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 Tollgate Residential Treatment Center which is proposed to be located in Litchfield, 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	Tollgate Residential Treatment Center	
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	N/A
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: _Mental Health Residential Living facility and Outpatient Clinic

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 xx☐ 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 xx☐ 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:

___571 Torrington Road Litchfield, CT 06759_____

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

___All of Connecticut, and open to a potential admission to every state within the United States._____

h. Estimated starting date for the project: _10/1/2010_____

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: $500K

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	$125,000
Land/Building Purchases-(lease)	$180,000
Construction/Renovation	$195,000
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	
Total Capital Cost	
Total Project Cost	$500,000
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 ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions XX☐ 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. Tollgate Residential Treatment Center

1) The types of services that would be provided are as follows: Mental Health Residential Living, individual and group therapy services by licensed clinicians, daily living groups provided by direct care staff, nursing services, psychiatrist services, drug and alcohol counseling by certified CASAC staff, Educational support(including high school diploma and GED tracks) and vocational/volunteer support services.

2) The types of services being proposed are as follows: individual and group therapy by licensed clinicians, daily living skill groups by direct care staff, nursing services, psychiatrist services, drug and alcohol counseling by CASAC certified staff, Educational support, vocational/ volunteer support services.
Tollgate Residential Treatment Center would apply for the following Department of Public Health categories:Mental Health Living Facility, and Outpatient Clinic.

3) Population to be served would be individuals 18 years of age and older who have behavioral health disorder which may include a co-occurring substance abuse disorder. The program will provide specific treatments for individuals with personality disorders.

4)The unmet need in the State of Connecticut, is a private longer care treatment facility of individuals 18 years and older who have a behavioral health disorder which may often include a co-occurring substance abuse disorder. With a focus on DBT and CBT. A large number of facilities in the State of Connecticut are State funded, adolescent in nature and offer a much shorter duration of stay than the type of treatment that Tollgate would offer to its population. This longer term focus on therapy, group work and DBT will have a greater likelihood to lead to overall member improvement in a reduction of their respective symptoms at the time of discharge in comparison with the programs that are shorter term in nature.

5)There are a limited number of programs in the area, but none of these programs appears to offer the comprehensive longer term focus that Tollgate Residential Treatment Center would offer. Tollgate Residential Treatment Center would be an all-inclusive facility that has a variety of health care and support professionals under one roof.

6)The anticipated effect of this proposal(if approved) on the health care services in the State of Connecticut would be immediate, relevant and long lasting. The all inclusive nature of this proposed facility would include comprehensive treatment unlike any facility in this geographic area. All of the various services: therapy, psychiatry, nursing, DBT, CASAC counselors, teachers, and job coaches would be located in one location.

7)Tollgate Residential Treatment Center would be responsible for providing these services located on a spacious 10 acre compound in scenic Litchfield, Connecticut. David Palmer would be CEO/Manager of Tollgate Residential Treatment Center.

8)The current payers of services at Tollgate Residential Treatment Center are individuals and their families in need of comprehensive behavioral health services that hospitals and other treatment facilities in the areas do not currently provide on a longer term basis. Treatment would be paid privately(out of pocket) by member's and their families and by member's or 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: Tollgate Residential Treatment Center

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

of BlueSky 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 Tollgate Residential Treatment Center (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: 07/31/2013

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

RECEIVED
2010 APR -7 P 12:33
CONNECTICUT OFFICE OF HEALTH CARE 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: 10-31575
Blue Sky Behavioral Health, LLC
Establish Tollgate Residential Treatment Center in Litchfield

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 Tollgate Residential Treatment Center in Litchfield, with a total associated capital expenditure of $500,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Register Citizen* 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 (KRM)

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 Register Citizen
190 Water Street
Torrington, CT 06790-0058

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 Carmen Cotto at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly Martone (KM)

Kimberly R. Martone
Director of Operations

Attachment

KRM:PF:CC:lmg

c: Danielle Pare, DPH

The Register Citizen **Letter of Intent**
Docket Number: 10-31575 **April 19, 2010**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Blue Sky Behavioral Health, LLC
Town:	Litchfield
Docket Number:	10-31575-LOI
Proposal:	Establish Tollgate Residential Treatment Center
Capital Expenditure:	$500,000

