March 22, 2010

Commissioner of the Office of Health Care Access
410 Capital Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Commissioner:
Please find attached Letter of Intent Form for Blue Sky Addictions Clinic which is proposed to be located in Danbury, Connecticut. Please feel free to contact me at (845) 406-8479 with any questions that you may have. My mailing address is: 3 Sand Road New Milford, CT 06776.

Sincerely yours,

David Palmer- CEO Blue Sky Behavioral Health, LLC

State of Connecticut
Office of Health Care Access
Letter of Intent Form
Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 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. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	Blue Sky Behavioral Health, LLC	
Doing Business As	Blue Sky Addictions Clinic	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	Blue Sky Behavioral Health, LLC C/O David Palmer 3 Sand Road New Milford,CT 06776	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	No	No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	David Palmer- CEO/Manager	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	David Palmer 3 Sand Road New Milford, CT 06776	
Contact Person Telephone Number	(845)406-8479	
Contact Person Fax Number	(845)279-7678	

Contact Person e-mail Address	djpalmer@sbcglobal.net	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: __Blue Sky Behavioral Health,LLC_____

b. Project Proposal: _Outpatient Clinic(psychiatrist, therapeutic groups, individual therapy sessions) and Substance Abuse Outpatient Clinic(CASAC certified staff) offering drug/alcohol counseling._____

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity

☐ Trauma Center ☐ Transplantation Programs

☐ Rehabilitation *(specify type)* _____

☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)

☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology

☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care

☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility

XX☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)

☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner

☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator

☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations

☐ Change in Ownership or Control XX☐ Land and/or Building Acquisitions

☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)

☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☐ Yes XX☐ No

If you checked "Yes" above, please check the appropriate box below:

☐ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service

☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☐ No

If you checked "Yes" above, please check the boxes below, as appropriate:

☐ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

f. Location of proposal, identifying Street Address, Town and Zip Code:

___2 Glen Hill Road Danbury, Ct 06810

g. List each town this project is intended to serve:

_____Potential referrals from all of Connecticut._____

h. Estimated starting date for the project: _10/1/10_____

i. If the proposal includes change in the number of beds provide the following information:N/A

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $_____

b. Please provide the following tentative capital expenditure/costs related to the proposal:

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	$100,000
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☐ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the vendor contract or quotation for each major medical/imaging equipment.

e. Type of financing or funding source (more than one can be checked):

XX☐ Applicant's Equity	XX☐ Capital Lease	☐ Conventional Loan
☐ Charitable Contributions	☐ Operating Lease	☐ CHEFA Financing
☐ Funded Depreciation	☐ Grant Funding	
☐ Other *(specify)* _____		

SECTION IV. PROJECT DESCRIPTION

In paragraph format, 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 items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

2. List the types of services 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 any unmet need and describe how this project will fulfill that need.

5. Are there any similar existing service providers in the proposed geographic area?

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that _____ 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.
(Facility Name)

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____

Section IV. Blue Sky Addictions Clinic

1) The types of services that will be provided are as follows: individual and group therapy services by licensed clinicians, psychiatrist services, drug and alcohol counseling by CASAC certified staff.

2)The types of services being proposed are: individual and group therapy by licensed clinicians, nursing services, psychiatrist services, and drug and alcohol counseling services. Blue Sky Addictions Clinic would apply for the following Department of Public Health categories: Outpatient Clinic(with Substance Abuse included).

3) Population to be served would be individuals 18 years of age and older with an addiction disorder who may have a co-occurring psychiatric disorder.

4) The unmet need in the State of Connecticut is a private treatment facility for the treatment of adults with an addiction disorder who may also have a co-occurring psychiatric disorder. The large majority of treatment facilities in the State of Connecticut are State funded, adolescent in nature and to not address the addiction disorder combined with the co-occurring psychiatric disorder. Most facilities in the State of Connecticut, primarily focus on either the treatment of one or the other(substance abuse or psychiatric disorder) but not both within a given individual's treatment. Blue Sky Addictions Clinic would offer one location for the treatment of these disorders which often occur in conjunction with one another.

