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OFFICE OF
HEALTH CARE ACCESS

Application Checklist

ns:

ease check each box below, as appropriate; and
The completed checklist *must* be submitted as the first page of the CON application.

☐ Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.

For OHCA Use Only:

Docket No.: 12-318II-CON Check No.: 0450
OHCA Verified by: K R Date: 12-21-12

☑ Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication*)

☑ Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.

☑ Attached are completed Financial Attachments I and II.

☐ Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☑ The following have been submitted on a CD

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2. An electronic copy of the documents in MS Word and MS Excel as appropriate.

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Blue Sky Behavioral Health, LLC

Mental Health Residential Living Center

DEC 17 2012

000002

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

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:

Applicant: Blue Sky Behavioral Health, LLC

Contact Person: David Palmer

Contact Person's Title: CEO

Contact Person's Address: 52 Federal Road Suite 2A
Danbury, CT 06810

Contact Person's Phone Number: 203-300-5055 ext 206

Contact Person's Fax Number: 203 - 942-2693

Contact Person's Email Address: dpalmer@blueskybh.com

Project Town: Danbury

Project Name: Mental Health Residential Living Center

Statute Reference: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure: $400,000

DEC 17 2012

000003

AFFIDAVIT

Applicant: Blue Sky Behavioral Health, LLC

Project Title: Mental Health Residential Living Center

I, David Palmer (Individual's Name), CEO (Position Title – CEO or CFO)

of Blue Sky Behavioral Health, LLC (Hospital or Facility Name) being duly sworn, depose and state that

Blue Sky Behavioral Health, LLC (Hospital or Facility Name)'s information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

DJ Palm
Signature

12/6/12
Date

Subscribed and sworn to before me on December 6, 2012

Betsy Bergman

Notary Public/Commissioner of Superior Court

My commission expires: 7/31/2013

BETSY BERGMAN
NOTARY PUBLIC
REG. #01BE4736701
VALID 7/31/09 - 7/31/2013

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PUBLIC NOTICES

Blue Sky Behavioral Health, LLC is applying for a certificate of need application pursuant to section 19-a - 638 of the CT general statutes, to operate a 6 bed mental health residential living center. The address would be 124 Franklin Street in Danbury with an estimated budget for the project of $400,000.00.

SITUATIONS WANTED

MARIA SILVA CLEANING
I would love to clean your house!
203-788-8184/203-312-4428

BUSINESS OPPORTUNITIES

Buy/Sell a Business?
VENTURE GROUP
BUSINESS BROKERS
Ron Zemper 203-794-9636

LOST AND FOUND

FOUND HI TECH FOLDING BIKE at Club Crystal in Danbury. Must have proper paperwork and ID to claim. Call 203-981-5888

FOUND IN NEW MILFORD DOLLAR STORE on 10/23, something of value. Call to describe. 860-355-3868

ABSOLUTELY FREE

FREE CLEAN WOOD PALLETS or firewood in New Milford.
203-417-9435

SOFA GREEN/WHITE ckered, good condition, you ta... t away. 203-746-5862

MERCHANDISE FOR SALE

AIR HOCKEY TABLE. Large table. works well. $70. Call 203-296-4324

ANTIQUE PINE WASH STAND (no open-ing for bowl) with 1 drawer. $100. 860-350-4942

ANTIQUE-OLD PINE OAK FURNITURE Night stands, tables, server from $199-499. 203-431-9431

ANTIQUE END TABLES AND SMALL ROCKER wooden. $25. Call 203-296-4324

APPLE LAPTOP IBOOK g4 2gig 80 gig, $230. 203-568-3610

ARMANI EMPORIO MEN'S WATCH AR5316 - SQUARE FACE STAINLESS STEEL DESIGNER WATCH NEVER USED $150.00 203-775-6925

ASKO DISHWASHER white 2 years old [remodeling kitchen] $250. 203-791-0145

BED Queen Pillowtop Mattress & Boxspring. Brand New. Still in Plastic. Sacrifice $250. 203-557-0949

BEDROOM CHERRY solid sleighbed, dresser, mirror, chest, night stand. Cost $2500. Sacrifice $850. 203-557-0949

BIONAIRE HEATER SPACE - ELECTRIC WITH OSCILLATION MODEL 748-577 WINTER IS COMING BE READY $20.00 203-775-6925

BROOKS BROTHERS MEN'S SIZE 9 WINGTIPS. $50. 203-746-0747

MERCHANDISE FOR SALE

CAMERA - CANNON 35MM EOS REBEL G QD $50.00 ALSO CANNON 35MM EOS REBEL G11 $50.00 BOTH CAMERAS W/ MANUALS IN WORKING ORDER 203-775-6925

CAR BOOSTER SEAT Evenflo, comfortable design, like new, $15, call 203-770-1238

CARRY-ON BAGS TRAVEL SUITCASES/BAGS, NEW, $10 TO $40, CALL 203-426-6476

CEDAR CHEST by: Lane Oak, $300. Call 203-792-1078

CHAIRS, wooden chair set of 10, $25. 203-792-1078

CHILD'S WORKBENCH Wooden, bench, tools, wood projects, $35. call 203-770-1238

CHILD SAFETY BED RAIL Evenflo rail, easy set up, $15, call 203-770-1238

CHILD'S WOODEN BENCH 30"x10"x20", 4 compartments. below, $20. 203-770-1238

CHINA CABINET, Oak, Excellent Condition. Please call 203-743-3196. Part of Set.

COFFEE MAKER, Westbend, 12 to 30 cups, $20. 203-792-1078

COMPAQ LAPTOP v5000 used but perfect winds xp 80 gig hd 1gigram, $190. 203-568-3610

COMPUTERS desktop must go fall clean up! $150. 203-568-3610

Copier Gestetner 3222-B-W office copier.Works. Downsizing.

MERCHANDISE FOR SALE

Desktop Computer
complete with LCD monitor, printer, stand etc. MS office $200, 203-994-5109

DINING ROOM TABLE Pine with table pad. Great condition. $250. 203-296-4324

DINING ROOM TABLE Oak. Top Inlay, Extension Leaf for Table. Oak. Please Call 203-743-3196.

DINING ROOM SERVER, Oak. quality Furniture. 203-743-3196. Part of Set.

DINING ROOM TABLE CHAIRS (6), Oak. Excellent Cond. Please call, 203-743-3196. Part of Set.

DISHWASHER asko white 2 years old, $250. 203-791-0145

ESPN GAME STATION 6 fun games for kids. $50. 203-417-7621

FIREWOOD Dry seasoned split $200.00 a cord Call 203 297-1889 or 860-354-9256

FRIGIDAIRE REFRIDGERATOR 26cu white side by side ice water in door, $250. 203-791-0145

GAZEBO COVER CANOPY TOP ONLY FOR 12' X 12' GAZEBO BEIGE GREAT FOR FALL PARTIES AND GET TOGETHERS BRAND NEW $50.00 203-775-6925

GOLF PULL CART PRO KENNEX FALL IS HERE FOR

MERCHANDISE FOR SALE

JOHN DEERE LEAF BAGGER INCLUDES MANUAL THE LEAVES ARE STARTING TO FALL - BE PREPARED FOR USE WITH RX, SX, SRX AND GX RIDING MOWERS AND LX LAWN TRACTOR. NEEDS CLOTH BAGS VERY GOOD CONDITION $50.00 203-775-6925

must see

KENMORE ELITE DOUBLE OVEN Black, model number 790, approx 4 years old, excellent condition, 30 inch. $400. Call 203-241-6982

Kerson Kerosene space heater for sale. Call 203-730-9440, $50.00.

KITCHEN POT UTENSILS HOLDER CRATER & BARREL, NEW $500, ASK $199. 203-426-6476

LAMPS & LAMP TABLES. $10-15. CALL 203-426-6476

LAMPS (2) Dark Green. Great Cond. Please Call 203-743-3196.

LAMPS, Burgandy shaded desk and floor lamps/etc. $200. 203.743.4454

LANDSCAPE EQUIPMENT. Exmark riding mower, 60", $2,500. 8 Ft, fisher snow plow, $2,500. Skid steer snow pusher, 8ft, $2,500. 203-948-4384

LEATHER COAT WOMENS S/M BEAUTIFUL COAT WINTER IS COMING FAST BLACK. 3/4 LENGTH, REMOVABLE LINER, $50.00 203-775-6925

MERCHANDISE FOR SALE

LUGGAGE - AMERICAN TOURISTER HARD SIDE LUGGAGE SET OF 4 PIECES - 27" PULLMAN, 24", 21" AND TOTE. BEIGE EXCELLENT FOR GOING TRAVELOVERSEAS $75.00 FOR SET OF 4 203-775-6925

MATTRESS & Boxspring. King size Pillowtop set, brand new, still in plastic. Sacrifice $399. 203-557-0949

MEN'S COLE-HAAN DRESS SHOES 5 pair size 9. $100. 203-746-0747

MEN'S FERRAGAMO SHOES Siz 9. Vintage. $125. 203-746-0747

MIGHTY MAC 8hp Chipper Shredder. Excellent cond. Works perfectly $375. 203-240-6146

MONA LISA WALL SCUPLTURE Unique item in new condition. $75 203-417-7621

MONITOR AOC 19" in LCD monito $65. Call 203-792-1078

MOVING BEST OFFER on every thing. brand new steam cleaner used twice, cost $300 asking $200 air conditioner $30. love sea earthtones, like new $90. recline great shape $50, rocker $30. 203 770-7321

NICE BAR stools. Mirrored w panthers. $ O. Liz 203-470-440

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PUBLIC NOTICES

Blue Sky Behavioral Health, LLC is applying for a certificate of need application pursuant to section 19-a - 638 of the CT general statutes, to operate a 6 bed mental health residential living center. The address would be 124 Franklin Street in Danbury with an estimated budget for the project of $400,000.00.

LEGAL NOTICE

The Planning Commission of Brookfield, CT will hold a Public Hearing in Room 133 of the Brookfield Town Hall on November 15, 2012 on the following applications:

44 & 52 Obtuse Road South #201200890: Re-subdivision - Ferry Farm Estates at 7:45 PM.
20 Vale Road #201200913: Proposed two-lot subdivision - Berkshire Corporate Park at 8:15 PM.

At this hearing interested persons may appear and be heard and written communications will be received. Said notice is on file in the Brookfield Land Use Office and Town Clerk's Office.

Dated in Brookfield, Connecticut, this **November 2, 2012 & November 12, 2012.**

Jon V[illegible]e, Chairman
Brookfi[illegible] Planning Commission

GENERAL HELP WANTED

DIGITAL SALES MANAGER

Hearst Media Services is looking for innovative, talented, digital experts who will lead our advertising sales teams to new heights while providing optimal solutions for our advertisers. The Digital Sales Manager will be a leader who can coach and develop the digital knowledge of our staff primarily through 4-legged sales calls.

This key leader on our advertising management team will work with our sales director to build a high-performance sales team dedicated to providing comprehensive solutions to our advertisers. He/she will ensure that the sales staff meets or exceeds revenue expectations and will be responsible for the digital revenue performance of their team. Excellent presentation and closing skills are essential, as is the ability to build rapport with staff and customers. The ability to manage multiple priorities in a deadline-driven environment while being aware of the competitive environment and the continual evolution of digital media is what we are seeking.

