STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 3, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed pursuant to Sections 19a-638 and 19a-639, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 09-31503-CON
The William W. Backus Hospital	**Establishment of a Satellite ED in Plainfield & Acquisition of a CT Scanner**

To: David A. Whitehead
President and Chief Executive Officer
The William W. Backus Hospital
326 Washington Street
Norwich, CT 06360

Dear Mr. Whitehead:

In accordance with the Connecticut General Statutes Section 4-179, the Proposed Final Decision dated December 2, 2010 by Hearing Officer Melanie A. Dillon is hereby adopted as the final decision of the Deputy Commissioner of the Office of Health Care Access, Department of Public Health in this matter. A copy of the Proposed Final Decision is attached hereto and incorporated herein.

Sincerely,

Kimberly R. Martone,
Director of Operations

cc: Melanie A. Dillon, Hearing Officer, OHCA/DPH
Jennifer L. Groves, Updike, Kelly & Spellacy, P.C.
John Blair, Brown Rudnick

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

In Re: **The William W. Backus Hospital**
Docket No. 09-31503-CON

FINAL DECISION

On December 2, 2010, a Proposed Final Decision was issued in the above matter pursuant to Section 4-179 of the Connecticut General Statutes. On December 2, 2010, The William W. Backus Hospital waived the right to file exceptions and to present briefs and oral argument.

In accordance with Connecticut General Statutes Section 4-179, the attached Proposed Final Decision dated December 2, 2010, by Hearing Officer Melanie A. Dillon is hereby adopted as the final decision of the Deputy Commissioner of the Department of Public Health in this matter. A copy of the Proposed Final Decision is attached hereto and incorporated herein.

WHEREFORE, it is the final decision of the Deputy Commissioner that the application of The William W. Backus Hospital for the establishment of a satellite emergency department in Plainfield and the acquisition of a CT scanner is hereby approved.

12·3·10
Date

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner

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Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicant: **The William W. Backus Hospital**

Docket Number: **09-31503-CON**

Project Title: **Establishment of a Satellite Emergency Department in Plainfield and Acquisition of a Computed Tomography Scanner**

Project Description: The William W. Backus Hospital ("Hospital" or "Applicant") is proposing to establish a satellite Emergency Department ("satellite ED") in Plainfield and to acquire a Computed Tomography ("CT") scanner for the same location. The project's total associated capital expenditure is $2,247,091.

Procedural History: On August 11, 2010, the Office of Health Care Access ("OHCA") received the Hospital's completed Certificate of Need ("CON") application. The Hospital 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 Hospital's Letter of Intent was published in *The Norwich Bulletin* on December 12, 2009.

On August 30, 2010, OHCA received a hearing request from Day Kimball Hospital. A public hearing regarding the CON application was held on October 14, 2010. On September 16, 2010, the Applicant and Day Kimball Hospital were notified of the date, time, and place of the hearing. On September 25, 2010, a notice to the public announcing the hearing was published in *The Norwich Bulletin.*

On September 10, 2010, Staff Attorney Melanie Dillon was appointed by Commissioner J. Robert Galvin to be the Hearing Officer and to rule on all motions, and to recommend findings of fact and conclusions of law. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the C.G.S.) and Sections 19a-638 and 19a-639, C.G.S. By petition dated October 8, 2010, Day Kimball Hospital requested Party or Intervenor status regarding the Applicant's CON application. On October 13, 2010, Day Kimball Hospital was designated as an Intervenor with full rights of participation.

The Hearing Officer heard testimony from the Applicant, Intervenor and elected officials in rendering this proposed final 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 this section as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

1. The Applicant is a licensed 213-bed general hospital located at 326 Washington Street in Norwich, Connecticut. It is a tax-exempt non-stock corporation. *(March 30, 2010, Initial CON Application, pages 4, 20 and 281)*

2. The Applicant operates an Emergency Department ("main ED") on its main campus in Norwich. The Hospital's main ED:
   - Is open 24 hours per day, 7 days per week;
   - Has 42 beds including 9 Convenient Care beds;
   - Provides all levels of emergency care (Levels I to VI);
   - Is the only American College of Surgeons-designated trauma center in eastern Connecticut; and
   - Has a helipad and is a support facility for LIFESTAR air ambulance.

   (March 30, 2010, Initial CON Application, pages 2-3)

3. The Applicant established "Convenient Care" in 2000, as a means of improving efficiency and reducing wait time for patients presenting at lower acuity levels. Convenient Care is a division of the main ED that treats a wide range of immediate but non-life threatening conditions, such as orthopedic injuries (breaks, sprains, etc.), lacerations and acute illnesses (flu or cold symptoms, etc.). *(March 30, 2010, Initial CON Application, page 5; and August 11, 2010, Completeness Response, page 454)*

4. Convenient Care beds are used for patients who do not need a high level of resources or who will not have a long length of stay in the main ED, but that often do need emergency-type services. *(October 14, 2010, Testimony of Dr. Robert D. Sidman, Chief of Emergency Medicine at Backus Hospital)*

5. The Applicant renovated and modernized its main ED as authorized under Docket Number 04-30424-CON, a project that included:
   - An increase of 20 main ED beds;
   - An increase of 21 staffed multi-purpose medical surgical beds;
   - Increased trauma capacity; and
   - Improved traffic flow in and around the main ED.

   (March 30, 2010, Initial CON Application, page 5; and July 13, 2005, Final Decision Docket No. 04-30424)

6. The Applicant provided five examples of initiatives that are part of its continual review and analysis of operational efficiency in the main ED:
   - Bedside registration:

- Chief-complaint-based nursing order sets;
- Information technology to determine optimum staffing;
- Patient flow redistribution to maximize patient throughput; and
- Improve hospital throughput efficiency to get admitted patients out of emergency department beds.

(August 11, 2010, Completeness Response, page 443)

7. The Applicant operates various satellite outpatient care centers at locations throughout eastern Connecticut, including Norwich, Colchester, Groton, Montville, Gales Ferry, and Plainfield. The Plainfield Health Center, located at 120-122 Plainfield Road in Plainfield, offers adult primary care, laboratory, and plain film x-ray services, as well as timeshare space for specialists.*(March 30, 2010, Initial CON Application, page 4; October 8, 2010, Prefiled Testimony of David Whitehead, President & Chief Executive Officer, Backus Hospital, page 563)*

8. Additional providers of emergency services in eastern Connecticut include:
   - Day Kimball Hospital, Putnam;
   - Lawrence & Memorial Hospital ("L&M"), New London;
   - Pequot Health Center (an affiliate of L&M), Groton; and
   - Windham Hospital, Willimantic.