5) There are a limited number of programs in the proposed geographic area, but none of these facilities appears to offer the scope of services that Blue Sky Addictions Clinic would offer. An all-inclusive outpatient facility that has various health care professionals such as a psychiatrist, therapists, nurses, job coaches, teachers and CASAC staff all in one location. This scope includes: adult population(18 years and older), treatment of dually diagnosed population, special focus on personality disorders, longer term DBT and CBT curriculum tracks than similar programs. Blue Sky Addictions Clinic will take a recovery management approach. This approach is essential for people with complex and persistent behavioral health disorders. To help facilitate this, Blue Sky Addictions Clinic plans to develop a private, secure social support network on the web for the people who finish its clinic program. The network will provide support, self-help and counselor advice via the internet as well as counselor telephone support for an indefinite period of time.

6) The anticipated effect of this proposal(if approved) on the health care delivery services in the State of Connecticut would be immediate, relevant and long lasting. The all inclusive nature would include comprehensive treatment unlike any other treatment facility currently existing in the state. All of the various services: therapy, psychiatry, nursing, long term DBT track, CASAC counselors, job coaches and educational support would all be housed in one location for the optimal delivery of services. State of

Connecticut residents in need of these services would be able to receive these services in state where they could be close to family supports while in treatment.

7) Blue Sky Addictions Clinic would be responsible for providing these services. David Palmer would be CEO/Manager of Blue Sky Addictions Clinic.

8)The current payers of service are individuals and their families in need of comprehensive behavioral health services that hospitals and other treatment facilities in the area don't have the length of time available to provide long term comprehensive care to the dually diagnosed behavioral health population. Treatment would be paid privately(out of pocket) by members and their families and my member and their families' insurance plans.

April 6, 2010

Commissioner of the Office of Health Care Access
410 Capital Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Commissioner:
Please find attached two attached affidavit for the (2) form 2030's that I sent to your office on March 22, 2010. When the 2 forms were sent to your office, I had forgotten to fill out the affidavit on each. One affidavit is for Tollgate Residential Treatment Center and the other affidavit is for Blue Sky Addictions Clinic. Please feel free to contact me at (845) 406-8479 with any questions.

Sincerely yours,

David Palmer- CEO Blue Sky Behavioral Health, LLC

AFFIDAVIT

To be completed by each Applicant

Applicant: David Palmer

Project Title: Blue Sky/Addictions Clinic

I, David Palmer (Name), CEO (Position – CEO or CFO)

of Blue Sky/Behavorial Health, LLC being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that Blue Sky/Addictions Clinic (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.

D J Pal — Signature

4/6/10 — Date

Subscribed and sworn to before me on April 6, 2010

Betsy Bergman

Notary Public/Commissioner of Superior Court

My commission expires: 7/31/13

BETSY BERGMAN
NOTARY PUBLIC
REG. #01BE4736701
VALID 7/31/09 - 7/31/13

RECEIVED
2010 APR -7 P 12:34
CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
HEALTHCARE ACCESS

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 19, 2010 Facsimile Only

David Palmer
Blue Sky Behavioral Health, LLC
3 Sand Road
New Milford, CT 06776

Re: Letter of Intent; Docket Number: 10-31574
Blue Sky Behavioral Health, LLC
Establish a Psychiatric Outpatient Treatment Facility for Adults and a Substance Abuse Outpatient Treatment for Adults Facility in Danbury

Dear Mr. Palmer,

On April 7, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Blue Sky Behavioral Health, LLC ("Applicant") to establish a Psychiatric Outpatient Treatment Facility for adults and a Substance Abuse Outpatient Treatment for adults in Danbury, with a total associated capital expenditure of $100,000.