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	1469
RECIPIENT ADDRESS	918452797678
DESTINATION ID	
ST. TIME	04/20 11:42
TIME USE	00'28
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 10-31575

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: 10-31575-CON
Blue Sky Behavioral Health, LLC
Establish Tollgate Residential Treatment Center in Litchfield

Dear Mr. Palmer:

Enclosed are the application forms for Blue Sky Behavioral Health, LLC Certificate of Need ("CON") proposal to establish Tollgate Residential Treatment Center in Litchfield, with a total associated capital expenditure of $500,000. 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 Carmen Cotto. 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 Carmen Cotto may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	10-31575-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:	Litchfield
Project Name:	Establish Tollgate Residential Treatment Center in Litchfield
Type proposal:	Section(s) 19a-638, C.G.S.
Est. Capital Expenditure:	$500,000

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. If the Applicant is a Connecticut hospital: 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. If the Applicant is not a Connecticut hospital (other health care facilities): 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: _____ 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)

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 ***
****

TRANSMISSION OK

TX/RX NO	1493
RECIPIENT ADDRESS	918452797678
DESTINATION ID	
ST. TIME	04/23 10:19
TIME USE	04'26
PAGES SENT	23
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 FIOCIA

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

NUMBER OF PAGES: 23
(including transmittal sheet

Comments:

10-31574-CON, 10-31575-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

10-31575

100 ANNOUNCEMENTS

110 LOST & FOUND

Found cat on prospect cat orange tabie 860-601-3531

ADVERTISE YOUR BUSINESS
Home Helpers. Gutters. Heating. Interior Decorating. Locksmiths, & Masonry

Landlords!
Place your apartment/house for rent ad here. 860-489-5555.

110 LOST & FOUND

Found: Two dogs on Rock Hall Road in Colebrook. One black and brown mixed Rottweiler, the other a mixed breed possibly Pit Bull and Golden Lab. Both are friendly, had collars no ID tags. One collar said Boomer on it. Contact Animal Control Officer of Colebrook CT. 860-379-4709 or Town Hall at 860-379-3559 x 202.

ADVERTISE YOUR BUSINESS
Home Helpers. Gutters. Heating, Interior Decorating. Locksmiths, & Masonry

Landlords!
Place your apartment/house for rent ad here. 860-489-5555.

LEGALS

PUBLIC NOTICE

Statute Reference: 19a-638
Applicant: Blue Sky Behavioral Health, LLC
Town: Litchfield
Docket Number: 10-31575-LOI
Proposal: Establish Telligate Residential Treatment Center
Capital Expenditure: $500,000

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.

LEGALS

NOTICE TO CREDITORS

ESTATE OF
Edward F. Yaklew
(10-467033)

The Honorable Michael F. Magistrali, Judge of the Court of Probate, District of Torrington, by decree dated April 20, 2010, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Gale Pellegren, Clerk

The fiduciary is:

Mary T. Wheeler
c/o Robert S. Stanek, Esq.
Elliott & Stanek, P.C.
168 North Main Street
Southington, CT 06489

110 LOST & FOUND

LOST DOG
Rusty is a 2yr old red Doberman Pinscher with natural ears and 8" tail. He was adopted from Doberman Rescue Unlimited in NH on March 27. He slipped out of his house on Winsted Rd. in Torrington and can't find his way home. Do not chase him, he will run away. Please? report any sightings to Ron 860-459-4765 or DRU 603-887-1200.