   (March 30, 2010, Initial CON Application, pages 16 and 148)

9. The Applicant explored expanding capacity at the main ED and concluded that further main ED expansion is not feasible. The Applicant also considered extending hours and/or expanding services at the Plainfield Health Center, or developing an urgent care center or a "Type B" ED that operates less than 24 hours per day. The Applicant determined that a full-service satellite ED, open 24 hours per day, 7 days per week, is necessary to meet the current and projected future demand for services within the Backus system and market. *(March 30, 2010, Initial CON Application, page 6; August 11, 2010, Completeness Response, pages 451-3 and 456-8; October 8, 2010, Prefiled Testimony of David Whitehead, pages 563-4; October 14, 2010, Testimony of Jon Geise, Principal, 3D Health)*

10. Although the Applicant is working on a major recruitment effort, has held a nursing job fair in the last few months, and has additional nurses and medical staff coming into the system (within the main ED and all of its satellite locations) to adjust to this new demand, additional staffing alone is insufficient to remedy the main ED capacity issues without additional ED beds for the patients. *(October 14, 2010, Testimony of Mr. Whitehead & Dr. Sidman)*

11. The Intervenor asserted that a lack of available inpatient beds for admitted patients is likely the source of the Applicant's main ED capacity issues.*(October 8, 2010, Prefiled Testimony of David White, page 270)*

12. Since only 13% of main ED patients are admitted to the Hospital, the most significant gains in throughput and capacity come from the 87% of patients who are discharged from the main ED. Therefore, an increase in inpatient beds would only marginally impact main ED length of stay. *(October 14, 2010, Testimony of Dr. Sidman)*

13. Constructing a satellite ED is more cost-effective than expansion of the main ED. Expansion on the main campus is projected to be higher per square foot – in excess of $375 per square foot, and perhaps as high as $500 per square foot, as compared to developer estimates in the range of $275 per square foot for the satellite ED. An expansion on the Hospital campus would automatically require State Traffic Commission review and would also require local Commission on city Plan approval through a special permit. Offsite roadway improvements in excess of $1 million would likely be required and an on-site parking facility ($12,000 per space) would be probable. *(March 30, 2010, Initial CON Application, page 24; August 11, 2010, Completeness Response, page 567 and Exhibit I)*

14. The proposed satellite ED will be located at Lot 5A, Norwich Road (Route 12) in Plainfield. *(August 11, 2010, Completeness Response, page 443)*

15. The Applicant will add the satellite ED to its existing general hospital license, as a satellite. *(March 30, 2010, Initial CON Application, page 26)*

16. The proposed satellite ED will:
    - Include 8 staffed treatment beds;
    - Handle primarily Levels I-IV visits and be open to Levels V & VI (Critical Care) visits;
    - Include a Convenient Care component;
    - Operate 24 hours per day, 7 days per week;
    - Offer ancillary laboratory and diagnostic radiology services, including CT scanning, ultrasound, and digital radiography.

    (March 30, 2010, Initial CON Application, page 4)

17. Freestanding or satellite EDs must have staffing and equipment commensurate with a hospital-based ED, and must meet all of the same physical plant, occupancy, construction, and other legal requirements of hospital-based EDs. *(March 30, 2010, Initial CON Application, page 7)*

18. The Hospital selected the proposed satellite ED's primary service area as towns within a 15-minute radius of the satellite ED in which the Hospital has the highest market share for ED services of any provider in the area. The Hospital selected the secondary service area as towns within a 15-minute radius of the satellite ED that are also in the Hospital service area and that contain a substantial number of residents who are currently served at the main ED.

Table 1: Proposed Service Area

Primary Service Area	Secondary Service Area
Canterbury	Brooklyn
Griswold-Lisbon	Killingly
Plainfield	Sterling
Voluntown	

(August 11, 2010, Completeness Response, page 453)

19. The Applicant does not consider all of Killingly in its service area; only the zip code of 06239 for Danielson is included; and the zip codes of 06241, 06233, 06263, and 06243 for Dayville are excluded. *(November 2, 2010, Backus Response to DKH late-file, page 766)*

20. The satellite ED will encompass approximately 13,000 square feet of space (with expansion capabilities) in a one-story building. The facility will include a dedicated waiting area, triage areas, treatment rooms (with rooms shelled for additional beds), a nurse station, all needed support spaces (including storage for medication and supplies, security, administrative offices and conference room space), and integrated laboratory and radiology service areas (including a CT scanning suite and separate radiology and ultrasound room). *(March 30, 2010, Initial CON Application, page 34)*

21. The proposed satellite ED will be staffed by a board certified emergency medicine physician, a RN, laboratory and radiology technicians, an ultrasound sonographer, an ED technician, and appropriate administrative and other staff. *(March 30, 2010, Initial CON Application, page 4)*

22. The satellite ED will not take any multi-system trauma patients or individuals who are anticipated to need a massive blood transfusion. These patients will be transported directly to a facility with admitting capabilities. It is recommended that individuals who are highly likely to require admittance to a hospital, individuals in need of labor and delivery services (excepting patients in imminent delivery), and individuals requiring behavioral health services will also bypass the satellite ED. *(March 30, 2010, Initial CON Application, page 27)*

23. The Applicant will work closely with EMS providers to determine which types of patients should be taken to the satellite ED and how to handle transfers of patients from that facility. *(October 8, 2010, Prefiled Testimony of Dr. Sidman, pages 650-1)*

24. Extensive integration between the satellite ED, main ED, and Hospital will allow the satellite ED to perform at a much higher level than would otherwise be possible, and the Applicant identified a number of strategies for such integration. *(March 30, 2010, Initial CON Application, pages 28-29)*

25. Establishment of the Satellite ED will:
    - Address capacity issues at its main ED, allowing the Hospital to safely treat patients at both facilities; and
    - Bring services to a community that does not have rapid access to an ED.

