Johnson Memorial Corporation

Alfred A. Lerz, *President*

Quality service from people who care

June 27, 2008

Honorable Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Johnson Memorial Hospital – Request for Emergency Letter of Intent Waiver

Dear Commissioner Vogel:

I am writing on behalf of Johnson Memorial Hospital ("JMH" or the "Hospital") to respectfully request that you waive the letter of intent requirement contained in Section 19a-638(a)(4) of the Connecticut General Statutes with respect to the Hospital's emergency need to terminate behavioral health services provided through its affiliate, Johnson Professional Associates, P.C. ("JPA").

The Hospital, as well as its parent corporation, Johnson Memorial Corporation (the "Network"), may be forced to cease operations if it cannot get costs under control and dedicate those savings to the immediate payment of vendors, secured creditors, and otherwise meet critical financial obligations. The Focus Group, which was hired by the Network Board of Trustees to replace former management, estimates that the Network's total liabilities are approximately eighty-five million dollars. Of that amount, roughly twenty-six million dollars are owed to vendors, which debts are substantially past due, and thirty million dollars are owed to secured creditors. Moreover, the Hospital presently has zero days "cash on hand" and the certified public accounting firm that audits the Network has indicated that it will issue a qualified "going concern" caveat to its September 30, 2007 report, which has still not been finalized.

Therefore, it is imperative that operating/cash losses be mitigated or stopped immediately; and, to that end, the proposed termination of behavioral health service provided through JPA is projected to result in immediate cash savings of $400,000 per year. This cash will be used to permit organized payment of overdue trade and vendor obligations, whose continued supply of items and services are necessary for Network, and particularly Hospital, operations. These efforts, in conjunction with other measures, will hopefully permit the Network and the Hospital to maintain continued access to all the other health care services provided to the community.

201 CHESTNUT HILL ROAD STAFFORD SPRINGS, CONNECTICUT 06076
PHONE: 860 684-4251 / 860 749-2201 FAX: 860 684-8165

As a final note, the Hospital has been actively working with other local providers of behavioral health services to address the needs of the patients currently being served through JPA. The details of these efforts will be addressed in detail in the Certificate of Need application.

In light of the foregoing, we respectfully request that you waive the letter of intent requirement so that we may submit our Certificate of Need application and terminate these services in an expedient fashion. Please feel free to contact me should you need any further information. I look forward to working with you on this and other matters.

Sincerely yours,

Peter J. Betts, LFACHE
Interim President and CEO

PJB:lc

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 9, 2008

Peter J. Betts, LFACHE
Interim President and CEO
Johnson Memorial Hospital
201 Chestnut Hill Road
Stafford Springs, CT 06076

RE: Certificate of Need Determination; Report Number: 08-31197-DTR
Johnson Memorial Corporation, Johnson Memorial Hospital, Inc. and Johnson Professional Associates, P.C.
Request for Emergency Certificate of Need Regarding the Termination of Behavioral Health Services in Stafford Springs and Enfield

Dear Mr. Betts:

On July 2, 2008, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Johnson Memorial Corporation, Johnson Memorial Hospital, Inc. and Johnson Professional Associates, P.C., (collectively the "Petitioners") , requesting an emergency CON for the termination of behavioral health services in Stafford Springs and Enfield, at no associated capital cost.

Please be advised that OHCA has reviewed your request and makes the following findings:

1. Johnson Memorial Corporation is the parent corporation of the following subsidiaries:
   - Johnson Memorial Hospital, Inc. ("Hospital"), an acute care hospital located at 201 Chestnut Hill Road in Stafford Springs, CT; and
   - Johnson Professional Associates, PC, a provider of behavioral health services offering treatment and counseling for adults with psychiatric disorders at the following locations:
     - Johnson Memorial Hospital, Ground Floor Annex, 201 Chestnut Hill Road, Stafford Springs, CT; and
     - Hazard Trade Mart, Office Suite 4, 151 Hazard Avenue, Enfield, CT.