GENERAL HELP WANTED

MEDIA SALES CONSULTANTS

Hearst Media Services is looking for talented, highly motivated sales professionals with an interest in multi-media advertising to join our team of digital media consultants.

If you love to sell and are knowledgeable about digital media, then we have the perfect opportunity for you to join us and help our customers to grow their businesses.

In addition to our 11 newspapers in greater Fairfield and Litchfield counties, and 13 web sites, we have partnerships with the biggest names in digital and social media.

With all this we can offer our advertisers unmatched reach and targeting capabilities - from the very local to the national scale.

Hearst Media Services prides itself on simplifying the marketing process for our customers, while helping advertisers track the impact of their campaigns and understand their advertising options.

In short, we help our customers grow their business! Do you have experience meeting and exceeding monthly sales goa[illegible]nticipating challenges and unco[illegible]g new opportunities to overco[illegible]them and continually finding new customers?

SCHOOLS & JOB TRAINING

AMERICAN RED CROSS

CNA/NURSE ASSISTANT TRAINING

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Flexible Payment Plan

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7 Park Lawn Drive
Bethel, CT
(located near Target)
203-702-1280

American Red Cross
1057 Broad Street 3rd Flr.
Bpt., CT 203- 338-0951

Approved by the
CT Commissioner of Higher Education
and CT Department of Public Health

CAREER TRAINING

☆ Certified Nurse's Aid
☆ Patient Care Technician Level I-II
☆ Phlebotomy

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BRANFORD HALL CAREER INSTITUTE
155 Main Street, Suite 302
Danbury, CT 06810
203-797-1461

SITUATIONS WANTED

MERCHANDISE FOR SALE

CHAIRS, wooden chair set of 10, $25. 203-792-1078

CHILD'S WORKBENCH Wooden, bench, tools, wood projects, $35. call 203-770-1238

CHILD SAFETY BED RAIL Evenflo rail, easy set up, $15, call 203-770-1238

CHILD'S WOODEN BENCH 30"x10"x20", 4 compartments. below, $20. 203-770-1238

CHINA CABINET, Oak, Excellent Condition. Please call 203-743-3196. Part of Set.

COFFEE MAKER, Westbend, 12 to 30 cups, $20. 203-792-1078

COMPAQ LAPTOP v5000 used but perfect winds xp 80 gig hd 1gigram, $190. 203-568-3610

COMPUTERS desktop must go fall clean up! $150. 203-568-3610

Copier Gestetner 3222-B-W office copier.Works. Downsizing. 203-746-1700 $25.00

COUCH & LOVESEAT- black leather - good condition $100 for both - pick up in Danbury ... call 203-994-3467

COVER FOR GAZEBO CANOPY TOP ONLY FOR 12' X 12' GAZEBO BEIGE BRAND NEW $50.00 203-775-6925

MERCHANDIS

LIONEL TRAIN 3 CAR MINUTEMAN 64 Roof opens & l elevates to firing po with O27 & O gaug Very clean, no ye cracks, chips or br best offer 20

LIVING ROOM/F End Tables -solid brown - two tier $40.00 for both- s VINTAGE 50'S

Loves Beige loveseat du new 203-297-

LUGGAGE - TOURISTER H LUGGAGE SET 27" PULLMAN, 2 TOTE. BEIGE EX GOING TRAVEL $75.00 FOR 203-775-

MATTRESS & King size Pillowtop still in plastic. Sa 203-557-

MEN'S COLE-H SHOES 5 pair size 9 0747

MEN'S FERRAGAM . Vintage. $125. 203

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Keonn
Norwalk, CT
CHANGE YOUR LIFE TODAY!
CDL A and B Classes Starting Now
Financial Aid Available For Those Who Qualify
Job Placement Assistance

BROOKFIELD TWNHS 2.5br,1.5ba, new paint/crpt, deck, pool/tennis. No smkg. $1375/mo. 860-354-4193

DANBURY Eastridge Lg. studio, pool, lndry, prkg. $825+sec. 203.733-8214

DANBURY Condo Studio, fresh paint, clean/quiet, near shops/ transp., prkg. & pool. $825/mo. Owner, 203-304-1352.

BRIDGEPORT 1BRS available. Located near Hospitals. $850. Tenant pays utils. Credit check. No pets. 203-520-8875

BRIDGEPORT RENOVATED apartments! Fitness Ctr, Pool, No. End, heat/hot water included! 5 min. to BPR (203) 612-4015

BROOKFIELD 1BR, EIK, big LR, lndry, lots of prkg, $1200 incl utils. Nice/quiet area. 203.798.1432/512.3520

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PUBLIC NOTICES

LEGAL NOTICE / TOWN OF BROOKFIELD
WATER POLLUTION CONTROL AUTHORITY

The Brookfield Water Pollution Control Authority will hold a public hearing on Wednesday, November 28, 2011 at 7:00 p.m. in the Auditorium at Brookfield High School, 45 Long Meadow Hill Road, Brookfield, Connecticut for the purpose of receiving public comment with respect to the levy of Supplemental Benefit Assessments pursuant to the provisions of Section 7-249 and Section 7-250 of the General Statutes against the following properties and the owners thereof as such properties have been especially benefited by the construction of the Federal Road Sewer Extension.

Property Address	Property Owner	Supplemental Assessment
63 GREAT HERON LANE	GOLDBLATT, PAUL REVOCABLE TRUST	7,394.18
314 STILL WATER CIRCLE	WILLIAMS, MIRA E	4,837.26
315 STILL WATER CIRCLE	SEGA, SALLY A	5,670.04
322 STILL WATER CIRCLE	KENYON, WINIFRED	4,837.26
323 STILL WATER CIRCLE	ZACCARIA, ANN M	4,772.19
324 STILL WATER CIRCLE	HUNT, PATRICK J & CONCETTA M	4,837.26
325 STILL WATER CIRCLE	GROSSMAN, MYRON & ROSLYN	5,670.04
331 STILL WATER CIRCLE	CALLAHAN, JAMES & BETTY & CONLEY, DANIELLE	5,552.41
332 STILL WATER CIRCLE	SPIRO, VIRGINIA M	4,837.26
334 STILL WATER CIRCLE	WEIGHART, EDITH C	4,837.26
335 STILL WATER CIRCLE	ARCO, ALDRED & LORRAINE	5,670.04

At such hearing the owners of the property against which such Supplemental Benefit Assessments may be levied shall have an opportunity to be heard thereon. A copy of the proposed Supplemental Benefit Assessments shall be available for public inspection at the office of the Brookfield Town Clerk not later than November 16, 2012.

Dated: November 13, 2012

BROOKFIELD WATER POLLUTION CONTROL AUTHORITY
BY: Nelson Malwitz, Chairman

Blue Sky Behavioral Health, LLC is applying for a certificate of need application pursuant to section 19-a - 638 of the CT general statutes, to operate a 6 bed mental health residential living center. The address would be 124 Franklin Street in Danbury with an estimated budget for the project of $400,000.00.

LEGAL NOTICE
BROOKFIELD WATER POLLUTION CONTROL AUTHORITY
HIGH MEADOW LIFTSTATION

PROBATE NOTICES

STATE OF CONNECTICUT
COURT OF PROBATE
DANBURY PROBATE DISTRICT

NOTICE TO CREDITORS

ESTATE OF
ANNE SYROTYNSKY
(12-0536)

The Hon. Dianne E. Yamin, Judge of the Court of Probate, Danbury Probate District, by decree dated

PROBATE NOTICES

STATE OF CONNECTICUT
COURT OF PROBATE
DANBURY PROBATE DISTRICT

NOTICE TO CREDITORS

ESTATE OF
ANNA RADACHOWSKY
AKA Arin Radachowsky
(12-0524)

The Hon. Dianne E. Yamin, Judge of the Court of Probate, Danbury

GENERAL HELP WANTED

BUS DRIVER KinderCare of Danbury is seeking exp'd P/T bus driver Must have "V" endorsement or CDL class B w/ P & S or P & V endorsement. Previous childcare exp pref'd. Call 203-748-2480

CARPENTER-SKILLED All phases of construction. Min 10 yrs experience. New Milford. 860-355-5041

CDL DRIVER- Seasonal /as needed basis, Clean lic & Hazmat/ Tanker endorsement nec. Must be exp'd & know Danbury & surrounding areas. Fax resume: 203-775-1003

DIGITAL SALES MANAGER

Hearst Media Services is looking for innovative, talented, digital experts who will lead our advertising sales teams to new heights while providing optimal solutions for our advertisers. The Digital Sales Manager will be a leader who can coach and develop the digital knowledge of our staff primarily through 4-legged sales calls.

This key leader on our advertising management team will work with our sales director to build a high-performance sales team dedicated to providing comprehensive solutions to our advertisers. He/she will ensure that the sales staff meets or exceeds revenue expectations and will be responsible for the digital revenue performance of their team. Excellent presentation and closing skills are essential, as is the ability to build rapport with staff and customers. The ability to manage multiple priorities in a deadline-driven environment while being aware of the competitive environment and the continual evolution of digital media is what we are seeking.

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With all this we can offer our advertisers unmatched reach, targeting and re-targeting capabilities - from the very local to the national scale. Hearst Media Services prides itself on simplifying the marketing process for our customers, while helping advertisers track the impact of their campaigns and understand their advertising options. In short, we help [illegible] customers

GENERA

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STYLISTS CO

Applicants CT cosmetol contact Sta

HUGE FAL Several Ope Weekly P Call Laur

INSURANCE needed for mo Insurance exp medical billing detail a must. to multi-task. 8am-3pm Ema drburio@charte

LABORER-SK construction. ence. New Milf

MECHANIC EX Apply in perso Equipment, 151 (Rt 6) Newtown,

MED CONS

Hearst Media for talented, hi professionals multi-media ad team of digital

If you love to edgeable about we have the pe you to join us a ers to grow their

In addition to o greater Fairfield ties, and 13 w partnerships wit in digital and soc

With all this advertisers unm targeting capabil local to the natio

Hearst Media S on simplifying th for our custom advertisers track campaigns and vertising options.

In short, we h grow their busin experience meet monthly sales

DEC 17 2012

1a)

The proposal is for a 6 bed Mental Health Residential Living Center to be located at 124 Franklin Street in Danbury, CT. If approved, this facility would be operated by Blue Sky Behavioral Health, LLC., which also began a Clinic licensed by the CT Department of Public Health in Danbury in January 2012(See Appendix 1).For discussion purposes, a Mental Health Residential Living Center is defined by the CT Department of Public Health a facility which provides a supervised, structured and supportive group living arrangement which includes psychosocial rehabilitative services and may also provide assistance in obtaining community services to persons in need of mental health services(See Appendix 1).