    (March 30, 2010, Initial CON Application, pages 5-6; and October 14, 2010, Testimony of Dr. Sidman)

26. The main ED has exceeded the projections developed at the time the most recent ED expansion was approved.

Table 2: Main ED Projected vs. Actual Visits

	FY 2007	FY 2008	FY 2009
Total Projected ED Visits	50,985	52,118	53,278
Total Actual ED Visits	54,064	58,141	63,672

(March 30, 2010, Initial CON Application, pages 5, 13 and 24; and July 13, 2005, Final Decision Docket No. 04-30424)

27. Visits at the main ED continue to grow for the satellite ED primary and secondary service areas, as well as overall.

Table 3: Main ED Visit Totals

	Satellite ED PSA*	Satellite ED SSA**	Total All Towns
2008	10,768	1,201	58,141
2009	12,188	1,322	63,672
2010	12,759	1,330	65,835

* Canterbury Griswold-Lisbon Plainfield Voluntown
** Brooklyn Killingly Sterling
(October 25, 2010, Backus late-file, page 763, and October 26, 2010, Supplemental Chart, page 767)

28. Between 1994 and 2005, when Backus sought approval to expand the main ED, visit volume increased by 25%. Volume grew by another 30% between FY 2005 and FY 2009. *(October 8, 2010, Prefiled Testimony of Dr. Sidman, page 640)*

29. Data show that between 2008 and 2010, total visit volume at the main ED grew by 11.7%, and that visit volume from the satellite ED PSA at the main ED grew by 15.6%. *(October 25, 2010, Backus late-file, page 763, and October 26, 2010, Supplemental Chart, page 767)*

30. Since 2005, with efforts to improve the efficiency of the main ED, Convenient Care hours have been increased (they are now 9 a.m. to 1 a.m. during peak times of operation), staffing has been increased, and a higher level of patient complexity is now seen in Convenient Care (generally Levels II and III but also up to Level V). *(October 14, 2010, Testimony of Dr. Sidman)*

31. The Applicant testified that a shift in Level II and III visits between FYs 2008 and 2009 was due to efforts to improve coding and documentation. *(October 14, 2010, Testimony of Dr. Sidman)*

32. After implementing measures aimed at improving operational efficiency and maximizing ED bed capacity, between 2005 and 2009, the Applicant reduced average length of stay ("ALOS") for Convenient Care patients by 21 minutes, for discharged patients by 33 minutes, and for admitted patients by 3 minutes. The percentage of patients leaving the main ED before complete evaluation ("LBCE") during this time dropped from 3.69% in 2005 to 0.54%. (The walk-out rate is a very sensitive and predictive measure of emergency department efficiency, and the Hospital strives for a one-percent level.) *(October 8, 2010, Prefiled Testimony of Dr. Sidman, pages 643-644; and October 14, 2010, Testimony of Dr. Sidman)*

33. Through September, 2010, ALOS increased for Convenient Care patients, discharged ED patients, and admitted ED patients. LBCE, which had been at 0.50% for 24 consecutive months, more than doubled to 1.24% in the four months preceding October. In 2010, patient satisfaction with the ED services has also declined. *(October 8, 2010, Prefiled Testimony of Dr. Sidman, pages 643-644; and October 14, 2010, Testimony of Dr. Sidman)*

34. The Applicant often calls on nursing staff from other areas of the Hospital to cover when the main ED is busy. *(October 8, 2010, Prefiled Testimony of Dr. Sidman, page 645)*

35. The main ED exceeded capacity in FY 2009 and is projected to continue exceeding capacity in FYs 2010 and 2015.

Table 4: Main ED Capacity

	FY 2009 (actual) Outpatient ED Visits	FY 2009 (actual) Admitted ED Visits	FY 2010 (projected) Outpatient ED Visits	FY 2010 (projected) Admitted ED Visits	FY 2015 (projected) Outpatient ED Visits	FY 2015 (projected) Admitted ED Visits
Total Visits	56,488	7,184	61,561	7,443	75,566*	8,427*
Benchmark patients/ room	1,600	1,000	1,600	1,000	1,600	1,000
Treatment Rooms Required	35.3	7.2	38.5	7.4	47.2	8.4
Total Treatment Rooms Required	42.5		45.9		55.6	
Total Actual Treatment Rooms	42		42		42	
Percent Capacity	101%		109%*		132%*	

* In prefiled testimony, the Applicant indicated that the actual total of outpatient and admitted visits was 65,835 for FY 2010, somewhat less than projected, and that capacity would then be at 103%. The Applicant indicated at the hearing that there was no need to update any other projected numbers.
Note: The Applicant calculated ED capacity using information provided in the book "Healthcare Facility Planning: Thinking Strategically" by Cynthia Hayward. *(March 30, 2010, Initial CON Application, pages 6 and 151; August 11, 2010, Completeness Response, pages 460-1; August 26, 2010, Supplemental Information, page 551; October 8, 2010, Prefiled Testimony of Dr. D. Sidman; October 14, 2010, Testimony of Mr. Geiss)*

36. By 2015, the Applicant will need 55.6 beds to accommodate a total of 83,993 visits at the main ED; this will leave the Applicant short 13.5 beds. *(March 30, 2010, Initial CON Application, pages 6 and 151; August 11, 2010, Completeness Response, pages 460-1; August 26, 2010, Supplemental Information, page 551; October 8, 2010, Prefiled Testimony of Dr. D. Sidman; October 14, 2010, Testimony of Mr. Geiss)*

37. Calculated on a daily basis, the main ED exceeded capacity 100 days of FY 2009 (27 percent of the time), with main ED census above 120% capacity 18 days of FY 2009. *(March 30, 2010, Initial CON Application, page 6)*

38. In recently completed FY 2010, the main ED operated at 103% capacity overall and census exceeded bed capacity on 152 of the 365 days (42% of the time). *(October 8, 2010, Prefiled Testimony of Mr. Geise., page 673)*

39. Over the course of the last year, the main ED has gone on diversion status four times. While typical time on diversion is two to four hours, on July 29, 2010, the Hospital requested diversion for a period of almost ten hours. *(August 11, 2010, Completeness Response, page 449)*

40. On days that the main ED exceeded capacity, ALOS increased:
    - In FY 2009, ALOS was 3.0 hours, but on days the main ED was operating above capacity, ALOS increased by 24 minutes, and when operating above 120% capacity, ALOS increased by 43 minutes; and
    - In FY 2010, ALOS was 3.1 hours, but on days the main ED was operating above capacity, ALOS increased by 30 minutes, and when operating above 120% capacity, ALOS increased by 47 minutes.