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

Sincerely,

Kimberly Martone (KR)

Kimberly R. Martone
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 19, 2010 Requisition # 31099

The News Times
333 Main Street
Danbury, CT 06810

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 **Friday, April 24, 2010.**

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 or Alexis Fedorjaczenko at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly Martone (KE)

Kimberly R. Martone
Director of Operations

Attachment

KRM:PF:AF:lmg

c: Danielle Pare, DPH

The News Times **Letter of Intent**
Docket Number: 10-31574 **April 19, 2010**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Blue Sky Behavioral Health, LLC
Town:	Danbury
Docket Number:	10-31574-LOI
Proposal:	Establish a Psychiatric Outpatient Treatment Facility for adults and a Substance Abuse Outpatient Treatment for adults facility in Danbury
Capital Expenditure:	$100,000

The Applicant may file its Certificate of Need application between June 6, 2010 and August 5, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 410 Capitol Avenue, MS13HCA, P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available at OHCA or on OHCA's website at www.ct.gov/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 ***
****

TRANSMISSION OK

TX/RX NO	1468
RECIPIENT ADDRESS	918452797678
DESTINATION ID	
ST. TIME	04/20 11:41
TIME USE	00'30
PAGES SENT	4
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: **DAVID PALMER**

FAX: **(845) 279-7678**

AGENCY: **BLUE SKY BEHAVIORAL HEALTH, LLC**

FROM: **PAOLO FIDUCIA**

DATE: **4/20/10** **TIME:**

NUMBER OF PAGES: **4**
(including transmittal sheet

Comments: Docket 10-31574

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Tuesday, April 20, 2010 10:49 AM
To: Greer, Leslie
Subject: Re: Legal Ads10-31574 & 10-31575

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061
E-mail: ads@graystoneadv.com
http://www.graystoneadv.com/

On 4/20/10 10:38 AM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached public notices in following newspapers:
>
> The News Times 10-31574
> The Register Citizen 10-31575
>
> For billing refer to requisition 31099 for both notices, if you have any questions feel free to call me.
>
> Thank you,
>
> Leslie M. Greer
> Office of Health Care Access
> A Division of Department of Public Health
> State of Connecticut
> 410 Capitol Avenue, MS#13HCA
> Hartford, CT 06134
> Phone: (860) 418-7001
> Fax: (860) 418-7053
> *Website: www.ct.gov/ohca* <http://www.ct.gov/ohca>
> Please consider the environment before printing this message

Greer, Leslie

From: Laurie [Laurie@graystoneadv.com]
Sent: Tuesday, April 20, 2010 4:02 PM
To: Greer, Leslie
Subject: FW: Legal Ads10-31574 & 10-31575
Attachments: 10-31574 News Times.doc; 10-31575 Register Citizen.doc

Your legal notices are all set to run as follows:

Danbury News Times (10-31574), 4/24 issue - $283.83
Torrington Register Citizen (10-31575), 4/24 issue - $148.67

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, Fax: 203-549-0061
email: laurie@graystoneadv.com
www.graystoneadv.com

------ Forwarded Message
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Tue, 20 Apr 2010 10:38:53 -0400
To: ads <ads@graystoneadv.com>
Conversation: Legal Ads10-31574 & 10-31575
Subject: Legal Ads10-31574 & 10-31575

To Whom It May Concern,
Please run the attached public notices in following newspapers:

The News Times	10-31574
The Register Citizen	10-31575

For billing refer to requisition 31099 for both notices, if you have any questions feel free to call me.

Thank you,

Leslie M. Greer
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7001
Fax: (860) 418-7053
Website: www.ct.gov/ohca <http://www.ct.gov/ohca>
Please consider the environment before printing this message

------ End of Forwarded Message

------ End of Forwarded Message

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 23, 2010 via fax and email only

David Palmer
Chief Executive Officer/Manager
Blue Sky Behavioral Health, LLC
3 Sand Road
New Milford, CT 06776

RE: Certificate of Need Application Forms; Docket Number: 10-31574-CON
Blue Sky Behavioral Health, LLC
Establish a Psychiatric Outpatient Treatment Facility for Adults and a Substance Abuse Outpatient Treatment Facility for Adults in Danbury

Dear Mr. Palmer:

Enclosed are the application forms for Blue Sky Behavioral Health, LLC Certificate of Need ("CON") proposal to establish a psychiatric outpatient treatment facility for adults and a substance abuse outpatient treatment facility for adults in Danbury, with a total associated capital expenditure of $100,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between June 6, 2010 and August 5, 2010.