2. The Hospital states that it " as well as its parent corporation, Johnson Memorial Corporation (the "Network") may be forced to cease operations if it cannot get costs under control and dedicate those savings to the immediate payment of vendors, secured creditors, and otherwise meet critical financial obligations."

3. The Hospital indicates that it is taking steps to mitigate or stop operating/cash losses. To this end, the Hospital proposes the termination of behavioral health services provided through Johnson Professional Associates, PC.

4. The Petitioners' request for an emergency CON specifically includes the following elements:
    a. Termination of behavioral health services provided though Johnson Professional Associates, PC, in Stafford Springs and Enfield, at no associated capital cost: and
    b. Permission to waive the CON Letter of Intent requirement under Section 19a-638(b).

5. A relevant excerpt from Section 19a-638(a)(3) of the Connecticut General Statues ("C.G.S.") states the following:

> *"Each health care facility ...which intends to terminate a health service offered by such facility...shall submit to the office, prior to the date of such termination..., a request to undertake such termination...."*

6. A relevant excerpt from Section 19a-638(b) C.G.S. states the following:

> *"Upon a showing by such facility or institution that the need for such...termination... is of an emergency situation, in that the ...termination...is necessary to maintain continued access to the health care services provided by the facility or institution..., the commissioner may waive the letter of intent requirement, provided that such request shall be submitted at least ten business day before the proposed date of institution of the ...termination...."*

OHCA makes the following determinations in this matter:

a. Pursuant to 19a-638(a)(3) C.G.S., CON authorization is required for the proposed termination of behavioral health services in Stafford Springs and Enfield.

b. Pursuant to 19a-638(b) C.G.S., OHCA deems it appropriate to waive the Letter of Intent for the CON required of the Petitioners regarding the termination of behavioral health services in Stafford Springs and Enfield.

c. Pursuant to 19a-638(b) C.G.S., the 60-day period to file the Petitioners' CON application will be between July 2, 2008, and August 30, 2008.

The CON application will be mailed to the Petitioners under a separate cover letter. If the Petitioners are unable to file the CON application by this date, please contact Jack A. Huber, Health Care Analyst at (860) 418-7034 to provide a status update. Please also feel free to contact him if you have any questions regarding this letter.

Sincerely,

Cristine A. Vogel
Commissioner

CAV:jah

Copy: Rose McLellan License and Applications Supervisor, DPH, DHSR

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3731
RECIPIENT ADDRESS	918606848165
DESTINATION ID	
ST. TIME	07/09 15:37
TIME USE	08'36
PAGES SENT	28
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: **MR. PETER J. BETTS**

FAX: **(860) 684-8165**

AGENCY: **JOHNSON MEMORIAL HOSPITAL**

FROM: **JACK HUBER**

DATE: **7/9/2008** **Time:** **~3:30 pm**

NUMBER OF PAGES: **28**
(including transmittal sheet)

Comments: Please find transmitted:

1. CON Determination Report
2. CON Application Forms

Hard Copies to follow vis US Postal Service
Will also e-mail an electronic version of the documents.

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3733
RECIPIENT ADDRESS	918606848165
DESTINATION ID	
ST. TIME	07/10 09:15
TIME USE	07'07
PAGES SENT	25
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MR. PETER J. BETTS

FAX: (860) 684-8165

AGENCY: JOHNSON MEMORIAL HOSPITAL DN:08-31197

FROM: JACK HUBER

DATE: 7/10/2008 **Time:** ~9:00 am

NUMBER OF PAGES: 24
(including transmittal sheet)

Comments: Please find CON Application Forms transmitted:

Hard Copies to follow via U.S. Postal Service.
Will also e-mail an electronic version of the documents.

