STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 11, 2008

Peter J. Betts, LFACHE
Interim President and CEO
Johnson Memorial Corporation
201 Chestnut Hill Road
Stafford Springs, CT 06076-0860

Peter Karl
President and CEO
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040-4188

RE: CON Application Forms; Docket Number: 08-31228-CON
Johnson Memorial Corporation and Eastern Connecticut Health Network, Inc.
Change in Ownership Through the Sale of Assets of Johnson Memorial Corporation and its Affiliates from Johnson Memorial Corporation to Eastern Connecticut Health Network, Inc.

Dear Gentlemen:

Enclosed are the application forms for Johnson Memorial Corporation's and Eastern Connecticut Health Network, Inc.'s (collectively the "Applicants") Certificate of Need ("CON") proposal for a change of ownership through the sale of assets of Johnson Memorial Corporation and its affiliates from Johnson Memorial Corporation to Eastern Connecticut Health Network, Inc. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between September 2, 2008, and November 1, 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, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicants' 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 analysts assigned to the CON application are Laurie Greci, Jack A. Huber and Tillman Foster. Please feel free to contact the analysts at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone /mk.
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 considered an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than September 2, 2008, and may be submitted no later than November 1, 2008. The OHCA Analysts assigned to your application are Jack A. Huber and Laurie Greci, covering programmatic and governance matters, and Tillman Foster, covering financial matters. The analysts may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	08-31228-CON	
Applicant Names:	Johnson Memorial Corporation and Eastern Connecticut Health Network, Inc.	
Contact People:	Peter Betts LFACHE Interim President and CEO	Peter Karl President and CEO
Contact Address:	Johnson Memorial Corporation 201 Chestnut Hill Road Strafford Springs, CT 06076-0860	Eastern Connecticut Health Network 71 Haynes Street Manchester, CT 06040-4188
Project Location:	Stafford Springs and Enfield	
Project Name:	A Change of Ownership through the Sale of Assets of Johnson Memorial Corporation and its Affiliates from Johnson Memorial Corporation to Eastern Connecticut Health Network, Inc.	
Proposal Type:	Section 19a-638, C.G.S.	

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

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, or 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 $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) 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).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE: _____	$_____.00

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

AFFIDAVIT

Applicant: Johnson Memorial Corporation

Project Title: _____

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

of _____ being duly sworn, depose and state that
(Corporation Name)

the 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: Eastern Connecticut Health Network, Inc.

Project Title: _____

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

of _____ being duly sworn, depose and state
(Network Name)

that the 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

Project Title: _____

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

of _____ being duly sworn, depose and state that
(Hospital Name)

the 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: Manchester Memorial Hospital

Project Title: _____

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

of _____ being duly sworn, depose and state that
(Hospital Name)

the 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: Rockville General Hospital

Project Title: _____

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

of _____ being duly sworn, depose and state that
(Hospital Name)

the 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: _____

1. Health Care Services

A. What health services currently offered under the Johnson Memorial Corporation umbrella will be affected either through some type of service modification or service termination by the proposed asset purchase agreement with Eastern Connecticut Health Network?

B. What health services currently offered under the Johnson Memorial Corporation umbrella will remain unaffected by the proposed asset purchase agreement with Eastern Connecticut Health Network?

C. What health services currently offered under the Eastern Connecticut Health Network will be affected by the proposed asset purchase agreement?

D. What health services currently offered under the Eastern Connecticut Health Network will remain unaffected by the proposed asset purchase agreement?

E. With respect to the proposed asset purchase agreement, what health services not currently offered under the Johnson Memorial Corporation umbrella will be incorporated into the service line from services offered by Eastern Connecticut Health Network?

F. Identify any proposed changes in the number of licensed inpatient beds by inpatient service for Johnson Memorial Hospital, Manchester Memorial Hospital and Rockville General Hospital.

2. Hospital Service Utilization

A. For the most recently completed 11-months of fiscal year 2008 (i.e. through August 31, 2008), please provide the inpatient service utilization in the format presented below for each of the following hospitals:

1. Johnson Memorial Hospital;
2. Manchester Memorial Hospital; and
3. Rockville General Hospital.

Inpatient Service Utilization Statistics

Inpatient Services	Patient Days	Discharges	ALOS	Staffed Beds	Occupancy Staffed Beds %*	Average Daily Census**
Medical/Surgical***						
ICU/CCU****						
Exempt Psychiatric						
Maternity						
Newborn						
Neonatal ICU						
Exempt Rehabilitation						
Pediatric****						

Long Term Care						
Alcohol/Drug Trtmt.						
Other						
Total Excl. Newborn						
Total Inpatient						

Note: *Defined as (patient days /365days x # staffed or licensed beds)
** Defined as (patient days / 365 days
***Excludes ICU/CCU and Pediatric days and discharges
****Excluded from Medical / Surgical