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 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 analysts assigned to the CON application are Paolo Fiducia and Alexis Fedorjaczenko. Please contact the analysts at (860) 418-7001 if you have questions.

Sincerely,

Kaila Riggott

Kaila Riggott
Planning Specialist

Enclosures

State of Connecticut
Department of Public Health
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 June 6, 2010, and may be submitted no later than and August 5, 2010. The Analysts assigned to your application are Paolo Fiducia and Alexis Fedorjaczenko may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	10-31574-CON
Applicant(s) Name:	Blue Sky Behavioral Health, LLC
Contact Person:	David Palmer
Contact Title:	Chief Executive Officer/manager
Contact Address:	Blue Sky Behavioral Health, LLC 3 Sand Road New Milford, CT 06776
Project Location:	Danbury
Project Name:	Establish a Psychiatric Outpatient Treatment Facility for Adults and a Substance Abuse Outpatient Treatment for Adults in Danbury
Type proposal:	Section(s) 19a-638, C.G.S.
Est. Capital Expenditure:	$100,000

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

ii. The service area towns and the basis for their selection;

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

iv. How and where the proposed patient population is currently being served;

v. All existing providers (name, address, services provided) of the proposed service in the towns listed above and in nearby towns; and

vi. The effect of the proposal on existing providers.

2. Projected Volume

a. Complete the following table for the first three fiscal years ("FY") of the proposed service.

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY****	FY****	FY****	FY****
Service type***				
Total				

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

c. Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.

d. Provide a copy of any articles, studies, or reports that support the statements made in this application justifying need for the proposal, along with a brief explanation

regarding the relevance of the selected articles.

3. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how this proposal contributes to the quality of health care delivery in the region.

c. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services

d. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

4. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

d. Financial Statements

i. <u>If the Applicant is a Connecticut hospital:</u> 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 hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

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

Table 2: Proposed Capital Expenditures/Costs

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

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross sq. feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

f. List all funding or financing sources for the proposal, and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Revenues, Expenses, and Patient Population Projections

a. Patient Population Mix

i. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for the proposed program.

Table 3: Patient Population Mix

	Current FY ***	**Year 1 FY *****	**Year 2 FY *****	**Year 3 FY *****
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** New programs may leave the "current" column blank.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

ii. Provide the basis for/assumptions used to project the patient population mix.

b. Financial Attachments I & II

i. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

ii. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

iii. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iv. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

v. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

vi. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

vii. Describe how this proposal is cost effective.

6. Other Review Criteria

a. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
   i. Voluntary efforts to improve productivity and contain costs;
   ii. Changes to the Applicant's teaching or research responsibilities; and/or
   iii. Special characteristics of the Applicant's patient or physician mix.

GENERAL AFFIDAVIT

Applicant: _____

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: _____	FOR OHCA USE ONLY:	DATE	INITIAL
PROJECT TITLE: _____	1. Check logged (Front desk)	_____	_____
DATE: _____	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: _____	$ 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)

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		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	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 NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

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.

