological (one surgeon started in 7/05)	Inpatient	15	0	121	123	126
	Outpatient	2	7	13	14	14
Total Cases	Inpatient	435	1,178	1,998	2,123	2,152
	Outpatient	526	957	1,262	1,381	1,415
One ear, nose, and throat surgeon began in 7/05, two additional surgeons are planned to be added in 2007; and one urological surgeon in 2007.						

(August 4, 2005, Prefiled Testimony of Kevin Hovan, page 5)

27. In five years, the Hospital has projected the need for additional operating rooms. Although some of the older operating rooms would be expanded to accommodate equipment, there is limited ability to expand within the footprint of the current buildings. The Hospital believes the financial investment to add additional operating rooms on the existing campus would be prohibitive. The Surgical Center will allow the Hospital to create the future needed capacity. *(August 11, 2005, Hearing Testimony of Keith Hovan)*

28. The Applicant stated that it anticipated serving the following surgical specialties at the Surgical Center: ear, nose, and throat; urology; orthopedics; podiatry; gastroenterology; pediatric surgery; general surgery; and plastic surgery. *(February 4, 2005, Initial CON Submission, page 18)*

29. Wilton Surgery Center provides ambulatory surgery services in pain management and ophthalmology. Since these two services will not be a focus at the Surgical Center, the Surgical Center should have no adverse impact on Wilton Pain Management Center, LLC. *(February 4, 2005, Initial CON Submission, page 18)*

30. The Applicant did not include ophthalmology, pain management, or podiatry, in the projected utilization statistics for the Surgical Center.

31. The proposed hours of operation for the Surgery Center will be Monday through Friday, 7:30 a.m. to 4:30 p.m. *(February 4, 2005, Initial CON Submission, page 5)*

32. The Applicant proposes to seek licensure for the Surgery Center as a free standing outpatient ambulatory surgical facility. *(February 4, 2005, Initial CON Submission, page 8)*

33. The Applicant proposes to utilize the Standard of Practice Guidelines of the America College of Surgeons and seek accreditation with the Joint Commission on Accreditation of Health Care Organizations, Accreditation Association for Ambulatory Health Care, and Medicare. *(February 4, 2005, Initial CON Submission, pages 24 and 54)*

34. The Applicant stated that Jay Klarsfeld, M.D. will be the Medical Director for the Surgical Center. *(May 12, 2005, Completeness Response, page 21)*

Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services
Financial Feasibility of the Proposal and its Impact on the Applicant's Rates and Financial Condition
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

35. The proposal has a capital expenditure of $7,227,182 as follows:

Table 5: Components of the Proposed Capital Expenditure

Component	Projected Capital Expenditure
Construction	$4,127,155
Medical Equipment, purchased	2,541,413
Non-Medical Equipment, purchased	304,329
Legal Fees, capitalized	254,285
Total Capital Expenditure	**$7,227,182**

(June 29, 2005, Second Completeness Response, page 24)

36. The construction costs consist of the following:

Table 6: Construction Costs

Construction Component	Cost
Building Work	$3,188,413
Architectural & Engineering	392,000
Contingency Allowance	402,242
Inflation Adjustment	144,500
Total Construction Cost	**$4,127,155**

(June 29, 2005, Second Completeness Response, page 24)

37. The Applicant proposes to fund the proposal with capital contributions from the members of RSC, an equipment loan, and conventional loans for the leasehold improvements and working capital. *(February 4, 2005, Initial CON Submission, pages 31 to 33)*

38. The Applicant's financial projections for revenue gains from operations associated with the CON proposal are presented in the following table:

Table 8: Financial Projections with the CON Proposal

Description	**FY 2007**	**FY 2008**	**FY 2009**
Revenue from Operations	$8,040,588	$9,176,927	$10,499,856
Operating Expenses:			
Direct Surgery Expense	3,424,513	3,746,414	4,420,761
Indirect Expenses	2,747,615	2,890,969	3,064,038
Total Operating Expenses	7,200,809	7,678,477	8,553,679
Gain from Operations	**$ 839,778**	**$ 1,498,450**	**$ 1,946,178**
Equivalent Full Time Employees	34.7	36.2	41.5

(June 29, 2005, Second Completeness Response, page 34)

39. The Hospital's current and projected payer mix and the Surgical Center's projected payer mix for the first three years of operation, based on net revenue, are reported in the following table:

Table 7: Projected Payer Mix for the Surgery Center

Payer	Danbury Hospital, Current and Projected	Surgical Center Projected
Medicare	31.6%	31.6%
Medicaid	5.7%	5.7%
TriCare (CHAMPUS)	0%	0%
Total Government Payers	37.3%	37.3%
Commercial Insurers	60.9%	60.9%
Self-Pay	1.8%	1.8%
Workers Compensation	0%	0%
Total Non-Government Payers	62.7%	62.7%

(February 4, 2005, Initial CON Submission, page 34 and May 12, 2005, Completeness Response, page 24)

40. Due to DHS's ownership interest in the Surgical Center, the Surgical Center is obligated to participate in Medicare and Medicaid programs and to provide care without regard to the patient's ability to pay in accordance with the Hospital's charity care policy. This requirement is in the Operating Agreement of the Surgical Center and may not be amended without the consent of DHS. *(February 4, 2005, Initial CON Submission, pages 23 and 54)*

41. The Surgical Center will be located on the ground floor of a building being constructed. The Applicant will lease approximately 16,778 of space. *(February 4, 2005, Initial CON Submission, pages 28 and 29)*

42. The Surgical Center will be managed by Surgery Consultants of America, Inc., a national corporation that specializes in the development and management of ambulatory surgical centers. *(February 4, 2005, Initial CON Submission, page 13)*

43. The proposed start date for operations at the Surgery Center is May 2006. *(June 29, 2005, Second Completeness Response, page 25)*

44. The Applicant stated that Surgery Center Billing, LLC has been engaged to bill for the propose services on its behalf. *(February 4, 2005, Initial CON Submission, page 27)*

45. 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. *(February 3, 2005, Completeness Response, pages 70 and 74)*

46. There is no State Health Plan in existence at this time. *(February 4, 2005, Initial CON Submission, page 5)*

47. The Applicant stated that the proposal is consistent with its long-range plans. *(February 4, 2005, Initial CON Submission, page 5)*

48. As a new provider, the Applicant has not undertaken any activities to improve productivity and contain costs. *(February 4, 2005, Initial CON Submission, page 26)*

49. The proposal will not result in changes to the Applicant's teaching and research responsibilities. *(February 4, 2005, Initial CON Submission, page 8)*

50. There are no distinguishing characteristics of the Applicant's patient/physician mix. *(February 4, 2005, Initial CON Submission, page 8)*

51. The Applicant has sufficient technical, financial and managerial competence to provide efficient and adequate services to the public. *(February 4, 2005, Initial CON Submission, Exhibit 5D)*

52. The Applicant's rates are sufficient to cover the proposed capital expenditure and operating expenses associated with the proposal. *(February 3, 2005, Completeness Response, page 18)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for the proposed service on case by case basis. Certificate of Need ("CON") applications do not lend themselves to general applicability due to a variety of complexity of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposed services.

Ridgefield Surgical Center, LLC ("Applicant") proposes to establish an ambulatory surgery center in Ridgefield, Connecticut. Danbury Health System, Inc. ("DHS") the parent corporation of Danbury Hospital ("Hospital') is the majority member of the limited liability company. At no time will DHS own less than 51% of the company. The remaining members are physicians, each of whom is currently a surgeon on staff at the Hospital. The physicians' specialties include: ear, nose and throat; urology; orthopedics; gastroenterology; general surgery, including pediatric surgery; and plastic surgery.

The Applicant based the need for the Surgery Center on: the growth and aging of population in the proposed service area; increase in surgical volume at the Hospital; the number of physicians that already have offices in Ridgefield; the Hospital's recruitment of physicians; and the wait times for surgery at the Hospital and at the Hospital's Duracell Center for Ambulatory Surgery ("Duracell Center"). The Applicant stated that the aging of the population and the increase in population will result in increased utilization of surgical services. The 55 and older age group, is projected to comprise 17% of the primary service area's population in 2006. As the information provided is proprietary, OHCA could not verify the Applicant's population projections.