B. For fiscal years ("FYs") 2006 through 2008, please provide the average daily total inpatient census numbers for each day by month in the format presented below for each of the following Hospitals:

1. Johnson Memorial Hospital;
2. Manchester Memorial Hospital; and
3. Rockville General Hospital.

Average Daily Total Inpatient Census Numbers

Average Daily Total Inpatient Census Numbers	**FY 2006 Actual**		**FY 2007 Actual**		**FY 2008 11 months Actual**
October 1					
2					
3....					
31					
November 1					
2					
3...					
30					
December 1					
2					
3.....					
31					
Etc., with the Remaining Months & Days in the Fiscal Year					

Note: Each day within a given FY is to be reflected as a separate line in the table.

C. For FYs 2006 through 2008, please provide the average daily medical-surgical inpatient census numbers for each day by month and year in the format presented below for each of the following hospitals:

1. Johnson Memorial Hospital;
2. Manchester Memorial Hospital; and
3. Rockville General Hospital.

Average Daily Medical-Surgical Inpatient Census Numbers

Average Daily M/S Inpatient Census Numbers	**FY 2006 Actual**		**FY 2007 Actual**		**FY 2008 Actual**
October 1					
2					

3....					
31					
November 1					
2					
3...					
30					
December 1					
2.....					
31					
Etc., with the Remaining Months & Days in the Fiscal Year					

Note: Each day within a given FY is to be reflected as a separate line in the table.

D. For the most recently completed 11-months of fiscal year 2008 (i.e. through August 31, 2008), please provide the outpatient service utilization in the format presented below for each of the following hospitals:

1. Johnson Memorial Hospital;
2. Manchester Memorial Hospital; and
3. Rockville General Hospital.

Outpatient Service Utilization Statistics

Outpatient Services	**FY 2008 11 Months Actual**
Description	**# Visits**
Hospital Emergency Room Visits	
Emergency Room: Treated and Admitted	
Emergency Room: Treated and Discharged	
Total Hospital Emergency Room Visits	
Hospital Clinic Visits	
Substance Abuse Treatment Clinic	
Dental Clinic	
Psychiatric Clinics	
Medical Clinic	
Specialty Clinic	
Total Hospital Clinic Visits	
Other Hospital Outpatient Visits	
Rehabilitation (PT/OT/ST)	
Cardiac Rehabilitation	
Chemotherapy	
Gastroenterology	
Other Outpatient	
Total Other Hospital Outpatient Visits	
Total Hospital Outpatient Visits	

3. State Health Plan

No questions at this time.

4. Long Range Plans of the Applicants

A. Please submit a copy of the long range plan or the strategic plan for:
   1. Eastern Connecticut Health Network, Inc.;
   2. Manchester Memorial Hospital; and
   3. Rockville General Hospital.

B. Beginning September 1, 2008, provide a timetable in gant chart format illustrating the major steps with associated dates of the proposal concentrating on the periods prior to the proposed sale of Johnson Memorial Corporation and after the completion of the integration of Johnson Memorial Corporation into the Eastern Connecticut Health Network.

C. Provide relevant excerpts from each Applicant's Board of Trustees meeting minutes, verifying their approval of the proposal.

D. Describe the interaction that has taken place between each Applicant and their respective medical staff officers, boards and physician groups in the formulation of the proposal.

E. Provide evidence of acceptance from each Applicant's medical staff officers, boards and physician groups verifying their approval of the proposal.

F. Describe the interaction that has taken place between each Applicant and their respective community leaders with respect to the proposal.

G. Provide any evidence of acceptance from the respective community leaders regarding their support of the proposal.

5. Clear Public Need

A. Explain how it was determined that there was a need for this proposal.

B. Provide a copy of any independent assessment of the financial condition of Johnson Memorial Corporation completed in preparation of this proposal.

C. Provide copies of any market share analyses and public information reports for Johnson Memorial Eastern Connecticut Health Network related to the proposal:

D. Provide a list of the primary and secondary service area towns for the health services originating under the Johnson Memorial Corporation umbrella. Provide a rationale for choosing the selected towns.

E. Provide a list of the primary and secondary service area towns for the health services originating under the Eastern Connecticut Health Network umbrella. Provide a rationale for choosing the selected towns.

F. Provide a list of the primary and secondary service area towns for each of the hospitals identified below as well as a rationale for choosing the selected towns.

1. Johnson Memorial Hospital;
2. Manchester Memorial Hospital; and
3. Rockville General Hospital.

G. Identify other existing providers of health care services (i.e. home health care, long term care emergency medical, urgent care , primary care, etc.) in the combined service area created in response to question 4.D. above. Describe how the proposal will affect these existing health care providers.