    (October 8, 2010, Prefiled Testimony of Jon Geise, page 673)

41. One reason for the increase in main ED visits is the growing number of uninsured and Medicaid patients who lack access to care at places other than an ED. *(October 8, 2010, Prefiled Testimony of Dr. Sidman, page 643)*

42. Approximately 40% of main ED visits involve uninsured individuals and Medicaid recipients, or about 38% when considering visits by residents of the Plainfield service area only. *(October 8, 2010, Prefiled Testimony of David Whitehead, page 565)*

43. Nationally, ED usage increased at roughly twice the rate of US population growth between 1997 and 2007 and is partially attributable to difficulties that adults with Medicaid experience in accessing primary care. Additionally, there is inadequate access to primary, preventative, and urgent care. *(October 8, 2010, Prefiled Testinomy of Robert. Smanik, page 13; October 8, 2010, Prefiled Testimony of Dr. Sidman, pages 653-659; Ning Tang, et al., "Trends and Characteristics of US Emergency Department Visits, 1997-2007." JAMA, August 11, 2010—Vol. 304, No. 6)*

44. The evidence demonstrates, however, that merely adding primary physicians in the Plainfield service area will not remedy the capacity issues at the main ED and that it will take a significant amount of time to alleviate the current and anticipated shortage of primary care physicians, particularly in light of the difficulties associated with recruitment, retention and overall availability of physicians in Windham and New London counties. *(October 13, 2010, Rebuttal Testimony of Jon Geise, page 741; October 8, 2010, Prefiled testimony of David A. Whitehead, page 566; Aseltine, Robert H, et al. "Connecticut Physician Workforce Survey 2008: Final Report on Physician Perceptions and Potential Impact on Access to Medical Care." Connecticut State Medical Society.)*

45. There is no standard definition that identifies patients who are emergent and must be treated in an ED versus patients who can be treated in an urgent care center. *(October 14, 2010, Testimony of Jon Geise)*

46. In this case, however, the evidence establishes that ED visits consist of the following levels of care: Critical care and Levels I through V. Level IV and V and critical care patients generally require treatment in an ED setting, while Levels I, II and some of III could be treated at an urgent care center, unless it is after hours or on the weekend. *(October 14, 2010, Testimony of Jon Geise; October 8, 2010, Prefiled Testimony of Robert Smanik, page 15-16)*

47. Using the above-described methodology, approximately three-quarters of ED visits at the main ED, from the service area and overall, consist of critical care outpatient, Levels V and IV, and some of Level III.

Table 5: ED Use by Level of Care

	FY 2010			FY 2009			FY 2008		
	Satellite ED PSA*	**Satellite ED SSA****	**Total All Towns**	**Satellite ED PSA***	**Satellite ED SSA****	**Total All Towns**	**Satellite ED PSA***	**Satellite ED SSA****	**Total All Towns**
Level I Outpatient	36	2	194	83	11	440	15	2	75
Level II Outpatient	1,073	98	5,776	1,063	89	5,944	2,756	291	15,717
Level III Outpatient	5,396	579	27,750	5,064	541	26,176	2,747	313	15,027
Level IV Outpatient	2,805	322	14,720	2,498	269	13,394	1,999	217	10,668
Level V Outpatient	2,918	285	14,633	3,003	367	15,471	3,003	356	15,378
Critical Care Outpatient	251	24	1,088	301	29	1,339	225	20	1,132
Other Visits	280	20	1,674	176	16	1,261	23	2	144
Total	**12,759**	**1,330**	**65,835**	**12,188**	**1,322**	**63,672**	**10,768**	**1,201**	**58,141**

* Canterbury Griswold-Lisbon Plainfield Voluntown

** Brooklyn Killingly Sterling

(October 25, 2010, Backus late-file, page 762-3, and October 26, 2010, Supplemental Chart, page 766-7)

48. In FY 2009, between 65% and 95% of the Backus ED patient population from the Plainfield service area were in need of ED services,when considering all "after hours" patients presenting during hours when an urgent care clinic would typically be closed, along with critical care patients, admitted ED patients, level IV and V patients, and some of level III patients.

Table 6: Hospital Emergency Visit Volume by Triage and Time of Day, FY 2010, Main ED, Plainfield Service Area Only

	Monday through Friday		Saturday & Sunday		Total
	8:00 AM to 7:59 PM	After Hours	9:00 AM to 5:59 PM	After Hours	
Level I Outpatient	24	8	3	3	38
Level II Outpatient	587	246	157	181	1,171
Level III Outpatient	2,873	1,193	1,035	847	5,948
Level IV Outpatient	1,627	589	472	392	3,080
Level V Outpatient	889	383	258	246	1,776
Critical Care Outpatient	31	25	17	10	83
Other Visits	167	60	32	24	283
Admitted ED Visits	918	342	245	205	1,710
Total	**7,116**	**2,846**	**2,219**	**1,908**	**14,089**

(October 25, 2010, Backus late-file, page 764)

49. The following table lists each of Backus Hospital's service area towns. Towns that are part of the satellite ED's service area are bolded. The table shows:
    - The proportion of total main ED visits that come from each town;
    - The market share each area hospital captures for these towns;
    - The number of visits to the Hospital's main ED in FY 2009, and
    - The % change in visits from FYs 2006 to 2009.

