Johnson
Memorial
Hospital, Inc.

Alfred A. Lerz, *President*

Quality service from people who care

May 10, 2007

Cristine Vogel, Commissioner
State of Connecticut
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134-0308

Re: Johnson Memorial Hospital Sleep Center Relocation

Dear Commissioner Vogel,

I am pleased to submit the enclosed Certificate of Need Determination regarding the relocation of Johnson Memorial Hospital's Sleep Center from Stafford Springs, CT to Enfield, CT. Over the years, our program has grown from a small two-bed program to a fully accredited four-bed program. In order to better accommodate our patients, it was decided to move the program from the hospital to an Enfield location. This would locate the program closer to the majority of patients that we serve. To ensure we have met all of the Office of Health Care Access requirements, we are submitting the enclosed Certificate of Need Determination for your review.

Thank you for your support of Johnson Memorial Hospital's programs that bring patient service close to home.

Sincerely,

Alfred A. Lerz
President

PAK:rlb
enc.

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	Johnson Memorial Hospital	
Doing Business As	Johnson Memorial Hospital	
Name of Parent Corporation	Johnson Memorial Corporation	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	Johnson Memorial Hospital 201 Chestnut Hill Road Stafford Springs, CT 06076	
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP	
Contact Person, including Title/Position: This Individual will be the Petitioner's Designee to receive all correspondence in this matter.	Peter Kuzmickas Vice President, Operations	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	201 Chestnut Hill Road Stafford Springs, CT 06076	

Contact Person's Telephone Number	T: 860-684-8102	
Contact Person's Fax Number	F: 860-684-8165	
Contact Person's e-mail Address	Peter.kuzmickas@jmhosp.org	

SECTION II. GENERAL PROPOSAL INFORMATION

Proposal/Project Title: Johnson Memorial Hospital Sleep Center Relocation and Expansion

a. Location of proposal, identifying Street Address, Town and Zip Code: 151 Hazard Avenue – Suite 9, Enfield, CT 06082

b. List each town this project is intended to serve: Bordering Massachusetts' Towns; Enfield; Ellington, East Windsor; South Windsor, Windsor Locks; Granby; Somers; Stafford; Suffield; Willington

c. Estimated starting date for the project: April 16, 2007

d. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☒	☐	Other (specify): Sleep Center			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 203,188

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	0
Major Medical Equipment Purchases	0
Non-Medical Equipment Purchases*	$19,188
Land/Building/Asset Purchases	0
Construction/Renovation	$96,000
Other (Non-Construction) Specify:_____	0
Total Capital Expenditure	$115,188
Medical Equipment - Fair Market Value of Leases	0
Major Medical Equipment - Fair Market Value of Leases	$88,000
Non-Medical Equipment - Fair Market Value of Leases*	0
Fair Market Value of Space –Capital Leases Only	0
Total Capital Cost	**$203,188**
Total Project Cost	$203,188
Capitalized Financing Costs (Informational Purpose Only)	$0

* Provide an itemized list of all non-medical equipment to be purchase and leased.

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Sleep Study Equipment	Viasys	Version Seven	Four	$22,000

Note: Provide copy of the vendor contract or quotation for the medical equipment.

c. Check each applicable financing method or funding source to be used for the proposal:

☐ Petitioner's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☒ Operating Lease ☐ CHEFA Financing

☒ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable.

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable?

3. Identify the current population served and the target population to be served.

4. Identify the entity that will be providing the service(s).

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service?

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

11. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

SECTION IV. PROPOSAL DESCRIPTION

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

   Response
   Johnson Memorial Hospital Sleep Center offers accredited sleep studies to help diagnose sleep disorders resulting from respiratory and neurological causes, such as: Sleep apnea, restless leg syndrome, insomnia, narcolepsy, snoring and hypertension.

   See Attachment A: Johnson Memorial Hospital General License

2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable?

   Response
   There are no changes in the services to be offered at the Enfield facility.