2a)

i) There are several reasons for choosing the proposed service location. The first reason involves the growth of the Danbury area. According to the 2010 U.S. Census figures, the population of Danbury reached 80,893, which is a growth of 7.4%. In fact, Danbury's population grew faster than any other town in Fairfield County(See Appendix 2). Fairfield County(the County in which Danbury is located), has also the largest population base(925,899) and the highest per capita income($82,558) which is the highest of any County(See Exhibit 2). With this growth, comes the potential need for increased mental health services in the area. Danbury Hospital has already recognized this increased growth and what this growth will potentially mean to its demand. Danbury Hospital has begun construction on a 150 million dollar addition that will add 300,000 square feet to its current location(See Appendix 3). Danbury Hospital has also merged with New Milford and is also in negotiations with Norwalk Hospital for a similar merger(See Appendix 3). Danbury Hospital anticipates that these mergers will build a uniform health care system in the greater Danbury area(See Appendix 3). All 3 hospitals have a psychiatric unit which could potentially refer people to the new Residential Living Center in Danbury. Blue Sky also has already established a relationship with Danbury Hospital which it hopes to continue moving forward(See Exhibit 3).

Another potential area of referrals to the proposed location is Western Connecticut State University(WCSU) located in Danbury Connecticut. Fall enrollment from 2006-2011 shows a steady increase in enrollment(See Exhibit 4). College students have an increased incidence in mental health and substance abuse issues(See Exhibit 4). Each year, approximately 1 in 5 American students have a mental health issue, which translates to 54 million people(See Appendix 4).SAMSHA also reports that substance abuse is also a major issue in colleges(See Appendix 4). In fact, 46.6 of all substance abuse treatment admissions for college students are alcohol related(See Appendix 4). Admissions could be made to the new facility of this population provided that the primary diagnosis is a mental health disorder. The secondary disorder

could be effectively treated at Blue Sky Clinic by one of its 2 CADC licensed drug and alcohol counselors.
Another reason for the proposed location concerns the favorable response from Danbury Zoning officials for zoning approval for this project. In speaking with zoning officials, the project is permissible under the 'group home' zoning guidelines(SeeAppendix 5). Combined with this is the opportunity to lease the property with the option to buy(See Appendix 5).
A final reason for choosing the location involves the demand that Blue Sky Clinic(Part of Blue Sky Behavioral Health) has seen for residential services since it began operation in January 2012(See Appendix 5). People in Danbury and surrounding towns have asked Blue Sky Clinic staff a total of 144 times for residential referrals. While certainly there is no guarantee that all of these referrals would have been appropriate for admission or led to an admission, it certainly is promising that there is such an unsolicited demand for such services in the area.

ii)
The location of the proposed site is in the Region 5 area of the Department of Mental Health and Addiction Services(DMHAS) and is comprised of the following towns: Barkhamsted, Beacon Falls, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Goshen, Hartland, Harwinton, Kent, Litchfield, Middlebury, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, North Canaan, Oxford, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Sherman, Southbury, Thomaston, Torrington, Warren, Washington, Waterbury, Watertown, Winchester, Winsted, Wolcott, and Woodbury.

According to a 2006 report commissioned by the CT State Office of Rural Health, the health care system in CT is not equipped to handle the demand for services(See Appendix 6). The report goes on to note that mental health and substance abuse issues are becoming the most prevalent issues that effect the general population and that this trend is expected to continue to increase in the future(See exhibit 6). The report further notes that improved prevention and readily available treatment options could significantly improve conditions for individuals in the State of Connecticut(See Appendix 6).

The Danbury area was also selected for this business venture because Blue Sky Clinic(Part of Blue Sky Behavioral Health) is located in Danbury and the Clinic would be an ideal spot for people living in the proposed facility to receive mental health and substance abuse counseling and treatment. Blue Sky Clinic offers a variety of different services: psychiatrist ,therapists, Dialectical Behavior Therapy(DBT), (2) CADC drug and alcohol counselors, various groups taught on site. This collaboration between Blue Sky Clinic and the proposed facility helps unify and coordinate the quality of care that is provided to the people who reside at 124 Franklin Street.

DEC 17 2012

The final reason for the location in the Danbury area involves Danbury's unique closeness to New York State. Danbury borders New York and many nearby New York towns could potentially be a referral source for the proposed facility.

iii.

The population that would be served by this facility would be adults ages 18-64 who have a primary diagnosis of a behavioral health disorder only or potentially a secondary diagnosis of substance abuse(co occurring disorder). According to the National Institute of Mental Health(NIMH), in 2009, the U.S. Census Bureau estimated that there were 307,006,550 people living in the United States. Of that number, approximately 75.5% are 18 and older. That translates to 231,789,945(See Appendix 7). It is estimated that 26.2% of adults suffer from a diagnosable mental or substance abuse disorder in a given year, which translates to 60.7 million people(See Appendix 7). However, these numbers are considered low and the number of people with a mental health or substance abuse disorder is more likely 32.4% or 1 in 3 Americans(See Appendix 7). Mental Health and substance abuse issues have a large economic impact in terms of the cost of care and lost productivity(See Appendix 6). Increased community prevention and more effective and available treatment would improve conditions dramatically(See Appendix 6).

If the CT data is looked at, during a single year, there are an estimated 600,000 adults with mental illness including 135,000 with serious mental illness(See Appendix 6). According to CMHS data for 2010, the CT State rate for adults with co-occurring disorders is 34% while the U.S. rate is much lower at 20%(See Appendix 6). In 2006 alone, 292 Connecticut residents died by suicide according to NAMI(See Appendix 7). According to NAMI, suicide is almost always the result of undertreated mental illness.According to NAMI, CT's public mental health system provides only 24.5% of services to adults who live with serious mental illness within the State. In fact, the State of CT spent just $170 per capita on mental health agency services.In 2006, that was only 2.6%(592 million) of State spending according to Nami. Jails and prisons most often see people with mental illness. According to Nami, in 2008,3400 adults with mental illness were incarcerated.

Substance abuse statistics are also not favorable in Connecticut as well. Since stats were first kept for CT, it has been in the top 10 states for illicit drug use, marijuana use and alcohol use for the 18-25 age group according to the U.S. Department of Health and Human Services(See Appendix 7). While the need continues to rise in the State of Connecticut, according to the U.S. Dept of Health and Human Services,the number of treatment facilities in CT has declined from 247 in 2002 to 2009 in 2006(See Appendix 7). Unmet need for

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substance abuse for 18-25 year olds in CT is the highest in the nation(See Appendix 7).

To summarize, mental health and substance abuse issues consume enormous amounts of time, energy, talent and financial resources currently within the State of CT. According to Healthy CT 2010 report, mental health disorders accounted for 17,344 hospitilizations and 332 million in total hospital charges(See Appendix 8). If we additionally take a look at alcohol and substance abuse stats in CT, the figures are also not encouraging. Alcohol and substance abuse issues account for over 650 deaths on average in a given year and over 77 million dollars in charges in 2007 (See Appendix 9). In a 2012 public hearing at the State Capital, Victoria Veltri a healthcare advocate stated that the number of prevention and treatment programs for mental health and substance abuse programs within Connecticut are undersized in there amount when compared to the current need for services(See Appendix 7).

The proposed facility is gong to focus on the 18-64 population in CT. In fact, 58.3% of the people treated in the State of CT with a diagnosable mental health disorder are between the ages of 18-64(See Appendix 8).

iv.
The proposed population is currently being served by 29 Mental Health Residential Living Centers in CT (See Appendix 10). Of these 29 locations, 4 are in the Region 5 area but only 2 of the 4 are currently listed as active. The 2 that are active are both located in Waterbury which is approximately 30 minutes outside of Danbury(See Appendix 10). The applicant believes that the number of facilities (2) is low when compared to the previously stated need in Connecticut for such services and although a definite possibility, a 30 minutes commute to receive such services from the Danbury area could potentially be a barrier to some to have access to services.

v.
The present service providers are as follows:

1)
Central Naugatuck Valley Help, Inc.
900 Watertown Avenue
Waterbury, CT 06708

Similar service-yes

2)
St. Vincent DePaul Mission Of Waterbury, Inc.
Suite 6, 173 Mark Lane

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Waterbury, CT 06704

Similar service-yes

vi)
The applicant anticipates minimal if any effect on the existing providers. The first reason for this involves the geographic location of the other two providers. Both providers are in Waterbury which is at least a half hour commute outside of Danbury. The applicant believes that such a distance would significantly decrease the likelihood that someone in the Waterbury area would bypass the Waterbury facilities to come down to Danbury due to the extra travel time.
The second reason involves the unique offerings of services that this facility would provide. Some of the offerings include:budgeting group,exercise group, art therapy, music therapy, vocational job hunting group, current events group, yoga group, transportation to church, Alcoholics Anonymous and Narcotics Anonymous if necessary. When inquiring with the other 2 service providers, neither offered the diverse offerings that the proposed facility would offer.

3.
Projected Volume(See Appendix 11)

c) Provide historical volumes.

Not Applicable as this is a new service.

d) Provide a copy that support statements and give an explanation of the articles.

1) Appendix 1 provides a definition of Mental Health Residential Living Center.

2)Appendix 2 shows various stats for the Fairfield County and Danbury where the proposal would take place .

3)Appendix 3 provides a copy of an agreement between Danbury Hospital and Blue Sky Clinic. This letter demonstrates that an existing relationship is in place and that this relationship existing could potentially lead to referrals to new location. This Appendix also shows information on the addition at Danbury Hospital and how Danbury Hospital envisions the growth of this area.

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4)Appendix 4 demonstrates substance abuse and mental health issues for college students. Proposed location is close to Western CT State University(a proposed referral source).

5)Appendix 5 shows the total number of requests that Blue Sky Clinic has received by month for residential service providers. It also shows for zoning approval, leer from person we would be leasing property from and appraisal for property.

6) Appendix 6 shows the CT Rural Health Report which supports the need for increased health care services in CT.
7)Appendix 7 shows various health stats that demonstrate the high levels of mental health in the United States.

8)Appendix 8 shows the CMHS data f or 2010 mental stats.

9)Appendix 9 shows data from the Health CT 2010 Report on mental health and substance abuse stats for CT.

10)Appendix 10 shows the number of providers for Mental Healthcare Residential Living Centers in the State of CT in total.

11) Appendix 11 shows Table 1 and projected volume and the assumptions associated with the table.

12)Shows curriculum vitale's for staff.

13) Shows current DPH licenses held by applicant.

14) Proposed capital expenditures

15) Income tax returns of owners and Patient Population Mix

16) Financial proposal with and without Con

17) 3 years of financial projections

18) Financial supplemental info.

4) Quality Measures
a) The following is a list of key professionals associated with this proposal(See Appendix 12 for their curriculum vitale's)

David Palmer- CEO
Kurt Neser-Risk Manager(Assistant MGR)
David Moore-Clinic Director where clients would receive clinical services
Paul Tang- Program Manager

4b)
This proposal contributes to the quality of healthcare by adding a 3rd Mental Health Residential Living Center to Region 5 and the only one being within a half hour away from Danbury. This proposal also offers a diverse selection of services to its clients as was previously discussed.

4c)
There are no Standard of Practice Guidelines that are applicable in this proposal.

5a)
The Applicant's ownership type is an LLC.

5b)
No the Applicant does not have a non-profit status. The Applicant is a for profit LLC.

5c)
See Appendix 13 for a copy of current DPH licenses
The Applicant currently holds 2 CT DPH licenses:
1) Mental Health Day Treatment Facility
2)Facility for the Care or Treatment of Substance Abusive or Dependent Persons

5d)
i) Not Applicable as the Applicant is not a hospital.

ii) The Applicant does not have an audited financial sheet as it is a new business venture.