Table 7: Main ED Market Share and Volume

FY 2009 Distrib		Backus	L&M	DK	Windham	All Other		FY 2009 Visits	% Change from FY 2006
PSA									
48%	Norwich	90%	7%	0%	1%	2%		27,486	39%
12%	**Griswold-Lisbon**	**87%**	**7%**	**2%**	**1%**	**2%**		**6,702**	**36%**
9%	Montville	57%	39%	0%	1%	4%		5,126	43%
6%	**Plainfield**	**49%**	**2%**	**44%**	**2%**	**2%**		**3,429**	**37%**
3%	Preston	78%	19%	0%	1%	2%		1,631	43%
3%	Sprague	82%	6%	1%	8%	3%		1,615	38%
2%	Bozrah	84%	8%	0%	2%	5%		948	15%
2%	**Canterbury**	**61%**	**4%**	**20%**	**13%**	**2%**		**1,180**	**30%**
2%	Lebanon	29%	2%	0%	36%	33%		864	40%
2%	**Voluntown**	**83%**	**9%**	**5%**	**1%**	**3%**		**877**	**37%**
1%	Franklin	74%	5%	0%	13%	8%		648	38%
1%	Ledyard	20%	77%	0%	0%	2%		829	31%
SSA									
1%	**Brooklyn**	**10%**	**1%**	**82%**	**5%**	**3%**		**319**	**36%**
2%	Colchester	17%	3%	0%	2%	79%		1,221	(8%)
1%	Gales Ferry	21%	76%	0%	1%	2%		587	19%
2%	Groton	4%	94%	0%	0%	2%		875	(4%)
1%	**Killingly**	**9%**	**1%**	**87%**	**2%**	**2%**		**549**	**49%**
2%	New London	4%	93%	0%	0%	2%		936	6%
1%	Salem	40%	34%	0%	0%	25%		518	28%
1%	**Sterling**	**39%**	**2%**	**54%**	**2%**	**3%**		**454**	**56%**
1%	Waterford	6%	91%	0%	0%	3%		494	28%

(March 30, 2010, Initial CON Application, pages 141 and 145)

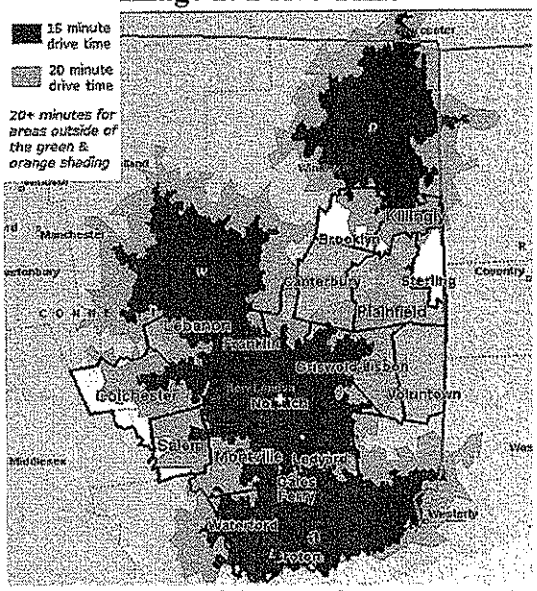
50. The Hospital captures the largest market share for emergency visit volume of all ED providers serving the proposal's PSA, with 87% of Griswold-Lisbon, 83% of Voluntown, 61% of Canterbury, and 49% of Plainfield. *(March 30, 2010, Initial CON Application, page 14 and 175)*

51. With 3,429 visits, Plainfield residents are one of the largest sources of ED visit volume at the main ED, ranking fourth overall in terms of source of ED visits at the main ED, and ranking first among towns not directly adjacent to Norwich. *(March 30, 2010, Initial CON Application, pages 14 and 141)*

52. Driven by factors including a high rate of population growth, market demand is expected to increase at a faster rate in Plainfield than in the Hospital's overall service area (14.1% as compared to 12.5% for the period FY 2010 to 2015). *(March 30, 2010, Initial CON Application, page 14 and 175)*

53. The PSA towns of Canterbury, Plainfield, and Voluntown have no ED located within a 15-minute drive time, and portions of these towns, as well as parts of Griswold-Lisbon, Brooklyn, Killingly, and Sterling are without an ED within a 20-minute drive time.

Image 1: Drive Time



(March 30, 2010, Initial CON Application, pages 6-10; October 8, 2010, Prefiled Testimony of David Whitehead, page 562)

54. The Applicant testified that emergency services time is measured in minutes, and provided examples such as that:
    - Without oxygen, the brain starts to die in 4-6 minutes;
    - A heart attack requires medications within 30 minutes or transfer to a tertiary care center within 90 minutes;
    - A stroke must be treated with clot-busting medications within 180 minutes;
    - A laceration that involved a major artery can lead to death in 10 minutes;

- Cardiac arrest and ventricular arrhythmias need to be reversed within minutes or death results.

(October 8, 2010, Prefiled Testimony of Dr. Sidman, page 647)

55. There is a lack of access to services in eastern Connecticut. *(October 8, 2010, Prefiled Testimony of Mr. Whitehead, pages 566-7)*

56. The greater Plainfield community supports the proposal for a freestanding ED in Plainfield. Hospital administrators have spoken about their plans with the fire department chiefs and assistant chiefs, EMS personnel, and chief municipal officers throughout the service area. *(March 30, 2010, Initial CON Application, page 8 and Exhibit B)*

57. Local and state officials have indicated strong support for the proposed satellite ED. *(October 14, 2010, Testimony of Senator Edith Prague; September 22, 2010, Letter of support from First Selectman Paul E. Sweet; September 2, 2010, Letter of support from Director of Recreation Myra Ambrogi; October 8, 2010, Prefiled Testimony of Mr. Whitehead, Exhibit E)*

58. First responders in the Plainfield area support the application, stating that a satellite ED in Plainfield will increase the efficiency of their operations by reducing the time spend on certain calls from dispatch to patient delivery, thus increasing ambulance availability. Letters were from the American Legion Ambulance Fund, Inc, Moosup; Atwood Hose Fire Company, Wauregan; Central Village Fire District, Central Village; Moosup Fire Department, Moosup; and Plainfield Fire Company No. 1, Plainfield. *October 8, 2010, Testimony of David Whitehead, Exhibit E)*

59. A hospital-commissioned market research study by The Center for Research showed that Plainfield residents have a preference for services provided by the Hospital, including emergency services. Residents surveyed also identified concerns about wait times at the Hospital's main ED. *(March 30, 2010, Initial CON Application, page 8)*

60. To project the number of visits to the proposed satellite ED, the Applicant considered "baseline" growth at the main ED; volume shift from the main ED to satellite ED; new patients from inside the service area; and new patients from outside the service area. Projections for 2012 and 2015 are presented below.