The Applicant's projected surgical volumes at the Surgical Center are 4,095, 4,630, and 5,241 procedures for FYs 2007, 2008, and 2009, respectively. The Applicant's projected endoscopy volumes are 1,020 1,051, and 1,082 procedures for FYs 2007, 2008, and 2009, respectively. The Surgical Center's projected volumes are expected to come primarily from the patients of the physician-members existing practices. The Hospital stated that its loss in volume will be replaced with surgeries performed by the physicians being recruited to the area as well as by the aging and growth of the population. The Hospital has been recruiting, and will continue to recruit, physicians to expand its services. In FY 2005, the Hospital recruited physicians that perform vascular, thoracic, orthopedic, spine and neurological surgery. In FY 2007, the Hospital anticipates recruiting additional surgeons to perform general, ear, nose, and throat, and urological surgery. In addition, the recent introduction of cardiac services at the Hospital,has provided additional inpatient procedures to be performed. The Hospital stated that many of the physicians being recruited to the area will be performing longer, more difficult inpatient surgical procedures. These surgeries will utilize additional operating room capacity and limit the number of ambulatory surgeries that can be performed at the Hospital. Based on the above OHCA

finds that the Applicant has demonstrated that its request for the establishment of an ambulatory surgery center with three operating rooms in Ridgefield will contribute to the accessibility of health services in its service area.

The proposal's total capital expenditure of $7,227,182 will be financed with the capital contributions of the RSC's member and conventional loans. The Applicant projects revenue gains from operations at the Surgical Center of $839,778, $1,498,450, and $1,946,178 in FYs 2007, 2008, and 2009, respectively. The Applicant's volume projections are reasonable and the Applicant's revenues appear sufficient to cover the proposed capital expenditure and operating costs associated with the project.

The proposal of Ridgefield Surgical Center, LLC to establish a three operating room, one endoscopy room ambulatory surgery center in Ridgefield will provide the residents of the proposed primary service area access to a freestanding facility for obtaining their ambulatory surgical procedures. The Hospital's charitable purposes will continue to be in effect and the Hospital's and the physician-members' patients may choose to have their surgeries performed either at the Hospital in Danbury or at the Surgical Center in Ridgefield. The Applicant's proposal will improve access to quality health care services in the region.

Therefore, based on the foregoing Findings and Rationale, the Certificate of Need application of Ridgefield Surgical Center, LLC to establish and operate an ambulatory surgery center at 901 Ethan Allen Highway in Ridgefield, Connecticut is hereby GRANTED.

Order

Ridgefield Surgical Center, LLC ("Applicant") is hereby authorized to establish and operate an ambulatory surgery center to be located at 901 Ethan Allen Highway in Ridgefield, Connecticut, at a total capital cost of $7,227,182. The authorization is subject to the following conditions:

1. The Applicant's ambulatory surgery center, to be located at 901 Ethan Allen Highway, Ridgefield, will consist of three (3) operating rooms, and one (1) endoscopy room, and one shelled operating room.

2. The procedures that may be performed at the Applicant's ambulatory surgery center in Ridgefield are limited to those within the following specialties: ear, nose, and throat surgery; plastic surgery; general surgery, including pediatric surgery; orthopedic surgery; urology; and gastroenterology procedures. Should the Applicant wish to perform surgical procedures within other specialties, Certification of Need authorization is required.

3. The Applicant shall request approval from OHCA through the Certificate of Need process authorization to equip the shelled operating room.

4. The Applicant will provide OHCA with utilization reports on a quarterly basis. The data elements and the format and submission requirements are described in Attachment 1.

5. The Applicant shall not exceed the approved total capital cost of $7,227,182. In the event that the Applicant learns of potential cost increases or expect that the final project costs will exceed those approved, the Applicant shall file with OHCA a request for approval of the revised CON project budget.

6. This authorization shall expire on September 27, 2007, unless the Applicant presents evidence to OHCA that Ridgefield Surgical Center, LLC 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

September 27, 2005

Signed by Cristine A. Vogel
Commissioner

Attachment 1

Ridgefield Surgical 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 Ridgefield, 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.

Outpatient Facility Encounter Data Layout
(Professional)

#	Description	Field Name	Data Type
1	Facility ID – CMS assigned National Provider Identifier (effective May 23, 2005) or OHCA assigned SID #.	facid	Char(10)
2	Fiscal Year – Hospital fiscal year runs from October 1 of a calendar year to September 30 of the following calendar year and is the year of discharge.	fy	Char(4)
3	Quarter – The quarter of discharge. 1. January 1 – March 31 - 2 2. April 1 – June 30 - 3 3. July 1 - September 30 - 4 4. October 1 – December 31 - 1	quart	Char(1)
4	Medical Record Number – 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 that 20 characters)**	mrn	Char(20)
5	Patient Control Number – 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 that 20 characters)**	patcont	Char(20)
6	Social Security Number – patient's SSN **Format: string (9, exclude hyphens)**	ssn	Char(9)
7	Date of birth – the month, day, and year of birth of the patient whose encounter is being recorded. **Format: date (8, mmddyyyy)**	dob	Date
8	Sex – patient's sex, to be numerically coded as follows: 1. Male = 1 2. Female = 2 3. Not determined = 3	sex	Char(1)
9	Race – patient-identified designation of a category from the following list, and 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 (e.g., Asian Indian, Chinese, Filipino, = 5 Japanese, Korean, Vietnamese, other Asian)	race	Char(1)