5e)
See Appendix 14 for Capital Expenditures

5f)
The proposal will be financed by the owners of the new facility: David Palmer and Joe Santoro who are the current owners of Blue Sky Clinic. The owners

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also intend to utilize assets of Blue Sky Clinic to assist with this new business venture as well as their personal assets. Please see Appendix 15).

6a)
(See Appendix 15 for Table 3-Patient Population Mix)

b) The assumptions used in this table come from the Applicant's personal experience in the healthcare field of over 15 years.

7a)
See Appendix 16

7b)
See Appendix 17

7c)
See Appendix 18

7d)
The proposed rate of $500/day was arrived at by the owner's years of health experience combined with checking rates with insurance companies and private companies that provide similar services. The rate would include clinical and residential services for that price.

7e)
See Attached

7f)
There are no incremental losses noted in this proposal from implementation this CON.

7g)
The proposal cost effective as it provides an opportunity for the owners to lease a property that newly renovated and have potentially half of lease payment put towards the purchase price if they choose buy it at some point and it offers potential clients rate($500day) that includes clinical and residential services.

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Appendix 1

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Licensure Of Private Freestanding Mental Health Residential Living Centers

19a-495-551. Licensure of private freestanding mental health residential living centers

(a) Definitions

(1) "Applicant" means any individual, firm, partnership, corporation or association applying for a license or renewal of a license under these regulations;

(2) "Commissioner" means the Commissioner of Health Services;

(3) "Department" means the Connecticut Department of Health services;

(4) "Director" means the individual designated by the executive director as directly responsible for the management of the residence;

(5) "Executive director" means the Chief Executive Officer of an agency or facility;

(6) "Goals" means attainable ends towards which residence or resident activities or services are directed and focused;

(7) "Governing body" means the individual or individuals with the ultimate authority and responsibility for the overall operation of a residence's program;

(8) "License" means the form of permission issued by the department that authorizes the applicant to operate a residence;

(9) "Licensee" means any individual, firm, partnership, corporation or association licensed to conduct a residence;

(10) "Objectives" means statements designed to achieve measurable and time limited statements of overall goals in an incremental process;

(11) "Physician" means an individual who has a license to practice medicine in Connecticut;

(12) "Psychosocial rehabilitation services" means services which are designed for individuals in need of mental health services which enable individuals to live, learn, and/or work in their own communities with maximum independence;

(13) "Resident" means an individual requiring the services of and admitted to a residential living center;

(14) "Residential Living Center" or "residence" means a facility which provides a supervised, structured and supportive group living arrangement which includes psychosocial rehabilitation services and may also provide assistance in obtaining necessary community services to persons in need of mental health service;

(b) Licensure Procedure

(1) No person shall operate a residence without a license issued by the Department in accordance with Connecticut General Statutes, Section 19a-491.

(2) Application for Licensure

(A) Application for the grant or renewal of a license to operate a residence shall be made in writing on forms provided by the Department; shall be signed by the person seeking the authority to operate the residence; shall be notarized, and shall include the following information:

(i) Evidence of compliance with local zoning ordinances and local building codes upon initial application and when applicable;

(ii) Local fire marshal's annual certificate of compliance;

(iii) Statement of ownership and operation;

(iv) Certificate of public liability insurance;

(v) Current organizational chart;

(vi) Description of services provided;

(vii) Names and titles of professional staff;

(viii) Evidence of financial capacity upon initial application.

(B) Application for license renewal shall be made in accordance with subdivision (A) above not less than 30 days preceding the date of expiration of the residence's current license.

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Appendix 2

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State & County QuickFacts

Fairfield County, Connecticut

People QuickFacts	Fairfield County	Connecticut
Population, 2011 estimate	925,899	3,580,709
Population, 2010 (April 1) estimates base	916,829	3,574,097
Population, percent change, April 1, 2010 to July 1, 2011	1.0%	0.2%
Population, 2010	916,829	3,574,097
Persons under 5 years, percent, 2011	6.0%	5.5%
Persons under 18 years, percent, 2011	24.4%	22.4%
Persons 65 years and over, percent, 2011	13.7%	14.4%
Female persons, percent, 2011	51.3%	51.3%
White persons, percent, 2011 (a)	80.9%	82.3%
Black persons, percent, 2011 (a)	11.8%	11.1%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.5%
Asian persons, percent, 2011 (a)	4.9%	4.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.8%	2.0%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	17.4%	13.8%
White persons not Hispanic, percent, 2011	66.0%	70.9%
Living in same house 1 year & over, percent, 2007-2011	89.4%	88.0%
Foreign born persons, percent, 2007-2011	20.1%	13.3%
Language other than English spoken at home, percent age 5+, 2007-2011	27.7%	20.8%
High school graduates, percent of persons age 25+, 2007-2011	88.4%	88.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	44.0%	35.7%
Veterans, 2007-2011	45,204	235,132
Mean travel time to work (minutes), workers age 16+, 2007-2011	28.2	24.7
Housing units, 2011	362,739	1,494,019
Homeownership rate, 2007-2011	70.4%	68.9%
Housing units in multi-unit structures, percent, 2007-2011	35.4%	34.6%
Median value of owner-occupied housing units, 2007-2011	$466,700	$293,100
Households, 2007-2011	332,139	1,360,115
Persons per household, 2007-2011	2.68	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$48,922	$37,627
Median household income, 2007-2011	$82,558	$69,243
Persons below poverty level, percent, 2007-2011	8.3%	9.5%

Business QuickFacts	Fairfield County	Connecticut
Private nonfarm establishments, 2010	27,027	89,234[1]
Private nonfarm employment, 2010	393,952	1,436,992[1]
Private nonfarm employment, percent change, 2000-2010	-11.5	-7.1[1]
Nonemployer establishments, 2010	84,224	255,793
Total number of firms, 2007	108,910	332,150
Black-owned firms, percent, 2007	4.7%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.4%	0.5%
Asian-owned firms, percent, 2007	3.3%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	5.9%	4.2%
Women-owned firms, percent, 2007	28.6%	28.1%
Manufacturers shipments, 2007 ($1000)	20,028,377	58,404,898

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Merchant wholesaler sales, 2007 ($1000)	78,881,637	107,917,037
Retail sales, 2007 ($1000)	15,702,222	52,165,480
Retail sales per capita, 2007	$17,661	$14,953
Accommodation and food services sales, 2007 ($1000)	1,861,946	9,138,437
Building permits, 2011	937	3,173

Geography QuickFacts	Fairfield County	Connecticut
Land area in square miles, 2010	624.89	4,842.36
Persons per square mile, 2010	1,467.2	738.1
FIPS Code	001	09
Metropolitan or Micropolitan Statistical Area	Bridgeport-Stamford-Norwalk, CT Metro Area	

1: Includes date not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
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State & County QuickFacts

Hartford County, Connecticut

People QuickFacts	Hartford County	Connecticut
Population, 2011 estimate	894,705	3,580,709
Population, 2010 (April 1) estimates base	894,014	3,574,097
Population, percent change, April 1, 2010 to July 1, 2011	0.1%	0.2%
Population, 2010	894,014	3,574,097
Persons under 5 years, percent, 2011	5.6%	5.5%
Persons under 18 years, percent, 2011	22.4%	22.4%
Persons 65 years and over, percent, 2011	14.7%	14.4%
Female persons, percent, 2011	51.6%	51.3%
White persons, percent, 2011 (a)	78.2%	82.3%
Black persons, percent, 2011 (a)	14.6%	11.1%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.5%
Asian persons, percent, 2011 (a)	4.5%	4.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	2.1%	2.0%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	15.7%	13.8%
White persons not Hispanic, percent, 2011	65.8%	70.9%
Living in same house 1 year & over, percent, 2007-2011	87.3%	88.0%
Foreign born persons, percent, 2007-2011	14.4%	13.3%
Language other than English spoken at home, percent age 5+, 2007-2011	23.8%	20.8%
High school graduates, percent of persons age 25+, 2007-2011	87.3%	88.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	33.9%	35.7%
Veterans, 2007-2011	57,628	235,132
Mean travel time to work (minutes), workers age 16+, 2007-2011	22.0	24.7
Housing units, 2011	375,454	1,494,019
Homeownership rate, 2007-2011	66.3%	68.9%
Housing units in multi-unit structures, percent, 2007-2011	38.6%	34.6%
Median value of owner-occupied housing units, 2007-2011	$248,000	$293,100
Households, 2007-2011	348,438	1,360,115
Persons per household, 2007-2011	2.47	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$33,991	$37,627
Median household income, 2007-2011	$64,007	$69,243
Persons below poverty level, percent, 2007-2011	11.0%	9.5%

Business QuickFacts	Hartford County	Connecticut
Private nonfarm establishments, 2010	22,843	89,234[1]
Private nonfarm employment, 2010	442,369	1,436,992[1]
Private nonfarm employment, percent change, 2000-2010	-7.2	-7.1[1]
Nonemployer establishments, 2010	54,638	255,793
Total number of firms, 2007	72,906	332,150
Black-owned firms, percent, 2007	6.3%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.5%	0.5%
Asian-owned firms, percent, 2007	3.9%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	0.0%	0.0%
Hispanic-owned firms, percent, 2007	4.1%	4.2%
Women-owned firms, percent, 2007	25.9%	28.1%
Manufacturers shipments, 2007 ($1000)	15,016,177	58,404,898

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Merchant wholesaler sales, 2007 ($1000)	15,631,406	107,917,037
Retail sales, 2007 ($1000)	13,820,736	52,165,480
Retail sales per capita, 2007	$15,811	$14,953
Accommodation and food services sales, 2007 ($1000)	1,637,963	9,138,437
Building permits, 2011	600	3,173

Geography QuickFacts	Hartford County	Connecticut
Land area in square miles, 2010	735.10	4,842.36
Persons per square mile, 2010	1,216.2	738.1
FIPS Code	003	09
Metropolitan or Micropolitan Statistical Area	Hartford-West Hartford-East Hartford, CT Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
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State & County QuickFacts

Litchfield County, Connecticut

People QuickFacts	Litchfield County	Connecticut
Population, 2011 estimate	188,789	3,580,709
Population, 2010 (April 1) estimates base	189,927	3,574,097
Population, percent change, April 1, 2010 to July 1, 2011	-0.6%	0.2%
Population, 2010	189,927	3,574,097
Persons under 5 years, percent, 2011	4.6%	5.5%
Persons under 18 years, percent, 2011	21.0%	22.4%
Persons 65 years and over, percent, 2011	16.4%	14.4%
Female persons, percent, 2011	50.6%	51.3%
White persons, percent, 2011 (a)	94.9%	82.3%
Black persons, percent, 2011 (a)	1.7%	11.1%
American Indian and Alaska Native persons, percent, 2011 (a)	0.3%	0.5%
Asian persons, percent, 2011 (a)	1.7%	4.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.5%	2.0%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	4.8%	13.8%
White persons not Hispanic, percent, 2011	90.9%	70.9%
Living in same house 1 year & over, percent, 2007-2011	91.4%	88.0%
Foreign born persons, percent, 2007-2011	6.3%	13.3%
Language other than English spoken at home, percent age 5+, 2007-2011	9.1%	20.8%
High school graduates, percent of persons age 25+, 2007-2011	91.3%	88.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	32.7%	35.7%
Veterans, 2007-2011	15,886	235,132
Mean travel time to work (minutes), workers age 16+, 2007-2011	26.7	24.7
Housing units, 2011	88,045	1,494,019
Homeownership rate, 2007-2011	78.9%	68.9%
Housing units in multi-unit structures, percent, 2007-2011	21.5%	34.6%
Median value of owner-occupied housing units, 2007-2011	$279,600	$293,100
Households, 2007-2011	76,477	1,360,115
Persons per household, 2007-2011	2.44	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$37,249	$37,627
Median household income, 2007-2011	$71,497	$69,243
Persons below poverty level, percent, 2007-2011	6.1%	9.5%