Table 8a: Projected Satellite & Main ED Volume, 2012

2012 (*volume for 9 months due to January start date)*	**Shift from Main ED to Satellite ED**	**Incremental new patients from PSA/SSA**	**In-migration from outside PSA/SSA**	**Total Satellite** (cols 2+3+4)	**Main ED Total**	**Grand Total** (cols 5+6)
Level I Outpatient	54	12	6	72	428	500
Level II Outpatient	667	156	83	906	6,193	7,099
Level III Outpatient	3,252	683	366	4,301	25,879	30,180
Level IV Outpatient	1,580	346	185	2,111	14,824	16,935
Level V Outpatient	523	105	134	762	11,147	11,909
Critical Care Outpatient	24	5	6	35	440	475
Admitted ED Visits	405	0	101	506	7,333	7,839
Other Visits	94	20	0	114	865	979
Total	**6,599**	**1,327**	**881**	**8,807**	**67,109**	**75,916**

(October 25, 2010, Backus late-file, page 765)

Table 8b: Projected Satellite & Main ED Volume, 2015

2015	**Shift from Main ED to Satellite ED**	**Incremental new patients from PSA/SSA**	**In-migration from outside PSA/SSA**	**Total Satellite** (cols 2+3+4)	**Main ED Total**	**Grand Total** (cols 5+6)
Level I Outpatient	82	17	9	108	471	579
Level II Outpatient	1,015	221	125	1,361	6,833	8,194
Level III Outpatient	4,937	966	548	6,451	28,769	35,220
Level IV Outpatient	2,406	488	277	3,171	16,194	19,365
Level V Outpatient	793	151	201	1,145	12,442	13,587
Critical Care Outpatient	36	6	9	51	494	545
Admitted ED Visits	592	0	151	743	7,835	8,578
Other Visits	142	29	0	171	952	1,123
Total	**10,003**	**1,878**	**1,320**	**13,201**	**73,990**	**87,191**

(October 25, 2010, Backus late-file, page 765)

61. The Applicant projects 8,807 visits at the satellite ED and 67,109 visits at the main ED in 2012, and 13,201 visits at the satellite ED and 87,191 visits at the main ED in 2015. *(October 25, 2010, Backus late-file, page 765)*

62. The Applicant's projections are reasonable and achievable given its historical increases in visit volume.

63. These projections do not take into account additional ED volume that is expected as a result of the growing number of access issues and the projected increase in Medicaid enrollment as a result of health care reform, and the fact that many physicians are

refusing to treat patients without insurance or with government insurance. *(October 14, 2010, Testimony of David Whitehead)*

64. In each year from 2012 to 2015, approximately 9% to 12% of total volume at the main ED will shift to the satellite ED. This represents about three-quarters of all visits at the new satellite ED facility. *(August 11, 2010, Completeness Response, pages 459-460)*

65. The proposal will have minimal impact on other existing providers of emergency services in eastern Connecticut since approximately three-quarters of the patient volume will come from the Applicant's main ED and the project is anticipated to be accomplished without material changes in market share for area providers. The additional quarter of volume includes incremental new patients from the PSA/SSA and immigration from outside the PSA/SSA. *(March 30, 2010, Initial CON Application, page 16)*

66. The Hospital projected ancillary volume for the proposed satellite ED based on historical ratios of ancillary procedures per visit at the main ED. These ratios were then applied to the projected visit volumes.

Table 9: Projected Ancillaries

Service	2012*	2013	2014	2015
CT	2,366	3,274	3,402	3,539
General Radiology	3,287	4,553	4,733	4,927
Lab	21,327	29,536	30,706	31,968
Procedures	1,213	1,680	1,746	1,818
Infusion-Injection	12,647	17,515	18,209	18,957
EKG	1,571	2,176	2,262	2,355
Therapeutics	1,151	1,594	1,657	1,725
Ultrasound	179	248	257	268
Total	43,741	60,576	62,972	65,557

** 2012 volume for 9 months due to January start date.*
(March 30, 2010, Initial CON Application, pages 17, 19 and 222)

67. The Hospital projected CT scan volume at the satellite ED by calculating per visit ratios based on the Hospital's FY 2009 experience at the main ED (only scans performed during the ED visit, not scans performed subsequent to any transfer and admission, were included). The Hospital applied these ratios to the projected visit volumes and thereby projects that the CT scanner will perform the following number of scans per year, by type of scan:

Table 10: Projected CT Scan Volume, by Type of Scan

Scan Type	2012*	2013	2014	2015
Abdomen	617	853	886	922
Chest	205	285	296	307
Neuro/ENT	694	961	999	1,040
Ortho	23	32	33	34
Spine & Pelvis	827	1,143	1,188	1,236
Total	**2,366**	**3,274**	**3,402**	**3,539**

** 2012 volume for 9 months due to January start date.*
(March 30, 2010, Initial CON Application, pages 31-33)

68. Professional radiology services will be provided by Norwich Diagnostic Imaging Associates, P.C., which has an exclusive agreement with the Hospital for these services. *(March 30, 2010, Initial CON Application, page 4)*

69. The satellite ED will be the sole tenant (lessee) in a freestanding building to be constructed and owned by a private developer. The developer will be responsible for construction costs with the Hospital assuming financial responsibility for the capital expenditure costs associated with the proposal. *(March 30, 2010, Initial CON Application, page 21)*

70. The proposal will incur the following capital expenditures, which will be financed through the use of funded depreciation.