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3732
RECIPIENT ADDRESS	918606848165
DESTINATION ID	
ST. TIME	07/10 09:13
TIME USE	01'21
PAGES SENT	4
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MR. PETER J. BETTS

FAX: (860) 684-8165

AGENCY: JOHNSON MEMORIAL HOSPITAL DN: 08-31197

FROM: JACK HUBER

DATE: 7/10/2008 **Time:** ~9:00 am

NUMBER OF PAGES: 4
(including transmittal sheet)

Comments: Please find CON Determination Report transmitted:

Hard Copy of the Report to follow via U.S. Postal Service

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 9, 2008

Peter J. Betts, LFACHE
Interim President and CEO
Johnson Memorial Hospital
201 Chestnut Hill Road
Strafford Springs, CT 06076

RE: Certificate of Need Application Forms, Docket Number: 08-31197-CON
Johnson Memorial Corporation, Johnson Memorial Hospital and Johnson Professional Associates, PC
Termination of Behavioral Health Services in Stafford Springs and Enfield

Dear Mr. Betts:

Enclosed are the application forms for Johnson Memorial Corporation's Certificate of Need ("CON") proposal for the termination of behavioral health services by Johnson Memorial Corporation, Johnson Memorial Hospital and Johnson Professional Associates, P.C., in Stafford Springs and Enfield, with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between July 2, 2008, and August 30, 2008.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

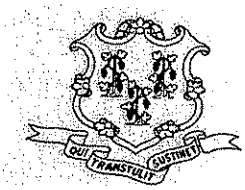
- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefiled testimony, late file submissions, and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The OHCA analyst assigned to the CON application is Jack A. Huber. Please feel free to contact him at (860) 418-7034, 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 a response of "Not Applicable" may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than July 2, 2008, and may be submitted no later than August 30, 2008. The OHCA Analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access at (860) 418-7034.

Docket Number: 08-31197-CON

Applicants Name: Johnson Memorial Corporation
Johnson Memorial Hospital, Inc., and
Johnson Professional Associates, PC

Contact Person: Peter Betts LFACHE

Contact Title: Interim President and CEO

Contact Address: Johnson Memorial Hospital, Inc.
201 Chestnut Hill Road
Strafford Springs, CT 06076

Project Locations: Stafford Springs and Enfield

Project Name: Termination of Behavioral Health Services

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

Estimate Total Capital Expenditure: $ 0

AFFIDAVIT

Applicant: Johnson Memorial Corporation

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Corporation 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: _____

AFFIDAVIT

Applicant: Johnson Memorial Hospital, Inc.

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: _____

AFFIDAVIT

Applicant: Johnson Professional Associates, P.C.

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Facility Name) said facility 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 Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____ DATE INITIAL

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000 or capital expenditure exceeding $3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ $ 1,000.00 b. Additional Fee: (Capital Expenditure Assessment)_____ $_____.00 (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) $_____.00 c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE:_____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

1. Expansion of Existing or New Service

What services are currently offered within your behavioral health program that the proposed termination will affect? Please list.

Terminating: _____
_____
_____
_____

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 behavioral health ("BH") services in Stafford Springs and Enfield, please answer the following:

i) Explain in detail the Applicants' rationale for this termination of BH services. Identify the process undertaken by the Applicants in making the decision to terminate (e.g. was board authorization received, patient feedback solicited, an analysis conducted of transportation issues for patients who will need to travel to other sites for services, etc).

ii) Did the Applicants determine there was no or insufficient public need for the continuation of this program at the Stafford Springs and Enfield sites? Please provide an explanation for each locale.

iii) Are the Applicants being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

iv) Will this termination require the vote of the Board of Directors of each Applicant? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination was discussed and authorized.

B. Provide or answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups, etc.) that are available and provided at the Stafford Springs and Enfield locations. Identify what the hours of operation are for each service location.

ii) List the service area towns for each service location. Provide a rationale for choosing the selected towns for each service location.

iii) Provide the units of service (i.e. clinic visits) for the past three completed fiscal years and fiscal year to date time periods by patient town of origin, for the each service location and in total for the entire service (i.e. both service locations).

iv) Discuss any scheduling backlogs that exist at each service location.