LEGALS

Notice of Sale of Real Estate for Taxes To Owners and Interest Holders of Record Whose Whereabouts Are Unknown or Whose Certified Mail Was Unclaimed

The Tax Collector of the City of Torrington gives Notice that a Tax Warrant is hereby levied on the taxpayer(s) named below for failure to pay real property taxes and/or sewer assessment charges due the City of Torrington, Connecticut and that in accordance with Chapter 204 of the Connecticut General Statutes a Tax Collector's Sale has been scheduled for the tax parcel as described below:

1. NAME AND ADDRESS OF DELINQUENT TAXPAYER(S) Description of the Property upon which Taxes are due, Amount of Taxes due including interest and charges attributed to the property as of the last day of the month:

Daniel Lucia c/o Survivor Anna Lucia, 85 Revere Street, Torrington, CT 06790
For Taxed Due On: Eagle Ridge, Map 244/Lot 006/Unit 031, Torrington, CT
In The Amount Of: $28,427.10

List of Mortgages, Lien Holders, and other record Encumbrancers whose interest in the property shall be affected are:

Daniel Lucia c/o Survivor Anna Lucia, 85 Revere Street, Torrington, CT 06790
Sony Daniel Lucia, 212 Eagle Ridge, Torrington, CT or of parts unknown
Richard Szabo, 70 Quail Run Road, Torrington, CT or 107 Highview Drive, Winsted, CT
Thomas Szabo, 70 Quail Run Road, Torrington, CT
State of Connecticut, Dept. of Social Services, 25 Sigourney Street, Hartford, CT.

ADDITIONAL TAXES, INTEREST, FEES AND OTHER CHARGES AUTHORIZED BY LAW ACCRUING AFTER THE LAST DAY OF THIS MONTH SHALL BE ADDED TO THE AMOUNT INDICATED AS DUE AND OWING.

2. TIME AND PLACE OF SALE:
Date: MAY 15, 2010
Time: 12:00 pm
Place: 68 EAST ALBERT STREET (SULLIVAN'S SENIOR CENTER) TORRINGTON, CT
Registration: 11:00 am

The Tax Collector may adjourn or cancel the sale in accordance with the provisions of CGS Section 12-157.

The Property is being sold "As Is - Where Is" with all faults and without representation or warranty except those specifically set forth in Connecticut General Statutes sections 12-157 through 159.

Bidders at the time of the sale must have cash or a certified check in the amount of $3000.00, made payable to R. Thomas Crovo, Tax Collector. This qualification amount is non-refundable to the Successful Bidder. The balance of the Sale price shall be due within 7 days of the conclusion of the sale.

Additional costs and fees associated with the sale shall be posted and announced the day of the sale.

Inquiries may be addressed to:
Municipal Revenue Recovery Services, LLC
860-584-1085 ext. 350 Monday through Friday 8:00 a.m. to 5:00 p.m.

200 RESIDENTIAL RENT

230 APARTMENTS UNFURNISHED

EFFIC. APT. - priv entrance. 1BA, BR & living rm w/ kitchenette, utils incl. 860-309-1255

Torrington 1Br remodled clean a must see $550 860-997-9159

TORRINGTON
2BR, 1st fl, yard & garage. Reduced $750. First, last & sec. 203-998-9872

TORRINGTON- 3BR, 1st Fl., 1st, last & sec. no pets. $900. ALSO 1BR Studio $600, utils incl. 860-480-1693

TORRINGTON- 7RM, 3 BR, w/w crpt, w/d hkup $900.
★★★☆★
2 BR w/porch & garage $575. no dogs 860-482-4354

Landlords!
Place your apartment/house for rent ad here. 860-489-5555.

230 APARTMENTS UNFURNISHED

TORRINGTON APTS!

23 North Street
1st Fl Studio, full kitch, new/remodeled, off st. park., walk to CVS/Kmart $675/mo.

25 Grove Street
Spacious 7 Rm, newly remodeled, newly insulated, 2BR, W/D hkup, new appls, off st. park., heated garage. $875/mo.

76 East Pearl Street
Spacious 6 Rm, newly remodeled, newly insulated, 2BR, W/D hkup, new appls, off st. park. $900/mo.

See Pics on Craig's List
860-489-9197

Torrington- Beautiful 5rm, 3br, gas ht. Avail immed. Sec 8 & HUD welcome. $800/mo. 860-309-1953

Torrington freshly painted, renovated 2 Br no pets first/last/sec $575 860-921-2471

Winsted new first fl 1 Br w/d hups off stree parking nice yard no pets $495 860-379-9276