Business QuickFacts	Litchfield County	Connecticut
Private nonfarm establishments, 2010	4,969	89,234[1]
Private nonfarm employment, 2010	51,583	1,436,992[1]
Private nonfarm employment, percent change, 2000-2010	-12.4	-7.1[1]
Nonemployer establishments, 2010	16,926	255,793
Total number of firms, 2007	21,435	332,150
Black-owned firms, percent, 2007	1.6%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.6%	0.5%
Asian-owned firms, percent, 2007	1.5%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	1.1%	4.2%
Women-owned firms, percent, 2007	28.5%	28.1%
Manufacturers shipments, 2007 ($1000)	D	58,404,898

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Merchant wholesaler sales, 2007 ($1000)	D	107,917,037
Retail sales, 2007 ($1000)	2,458,157	52,165,480
Retail sales per capita, 2007	$13,043	$14,953
Accommodation and food services sales, 2007 ($1000)	245,161	9,138,437
Building permits, 2011	111	3,173

Geography QuickFacts	Litchfield County	Connecticut
Land area in square miles, 2010	920.56	4,842.36
Persons per square mile, 2010	206.3	738.1
FIPS Code	005	09
Metropolitan or Micropolitan Statistical Area	Torrington, CT Micro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
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Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
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Middlesex County, Connecticut

People QuickFacts	Middlesex County	Connecticut
Population, 2011 estimate	166,043	3,580,709
Population, 2010 (April 1) estimates base	165,676	3,574,097
Population, percent change, April 1, 2010 to July 1, 2011	0.2%	0.2%
Population, 2010	165,676	3,574,097
Persons under 5 years, percent, 2011	4.8%	5.5%
Persons under 18 years, percent, 2011	20.7%	22.4%
Persons 65 years and over, percent, 2011	15.9%	14.4%
Female persons, percent, 2011	51.1%	51.3%
White persons, percent, 2011 (a)	90.3%	82.3%
Black persons, percent, 2011 (a)	5.0%	11.1%
American Indian and Alaska Native persons, percent, 2011 (a)	0.2%	0.5%
Asian persons, percent, 2011 (a)	2.6%	4.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.8%	2.0%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	5.0%	13.8%
White persons not Hispanic, percent, 2011	86.1%	70.9%
Living in same house 1 year & over, percent, 2007-2011	89.4%	88.0%
Foreign born persons, percent, 2007-2011	7.6%	13.3%
Language other than English spoken at home, percent age 5+, 2007-2011	10.7%	20.8%
High school graduates, percent of persons age 25+, 2007-2011	93.0%	88.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	38.3%	35.7%
Veterans, 2007-2011	13,218	235,132
Mean travel time to work (minutes), workers age 16+, 2007-2011	24.6	24.7
Housing units, 2011	75,270	1,494,019
Homeownership rate, 2007-2011	76.1%	68.9%
Housing units in multi-unit structures, percent, 2007-2011	22.8%	34.6%
Median value of owner-occupied housing units, 2007-2011	$306,900	$293,100
Households, 2007-2011	66,798	1,360,115
Persons per household, 2007-2011	2.37	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$39,347	$37,627
Median household income, 2007-2011	$77,095	$69,243
Persons below poverty level, percent, 2007-2011	5.9%	9.5%

Business QuickFacts	Middlesex County	Connecticut
Private nonfarm establishments, 2010	4,220	89,234[1]
Private nonfarm employment, 2010	57,798	1,436,992[1]
Private nonfarm employment, percent change, 2000-2010	-4.4	-7.1[1]
Nonemployer establishments, 2010	12,938	255,793
Total number of firms, 2007	15,693	332,150
Black-owned firms, percent, 2007	1.3%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.4%	0.5%
Asian-owned firms, percent, 2007	3.4%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	0.2%	0.0%
Hispanic-owned firms, percent, 2007	1.5%	4.2%
Women-owned firms, percent, 2007	28.0%	28.1%
Manufacturers shipments, 2007 ($1000)	3,336,020	58,404,898

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Merchant wholesaler sales, 2007 ($1000)	953,882	107,917,037
Retail sales, 2007 ($1000)	2,129,195	52,165,480
Retail sales per capita, 2007	$12,980	$14,953
Accommodation and food services sales, 2007 ($1000)	293,408	9,138,437
Building permits, 2011	190	3,173

Geography QuickFacts	Middlesex County	Connecticut
Land area in square miles, 2010	369.30	4,842.36
Persons per square mile, 2010	448.6	738.1
FIPS Code	007	09
Metropolitan or Micropolitan Statistical Area	Hartford-West Hartford-East Hartford, CT Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
FN: Footnote on this item for this area in place of data
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X: Not applicable
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Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
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DEC 17 2012

New Haven County, Connecticut

100026

People QuickFacts	New Haven County	Connecticut
Population, 2011 estimate	861,113	3,580,709
Population, 2010 (April 1) estimates base	862,477	3,574,097
Population, percent change, April 1, 2010 to July 1, 2011	-0.2%	0.2%
Population, 2010	862,477	3,574,097
Persons under 5 years, percent, 2011	5.5%	5.5%
Persons under 18 years, percent, 2011	21.9%	22.4%
Persons 65 years and over, percent, 2011	14.6%	14.4%
Female persons, percent, 2011	51.8%	51.3%
White persons, percent, 2011 (a)	79.9%	82.3%
Black persons, percent, 2011 (a)	13.7%	11.1%
American Indian and Alaska Native persons, percent, 2011 (a)	0.4%	0.5%
Asian persons, percent, 2011 (a)	3.7%	4.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	2.1%	2.0%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	15.4%	13.8%
White persons not Hispanic, percent, 2011	67.2%	70.9%
Living in same house 1 year & over, percent, 2007-2011	87.8%	88.0%
Foreign born persons, percent, 2007-2011	11.6%	13.3%
Language other than English spoken at home, percent age 5+, 2007-2011	20.4%	20.8%
High school graduates, percent of persons age 25+, 2007-2011	87.8%	88.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	32.3%	35.7%
Veterans, 2007-2011	55,301	235,132
Mean travel time to work (minutes), workers age 16+, 2007-2011	24.1	24.7
Housing units, 2011	363,231	1,494,019
Homeownership rate, 2007-2011	64.8%	68.9%
Housing units in multi-unit structures, percent, 2007-2011	40.1%	34.6%
Median value of owner-occupied housing units, 2007-2011	$270,900	$293,100
Households, 2007-2011	330,396	1,360,115
Persons per household, 2007-2011	2.51	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$32,509	$37,627
Median household income, 2007-2011	$62,497	$69,243
Persons below poverty level, percent, 2007-2011	11.4%	9.5%

Business QuickFacts	New Haven County	Connecticut
Private nonfarm establishments, 2010	19,607	89,234[1]
Private nonfarm employment, 2010	321,031	1,436,992[1]
Private nonfarm employment, percent change, 2000-2010	-5.3	-7.1[1]
Nonemployer establishments, 2010	55,320	255,793
Total number of firms, 2007	74,477	332,150
Black-owned firms, percent, 2007	5.0%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.5%	0.5%
Asian-owned firms, percent, 2007	3.7%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	4.4%	4.2%
Women-owned firms, percent, 2007	28.2%	28.1%
Manufacturers shipments, 2007 ($1000)	10,493,031	58,404,898

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Merchant wholesaler sales, 2007 ($1000)	9,890,749	107,917,037
Retail sales, 2007 ($1000)	11,785,336	52,165,430
Retail sales per capita, 2007	$13,970	$14,953
Accommodation and food services sales, 2007 ($1000)	1,345,875	9,138,437
Building permits, 2011	689	3,173

Geography QuickFacts	New Haven County	Connecticut
Land area in square miles, 2010	604.51	4,842.36
Persons per square mile, 2010	1,426.7	738.1
FIPS Code	009	09
Metropolitan or Micropolitan Statistical Area	New Haven-Milford, CT Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
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State & County QuickFacts

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New London County, Connecticut

People QuickFacts	New London County	Connecticut
Population, 2011 estimate	273,502	3,580,709
Population, 2010 (April 1) estimates base	274,055	3,574,097
Population, percent change, April 1, 2010 to July 1, 2011	-0.2%	0.2%
Population, 2010	274,055	3,574,097
Persons under 5 years, percent, 2011	5.3%	5.5%
Persons under 18 years, percent, 2011	21.2%	22.4%
Persons 65 years and over, percent, 2011	14.6%	14.4%
Female persons, percent, 2011	50.1%	51.3%
White persons, percent, 2011 (a)	84.8%	82.3%
Black persons, percent, 2011 (a)	6.5%	11.1%
American Indian and Alaska Native persons, percent, 2011 (a)	1.0%	0.5%
Asian persons, percent, 2011 (a)	4.3%	4.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	3.2%	2.0%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	8.8%	13.8%
White persons not Hispanic, percent, 2011	78.1%	70.9%
Living in same house 1 year & over, percent, 2007-2011	84.7%	88.0%
Foreign born persons, percent, 2007-2011	8.5%	13.3%
Language other than English spoken at home, percent age 5+, 2007-2011	13.8%	20.8%
High school graduates, percent of persons age 25+, 2007-2011	90.1%	88.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	30.9%	35.7%
Veterans, 2007-2011	26,181	235,132
Mean travel time to work (minutes), workers age 16+, 2007-2011	22.6	24.7
Housing units, 2011	121,662	1,494,019
Homeownership rate, 2007-2011	69.4%	68.9%
Housing units in multi-unit structures, percent, 2007-2011	28.3%	34.6%
Median value of owner-occupied housing units, 2007-2011	$265,700	$293,100
Households, 2007-2011	107,115	1,360,115
Persons per household, 2007-2011	2.42	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$33,478	$37,627
Median household income, 2007-2011	$67,010	$69,243
Persons below poverty level, percent, 2007-2011	7.7%	9.5%

Business QuickFacts	New London County	Connecticut
Private nonfarm establishments, 2010	5,791	89,234[1]
Private nonfarm employment, 2010	107,017	1,436,992[1]
Private nonfarm employment, percent change, 2000-2010	1.2	-7.1[1]
Nonemployer establishments, 2010	15,886	255,793
Total number of firms, 2007	21,733	332,150
Black-owned firms, percent, 2007	2.1%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.9%	0.5%
Asian-owned firms, percent, 2007	2.8%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	2.6%	4.2%
Women-owned firms, percent, 2007	28.2%	28.1%

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Manufacturers shipments, 2007 ($1000)	D	58,404,896
Merchant wholesaler sales, 2007 ($1000)	D	107,917,037
Retail sales, 2007 ($1000)	3,882,978	52,165,480
Retail sales per capita, 2007	$14,682	$14,953
Accommodation and food services sales, 2007 ($1000)	3,444,661	9,138,437
Building permits, 2011	209	3,173