Table 11: Proposed Capital Expenditures

Item	Expenditure
Medical Equipment Purchase	$600,000
Imaging Equipment Purchase	$1,444,591
Non-Medical Equipment Purchase	$502,500
Total Capital Expenditure	**$2,247,091**

Note: The Imaging equipment purchase consists of a radiography system, ultrasound system, and CT scanner.
(March 30, 2010, Initial CON Application, page 21)

71. The Applicant projects an incremental loss from operations for the satellite ED in FYs 2012-2015 due to the fact that approximately three-quarters of the projected volume consists of existing patients and the Hospital's financials already include the revenue and associated expenses for this volume. The satellite ED overall, however, will show a positive margin from operations of more than $1 million each year, and the Applicant projects a gain from operations for the entire Hospital, including the satellite ED, of $5.5 million, $6.4 million, $7.8 million, and $9.4 million during the same period. *(March 30, 2010, Initial CON Application, pages 24, 226 and 226a; August 11, 2010, Completeness Response, pages 462-463)*

72. Despite the incremental loss for the satellite ED, the Hospital views the proposal as the most cost-effective solution to the main ED's capacity issues and as a strategic investment to address significant service and quality issues. *(March 30, 2010, Initial CON Application, page 24)*

73. The Hospital projected the patient population mix for the proposed satellite ED based on the current FY 2010 patient population mix for residents of the Plainfield service area seen at the main ED. The Applicant does not anticipate that the patient population mix for the satellite ED or main ED will change between now and 2015.

Table 12: Patient Population Mix

Payer	**Satellite ED** 2010 current and 2012 through 2015 projected	**Main ED** 2010 current and 2011 through 2015 projected
Medicare*	15.5%	20.9%
Medicaid*	29.4%	31.2%
CHAMUS & TriCare	2.8%	2.8%
Total Government	**47.7%**	**54.9%**
Commercial	41.6%	34.3%
Uninsured	8.1%	8.7%
Workers Comp.	2.6%	2.1%
Total Non-Government	**52.3%**	**45.1%**
Total	**100%**	**100%**

** Includes managed care activity.*
(March 30, 2010, Initial CON Application, page 22; August 11, 2010, Completeness Response, page 461)

74. The Hospital has sufficient technical, financial and managerial competence and expertise to provide efficient and adequate service to the public. *(March 30, 2010, Initial CON Application, page 25 and Exhibit K)*

75. The Hospital will bill for the proposed services in accordance with the rate schedule used at the Hospital's main ED. *(March 30, 2010, Initial CON Application, page 23)*

76. The Applicant aims to begin construction in early 2011 for an early 2012 opening. *(March 30, 2010, Initial CON Application, page 35; October 14, 2010, Testimony of David Whitehead)*

77. The proposal will not result in any changes to the Hospitals teaching or research responsibilities. *(March 30, 2010, Initial CON Application, page 26)*

78. The proposal is consistent with the Applicant's long-range focus on improving the healthcare service delivery system in eastern Connecticut. *(March 30, 2010, Initial CON Application, page 25)*

79. The Hospital retained Wellspring Partners to evaluate the Hospital's performance across various areas of focus (i.e., labor productivity, human resource expense, non-labor expense, revenue cycle, clinical documentation, length of stay management, and physician services) and to collaborate with Backus management on an operational effectiveness plan. The evaluation is in process and plan recommendations are being implemented. *(March 30, 2010, Initial CON Application, pages 25-26)*

80. The Hospital's proposal will impact favorably on the interests of healthcare consumers and payers by increasing access to emergency services, and will contribute to the overall quality of healthcare delivery in the region. *(March 30, 2010, Initial CON Application, pages 27-29)*

DISCUSSION

OHCA approaches community and regional CON proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors that 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 proposed services, the current utilization of services and the financial feasibility of the proposal.

The Applicant is a licensed 213-bed general hospital located at 326 Washington Street in Norwich, Connecticut. The Applicant operates a main ED on its main campus in Norwich and is proposing to establish a satellite ED at lot 5A on Norwich Road (Route 12) in Plainfield. The Applicant is also proposing to acquire a CT scanner for the same location.

The Hospital is proposing to establish a satellite ED in order to address capacity issues at its main ED. Increases in visit volumes have been consistently high. FF 28. In FYs 2007, 2008, and 2009, the main ED exceeded the visit projections developed at the time of the last main ED expansion; by 2009 the actual ED visits was more than 10,000 visits above projected. FF 26. Visit volume grew by 11.7% between 2008 and 2010, and visit volume from the satellite ED PSA at the main ED grew by 15.6%. FF 29. The main ED reached 101% capacity in 2009 and 103% capacity in 2010, and is projected to reach 132% capacity by 2015, by which point the main ED will be short 13.5 beds. FF 35-36. Data show that when the main ED nears or reaches capacity, its quality metrics go down; ALOS and LBCE increase, and patient satisfaction declines. FF 32-33; 37-40. OHCA finds that the Applicant has demonstrated capacity problems at the main ED which need to be addressed in order to continue to provide access to timely and high quality services.

The Applicant has implemented a number of facility and process improvement strategies to improve efficiency at the main ED. FF 5-6. The Applicant has also examined a variety of options to address its capacity issues, such as expanding the main ED or offering urgent care services, and has determined that developing a satellite ED is the most cost effective solution and will most appropriately address the needs of the patient population. FF 9-13. Data show that approximately three-quarters of visits at the main ED, both from the proposed service area and overall, consist of patients in need of emergency-level services as compared to urgent care or other services. FF 47-48. The Hospital acknowledged that access issues, particularly for adult Medicaid patients, drive up ED utilization, but demonstrated that such issues cannot be immediately addressed through recruitment of primary care physicians, and that capacity issues at the main ED remain a pressing problem. FF 41-44. OHCA finds that the evidence is sufficient to establish the need for additional emergency-level services to serve the Hospital's existing patient population, and that the proposed satellite ED is an appropriate solution to this need.

The Plainfield area has both the volume to support a satellite ED and the need for such services. Plainfield residents account for 3,429 visits to the main ED, ranking fourth overall in terms of source of visits at the main ED, and ranking first among towns not directly adjacent to Norwich. In total, residents of the proposed satellite ED PSA and SSA comprised 13,477 visits at the main ED in FY 2009. FF 47; 51. Backus also captures the

largest market share for ED visit volume of all ED providers serving the proposal's PSA, with 87% of Griswold-Lisbon, 83% of Voluntown, 61% of Canterbury, and 49% of Plainfield. FF 49-50. Evidence also points to a lack of access to services in eastern Connecticut including the proposed service area. FF 53; 55. Thus, OHCA finds that the establishment of a satellite ED will improve access for the Hospital's patients residing in Plainfield and the adjacent towns that have been designated as the satellite ED's service area.