   In this proposal, the occupant is seeking to:
   - expand the number of sleep laboratory beds from two to four
   - move the facility from Johnson Memorial Hospital in Stafford Springs, CT to Enfield, CT to better meet the current/future demands of patients.

   No new DPH licensure categories are being sought.

3. Identify the current population served and the target population to be served.

   Response
   The current population served and targeted population to be served are as follows: Bordering Massachusetts' Towns; Enfield; Ellington, East Windsor; South Windsor, Windsor Locks; Granby; Somers; Stafford; Suffield; Willington. We are moving the sleep laboratory to Enfield to be closer to the majority of our current population being served. The Enfield location is more convenient and should mean less travel for most of our population.

4. Identify the entity that will be providing the service(s).

   Response
   Johnson Memorial Hospital will be responsible for providing this service as it currently does.

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

   Response
   Johnson Memorial Hospital will be responsible for providing this service as it currently does.

6. Identify the entity that owns/leases or will lease the physical space of the proposed equipment/service?

   Response
   Johnson Memorial Hospital is the entity that leases the physical space.

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

   Response
   Not applicable.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

   Response
   Johnson Memorial Hospital is the sole party affiliated with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

   Response
   See Attachment B: Johnson Memorial Hospital Organizational Chart

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

    Response
    Not applicable.

11. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

    Response
    Johnson Memorial Hospital contracts with all governmental and third party payers that operate in Connecticut. The payer mix is not expected to be impacted by the relocation and expansion.

SECTION V. AFFIDAVIT

To be completed by each Petitioner

Petitioner: Johnson Memorial Hospital

Project Title: Johnson Memorial Hospital Sleep Center Relocation and Expansion

I, Alfred A. Lerz (Name), President & CEO (Position – CEO or CFO)

of Johnson Memorial Hospital (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Johnson Memorial Hospital (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

5/10/07
Date

Subscribed and sworn to before me on May 10th, 2007

Lisa Corrivan
Notary Public/Commissioner of Superior Court

My commission expires: 05/31/2010

STATE OF CONNECTICUT

Attachment A

Department of Public Health

LICENSE

License No. 0033

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Johnson Memorial Hospital, Inc. of Stafford Springs, CT, d/b/a Johnson Memorial Hospital is hereby licensed to maintain and operate a General Hospital.

Johnson Memorial Hospital is located at 201 Chestnut Hill Rd., Stafford Springs, CT 06076

The maximum number of beds shall not exceed at any time:

9 Bassinets
92 General Hospital beds

This license expires **December 31, 2007** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2006.