Geography QuickFacts	New London County	Connecticut
Land area in square miles, 2010	664.88	4,842.36
Persons per square mile, 2010	412.2	738.1
FIPS Code	011	09
Metropolitan or Micropolitan Statistical Area	Norwich-New London, CT Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

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Tolland County, Connecticut

000030

People QuickFacts	Tolland County	Connecticut
Population, 2011 estimate	152,507	3,580,709
Population, 2010 (April 1) estimates base	152,691	3,574,097
Population, percent change, April 1, 2010 to July 1, 2011	-0.1%	0.2%
Population, 2010	152,691	3,574,097
Persons under 5 years, percent, 2011	4.4%	5.5%
Persons under 18 years, percent, 2011	19.7%	22.4%
Persons 65 years and over, percent, 2011	12.3%	14.4%
Female persons, percent, 2011	49.5%	51.3%
White persons, percent, 2011 (a)	90.7%	82.3%
Black persons, percent, 2011 (a)	3.7%	11.1%
American Indian and Alaska Native persons, percent, 2011 (a)	0.2%	0.5%
Asian persons, percent, 2011 (a)	3.6%	4.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.7%	2.0%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	4.6%	13.8%
White persons not Hispanic, percent, 2011	87.0%	70.9%
Living in same house 1 year & over, percent, 2007-2011	84.6%	88.0%
Foreign born persons, percent, 2007-2011	6.7%	13.3%
Language other than English spoken at home, percent age 5+, 2007-2011	9.9%	20.8%
High school graduates, percent of persons age 25+, 2007-2011	92.4%	88.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	36.5%	35.7%
Veterans, 2007-2011	11,229	235,132
Mean travel time to work (minutes), workers age 16+, 2007-2011	25.1	24.7
Housing units, 2011	58,273	1,494,019
Homeownership rate, 2007-2011	76.4%	68.9%
Housing units in multi-unit structures, percent, 2007-2011	24.3%	34.6%
Median value of owner-occupied housing units, 2007-2011	$266,300	$293,100
Households, 2007-2011	54,386	1,360,115
Persons per household, 2007-2011	2.54	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$33,929	$37,627
Median household income, 2007-2011	$80,333	$69,243
Persons below poverty level, percent, 2007-2011	6.7%	9.5%

Business QuickFacts	Tolland County	Connecticut
Private nonfarm establishments, 2010	2,486	89,234[1]
Private nonfarm employment, 2010	29,156	1,436,992[1]
Private nonfarm employment, percent change, 2000-2010	NA	-7.1[1]
Nonemployer establishments, 2010	9,209	255,793
Total number of firms, 2007	11,698	332,150
Black-owned firms, percent, 2007	S	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	2.9%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	1.8%	4.2%
Women-owned firms, percent, 2007	32.5%	28.1%
Manufacturers shipments, 2007 ($1000)	1,021,759	58,404,898

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Merchant wholesaler sales, 2007 ($1000)	214,311	107,917,037
Retail sales, 2007 ($1000)	1,206,302	52,165,480
Retail sales per capita, 2007	$8,140	$14,953
Accommodation and food services sales, 2007 ($1000)	173,091	9,138,437
Building permits, 2011	333	3,173

Geography QuickFacts	Tolland County	Connecticut
Land area in square miles, 2010	410.21	4,842.36
Persons per square mile, 2010	372.2	738.1
FIPS Code	013	09
Metropolitan or Micropolitan Statistical Area	Hartford-West Hartford-East Hartford, CT Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

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Windham County, Connecticut

People QuickFacts	Windham County	Connecticut
Population, 2011 estimate	118,151	3,580,709
Population, 2010 (April 1) estimates base	118,428	3,574,097
Population, percent change, April 1, 2010 to July 1, 2011	-0.2%	0.2%
Population, 2010	118,428	3,574,097
Persons under 5 years, percent, 2011	5.3%	5.5%
Persons under 18 years, percent, 2011	21.8%	22.4%
Persons 65 years and over, percent, 2011	13.2%	14.4%
Female persons, percent, 2011	50.4%	51.3%
White persons, percent, 2011 (a)	93.2%	82.3%
Black persons, percent, 2011 (a)	2.8%	11.1%
American Indian and Alaska Native persons, percent, 2011 (a)	0.6%	0.5%
Asian persons, percent, 2011 (a)	1.3%	4.0%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	2.0%	2.0%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	9.9%	13.8%
White persons not Hispanic, percent, 2011	85.1%	70.9%
Living in same house 1 year & over, percent, 2007-2011	87.7%	88.0%
Foreign born persons, percent, 2007-2011	4.6%	13.3%
Language other than English spoken at home, percent age 5+, 2007-2011	12.6%	20.8%
High school graduates, percent of persons age 25+, 2007-2011	85.5%	88.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	22.0%	35.7%
Veterans, 2007-2011	10,485	235,132
Mean travel time to work (minutes), workers age 16+, 2007-2011	25.8	24.7
Housing units, 2011	49,345	1,494,019
Homeownership rate, 2007-2011	70.9%	68.9%
Housing units in multi-unit structures, percent, 2007-2011	26.6%	34.6%
Median value of owner-occupied housing units, 2007-2011	$227,000	$293,100
Households, 2007-2011	44,366	1,360,115
Persons per household, 2007-2011	2.56	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$27,634	$37,627
Median household income, 2007-2011	$60,063	$69,243
Persons below poverty level, percent, 2007-2011	10.9%	9.5%

Business QuickFacts	Windham County	Connecticut
Private nonfarm establishments, 2010	2,149	89,234[1]
Private nonfarm employment, 2010	28,270	1,436,992[1]
Private nonfarm employment, percent change, 2000-2010	-9.3	-7.1[1]
Nonemployer establishments, 2010	6,652	255,793
Total number of firms, 2007	8,491	332,150
Black-owned firms, percent, 2007	0.9%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.8%	0.5%
Asian-owned firms, percent, 2007	1.9%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	S	4.2%
Women-owned firms, percent, 2007	24.4%	28.1%
Manufacturers shipments, 2007 ($1000)	1,776,526	58,404,898

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Merchant wholesaler sales, 2007 ($1000)	546,686	107,917,037
Retail sales, 2007 ($1000)	1,180,554	52,165,430
Retail sales per capita, 2007	$10,120	$14,953
Accommodation and food services sales, 2007 ($1000)	136,332	9,138,437
Building permits, 2011	104	3,173

Geography QuickFacts	Windham County	Connecticut
Land area in square miles, 2010	512.91	4,842.36
Persons per square mile, 2010	230.9	738.1
FIPS Code	015	09
Metropolitan or Micropolitan Statistical Area	Willimantic, CT Micro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
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5-hour ENERGY What about caffei

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Editor Mark Langlois mark.langlois@patch.com

Government, Business, The Neighborhood Files

Danbury Population hits 80,893, 7.4 percent higher than 2000 Census

Danbury is growing faster than Fairfield County and the state, according to latest Census figures released Wednesday.

By Mark Langlois | Email the author | March 9, 2011

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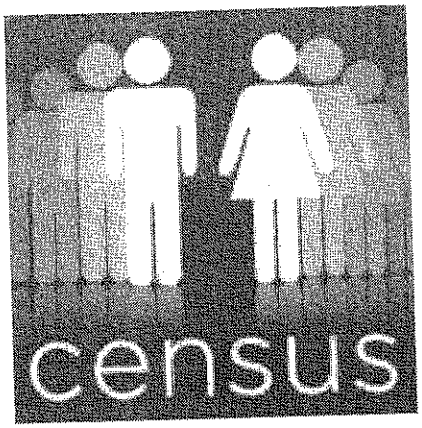

Danbury's population grew faster than Fairfield County's and the state of Connecticut's in the last decade, a released Wednesday. Danbury's Hispanic and Latino population grew at the fastest rate of any population was in 2000.

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Appendix 3

DEC 17 2012

WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL

Department of Psychiatry

24 Hospital Avenue
Danbury, Connecticut 06810
203.739.6980 phone
danburyhospital.org

January 24, 2012

Department of Public Health
State of Connecticut

Re: Department of Public Health Code 19a-495-550
Letter of Agreement between Blue Sky Behavior Health Clinic and Danbury Hospital Psychiatric Department

To Whom It May Concern,

This letter is to acknowledge that Blue Sky Behavioral Health, located at 52 Federal Rd. in Danbury, CT and Danbury Hospital Department of Psychiatry agree that Danbury Hospital's Crisis Intervention team and emergency services will evaluate patients by Blue Sky Behavioral Health in need of emergency psychiatric care. This may include temporary stabilization or inpatient care.

In the event that a client of Blue Sky Behavioral Health Day Treatment and Clinic for Adults requires emergency psychiatric services, Blue Sky's clinical staff will contact Danbury's Hospital Crisis Intervention team so that they can be prepared with information to begin the psychiatric evaluation. In collaboration with Blue Sky Behavioral Health Clinic Staff, the crisis intervention team will then determine if the patient may bypass emergency room services and be directly admitted to the psychiatric unit. Emergency services at Danbury Hospital may include but are not limited to possible psychiatric hospitalization.

Danbury Hospital's Crisis Intervention team will evaluate Blue Sky's patients following the same policies and procedures it utilizes in evaluating all emergency psychiatric patients presenting to its emergency department. This agreement is made in the effort to better coordinate care and whenever appropriate provide the ability for Blue Sky Behavioral Health clients to more readily and efficiently access psychiatric inpatient and emergency services through Danbury Hospital.

Sincerely,

Charles Herrick, MD
Chairman
Department of Psychiatry

David Gureasko-Moore, PhD
Clinic Director
Blue Sky Behavioral Health

DP 1/26/12
1/25/12
1/25/12

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1/25/2012

Patrick Broderick, MD, FACEP
Chairman
Department of Emergency Medicine
Danbury Hospital

Halana Finnie NP

Halana Finnie, MS, PMHNP, CNS-BC, FNP
Director, Patient Care Services, Behavioral Health
Danbury Hospital

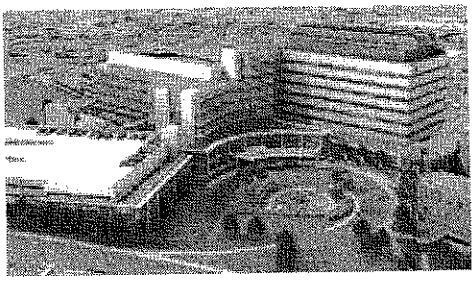
David Palmer
CEO
Blue Sky Behavioral Health

DEC 17 2014

Press Releases & Announcements

A "Towering" Achievement - Danbury Hospital's $150 Million Expansion Project to Begin this Spring

Friday, January 28, 2011 - Danbury, CT



Hospitals generally seek to improve the quality of life for their individual patients, however, Danbury Hospital is seeking to better the level of care for all of Western Connecticut and nearby New York by building a new clinical addition that will rival some of the most prominent medical institutions in the country. The hospital has plans for $150 million project that will add approximately 300,000 square feet of new construction to Danbury Hospital's existing campus, the largest expansion in the hospital's 125-year history. The contemporary North Tower building will feature a welcoming patient centered environment, more private rooms, latest technology and design efficiencies and an expanded, sophisticated Emergency Department (ED) able to service 88,000 visits per year.