#	Description	Field Name	Data Type
	F. Two or more races = 6 G. Some other race = 7 H. Unknown = 8		
10	Ethnicity – patient-identified ethnic origin from categories listed and coded as follows: A. Hispanic/Latino = 1 (i.e., Mexican, Puerto Rican, Cuban or other Hispanic or Latino) B. Non-Hispanic/Latino = 2	pat_eth	Char(1)
11	Patient's State – patient indicated state of primary residence.	patstate	Char(2)
12	Town – patient indicated town of primary residence.	twn_cty	Char(3)
13	Zip Code – zip code of the patient's primary residence	patzip	Char(5)
14	Relationship to Insured1 – means the categories of patient's relationship to the identified insured or sponsor as listed below: 1. Self = 1 2. Spouse = 2 3. Child = 3 4. Other = 4	r_insure1	Char(3)
15	Employment status (e_stat) – means the categories of patient's employment status as listed below: 1. Employed = 1 2. Full-time student = 2 3. Part-time student = 3 4. Retired = 4 5. Other = 5	e-stat	Char(1)
16	Insured1's employer – means the name of the insured's employer.	employ1	Char(50)
17	Insured1's state of residence – means the insured's state of primary residence.	i1_state	Char (2)
18	Insured2's employer – means the name of the insured's employer.	employ2	Char (50)
19	Insured2's state of residence – means the insured's state of primary residence.	i2_state	Char (2)
20	Insured3's employer – means the name of the insured's employer.	employ3	Char (50)
21	Insured3's state of residence – means the insured's state of primary residence.	i3_state	Char (2)
22	Principal Diagnosis – 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)**	dx1	Char(5)

#	Description	Field Name	Data Type
23	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)**	dx2	Char(5)
24		dx3	Char(5)
25		dx4	Char(5)
26		dx5	Char(5)
27		dx6	Char(5)
28		dx7	Char(5)
29		dx8	Char(5)
30		dx9	Char(5)
31		dx10	Char(5)
32	E-code (ecode1 to ecode3) – 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)**	ecode1	Char(5)
33		ecode2	Char(5)
34		ecode3	Char(5)
35	Date of service– the month, day, and year for each procedure, service or supply. "To (dost) & From (dosf)" are for a series of identical services provider recorded. **Format: date (8, mmddyyyy)**	dosf	Date
36		dost	Date
37	Principal Procedure - the HCPCS/CPT code for the procedure most closely related to the principal diagnosis that is performed for the definitive treatment of the patient.	px1	Char(5)
38	Modifier (mod1 & mod2) – 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	mod1	Char(2)
39		mod2	Char(2)
40	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum1	Char(2)
41	Units of services – number of days for multiple days or units of supply.	Units1	Num (4)
42	Charge – charge for the listed service	Charge1	Num (6)
43	Secondary Procedure (px2 through px10) – the HCPCS/CPT codes for other significant procedures	Px2	Char(5)
44	Modifier (mod3 & mod4) – means by which a physician indicates	mod3	Char(2)

#	Description	Field Name	Data Type
	that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code		
45		mod4	Char(2)
46	Dx Reference Number (dxnum) – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum2	Char(2)
47	Units of services – number of days for multiple days or units of supply.	Units2	Num (4)
48	Charge – charge for the listed service	Charge2	Num (6)
49		px3	Char(5)
50	Modifier (mod5 & mod6) – 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	mod5	Char(2)
51		mod6	Char(2)
52	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum3	Char(2)
53	Units of services – number of days for multiple days or units of supply.	Units3	Num (4)
54	Charge – charge for the listed service	Charge3	Num (6)
55		px4	Char(5)
56	Modifier (mod7 & mod8) – 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	mod7	Char(2)
57		mod8	Char(2)
58	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum4	Char(2)
59	Units of services – number of days for multiple days or units of supply.	Units4	Num (4)
60	Charge – charge for the listed service	Charge4	Num (6)
61		px5	Char(5)
62	Modifier (mod9 & 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	mod9	Char(2)
63		mod10	Char(2)
64	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum5	Char(2)
65	Units of services – number of days for multiple days or units of supply.	Units5	Num (4)
66	Charge – charge for the listed service	Charge5	Num (6)
67		px6	Char(5)
68	Modifier (mod11 & mod12) – 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	mod11	Char(2)