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

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DAVID PALMER

FAX: 845 279 7678

AGENCY: BLUE SKY BEHAVIORAL HEALTH, LLC

FROM: PAOLO FIDUCIA

DATE: 4/23/10 **TIME:** 10:15 AM

NUMBER OF PAGES: 23
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Comments:

10-31574-CON, 10-31575-CON

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10-31574

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Spring Positions
$18.50 base/appt
Part-time work, flex sched, all majors, sales/service, no exp nec, all ages 17+, cond. apply, Call Today! 203-762-9992

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Sales positions are rarely available! We have an opening for a talented individual to sell both new & certified pre owned vehicles. Terrific incentive package including a generous salary & commission. Please contact Charles Monaco for an interview appt.
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BURNER SERVICE TECH needed. Must have B2 or S1 license. Plse call Dave or Julie 203-731-4397 or 203-401-9840

CABINET MAKER Exp pref'd. Good working cond., benefits. Easy access 95-15-84. 203-261-4315; Fax 203-261-4882.

CARETAKER - FT Hands-on/Live-out Private Estate. Landscape Maint/Handyman work. Fax 860-350-4182.

GENERAL HELP WANTED

CHILD CARE
By state law, providers must be licensed

CLEANER/HOUSEKEEPER for Ridgefield family. Duties incl: house cleaning, laundry, after-school driving for kids, errands & occasional cooking/baking. 3 days/wk, 8am-6pm. Must be legal to work in U.S. Valid drivers license. Clear English language. Looking for "Alice" to help our active family! $22/hr. Fax resume/inquiries: 203-431-8339.

COMPANION needed for elderly woman in Ridgefield. Live-in. 24x7 M-F Must have car, refs. & speak English. CNA's welcome. 203-240-1061.

CONSTRUCTION
Material Inspector
We offer full training & rewarding pay to the right people. Call for interview 203-743-7261. EOE.

CONSTRUCTION LABORER with experience in concrete curbs/walks 203-874-1228 EOE

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Call Mon - Thurs at Orange 203-795-6035 or Trumbull 203-502-8350

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GENERAL HELP WANTED

FACTORY WORK Seeking individual to work F/T in small manufacturing company in Danbury. Job entails running machines, sorting & cleaning parts, assisting others in shop, doing whatever needs to be done. Will train the right person. Must be US Citizen or have proper work papers. Fax resume to 203-748-6212 or email to classifiedz@ctpost.com in Subject line put AD#1496313

FLASH DESIGNER

The Hearst Connecticut Media Group is looking for an experienced graphic artist with excellent web graphic and Flash skills in animation, as well as Action Script knowledge.

The successful candidate must be able to work within tight deadlines to produce and validate Flash ads. A 2-4 year degree in Design, Graphic Design, or Animation, or equal combination of education and experience is required. Advertising agency experience a plus. An online portfolio must be available.

This is a Full-Time position in Danbury, CT offering full benefits.

Please email resume and portfolio to employment@connecticutmediagroup.com and indicate Flash Designer in the subject field.

Full/Part Time Server & Bartender.
Experience a must.
Apply in person:
122 Litchfield Rd.
New Milford.

General Help
RAPID EXPANSION! GREAT PAY
Immediate openings, customer sales/svc, no exp. nec., conditions apply, all ages 17+, 203-762-9992

GLASS & Mirror Installer, 5+ years exp. Drivers lic. & English speaking req'd. Stamford. Fax res. 203-327-9698 or Call 203-327-5730.

HOUSEKEEPER/NANNY, live-in, 11yr old boy, New Canaan, cleaning, errands, great w/ kids, non-smoker, ext. driver, dog lover, ref. a must, $600/week. Ellen 917-455-1059.

LANDSCAPE
Worker Experienced. Motivated person w/clean driving rec'd. English a must. Call 203-984-9226

GENERAL HELP WANTED

MEDIA SALES

If you are goal-driven with a passion for excellence, the Hearst Connecticut Media Group has an outstanding opportunity for you to join our growing local sales team. As an Advertising Media Consultant, you will develop & sell successful advertising campaigns for local businesses in Fairfield County. We are looking for people with the following skills:

•2 or more years of successful, measured outside sales experience,
•Excellent prospecting & closing abilities,
•A desire to make a lot of calls,
•Comfort in a digital-driven environment,
•A passion for achieving success.