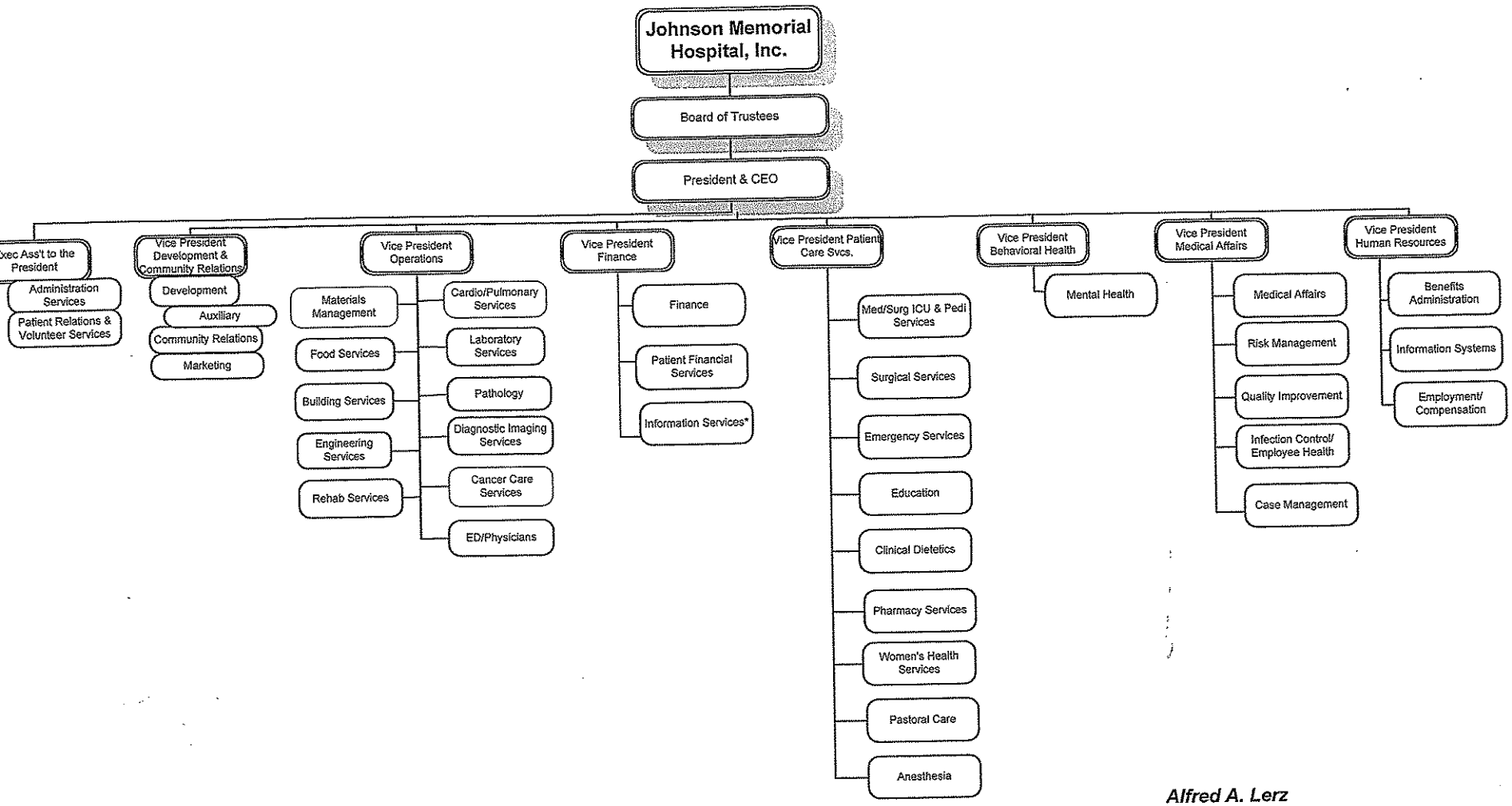
License revised to reflect:
INCREASE IN BED CAPACITY 3 BEDS EFF: 9/8/06

Satellites
Jmh Behavioral Health Services, 151 Hazard Avenue, Enfield, CT

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

Attachment B



Alfred A. Lerz
President

02/2007
Date

JMH
02/2007

* - McKesson Employees

VIASYS Respiratory Care

22745 Savi Ranch Parkway
Yorba Linda, Ca 92887-4645
800 231-2466 ext 3759
VIASYS Fax: 714-283-8419

QUOTATION/PURCHASE AGREEMENT

Attn: JAMES LIETZ, DIR. CARDIOPULMONARY SVCS
JOHNSON MEMORIAL HOSPITAL
RECEIVING DEPT
201 CHESTNUT HILL ROAD
STAFFORD SPRGS, CT 06076

Tel: 860 684-8175
Fax:

Date: 10/24/2006
Validity: 12/26/2006
FOB Point: DESTINATION

Quotation No: SPU000542
Payment Terms: 30 Days

Balance 30 Days: 87,774.95

Basic Configuration:	Qty	Part Number	Premier Price	Extended Price
ACQUISITION STN 1 BED CEPHALO VER 7 1-bed Diagnostic Sleep System with Cephalo Pro amplifier and version 7 software. Perform PSG/MSLT/MWT/ & NPT, including HEART RATE VARIABILITY technology- The only company to measure the heart's sympathetic response to OSA, graphs both bradycardia and tachycardia over time. Advanced HRV plots that separate HR responses by stage and pre and post treatment. Cephalo Amplifier - USB amplifier with on-board POX; 40 channels including 8 DC/ 23 referential / 9 differential; Collection rate up to 1000 Hz :: Display up to 64 channels per bed, move channels, re-reference & filter pre/post acquisition. On screen tech notes, bi-directional scrolling, auto-assist scoring. Includes basic LabManager for schedules & reports, Reference Manual, and isolation transformer. Network ready.	4	776630-101	17,000.00	68,000.00
LABMANAGER OPTION CRYPKEY Fully integrated Sleep/Wake database, incorporating Integrated score set data, multi-bed scheduler, data querying, custom score set reports, management reports, report customization within Lab Manager itself or incorporate Microsoft Word and use MS Word Reporting (for easier automated parameter import function, if/then else statements, etc.), and connect to data exchange gateway through Lab Manager.	4	775767	0.00	0.00
RESPIT QDC W/FVL OPT 120V CRYPKEY Respitrace QDC providing real-time collection of Flow Volume Loops and Konno Mead Loops. Loops are derived from the exclusive application of CALIBRATED Respiratory Inductive Plethysmography (RIP), with graphical and numerical analysis of each patient breath. Viasys Flow Volume Loops require no flow sensor on the face, are excellent for pre-treatment UARS detection with associated reporting, work of breathing graphics, as well as Tx titrations.	4	775786-101	2,000.00	8,000.00
VID SYS 5 BASIC W/VID BD & CRYPKEY Basic Video System, complete with camera, cables, video board, and associated software. Unobtrusive dome cameras, IR source included. Camera installation sold separately.	4	11463-101	1,500.00	6,000.00
COMUNICATOR TWO-WAY SET Two-Way Talk/Listen System (ASK-4 Kit #500), featuring hands-free listen and talkback at remote speaker/microphone, desktop base station, record and playback, volume control for listen and talkback, and 12Vdc power transformer. (Audio cable, 466391 and RCA 3.5mm plugs, 467300 sold separately).	4	466403	664.05	2,656.20
AUDIO CABLE RCA - 3.5MM PLUG RCA plugs for communicator system Audio Cable (2 required per communicator).	8	467300	0.00	0.00
CBL 10 BASE T 100' PLENUM CAT 5 Cable, 10BaseT compatible, 100 feet	4	465813	0.00	0.00
GX620 XP SOMNOSTAR PRO 115V ENGL Dell Optiplex GX620 Tower with Windows XP; Pentium 4; 3.2 GHz; 800FSB; 2M Cache, Intel Gigabit NIC; 160GB HDD: DVD+/--RW,1gb RAM; Monitor sold separately.	4	11457-401	0.00	0.00
MONITOR, 20" 2001FP, DELL Dell 20" Flat Panel Monitor.	4	96011	1,000.00	4,000.00
AS500 SOUND BAR FOR DELL 1703FP MTR Sound/speaker system located on bottom of flat panel monitor.	4	467203	0.00	0.00
KIT HP5740 PRINTER	1	11456	0.00	0.00

VIASYS™ HEALTHCARE
Excellence for Life
RESPIRATORY CARE

Rpt: D_UNIT_P - rev 09/09/06

Attn: **JAMES LIETZ, DIR. CARDIOPULMONARY SVCS**		**Date:**	10/24/2006	**Quotation No:**	SPU000542
JOHNSON MEMORIAL HOSPITAL		**Validity:**	12/26/2006	**Payment Terms:**	30 Days
RECEIVING DEPT		**FOB Point:**	DESTINATION		
201 CHESTNUT HILL ROAD	**Tel:** 860 684-8175				
STAFFORD SPRGS, CT 06076	**Fax:**			**Balance 30 Days:**	87,774.95

Basic Configuration:

	Qty	Part Number	Premier Price	Extended Price
SLEEP CUST TRNG 3 DAY ON SITE	1	769640-SLP3-OS	0.00	0.00
3-Day onsite training for 2 persons with qualified VIASYS Clinical Specialist. VIASYS offers AARC approved CEU's for training. Two individuals can qualify for CEU's for onsite course. Additional training must be purchased for more than two to qualify.				
STARTECH 8 PORT ETHERNET SWITCH	1	466743	118.75	118.75
Allows for peer-to-peer networking with up to 8 computers per ethernet switch.				
SWR KIT S'STAR PRO SWR BUNDLE VER 7	5	776648	95.00	475.00
SLEEP CUST TRNG 3 DAY YORBA 1 PERSN	1	769640-SLP3-Y1	1,800.00	1,800.00
3-Day Yorba Linda, CA training for 1 person including airfare, hotel, and airport transfers upon arrival. VIASYS offers AARC approved CEU's for training.				
BCI CAPNOCHECK PLUS (SEE DESC#2)	2	PT0044	0.00	0.00
CONSISTING OF MFG PN'S: 1 ea 9004-050 BCI CAPNOCHECK SLEEP CAPNOGRAPGH 1 ea 8217 CALIBRATION KIT 1 ea 9014 ANALOG CBL				
SMC INSTR RETURNED FOR CREDIT	1	SMCTRADE-IN	-3,275.00	-3,275.00
VIASYS HEATHCARE MAY REQUEST EQUIPMENT BE RETURNED FOR CREDIT OR THE EQUIPMENT MAY BE DISABLED ONSITE BY VIASYS STAFF				

PLEASE REVIEW NEXT PAGE FOR PAYMENT OPTIONS AND ADDITIONAL COMMENTS

Attn:	**JAMES LIETZ, DIR. CARDIOPULMONARY SVCS**	**Date:**	10/24/2006	**Quotation No:**	SPU000542
JOHNSON MEMORIAL HOSPITAL		**Validity:**	12/26/2006	**Payment Terms:**	30 Days
RECEIVING DEPT		**FOB Point:**	DESTINATION		
201 CHESTNUT HILL ROAD	**Tel:** 860 684-8175				
STAFFORD SPRGS, CT 06076	**Fax:**			**Balance 30 Days:**	87,774.95

Total Premier Price

PRODUCT TOTAL (Excluding All Taxes & Duties): $87,774.95

Savings Based On Premier Purchasing Partners L.P. Agreement, Pulmonary Contact: PP-CE-360 Expires 06/30/2008 - Sleep Contract: PP-CE-363 Expires May 31, 2008

Additional Comments:

SPECIAL OFFER: IN RETURN FOR AN ORDER BY DECEMBER 15TH, VIASYS WILL EXTEND THE FOLLOWING SPECIALS: FULL SECOND YEAR WARRANTY VALUED AT $8,000, FREE SOFTWARE UPGRADES TO QUOTED COMPUTERS FOR FIRST THREE YEARS, TWO CAPNOGRAPH ETCO2 MONITORS VALUED AT $5,000. ORDER MUST BE IN BY DECEMBER 15TH FOR THESE SPECIALS TO BE VALID.

Customers that purchase their own computer(s) may incur additional charges involved for on-site visits and/or changes to the operating system. All software is validated on Viasys approved configurations, and therefore, Viasys cannot accept responsibility to validate information generated from customer supplied computers. Customer supplied computers may not be compatible and may void all warranties.

This quotation includes one year full parts and labor warranty
Sale is subject to credit approval.
Computer configurations are subject to availability. VIASYS Respiratory Care, Inc may substitute equivalent models at our discretion

Delivery Requirement

Freight delivery assumes that a loading dock is available for delivery and that receiving facility's staff is responsible for moving the equipment once it leaves the truck.
Trucks with lift gates and inside delivery are available but must be specified on the P.O. or on this signed quote. Unpacking/Uncrating requirements must also be stated on the purchase order. (Additional charges may apply)

_____ Purchaser's Signature

Please Note: If the delivery location is different than the address on this quote, you must specify the delivery address on the P.O. or on this signed quote.