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

vi) Describe the pattern of referrals to each service location.

C. Regarding the impact on the patient and provider community of the proposed termination of BH services, provide the following information for each service location:

a. Explain the procedures that the Applicants will follow in terminating these services and transferring patients to other programs.

b. Describe the other programs that patients will be transferred or referred to, and compare the services offered under these programs to those offered in the BH program.

c. Provide the information as outlined in the following table concerning the existing providers services in each site's 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.

d. Has your facility contacted any other providers in the Stafford Springs and Enfield service areas to see if they are willing and able to absorb the patient population base for displaced patients? Please provide a detailed explanation, including any written agreements or memorandum of understanding between the Applicants and any other facilities as related to the proposal.

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

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

D. 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.

E. 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:

_____

_____

_____

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

5. Quality Measures

A. Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by the applicable Applicant(s) for each service location.

B. 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.

C. 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]

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)_____		

[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.

7. Miscellaneous

A. Will this proposal result in any new 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.

8. Financial Information

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

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

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Do the Applicants have Tax Exempt Status? Identify for each entity.

Johnson Memorial Corporation	☐ Yes	☐ No
Johnson Memorial Hospital	☐ Yes	☐ No
Johnson Professional Associates	☐ Yes	☐ No

C. Verify that this termination of services has not resulted in any capital expenditures or capital costs to either Applicant.

9. Revenue, Expense and Volume Projections

A) Please provide the Johnson Memorial Corporation FY 2007 Finalized Audited Financial Statements and the FY 2007 Finalized Audited Financial Statements of all its subsidiaries and affiliates. The Johnson Memorial Hospital's Finalized Audited Financial Statements must include the Independent Auditor's Agreed-Upon-Procedures Report for the Hospital.

Note: These statements should be externally prepared and submitted on the preparer's letterhead.

B) Provide an unaudited Balance Sheet and Statement of Operation for Johnson Memorial Corporation as of March 31, 2008. Provide the same information for Johnson Memorial Hospital, Inc. and Johnson Professional Associates, P.C.

C) Please provide the current payer mix for the behavioral health service based on actual patient payer mix in the following reporting format:

Total Facility Description	Payer Mix
Medicare*	%
Medicaid* (includes other medical assistance)	
CHAMPUS or TriCare	
Total Government Payers	
Commercial Insurers*	
Uninsured	
Workers Compensation	
Total Non-Government Payers	
Total Payer Mix	100.0%

*Includes managed care activity.

C. Provide the following information for the financial and statistical projections for each service location and in total for Johnson Professional Associates, making sure to account for the projected $400,000 annual cash savings anticipated by the proposed termination:

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, Financial Attachment I, in three parts: Part A. for Stafford Springs; Part B. for Enfield; and Part C. for the sum total representing Johnson Professional Associates.** Please note that Part C. actual results for the fiscal year reported in the first column must agree with the Johnson Professional Associates PC's financial statements.

ii) Please complete the enclosed, OHCA's **Financial Attachment II, Parts A., B., and C.**

iii) Provide 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.).

iv) Provide a discussion of any incremental gains or losses from operations that will be a direct result of the requested termination of the behavioral health services.

D. Provide the following information for the financial and statistical projections for Johnson Memorial Corporation and Johnson Memorial Hospital, making sure to account for the projected $400,000 annual cash savings anticipated by the proposed termination:

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, Financial Attachment III in two parts: Part A for Johnson Memorial Corporation and Part B. for Johnson Memorial Hospital.** Please note that the actual results for the fiscal year reported in the first column must agree with each Applicant's financial statements.

ii) Please complete the enclosed, OHCA's **Financial Attachment IV, Parts A. and B.**

iii) Provide 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.).

iv) Provide a discussion of any incremental gains or losses from operations that will be a direct result of the requested termination of the behavioral health services.