The CT Media Group consists of 4 daily newspapers, 7 weeklies and 17 websites reaching 70% of the affluent Fairfield County market. As a part of Hearst Corporation, a national leader in print and online media, you will have all the tools you need to succeed. All that is missing is you!

We offer a competitive base salary with unlimited commission potential, paid vacation, full medical benefits and a 401K with company match.

If you meet the requirements above, email your resume to employment@connecticutmediagroup.com. Please reference Media Sales in subject line.

NURSERY SALES: Our garden center is seeking a self-motivated person w/horticultural knowledge of woody ornamentals to join our nursery sales team. Job includes all aspects of sales including: Outdoor merchandising & plant care. Assisting in nursery operations. Customer interaction. Current drivers license needed. Sam Bridge Nursery, 437 North St., Greenwich, CT 06830 (203) 869-2410, Fax (203) 869-2049 Ron@sambridge.com

OFFICE MANAGER wanted with strong accounting, computer, organizational skills and work ethic skills. Please fax resume to 203-730-2300

OFFICE ASSISTANT Temporary in Bethel, general office duties. M-F 10:30am-4:30 pm Quick books exp a must. Knowledge of Microsoft & Excel 203 744-0400

GENERAL HELP WANTED

ONLINE LISTINGS EDITOR

Hearst Newspapers is looking for a full-time Online Listings Editor based in Greenwich, Conn. We seek someone who is passionate about online and community journalism and has a good grasp of how multimedia online environments work. Job responsibilities include helping to manage the rollout of community listings for the site directories; writing editing and producing high-quality business profiles; researching and aggregating town data; overseeing freelancers; and acting as a social media liaison. Two or more years experience required, with a degree in Journalism or related discipline. You will need a car and valid driver's license, as this job requires some travel within the communities we cover. Please send resumes ssteee.ebcult@hcnl.com. No phone calls please.

PLANT HEALTH CARE TECHNICIAN
Rapidly growing co. seeks dependable employee w/min. 5 yrs exp. Must have knowledge of local trees & shrubs, valid driver's license and pesticide applicator's license. Top pay DOE, pd holidays, health ins, bonuses. Email: greenleaflic@optonline.net or call (203)563-9559

PLUMBING SERVICE TECH-Stamford Perspective employee must possess a Valid Driver's Lic., Plumbing Lic. or 3 yr min exp. & be able to cover On-call Rotation. Please Call 203-323-3743.

QUALITY CONTROL
Earn up to $100 per day. Evaluate retail stores. Training provided. No exp req'd. Call 888-615-5245

RESTAURANT HELP
Danbury, PT Bartender, PT cook. All janitorial help. Exp pref'd. Email: m@bhickhons @gmail.com

RESTAURANT HELP
Waitstaff, bartenders, runners, busboys & hostess. Apply in person: Riviera Maya 20 Summer St., Stamford, CT 06905; 203-588-9400

RESTAURANT Exp. Servers, Bussers, Food Runners, Cocktail Servers. Apply in person 2-5 p.m. daily 2000 Black Rock Tpke, Fairfield.

RESTAURANT Now hiring all positions: cooks, servers, dishwashers, bartenders, hostesses, etc. Please apply in person: Mon-Fri, 10am-4pm. Blue Chip Restaurant, 5 Eagle Rd., Danbury, CT

SALES (INSIDE)
Building Supply
PT temp to hire opty in Bridgeport. MUST have exp in bldg supply sales.
Fax or email ONLY
845-452-7473
dianeschroeder@jimwaters.com

SALES MANAGER
Danbury area. Construction experience & computer skills required. Fax resume 203-792-5570.

GENERAL HELP WANTED

SALES: Interested in a Real Estate Sales career? Request your free booklet. Call 203.431.1400 Ext. 104 or email: klewis@weichert realtors.net

SEAMSTRESS/TAILOR & UPHOLSTERER-
Exp'd for Custom Decorative/Drapery Workroom in Norwalk, CT. Salary based on exp. Willing to train if you have sewing exp. Fax resumes to 203-838-0267. Call Laura 203-661-0079 or Bill 203-943-0282.