Patient-Centric Model of Care

"We have always sought to deliver 'a higher level of care' in a way that positively impacts our patients and community," said John Murphy, MD, President of Danbury Hospital. "This project means that we will no longer be bound by space constraints and we can now make our patient-centric vision a reality. Our new model is all about elevating the quality of care, improving patient and physician access and maximizing patient privacy."

Dr. Murphy notes that one important way of achieving this goal is by providing single patient rooms in the new facility. According to a recent article in the Journal of the American Medical Association, single patient rooms offer many benefits to both the patient and medical provider, including:

- Increased patient privacy and cultural-sensitivity
- Enhanced patient communication among medical staff
- Improved patients' emotional and psychological well-being and, ultimately, overall health
- Lower infection rates
- Reduction of medical errors

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Building Enhancements

Dr. Murphy adds that the entire building will create a greater synergy between new and existing departments, while enhancing overall campus connectivity by featuring:

- A main entry with double height lobby space
- Shell space to accommodate a modern surgical platform in the near future
- Three 35-bed medical /surgical floors, many of which offer single rooms
- A 30-bed Intensive Care Unit / Critical Care Unit
- A 40,000 square-foot, state-of-the-art Emergency Department (ED)
- A roof-top helipad
- Added parking with covered access to the main building

Improved Emergency Department

A report by the American College for Emergency Physicians found that patients who need to be seen in 1 to 14 minutes in an ED are being seen in twice that timeframe due to overpopulation.

"When our Emergency Department was renovated in 1998, it was designed to service a maximum of 40,000 patients," adds Patrick Broderick, MD, Chairman of Emergency Services at Danbury Hospital. "Right now, nearly 70,000 patients visit our ED each year. Even though our space is limited, we've worked very hard to maintain a high level of patient satisfaction. Going forward, our new and improved ED alone will transform our ability to treat our ever-growing patient population."

Dr. Broderick notes that the increased physical space from 24,000 to 40,000 square feet will accommodate approximately 88,000 visits per year. Other amenities in the new ED include:

- A fast-track area
- A triage area
- More adult treatment rooms
- An Observation Unit for overnight observation patients, which will free-up inpatient beds located throughout other areas of the Hospital
- 100 percent private rooms instead of curtained bays for optimal infection control and patient privacy
- A dedicated radiology department with a CT scanner and 3 X-ray units
- Increased medical workstation and storage areas
- Sophisticated computer systems to give complete, up-to-the minute status reports on every patient in every emergency bed

"Overall, our new ED expansion will improve the efficiency of care for patients, as well as more appropriately accommodate the needs of a modern hospital environment," said Dr. Murphy.

Boosting the Economy

Besides being a crucial healthcare initiative, Dr. Murphy notes that the North Tower expansion project is also a major economic driver as it will create 500 new jobs and infuse an estimated $250 million into the local economy over the next few years. "This project marks a major step forward in the support of our many long-term goals, resulting in Danbury Hospital becoming a top healthcare destination in the CT and NY region," adds Dr. Murphy. "We eagerly anticipate working closely with both our medical partners and the

DEC 17 2012

greater Danbury community throughout the coming months as we build a hospital to meet today's and also the future needs of our community!"

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Ground breaking of the first phase of the project - the garage - will begin in spring 2011, and is targeted for completion in 2014.

About Danbury Hospital

Danbury Hospital is a 371-bed regional medical center and university teaching hospital associated with the University of Vermont College of Medicine, the Yale University School of Medicine, the University of Connecticut School of Medicine and Columbia University Medical Center. The hospital provides centers of excellence in cardiovascular services, cancer, weight loss surgery, orthopedics, digestive disorders, radiology and diagnostic imaging. It also offers specialized programs for sleep disorders and asthma management. Medical staff members are board-certified in their specialties, and most serve on the faculty of the nation's finest medical centers offering a higher level of experience.

For more information, or to find a doctor, visit DanburyHospital.org, or call us toll free at 1-800-516-3658.

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Appendix 4

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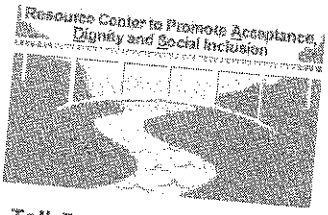
Resource Center to Promote Acceptance, Dignity and Social Inclusion

About Us | FAQs | Contact Us

Search... Go Site Data Library

000042



SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center)

Toll-Free: 1-800-540-0320
promoteacceptance@samhsa.hhs.gov

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Training Teleconferences

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Read the latest SAMHSA ADS Center Steering Committee Feature Column

Department of Health and Human Services

Substance Abuse & Mental Health Services Administration Center for Mental Health Services

Last Updated: 6/22/2012

To view or print a PDF you need to download free Adobe Reader software.

Information by AUDIENCE

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Mental Health: What a Difference Student Awareness Makes

Purpose: To give college students like you ideas for generating mental health awareness on campus.

Each year, approximately 4 million students enroll in college for the first time. Most students are on their own for the first time. With this freedom comes added pressures and anxieties?such as trying to belong in a new setting, keeping up with schoolwork, all-night study sessions, caffeine consumption, and roommates.

Sometimes these pressures can be overwhelming. Unfortunately, a fear of seeking help is common on college campuses, where the need to ?fit in? is so strong.

The negative beliefs, attitudes and discriminatory behaviors associated with mental health problems are major reasons that people do not seek help and support. In fact, while an estimated one in five Americans 18 and older?which translates to more than 54 million Americans ? will experience mental health problems in any given year,[1] fewer than 8 million will seek treatment. [2]

How Healthy Is College?

More than 16 million young people attend colleges and universities in the United States (ACHA, 2006). According to the Suicide Prevention Resource Center, one-fifth of college students experience a mental illness, and more and more students arrive on campus these days having received mental health services before starting their college careers (Suicide Prevention Resource Center, 2004). Also, increasing numbers of students are seeking help for emotional problems that occur after they arrive at college. Clinical depression often emerges for the first time in adolescence (Centers for Disease Control and Prevention, 1997).[3]

Suicide, the eighth leading cause of death for all Americans, is the second leading cause of death for college -age individuals. College-age adults are especially vulnerable to mental health problems, in part because many mental health issues first emerge in the late teens or early 20s. Overall, an estimated 27 percent of young adults between the ages of 18 and 24 have diagnosable mental health problems.4

According to a study of college freshmen, their feelings about their physical and emotional health hit record lows in 2001. (The downward trends occurred before September 11.) For example, the percentage of freshmen who reported feeling that there was a very good chance they would seek personal counseling while attending college reached a 28-year high at 6.6 percent. Nearly 20 percent of first-year male students reported feeling frequently overwhelmed by what they had to do, as did more than 35 percent of first-year female students.[5]

How Can You Generate Awareness on Campus?

By teaming up with a school's campus counseling services, psychology club (e.g., Psi Chi), office of disability, office of student affairs, office of diversity, or other groups, students can raise awareness of mental health problems and the importance of good mental health—especially during May (Mental Health Month) and the first week in October (Mental Illness Awareness Week).

In addition, these ideas have been used on college campuses across the country:

- **Add signage to high-traffic areas.** Harvard University students wrote their stories about dealing with mental health problems (using just a black marker on a white board) and displayed them in the school's science center, where there was a lot of student traffic. You can also put statistics ("1 in 5 of us will experience a mental health problem") or quotes ("Mental Health Recovery Happens") on these signs and display them on campus.
- **Make a presentation** to your psychology class and/or to other students in departments related to mental health–e.g., nursing or biology. Ensure that the future leaders are familiar with mental health

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issues.

- **Incorporate mental health into Freshman Orientation.** Many new students experience a lot of stress and anxiety. See if you can schedule a speaker, distribute brochures, or show a video on mental health issues.

- **Write a letter to the editor** of your school newspaper. Tie your letter into finals time, when stress is highest; or write at the beginning of the year, when new students arrive, or at the end of the year (May Is Mental Health Month).

- **Get your message on the airwaves.** Ask your campus radio station to highlight mental health issues by airing a public service announcement (PSA).

- **Train campus leaders**. Conduct mental health education and training for resident assistants and fraternity/sorority leadership. In 2001-2002, The Campaign for America's Mental Health conducted "Finding Hope and Healing" trainings for these audiences at campuses across the country.

- **Show a movie** that spurs conversation around mental health issues. Most importantly, show a movie that depicts reality, not one that buys into the stereotypes. Movies to consider: *Girl, Interrupted*; *A Beautiful Mind*; *Bennie and Joon*; *Ordinary People;* and *Shine*.

- **Offer free mental health screenings.** Work with your school's counseling services to conduct voluntary screenings for depression, eating disorders, and drug/alcohol and/or anxiety disorders. Local mental health organizations should be able to help you set these up as well.

- **Organize a run/walk**. Every year, *Active Minds on Campus at the University of Pennsylvania* (an affiliate of *Active Minds on Campus,* a national organization) organizes a "Stamp Out Stigma" run. The national organization works with colleges around the country to sponsor mental health runs (e.g., *Active Bodies for Active Minds* at Duke University). It's a great way to engage the general student population. (Consider teaming up with a local running club to recruit runners.)

- **Organize a benefit concert.** The Harvard Mental Health Group brought together the school's talented classical, jazz, and folk artists to participate in "Melodies of the Mind," a concert that benefited a national mental health organization.

- **Organize a "De-Stress Fest."** Every semester, Metro State College of Denver offers a day where the student lounge is transformed into a haven for unwinding and learning self-care. With the student health center, they invite massage therapists, aroma therapists, acupuncturists, biofeedback technicians, nutritionists, touch therapists, and Tai Chi specialists who provide nontraditional techniques of stress reduction. The center also sets up a "relaxation booth" where students engage in "Massage for the Masses," presenting free yoga and massage as a means to reduce stress.

- **Establish your own group.** National organizations like *Active Minds, Inc.*, and *Mentality* help mobilize students to create their own group on campus.

"Making participation enjoyable, publicizing events, and recruiting others are central to the effectiveness of your events," says Alison Malmon, founder of Active Minds on Campus.

Which Organizations Can Help?

Active Minds on Campus http://www.activeminds.org/ , a national organization, is specifically focused on college mental health issues and helping colleges create campaigns to counter stigma and discrimination. National organizations such as National Alliance on Mental Illness (*NAMI on Campus*) http://www.nami.org , the National Mental Health Association http://www.nmha.org/ (*Finding Hope and Help*), and the National Mental Health Awareness Campaign http://www.nostigma.org (*Change Your Mind*) have college campaigns and provide ideas and materials for college students. The Jed Foundation http://www.jedfoundation.org is an organization committed to reducing the youth suicide rate and strengthening the mental health safety net provided to college students nationwide.

The resources named here are neither an exhaustive list nor imply endorsement by SAMHSA or the U.S. Department of Health and Human Services.