VIASYS RC Sales Representative

STEVE PUZAK 800 231-2466 ext3759

Purchaser's Signature

Title **Date**

VIASYS™ HEALTHCARE
Excellence for Life
RESPIRATORY CARE

Johnson
Memorial
Hospital, Inc.

Alfred A. Lerz, *President*

Quality service from people who care

May 9, 2007

To: Peter Kuzmickas
Vice President, Operations
From: James Lietz
Director, Cardiopulmonary Services

Subject: Itemized list of all non medical equipment purchases, related to JMH Sleep Center relocation/expansion.

- (3) sets queen size mattresses and box springs
- (3) bed frames and headboards
- (4) televisions and mounting hardware
- One microwave
- One refrigerator
- (4) phones
- (2) supply carts
- One desk and one table
- (8) chairs
- (4) APC electrical backup units
- Fire/ burglar alarm system
- Interior and exterior signage
- One computer
- (4) radios
- (4) lamps
- (8) bedside tables
- Linens
- Audio/video/phone cable plus travel and labor
- Office supplies

Total Expenditure: $19,188

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 19, 2007

Peter Kuzmickas
Vice President, Operations
Johnson Memorial Hospital
201 Chestnut Road
Stafford Springs, CT 06076

RE: Certificate of Need Application Forms, Docket Number 07-30970-CON
Johnson Memorial Hospital
Terminate Sleep Lab Services in Stafford Springs and Establish Sleep Lab Services in Enfield and Add 2 Beds

Dear Mr. Kuzmickas:

Enclosed are the application forms for Johnson Memorial Hospital's Certificate of Need ("CON") proposal to terminate sleep lab services in Stafford Springs and establish sleep lab services in Enfield and add 2 beds with an associated capital expenditure of $203,188. According to the parameters stated in Sections 19a-638 of the Connecticut General Statutes the CON application may be filed between July 22, 2007, and September 20, 2007.

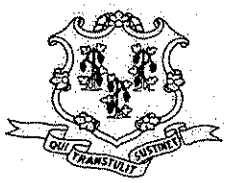
When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and three (3) hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him at (860) 418-7035, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures



State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than July 22, 2007, and may be submitted no later than September 20, 2007. The Analyst assigned to your application is Paolo Fiducia and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-30970-CON

Applicant(s) Name: Johnson Memorial Hospital

Contact Person: Peter Kuzmickas
Contact Title: Vice President, Operations
Johnson Memorial Hospital
Contact Address: 201 Chestnut Road
Stafford Springs, CT 06076

Project Location: Enfield

Project Name: Terminate Sleep Lab Services in Stafford Springs and Establish Sleep Lab Services in Enfield and Add 2 Beds

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $203,188

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Regarding this termination of services, please answer the following:

i) Explain in detail the Applicant's rationale for this termination of services. Identify the process undertaken by the Applicant in making the decision to terminate.

ii) Did the Applicant determine there was no or insufficient public need for the continuation of this program?

B. Provide or answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Stafford Springs location.

ii) Identify the primary and secondary service area towns for the Stafford Springs service location.

iii) Provide the units of service (i.e. clinic visits) for the past three fiscal or calendar years by patient town of origin, for the Stafford Springs service location.

iv) Discuss any scheduling backlogs that exist at the Stafford Springs service location at the time of the decision to terminate this service location.

v) Are there any waiting lists in place? If so, identify the number of patients on the waiting list.

vi) Describe the pattern of referrals to the Stafford Springs service location that exist prior to termination of this service location.

C. Regarding the impact on the patient and provider community of the termination of services, provide the following information:

i) Discuss how the services described above will continue to be made available to the patients that have previously utilized this service location. List any special populations that are utilizing the services and explain how these clients will continue to access this service after it is closed.

ii) Provide the information as outlined in the following table concerning the existing providers services in the Stafford Springs service area:

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day.
[2] Number of clients served by Provider for the most recent 12 month period, if known.

iii) What will be the effect of the termination of the Stafford Springs service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iv) Will this termination of services create any barriers to access in the region? If so, please discuss such barriers, as they now exist.

v) Provide information and supporting documentation addressing the issue of transportation for the Stafford Springs patients. Describe

how patients would be able to travel to a new service location if without benefit of a personal vehicle.