SEAMSTRESS, TAILORS FT/PT,
Apply in person at Fashion By Rouhy, 351 Boston Post Rd, Milford.

TREE CLIMBERS in Fld Cty. Must have 2 yrs experience & own climbing gear. $30/hr. 25 hrs/wk. Se Habla Espanol 203-449-7300

TREE SERVICE GROUND MAN
Rapidly growing company seeks dependable employee w/min. 3 yrs exp. Commercial Driver's Lic. req'd. Top pay DOE, pd holidays, health ins, bonuses. Email: greenleaflic@optonline.net or call (203)563-9559

TREE WORK, ground or climbing exp. Must have CT drivers lic. Bilingual English/Spanish. Call 203-650-6519

TREE WORK Aerial Truck oper/climber Exp pref'd. May train Must have valid drivers lic. Small, active Co in Redding. Eves. 203-938-9782.

WAITSTAFF
at Mario's Pasta Garden 174 Federal Rd Brookfield. Call 203-775-0426

HEALTH CARE & EMPLOYMENT OP

DENTAL OFFICE
Office Mgr/Receptionist
Stamford. 4 days.
EXP ONLY. Benefits.
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ANNOUNCEMENTS

ATTENTION NEWS-TIMES POLICY REGARDING PAYMENT OF ADS

ANY account not paid as agreed will be subject to collection costs of 25% of the unpaid balance or $20, whichever is greater.

LOST & FOUND

LOST: CAT, BLACK, male, w/ white paws & belly, red collar, named Lucky. Lost on 4/19 on Laurel St & Westville Ave Danbury 203-743-0009

LOST: DOG, Airedale Terrier, black/tan, neutered, male. Has collars & tags. Lost in Northern Ridgefield on 4/14. 914-912-9279

LOST: Engagement Ring, Sentimental value. Lost on 4/8 btw Main St. and Stop & Shop, Mill Plain Rd Danbury. Reward. Call 203-740-7142

MERCHANDISE FOR SALE

ABSOLUTELY FREE

DINING ROOM SET
Table & 6 chairs, in decent condition. Incls. leaves. Drk. wood, U-pick-up. Call (203) 826-9817

FREE 10X10 light mauve rug, never used, older Hotpoint D/W, avocado, 860-354-1344

FREE LAWN mower, needs work. You pick up. Call 203-797-8344 lv msg in no ansr

LAWN MOWER
Lawnchief Riding mower 12½" (Does not start-Good for parts) Call 718-904-5313

REFRIGERATOR FREEZER
FREE SUBZERO REF/FZR 48" side by side drs, ice maker, almond, gd cond, runs ex! 203-778-0603

MERCHANDISE FOR SALE

55 gallon USED DRUMS, Clean, plastic $5/metal $10. Great for sand, compost, dock floats, etc 775-4727, 9-5p Steve

ABOVE GROUND POOL
15 x 30 oval above ground pool. Come take it down and it's yours for back yard fun. $100. 203-775-7665

AIR CONDITIONER Single room AC. 6500 BTU, with remote, $100. Hardly used. 203-775-2748

AIR CONDITIONER Comfort Touch. 5000 btu Sharp air conditioner with Energy Saver, Good Condition, works great! $75. Please call Matt M 203-788-2497 if interested.

AIR COND. Honeywell Gd. Cond. Evenings 203-942-2904

AIR PURIFIER AIR PURIFIER, HONEYWELL, MODEL # QUIETCLEAN, NEVER USED, COMPLETE WITH INSTRUCTION MANUAL, ORIGINAL COST = $109, ASKING $50.00. CALL (203) 426-8476.