13. B(i). Please provide one year of actual results and three years of projections of S3. site ; 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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$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.

13. B(i). Please provide one year of actual results and three years of projections of Enfield Site 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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$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.

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.

13.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

Year 1	(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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

13.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

Year 1	(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
Total Facility by				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

13.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

Year 1	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Incremental Expenses:				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 NonGovenrment		$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 ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Hospital Health System: 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.

13. B(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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$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.

13.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

Year 1	(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
Total Facility by Payer Category:				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

13.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

Year 1	(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
Total Facility by				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 10, 2008

Peter J. Betts, LFACHE
Interim President and CEO
Johnson Memorial Hospital
201 Chestnut Hill Road
Stafford Springs, CT 06076

Re: Letter of Intent; Docket Number: 08-31197
Johnson Memorial Corporation, Johnson Memorial Hospital and Johnson Professional Associates, P.C.
Termination of Behavioral Health Services by Johnson Professional Associates, P.C.
Notice of Letter of Intent

Dear Mr. Betts:

On July 2, 2008 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Johnson Memorial Corporation, Johnson Memorial Hospital and Johnson Professional Associates, P.C. ("Applicants") for the termination of behavioral health services by Johnson Professional Associates, P.C. in Stafford Springs and Enfield, with no capital expenditure.

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,

Barbara A. Durdy,
Director of Operations

BAD:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 10, 2008

Requisition # HCA09-008
Email: Legals@JournalInquirer.com

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 **Monday, July 14, 2008.**

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 Jack Huber at (860) 418-7034.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Barbara A. Durdy,
Director of Operations

Attachment

BAD:JAH:lmg

c: Sandy Salus, OHCA

Journal Inquirer
Docket Number 08-31197

Letter of Intent
July 10, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicants:	Johnson Memorial Corporation, Johnson Memorial Hospital and Johnson Professional Associates, P.C.
Towns:	Stafford Springs and Enfield
Docket Number:	08-31197-LOI
Proposal:	Termination of Behavioral Health Services by Johnson Professional Associates, P.C.
Capital Expenditure:	$0

The Applicants may file its Certificate of Need application between July 2, 2008 and August 30, 2008. 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 Applicants.

Greer, Leslie

From: postmaster@journalinquirer.com
Sent: Thursday, July 10, 2008 4:26 PM
To: Greer, Leslie
Subject: Message delivered (legals@journalinquirer.com)

Attachments: DSN48767056.txt; ATT3644290.dat


DSN48767056.txt (363 B)


ATT3644290.dat (1 KB)

Your message has been delivered to the following recipient(s):

legals
(Was addressed to legals@journalinquirer.com) Message delivered

Greer, Leslie

From: legals@journalinquirer.com
Sent: Friday, July 11, 2008 10:26 AM
To: Greer, Leslie
Subject: RE: Legal Ad 08-31197

Good Morning Leslie,

Pretty day out there, am so glad it's Friday.

Your legal is set to run for the 14th and the cost is $118.05.

Thanks and have a good weekend
Sandy
Classified Dept.

---- Original Message ----
From: Leslie.Greer@ct.gov
To: legals@JournalInquirer.com
Subject: Legal Ad 08-31197
Date: Thu, 10 Jul 2008 15:23:50 -0400

>Legal Ad,
>
>Please run the attached public notice in your newspaper no later than
>Monday, July 14, 2008. Please notify me that you have received this
>request.
>
>
>
>Thank you,
>
>
>
>Leslie M. Greer
>
>Office of Health Care Access
>
>State of Connecticut
>
>410 Capitol Avenue
>
>Hartford, CT 06134
>
>Phone: (860) 418-7001
>
>Fax: (860) 418-7053
>
>Website: www.ct.gov/ohca <http://www.ct.gov/ohca>