230 APARTMENTS UNFURNISHED

WINSTED
2 bd Townhouse generous 1045 sf. $860 mo. Includes hdtop private entrance/park. Large renovated kitch. Mon. - Fri. 8:30-4:30 Open house, Saturdays 12 - 3pm
qualitymanagement.com
860-379-7801

645 GENERAL HELP WANTED

Carpet Cleaners (20) $400-$1500/week our branchs overloaded with spring lever cleaning customers. We need 20 sharp, hardworking people to train for carpet cleaning & mgmt. Positions. Must have your own vehicle and excellent work ethic. Full time permanent work. $400-$1500/week. Call Mon or Tues to schedule interview 203-759-6577

ADVERTISE YOUR BUSINESS
Home Helpers. Gutters. Heating, Interior Decorating. Locksmiths, & Masonry

Landlords!
Place your apartment/house for rent ad here. 860-489-5555.

LEGALS

Notice of Sale of Real Estate for Taxes To Owners and Interest Holders of Record Whose Whereabouts Are Unknown or Whose Certified Mail Was Unclaimed

The Tax Collector of the City of Torrington gives Notice that a Tax Warrant is hereby levied on the taxpayer(s) named below for failure to pay real property taxes and/or sewer assessment charges due the City of Torrington, Connecticut and that in accordance with Chapter 204 of the Connecticut General Statutes a Tax Collector's Sale has been scheduled for the tax parcel as described below:

1. NAME AND ADDRESS OF DELINQUENT TAXPAYER(S) Description of the Property upon which Taxes are due, Amount of Taxes due including interest and charges attributed to the property as of the last day of the month:

United Development Group, LLC, 27 Palmer Road, Morris, CT 06763
For Taxed Due On: Goshen Road, Map 222/Lot 001/Unit 004, Torrington, CT
In The Amount Of: $7,451.48
List of Mortgages, Lien Holders, and other record Encumbrancers whose interest in the property shall be affected are:

United Development Group, LLC, 27 Palmer Road, Morris, CT
F & J Holdings, LLC, 150 Prospect Street, Waterbury, CT
F & J Holdings, LLC, c/o John R. Weghiszewicz, 92 Northridge Drive, Middlebury, CT
Thomas Provenzano, 869 Goshen Road, Torrington, CT or 296 Reynolds Bridge Road, Thomaston, CT 06787
United Development Group, LLC, c/o Maureen E. Norris, 271 Valley View Road, Thomaston, CT
City of Torrington, Land Use, 140 Main Street, Torrington, CT
TA Operation, LLC, 24601 Center Ridge Road, Westlake, OH 44145
TA Operation, LLC, c/o Halloran & Sage, One Goodwin Square, 225 Asylum Street, Hartford, CT

ADDITIONAL TAXES, INTEREST, FEES AND OTHER CHARGES AUTHORIZED BY LAW ACCRUING AFTER THE LAST DAY OF THIS MONTH SHALL BE ADDED TO THE AMOUNT INDICATED AS DUE AND OWING.

2. TIME AND PLACE OF SALE:
Date: MAY 15, 2010
Time: 12:00 pm
Place: 68 EAST ALBERT STREET (SULLIVAN'S SENIOR CENTER) TORRINGTON, CT
Registration: 11:00 am

The Tax Collector may adjourn or cancel the sale in accordance with the provisions of CGS Section 12-157.

The Property is being sold "As Is - Where Is" with all faults and without representation or warranty except those specifically set forth in Connecticut General Statutes sections 12-157 through 159.

Bidders at the time of the sale must have cash or a certified check in the amount of $3000.00, made payable to R. Thomas Crovo, Tax Collector. This qualification amount is non-refundable to the Successful Bidder. The balance of the Sale price shall be due within 7 days of the conclusion of the sale.

Additional costs and fees associated with the sale shall be posted and announced the day of the sale.

Inquiries may be addressed to:
Municipal Revenue Recovery Services, LLC
860-584-1085 ext. 350 Monday through Friday 8:00 a.m. to 5:00 p.m.