D. Explain how it was determined there was a need for the proposal in Enfield.

E. Explain how it was determined there was a need for the additional 2 sleep beds in Enfield.

F. Has the applicant undertaken any needs assessment for the proposed sleep laboratory in Enfield.

G. Has the applicant considered alternative locations other than Enfield?, if so, provide a list and describe all of the alternative locations.

H. Provide the following information:
   a) Primary and secondary service area towns
   b) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   c) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
   d) Scheduling backlogs in service area
   e) Travel distance from proposed site to service area towns
   f) Hours of operation of existing/proposed service

I. Identify the existing providers of the proposed service in the Enfield service area.

J. Provide the information as outlined in the following table concerning the existing provider's of sleep services in the Enfield service area:

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day.

[2] Number of clients served by Provider for the most recent 12 month period, if known.

K. What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

L. Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

M. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

N. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____

_____

_____

_____

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology	☐ National Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☐ Report of the Inter-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Society Abuse and Mental Health Services Administration

☐Other: Specify _____

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.
Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH	☐ JCAHO
☐ Fire Marshall Report	☐ Other States Health Dept. Reports (new out-of-state providers)
☐ AAAHC	☐ AAAASF
☐ Other: _____	

Note: Above referenced acronyms are defined below. [1]

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

F. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital (Applicant), Physicians and any staff related to the proposal, for the past five (5) years.

G. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital (Applicant), Physician(s) working at the Hospital and/or any staff related to the proposal.

H. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

- ☐ Energy conservation
- ☐ Group purchasing
- ☐ Reengineering
- ☐ None of the above
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the total current assets balance as of the date of submission of this application.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date. (For new service only)

iv) Provide the name and units of service for the new cost center to be established for the proposal.

v) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	

Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description of the any new construction or required renovation. Including the related gross square feet.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	$_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$_____
CON Proposed debt financing	$_____
Interest rate	_____%
Monthly payment	$_____
Term	_____ Years
Debt service reserve fund	$_____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	$_____
CON Proposed lease financing	$_____
Fair market value of leased assets at lease inception	$_____
Interest rate	_____%
Monthly payment	$_____
Term	_____ Years

☐ Other financing alternatives:

Amount	$ _____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iii) Please complete the enclosed, OHCA's **Financial Attachment II**.

iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

v) Provide a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective.

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:

# of Months in Operation

FY _____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 19, 2007

Peter Kuzmickas
Vice President, Operations
Johnson Memorial Hospital
201 Chestnut Hill Road
Stafford Springs, CT 06076-0860

Re: Letter of Intent, Docket Number 07-30970
Johnson Memorial Hospital
Terminate Sleep Lab Services in Stafford Springs and Establish Sleep Lab Services in Enfield and Add 2 Beds
Notice of Letter of Intent

Dear Mr. Kuzmickas:

On May 23, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Johnson Memorial Hospital ("Applicant") for the Termination of Sleep Lab Services in Stafford Springs and Establish Sleep Lab Services in Enfield and Add 2 Beds, at a total capital expenditure of $203,188.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Journal Inquirer* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:bko

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 19, 2007

Requisition # HCA07-214
FAX #: 646-9867

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Saturday, June 23, 2007.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact **Paolo Fiducia** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

Journal Inquirer
Docket Number 07-30970

Letter of Intent
June 19, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Johnson Memorial Hospital
Town:	Enfield
Docket Number:	07-30970
Proposal:	Terminate Sleep Lab Services in Stafford Springs and Establish Sleep Lab Services in Enfield and Add 2 Beds
Capital Expenditure:	$203,188

The Applicant may file its Certificate of Need application between July 22, 2007 and September 20, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

****
*** TX REPORT ***
****

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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 19, 2007

Requisition # HCA07-214
FAX #: 646-9867

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Sincerely,

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