H. 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 "None of the above" is checked, please provide an explanation.

6. Quality Measures

A. Describe in detail how the proposal will impact the quality of care in each of the Applicant service areas.

B. Explain how the proposal will affect the delivery of patient care in each of the Applicant service areas.

C. Submit a list of **all** key Johnson Memorial Corporation and Eastern Connecticut Health Network, Inc., professional and administrative personnel, including the Chief Executive Officers (CEO), Chief Financial Officers (CFO) and other administrative offices, etc., involved in the proposal and submit a copy of each individual's Curriculum Vitae.

D. Submit a list of **all** key hospital professional and administrative personnel, including the Chief Executive Officers (CEO) and Chief Financial Officers (CFO), Medical Directors, physicians, etc., involved in the proposal from Johnson Memorial Hospital, Manchester Memorial Hospital and Rockville General Hospital. Also submit a copy of each individual's 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 Johnson Memorial Hospital, Manchester Memorial Hospital and Rockville General Hospital:

☐ DPH ☐ JCAHO

☐ Fire Marshall Report ☐ Other States Health Dept. Reports (new out-of-state providers)

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

F. As applicable, provide a copy of the following documents for Johnson Memorial Hospital, Manchester Memorial Hospital and Rockville General Hospital:

☐ A copy of the related Quality Assurance plans.

☐ Protocols for new services proposed.

☐ Patient selection criteria/intake forms, if any new service is proposed.

7. Improvements to Productivity and Containment of Costs

A. In the past year have Johnson Memorial Corporation and affiliates 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.

B. In the past year have Eastern Connecticut Health Network and affiliates 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)_____

C. With respect to Johnson Memorial Corporation and affiliates, identify any productivity improvements that Eastern Connecticut Health Network plans to implement regarding the proposal.

8. Miscellaneous

A. Will this proposal result in any new change to the teaching or research responsibilities of Johnson Memorial Hospital, Manchester Memorial Hospital or Rockville General Hospital?

☐ Yes ☐ No

If "Yes" is checked, please provide an explanation for each applicable hospital.

B. Are there any characteristics of the patient/physician mix at Johnson Memorial Hospital, Manchester Memorial Hospital or Rockville General Hospital that makes the proposal unique?

☐ Yes ☐ No

If "Yes" is checked, please provide an explanation for each applicable hospital.

C. Provide the following licensing information for Johnson Memorial Hospital, Manchester Memorial Hospital and Rockville General Hospital and any of their health care affiliates:

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

2. The DPH licensure category you are seeking, if different from the above.

3. If not applicable, please explain why.

9. Affiliations, Mergers, Acquisitions and Changes in Ownership

A. As referenced in the Applicants' September 2, 2008 letter to OHCA, provide a copy of the signed "Letter of Intent" describing the proposed transaction between the Applicants.

B. What is the anticipated outcome of the proposed transaction as it relates to Johnson Memorial Corporation and affiliates new organizational structure? Will the Johnson Memorial Corporation and affiliates be absorbed into the Eastern Connecticut Health Network or will the Johnson Memorial Corporation and affiliates retain status as a separate entity. Please explain how Johnson Memorial Corporation and affiliates will be reflected in the Eastern Connecticut Health Network structure. Provide a projected corporate chart of organization for the Eastern Connecticut Health Network, which reflects the proposed change.

C. Provide a copy of the asset purchase agreement between the Applicants.

Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

D. Provide a copy of any other written contracts, agreements or memorandums of understanding between the Applicants and/or their various related subsidiaries.

Note: If a final version is not available, provide a draft of each document with an estimated date by which the final contract, agreement or memorandum will be available.

E. What existing and new hospital-related contractual arrangements with managed care companies will have to be renegotiated and/or re-executed?

F. Document by type and location any existing and/or new hospital-related contractual arrangements (i.e. for medical equipment and/or imaging equipment leases or purchases) with vendors. Identify all contractual arrangements that will have to be renegotiated and/or re-executed?

G. Identify the following items for the health care entities within the Johnson Memorial Corporation:

1. Medical staff composition.
2. Physician referral patterns for only the services that are expected to change due to the proposal.
3. Corporate or subsidiary structural relationships.
4. Shared service arrangements (e.g., health services, group purchasing, billing etc.).

H. Identify the following items for health care entities within the Eastern Connecticut Health Network:

1. Medical staff composition.
2. Physician referral patterns for only the services that are expected to change due to the proposal.
3. Corporate or subsidiary structural relationships.
4. Shared service arrangements (e.g., health services, group purchasing, billing etc.).

I. Describe the current medical staff organization at Johnson Memorial Hospital. In addition identify the following:

1. The degree to which the Johnson Memorial Hospital medical staff is currently integrated into the Eastern Connecticut Health Network medical staff organization;
2. The anticipated degree of further integration of the Johnson Memorial Hospital medical staff into the Eastern Connecticut Health Network medical staff organization.