LEGALS

NOTICE OF LEVY OF TAX WARRANT AND TAX SALE

The Torrington Tax Collector gives Notice that a Tax Warrant is hereby levied on the taxpayer(s) named below for failure to pay real property taxes and/or sewer assessment charges due the City of Torrington, Connecticut and that in accordance with Chapter 204 of the Connecticut General Statutes a Tax Collector's Sale has been scheduled for each of the tax parcels as described below:

NAME AND ADDRESS OF DELINQUENT TAXPAYER(S) Description of the Property upon which Taxes are due, Amount of Taxes due including interest and charges attributable to the property as of the last day of the month:

Fenna Properties, LLC, 270 Cornwall Bridge Road, Sharon, CT 06069
For Taxes due on: Fenna Street, M/L/U 108/013/001 and M/L/U 108/013/002, Torrington, CT
In the Amount of: $3,252.65 CORRECTED AMOUNT

Michael E. Joseph, 501 Riverside Avenue, Torrington, CT 06790
For Taxes due on: Rosita Boulevard, M/L/U 108/103/006, Torrington, CT 06790
In the Amount of: $5,866.22

Daniel Lucia, c/o Anna Lucia, Survivor, 85 Revere Street, Torrington, CT 06790
For Taxes due on: Eagle Ridge, M/L/U 244/006/031, Torrington, CT
In the Amount of: $28,427.10

Matzazian Enterprises, LLC, 310 Watertown Road, Morris, CT 06763
For Taxes due on: View Street, M/L/U 126/013/026, Torrington, CT
In the Amount of: $3,084.83

Matthew Mills, 5945 Providence Road, Apt. 8, Charlotte, NC 28226-5884
For Taxes due on: Hill Street, M/L/U 126/013/020, Torrington, CT
In the Amount of: $2,553.17

Optimum Fund, LLC, 261 North York Street, Ste. 203, Elmhurst, IL 60126
For Taxes due on: Winsted Road, M/L/U 238-001-002, Torrington, CT
In the Amount of: $75,917.52

Carol J. Ryman, 25 Cleve Court, Torrington, CT 06790
For Taxes due on: 25 Cleve Court, M/L/U 249/002/087, Torrington, CT
In the Amount of: $26,856.92

Francis Tapparo, 327 North Elm Street, Torrington, CT 06790
For Taxes due on: 325 North Elm Street, M/L/U 108/015/019, Torrington, CT
In the Amount of: $31,555.83

Francis Tapparo, 327 North Elm Street, Torrington, CT 06790
For Taxes due on: Winsted Road, M/L/U 244/002/007, Torrington, CT
In the Amount of: $14,024.05

United Development Group, LLC, 27 Palmer Road, Morris, CT 06763
For Taxes due on: Goshen Road, M/L/U 222/001/004, Torrington, CT
In the Amount of: $7,451.48

Ivars Zarins, c/o Sarah Archer, Fiduciary, 167 Heights Drive, Torrington, CT 06790
For Taxes due on: 31 North Chapel Street, M/L/U 121/006/006, Torrington, CT
In the Amount of: $28,834.31

ADDITIONAL TAXES, INTEREST, FEES AND OTHER CHARGES AUTHORIZED BY LAW ACCRUING AFTER THE LAST DAY OF THIS MONTH SHALL BE ADDED TO THE AMOUNT INDICATED AS DUE AND OWING.

TIME AND PLACE OF SALE:
Date: MAY 15, 2010
Time: 12:00 pm
Place: 68 East Albert Street (Sullivan's Senior Center) Torrington, CT
Registration: 11:00 am

The Tax Collector may adjourn or cancel the sale in accordance with the provisions of CGS Section 12-157.

The Property is being sold "As Is - Where Is" with all faults and without representation or warranty except those specifically set forth in Connecticut General Statutes sections 12-157 through 159.

Bidders at the time of the sale must have cash or a certified check in the amount of $3000.00, made payable to R. Thomas Crovo, Tax Collector. This qualification amount is non-refundable to the Successful Bidder. The balance of the Sale price shall be due within 7 business days of the conclusion of the sale.

Additional costs and fees associated with the sale shall be posted and announced the day of the sale.

Inquiries may be directed to:
Municipal Revenue Recovery Services, LLC
860-584-1085 ext. 350 Monday through Friday 8:00 a.m. to 5:00 p.m.

645 GENERAL HELP WANT