#	Description	Field Name	Data Type
69		mod12	Char(2)
70	Dx Reference Number (dxnum) – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum6	Char(2)
71	Units of services – number of days for multiple days or units of supply.	Units6	Num (4)
72	Charge – charge for the listed service	Charge6	Num (6)
73		px7	Char(5)
74	Modifier (mod13 & mod14) – 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	mod13	Char(2)
75		mod14	Char(2)
76	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum7	Char(2)
77	Units of services – number of days for multiple days or units of supply.	Units7	Num (4)
78	Charge – charge for the listed service	Charge7	Num (6)
79		px8	Char(5)
80	Modifier (mod15 & mod16) – 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	mod15	Char(2)
81		mod16	Char(2)
82	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum8	Char(2)
83	Units of services – number of days for multiple days or units of supply.	Units8	Num (4)
84	Charge – charge for the listed service	Charge8	Num (6)
85		px9	Char(5)
86	Modifier (mod17 & mod18) – 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	mod17	Char(2)
87		mod18	Char(2)
88	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum9	Char(2)
89	Units of services – number of days for multiple days or units of supply.	Units9	Num (4)
90	Charge – charge for the listed service	Charge9	Num (6)
91		px10	Char(5)
92	Modifier (mod19 & mod20) – 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	mod19	Char(2)
93		mod20	Char(2)
94	Dx Reference Number (dxnum) – diagnosis code number relating	Dxnum10	Char(2)

#	Description	Field Name	Data Type
	the date of service and procedures performed to the primary diagnosis.		
95	Units of services – number of days for multiple days or units of supply.	Units10	Num (4)
96	Charge – charge for the listed service	Charge10	Num (6)
97	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: Self pay = A Worker's Compensation = B Medicare = C Medicaid = D Commercial Insurance Company = E Medicare Managed Care = F Medicaid Managed Care = G Commercial Insurance Managed Care = H CHAMPUS or TRICARE = I Other Government Payment = J Title V = Q No Charge or Free Care = R Other = M	ppayer	Char(1)
98		spayer	Char(1)
99		tpayer	Char(1)
100	Payer Identification (payer1, payer2, payer3) – the insured's group number (or National Plan ID) 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 (9, zero filled to left if fewer than 9 characters)**	payer1	Char(5)
101		payer2	Char(5)
102		payer3	Char(5)
	Encounter type – indicates the priority of the encounter. Emergent = 1 Urgent = 2 Elective = 3	etype	Char(1)
103	Referring Physician - State license number of the physician that referred the patient to the service/treatment/procedure rendered.	rphysid	Char(6)
104	Operating Physician – State license number identifying the provider who performed the service/treatment/procedure	ophysid	Char(6)
105	Charges – Sum of all charges for this encounter	chrg_tot	Num(8)
106	**Disposition – the circumstances of the patient's discharge, categories of which are defined below:**	pstat	Char(2)

#	Description	Field Name	Data Type
	Discharged to home or self care, (routine discharge) 01 Discharged or transferred to another short term general hospital for inpatient care 02 Discharged or transferred to a skilled nursing facility (SNF) 03 Discharged or transferred to an intermediate care facility (ICF) 04 Transferred to another type of institution for inpatient care 05 Discharged or transferred to a home under care of an organized home health service organization 06 Left or discontinued care against medical advice 07 **Discharged or transferred to home under the care of a home IV Provider 08** Admitted as an inpatient to this hospital 09 Expired 20 Expired at home 40 Expired in a medical facility (e.g. hospital, SNF, ICF or free standing hospice) 41 Expired – place unknown 42 Hospice – home 50 Hospice – medical facility 51 Discharged or transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital 62 Discharged or transferred to Medicare certified long term care hospital (LTCH) 63 Discharged or transferred to a nursing facility certified under Medicaid but not certified under Medicare 64 Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 65		