J. Provide for Johnson Memorial Hospital, Manchester Memorial Hospital and Rockville General Hospital the following information:

1. Articles of Incorporation, Articles of Organization or Partnership Agreements (all that are appropriate).
2. Legal chart of corporate or entity structure.
3. Board of Directors or governing body resolutions approving the proposal.
4. Current and proposed percentage of ownership.
5. Changes in legal status.
6. Changes in membership of board of directors or governing body.
7. Changes in independence of board of directors or governing body.
8. Changes in facility licensed beds, health care services, service areas, locations and management.
9. Medicare provider number.

10. Financial Information

A. Type of ownership for Johnson Memorial Corporation and its affiliates. Please identify each entity under its appropriate category.

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

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Type of ownership for Eastern Connecticut Health Network and its affiliates. Please identify each entity under its appropriate category.

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

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

C. Do the following entities have Tax Exempt Status? Identify for each entity.

Johnson Memorial Corporation	☐ Yes	☐ No
Johnson Memorial Hospital	☐ Yes	☐ No
Eastern Connecticut Health Network	☐ Yes	☐ No
Manchester Memorial Hospital	☐ Yes	☐ No
Rockville General Hospital	☐ Yes	☐ No

D. Provide the following financial information:

1. Provide the latest cash equivalent balance for each of the aforementioned entities in 10. D. 1. above, as of the date of submission of this application.

2. Provide a copy of the most recently completed 11-months internal monthly financial statements through August 31, 2008 including balance sheet and statement of operations for each of the aforementioned entities in 10. D. 1. above.

11. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	$
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:	
Total Capital Expenditure	$
Medical Equipment (Lease (FMV))	$
Imaging Equipment (Lease (FMV)	

Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	**$**
Capitalized Financing Costs	
Total Capital Expenditure with Cap. Fin. Costs	$

B. Provide an itemization and associated narrative of the costs within each cost category identified in the table above.

12. Type of Financing

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

☐ Applicant 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:

1. Letter of interest from the lending institution.
2. Letter of interest from CHEFA.
3. Amortization schedule (if not level amortization payments).
4. Lease agreement.

13. **Revenue, Expense and Volume Projections**

A. Payer Mix Projections

Please provide Johnson Memorial Hospital's, Manchester Memorial Hospital's and Rockville General Hospital's 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 or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

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

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

1. Provide a summary of revenue, expense and volume statistics, without the CON proposal, incremental to the CON proposal, and with the CON proposal for the following entities:

    a. Johnson Memorial Corporation;
    b. Johnson Memorial Hospital;
    c. Eastern Connecticut Health Network;
    d. Manchester Memorial Hospital; and
    e. Rockville General Hospital

    Please see Financial Attachment I included in the CON forms package. Please note that the actual results for the fiscal year reported in the first column must agree with each entity's audited financial statements.

2. Provide the assumptions utilized in developing the projections for each entity (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, proposal commencement of operation date, etc.).

3. For the current (i.e. CFY) and first three full fiscal years (i.e. FY 1, FY 2 and FY 3) following the completion of the proposed transaction, provide the number of Hospital full time equivalents in the format presented below for the following entities: the successor to Johnson Memorial Hospital, Manchester Memorial Hospital and Rockville General Hospital.

Hospital Full Time Equivalents

Description	CFY	FY 1	FY 2	FY 3
Total Nursing FTEs				
Total Physician FTEs				
Total Non-Nursing & Non-Physician FTEs				
Total Hospital Full Time Equivalents				

4. Provide 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.

5. What will be the status going forward regarding Johnson Memorial Hospital's and Johnson Memorial Corporation's temporarily and permanently restricted net assets?

6. Provide a copy of the proposed Pricemaster/Chargemaster for Johnson Memorial Hospital, Manchester Memorial Hospital and Rockville General Hospital following Johnson Memorial Corporation's acquisition and integration into Eastern Connecticut Health Network.

7. Provide a copy of any "turn-around plan" which Eastern Connecticut Health Network has in place concerning Johnson Memorial Corporation's current financial position.

8. Provide a copy of Eastern Connecticut Health Network's transition plan for assuming Johnson Memorial Corporation and affiliates.

9. Describe how this proposal is cost effective.

10. Describe how the proposal will best serve the interests of residents in the defined service area.

13. C. 1. Please provide one year of actual results and three years of Johnson Memorial Corporation 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 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. 1. Please provide one year of actual results and three years of Johnson Memorial Hospital 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 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. 1. Please provide one year of actual results and three years of Eastern Connecticut Health Network 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 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. 1. Please provide one year of actual results and three years of Manchester Memorial Hospital 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 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. 1. Please provide one year of actual results and three years of Rockville General Hospital 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 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.