The proposed satellite ED is projected to accommodate 8,807 visits in FY 2012, and 13,201 visits in FY 2015. Of these visits, approximately three-quarters will consist of patients who would have previously gone to the main ED. With the proposal, the main ED is projected to have 67,109 visits in FY 2012 and 87,191 visits in FY 2015. FF 60-63. The proposal will incur capital expenditures totaling $2,247,091, which include purchase of a CT scanner and other equipment required to support operations at the satellite ED. The project will be financed through the use of funded depreciation. Despite an incremental loss due to the large portion of patients who are already being treated by the hospital, the overall project will show a positive margin from operations of more than $1 million each year, and the Applicant projects a gain from operations for the entire Hospital, as well. FF 74-75. Given the historical increases in visit volume seen at the main ED, OHCA finds that the financial projections, and the visit volumes upon which they are based, are reasonable and achievable. Based on the above, OHCA finds that the CON proposal is financially feasible.

ORDER

Based upon the foregoing Findings and Rationale, the Certificate of Need application of Backus Hospital for the establishment of a satellite Emergency Department in Plainfield and acquisition of a CT scanner for the same location, is hereby **APPROVED**, subject to the following conditions:

1. The Applicant shall submit to OHCA in writing the CT scanner's initial date of operation, within 30 calendar days subsequent to the start of operation.

2. Should the Applicant plan to operate the CT scanner identified in this proposal at a location other than proposed site of the satellite ED, the Applicant shall notify OHCA of the new location, no later than 30 calendar days after the equipment's relocation.

3. The Applicant shall report to OHCA the date of the opening of the satellite ED, no later than 30 calendar days following said opening.

4. OHCA requires the Applicant to make submissions of data regarding patient volume at both the main ED and satellite ED. The first submission may be for a partial period beginning with commencement of operations at the satellite ED. Subsequent submissions shall occur biannually according to the Applicant's Fiscal Year for the first two full years of operation of the satellite ED. Data submissions are aggregated and not patient level data and shall be submitted in the table format used in

Attachment A.

5. Concurrent with the data filings required by condition #4 above, the Applicant is also required to file the following, for the same time frames:
   - The number of patient transfers from the satellite ED to main ED;
   - The number of patient transfers from the satellite ED to Hospital;
   - The number of times and length of time the main ED goes on diversion; and
   - The number of times and length of time the satellite ED goes on diversion.

6. OHCA requires meetings between the Applicant and OHCA concerning the operation of the satellite ED for the first two years of operation. The first meeting with OHCA shall occur approximately one year following commencement of operations at the satellite ED and the second and final meeting shall occur approximately one year following the first meeting. Unless otherwise notified in writing by OHCA, the meetings will focus on operational and access issues, including, but not limited to, primary care physician recruitment, integration between the satellite ED and the main ED, visit volumes and patient acuity at the satellite and main EDs, and other issues to be determined by OHCA.

Should Backus Hospital fail to comply with any of the aforementioned conditions, OHCA reserves the right to take additional action as authorized by law. All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

Based upon the foregoing, I respectfully recommend that the Deputy Commissioner approve Backus Hospital's request to establish a satellite ED in Plainfield and to acquire a CT scanner for the same location.

12-2-10
Date

Melanie A. Dillon, Esq.
Hearing Officer

NG:MD:af

Attachment A

Table A1: Admitted Patient Volume: Satellite ED

	Partial FY of Operations		First Full FY of Operations		Second Full FY of Operations	
	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Level I Outpatient						
Level II Outpatient						
Level III Outpatient						
Level IV Outpatient						
Level V Outpatient						
Critical Care Outpatient						
Other Visits*						
Total						

* Specify
** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.

Table A2: Admitted Patient Volume: Main ED

	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Level I Outpatient						
Level II Outpatient						
Level III Outpatient						
Level IV Outpatient						
Level V Outpatient						
Critical Care Outpatient						
Other Visits*						
Total						

* Specify
** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.

Table B1: Non-Admitted Patient Volume: Satellite ED

	Partial FY of Operations		First Full FY of Operations		Second Full FY of Operations	
	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Level I Outpatient						
Level II Outpatient						

Level III Outpatient						
Level IV Outpatient						
Level V Outpatient						
Critical Care Outpatient						
Other Visits*						
Total						

* Specify
** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.

Table B2: Non-Admitted Patient Volume: Main ED

	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Level I Outpatient						
Level II Outpatient						
Level III Outpatient						
Level IV Outpatient						
Level V Outpatient						
Critical Care Outpatient						
Other Visits*						
Total						

* Specify
** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.

Table C1: Total of Admitted and Non-Admitted Patient Volume: Satellite ED

	Partial FY of Operations		First Full FY of Operations		Second Full FY of Operations	
	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Level I Outpatient						
Level II Outpatient						
Level III Outpatient						
Level IV Outpatient						
Level V Outpatient						
Critical Care Outpatient						
Other Visits*						
Total						

* Specify

** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.

Table C2: Total of Admitted and Non-Admitted Patient Volume: Main ED

	Partial FY of Operations		First Full FY of Operations		Second Full FY of Operations	
	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Level I Outpatient						
Level II Outpatient						
Level III Outpatient						
Level IV Outpatient						
Level V Outpatient						
Critical Care Outpatient						
Other Visits*						
Total						

* Specify
** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.

Table D1: Patient Volume by Town of Origin: Satellite ED

	Partial FY of Operations		First Full FY of Operations		Second Full FY of Operations	
	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Town A						
Town B						
(add rows as needed)						
Total						

** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.

Table D2: Patient Volume by Town of Origin: Main ED

	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Town A						
Town B						
(add rows as needed)						
Total						

** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.

Table E: Patient Population Mix: Satellite ED

	Partial FY of Operations		First Full FY of Operations		Second Full FY of Operations	
	1/1/12 to 2/29/12**	3/1/12 to 8/31/12	9/1/12 to 2/28/13	3/1/13 to 8/31/13	9/1/13 to 2/28/14	3/1/14 to 8/31/14
Medicare*						

Medicaid*						
CHAMUS & TriCare						
Total Government						
Commercial						
Uninsured						
Workers Comp.						
Total Non-Government						
Total						

* Includes managed care activity

** Estimated start date based on CON application may differ from actual start date reported to OHCA in condition #3. Actual Applicant start date should be used for initial partial data filing.