ANTIQUE HIGH chair 1926. All wood. folds play table $100 203-775-3058

ANTIQUE CAMERAS polaroid and bell stir and howell movie camera $40. 203-837-7985

MERCHANDISE FOR SALE

Antique school desk separate wood (probably maple) chair and desk on Bolt down metal pedicels. Has hole for inkwell. Condition is very good. $175 USD 203-792-7570

Antique curious cabinet beautiful curious cabinet for dining room dishes.etc. 203-837-7956 $50.00 USD

ANTI THEFT STEERING WHEEL
Gorilla Grip Lock & Car Alarm- NEW $40. 203-744-2483

BABY SWING
Fisher Price Pa-pasan 2 way baby swing Excellent cond. very clean!! Plays music and sounds, swings both ways. Paid $140, selling for $75 or b/o. Call 914-980-6064, Lots of other baby stuff too!

BEDRM SET (5pc)
$280, "3 piece entertainment center $180 "Couch w/pillows $85 "2 glass tables $65. 203-826-9361

BEDROOM SET
Beautiful solid wood bookcase headboard, tripple dresser with large mirror, chest of drawers, two night tables, $450, 203-438-5448

BICYCLE
Princess White Girls Bike Almost NEW 20" in Pristine condition. For Girly Girls age 6-12. Professional Assembled used for just minutes in Perfect cond with streamers and pouch. Free Pink Helmet too. Was 65.00 plus 15.00 assembly ready to drive home! $40. 203-746-7678

MERCHANDISE FOR SALE

BIKE HELMET
Hello Kitty Multi-Sport Bike Helmet Brand New, ages 3-5, $10. 203-300-7746

Bob Long Defiant 2 paintball markers with owners manual with red Proto bag Used Bob Long Defiant 2 that works just like new, comes with complete owners manual and large red Proto paintball bag with handle and wheels that can hold all your gear. Call 203-470-6305 for more information $375 USD

BOOK: KONG, KING OF SKULL ISLAND Illustrated Hardcover that is the prequel and sequel to KING KONG. Written and illustrated by Joe DeVito New $24, sacrifice $6, 203-797-0442

BOX SCRAPER
Brand new low behind 38" for tractor Brinly-Hardy Company. For gravel, sand, and snow. $200.00 203-938-3682

BOYS BIKE
Huffy Howler, 10 speed, black and red color, $70. call 860-350-3282

BOYS NURSERY SET
Blue Jean Bear complete nursery bedding set. includes wall hanging and clips, comforter, curtain with valance, 2 receiving blankets, 2 mattress sheets, pillow, and dust ruffle. Also have diaper sack, mobile, and lamp priced individually, $30. If interested 860-355-5587

BRACELET
Lia Sophia Party Girl Charm Bracelet, style #10751, brand new, Reg. $50, $25. Call 860-350-3282

Foreclosures

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket No. LLI-CV09-5006096-S
Case Name: Chase Home Finance LLC vs. Eric E. Romandi, et Al.
Property Address: 108 Rooster Tail Hollow Road, New Milford, CT 06777
Property Type: Residential
Date of Sale: Saturday, May 1, 2010.
Committee Name: David A. Huntoon, Esq.
Committee Phone Number: 860-868-0078
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

PUBLIC NOTICES

LEGAL DEADLINE
ALL LEGALS MUST BE RECEIVED BY NOON 3 DAYS PRIOR TO ITS RUN DATE.
(This does not count Sunday)
Some legals may require pre-payment, please call for more info. 203-731-3418

PUBLIC NOTICE

Statute Reference:	19a-638
Applicant:	Blue Sky Behavioral Health, LLC
Town:	Danbury
Docket Number:	10-31574-LOI
Proposal:	Establish a Psychiatric Outpatient Treatment Facility for adults and a Substance Abuse Outpatient Treatment for adults facility in Danbury.
Capital Expenditure:	$100,000

The Applicant may file its Certificate of Need application between June 8, 2010 and August 6, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 410 Capitol Avenue, MS13HCA, P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available at OHCA or on OHCA's website at www.ct.gov/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.