Building Bridges. Mental Health on Campus: Student Mental Health Leaders and College Administrators, Counselors, and Faculty in Dialogue, provides information on the Mental Health on Campus dialogue meeting where student mental health consumers and college representatives discussed openly attitudes and practices that either hinder or promote recovery. Meeting participants identified attitudinal, cultural, and systemic barriers to mental health, and developed a set of recommendations to overcome them. http://download.ncadi.samhsa.gov/ken/pdf/SMA07-4310/Building_Bridges_62p.pdf

Free teleconference training on this topic is available at Web site stopstigma.samhsa.gov/archtel.htm. Scroll to **Combating Stigma on Campus** for instructions. Also, articles, fact sheets, resource organizations, and other materials on this topic are available at Web site http://www.promoteacceptance.samhsa.gov/teleconferences/archive/default.aspx

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For more information about how to address discrimination and stigma, contact the SAMHSA Resource Center to Promote Acceptance, Dignity and Social Inclusion (ADS Center) http://www.promoteacceptance.samhsa.gov/default.aspx , e-mail promoteacceptance@samhsa.hhs.gov, or call 800-540-0320, a program of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

You can also locate additional resources at http://www.whatadifference.samhsa.gov.

---

[1] http://www.nimh.nih.gov/healthinformation/statisticsmenu.cfm
[2] Mental Health: A Report of the Surgeon General (1999)
[3] *Building Bridges. Mental Health on Campus: Student Mental Health Leaders and College Administrators, Counselors, and Faculty in Dialogue.* (2007). HHS Pub. No. SMA-4310. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
[4] http://www.nami.org/Template.cfm?Section=NAMI_on_Campus&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=19&ContentID=12235
[5] http://www.gseis.ucla.edu/heri/norms_pr_01.html

This Web site was developed under contract with the Office of Consumer Affairs in SAMHSA's Center for Mental Health Services. The views, opinions, and content provided on this Web site do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. The resources listed in this Web site are not all-inclusive and inclusion on this Web site does not constitute an endorsement by SAMHSA or HHS.

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Skip Repetitive Navigation

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Substance Abuse & Mental Health Services Administration

SAMHSA News Release

Date: 2/7/2012 12:05 AM
Media Contact: SAMHSA Press Office
Telephone: 240-276-2130

Nearly half of all substance abuse treatment admissions involving college students were primarily for treating alcohol disorders

New report shows college students have a significantly higher rate of treatment admissions for alcohol problems than their non-student counterparts

A new report shows that nearly half (46.6 percent) of all substance abuse treatment admissions involving college or other post secondary school students ages 18 to 24 were primarily related to alcohol disorders. The rate of primary alcohol-related treatment admissions is far higher among college students than for non-college students in the same age bracket (46.6 percent versus 30.6 percent) according to this new report by the Substance Abuse and Mental Health Services Administration (SAMHSA).

"This report confirms the pervasive and potentially devastating role that alcohol plays on far too many college campuses," said SAMHSA Administrator Pamela S. Hyde. "Other SAMHSA studies have shown that one in four full-time college students have experienced past year alcohol abuse or dependence. SAMHSA is working with the academic community and its partners in behavioral health to help students prevent exposure to the dangers of alcohol misuse and encourage those who have a problem to seek treatment."

The SAMHSA report shows that in 2009 there were 12,000 treatment admissions involving college students. While the rate of college student treatment admissions linked primarily to alcohol was far higher than for non-college students, both groups had similar admission rates for primary marijuana-related problems – 30.9 percent for college students versus 30 percent for non-college students.

College students had lower rates of treatment admissions than nonstudents their age for other types of primary substance abuse such as:

- Heroin – 7.2 percent for college students versus 16.1 percent for nonstudents
- Other opiates– 8.3 percent for college students versus 10.5 percent for nonstudents
- Cocaine – 1.9 percent for college students versus 4.2 percent for nonstudents
- Methamphetamine – 1 percent for college students versus 4.4 percent for nonstudents

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For those seeking help with a substance abuse problem SAMHSA offers an on-line treatment locator service that can be accessed at www.samhsa.gov/treatment or by calling 1-800-662-HELP (4357).

Valuable information about the prevention and treatment of alcohol use and misuse by college students is available at: http://www.collegedrinkingprevention.gov.

The report *Data Spotlight: Nearly Half of College Student Admissions Were for Alcohol Abuse,* is based on SAMHSA's 2009 Treatment Episode Data Set(TEDS). The TEDS report collects and analyzes reports by thousands of substance abuse treatment facilities throughout the nation. TEDS is an administrative data system that indicates the national flow of admissions to specialty providers of substance abuse treatment. This report is available on the web at: http://www.samhsa.gov/data/spotlight/Spotlight054College2012.pdf. For related publications and information visit the SAMHSA website at www.samhsa.gov.

SAMHSA is a public health agency within the Department of Health and Human Services. Its mission is to reduce the impact of substance abuse and mental illness on America's communities.

Last updated: 2/7/2012 8:21 AM

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"Knocking at the College Door – Projections of High School Graduates by State and Ethnicity, 1992 – 2002", March 2008, from the Western Interstate Commission for Higher Education).

Danbury High School is WCSU's largest feeder, and its projected senior class size does not follow the state-wide pattern of steady decline. It fluctuates from year-to-year, sometimes growing by as much as 10 percent one year only to decline by a similar degree the following year. (See Appendix 2, page 18 of "Danbury Public Schools Enrollment Projected to 2021") In many years, Danbury's cohort moves in the opposite direction of the state cohort or declines by a smaller percentage than the state cohort. Years like 2012, however, where Danbury's cohort declines by a larger percentage than the state cohort (-6.08% for Danbury vs. -1.64% for the state) look to be very difficult for WCSU.

WCSU – Fall Enrollment – By Head Count

Period	# UG	# Grad	Total	% Chg
Fall 2006	5,384	702	6,086	+3.03%
Fall 2007	5,519	692	6,211	+2.05%
Fall 2008	5,769	693	6,462	+4.04%
Fall 2009	5,869	748	6,617	+2.40%
Fall 2010	5,960	622	6,582	-0.53%
Fall 2011	5,815	592	6,407	-2.66%
Fall 2012	TBD	TBD	TBD	TBD

Residential Students:

For several years during the past decade, WCSU could not meet the demand for student housing, even after converting 123 rooms to triple occupancy from double occupancy, and we risked losing students for whom we could not provide housing. During this time, we reached out to BRT, Inc. to help satisfy the demand with housing at Brookview Commons. During the last few years however, largely as a result of the weak economy, demand fell sharply, and WCSU began FY12 with empty beds. The housing program makes a substantial contribution to the health of WCSU's overall finances. Housing vacancies represent lost revenue.

Demand for WCSU On-Campus Housing

Year	Average Number of Occupied Beds (Fall & Spring)
2007	1,594
2008	1,489 (Fairfield closed for renovation)
2009	1,556
2010	1,618
2011	1,583
2012	1,504
2013	1,505

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Appendix 5

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Request at Blue Sky Clinic for a Residential Provider

January-8
Feb- 10
March 14
April- 7
May 22
June 16
July 10
Aug 21
Sept 12
Oct 15
Nov 9

---

144 people

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CITY OF DANBURY
155 DEER HILL AVENUE
DANBURY, CONNECTICUT 06810

PLANNING & ZONING DEPARTMENT
(203) 797-4525
(203) 797-4586 (FAX)

November 15, 2012

Blue Sky Behavioral Health, LLC
David Palmer, CEO
124 Franklin Street
Danbury, CT 06810

Subject: **124 Franklin Street,** Assessor's Lot # G13030
RA-40 Zone, Group Home

To Whom It May Concern:

I am the duly appointed Zoning Enforcement Officer of the City of Danbury, County of Fairfield, in the State of Connecticut.

The Planning and Zoning Department of the City of Danbury approves the use of **124 Franklin Street** as a Group Home, as defined in the City of Danbury Zoning Regulations. It is understood that the residents living at this facility have a primary diagnosis of a mental health impairment and are not capable of living independently.

Please do not hesitate to contact me if there are any further questions.

Sean P. Hearty

Zoning Enforcement Officer

SPH:pml

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Grading. Any stripping, excavation, filling, stockpiling, or any combination thereof, and also including the land in its excavated or filled condition.

Grading Permit. A permit issued by the Environmental Inspector or other staff person designated by the Director of Health to authorize work to be performed under Section 8.A.

Grocery store. Any store (also known as a supermarket, food store or food market) which is primarily engaged in the sale of a wide variety of baked goods, beverages, canned goods, frozen foods, cereals, dairy products, produce, meats, seafood, and poultry. Specialty food stores primarily engaged in the sale of a limited line of foods and/or condiments (e.g. cheese, chocolate, jellies and jams, herbs and spices) shall, for the purposes of these Regulations, be defined as retail stores and subject to all regulations herein for retail stores.

Grocery store beer permit. A permit granted by the Connecticut Department of Liquor Control to any grocery store as defined herein allowing the retail sale of beer in standard containers not to be consumed on the premises.

Group day care home. The use of land and structures for a program of supplementary care, licensed by the State, for not less than 7 nor more than 12 related or unrelated children on a regular basis for a part of the 24 hours in one or more days in the week.

Group home. A one family dwelling shared by six or fewer handicapped persons and necessary resident staff members who live together as a single housekeeping unit and in a long-term, family-like environment in which staff persons provide care, education, and participation in community activities for the residents with the primary goal of enabling the resident to live as independently as possible in order to reach their maximum potential. As used herein, the term "handicapped" shall mean having: (1) a physical or mental impairment that substantially limits one or more of such person's major life activities so that such person is incapable of living independently; (2) a record of having such an impairment; or (3) being regarded as having such an impairment. However, "handicapped" shall not include current illegal use of or addiction to a controlled substance, nor shall it include any person whose residency in the home would constitute a direct threat to the health and safety of other individuals. The term "group home for the handicapped" shall not include alcoholism or drug treatment centers, work release facilities for convicts or ex-convicts, or other housing facilities serving as an alternative to incarceration.

Hazardous materials. Any substance or combination of substances which, because of quantity, concentration, or physical, chemical, or infectious characteristics, pose a present or potential hazard to soil, groundwater, surface water, atmosphere, wildlife, vegetation, or human health if discharged, placed, or disposed into or onto any land or water within the municipal boundaries of the City. Hazardous materials include but are not limited to any of the following chemical substances: (1) any substance on the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA) Hazardous Substance list (40 CFR 355.20); (2) any substance on the Superfund Amendments and Reauthorization Act of 1986 (SARA) list of "Extremely Hazardous Substances" (40 CFR 355); (3) any "Hazardous Chemical" as defined by the Federal Occupational Safety and Health Administration (OSHA) pursuant to the Hazardous Communication Act (29 CFR 1910.1200); (4) any substance on the "Toxic Chemicals" list promulgated by SARA (40 CFR 372.45); (5) any substance on the Hazardous Substances list promulgated by DOT (40 CFR 172.101); and, (6) any substance as defined by Danbury's "Hazardous Substances Ordinance" (40 CFR 117.3).

Health center. A business whose primary purpose is to provide facilities and programs for athletic, physical fitness, or weight reduction activities, including gymnasiums, swimming pools, game courts, exercise equipment, locker rooms, shower or bath facilities, saunas, and similar facilities and services. Services may also include therapeutic massage as an accessory use administered in conjunction with athletic, physical fitness, or weight reduction programs, provided such treatment is administered solely by a massage therapist currently licensed to practice massage therapy by the State of Connecticut.

Height. For a building, the vertical distance from the mean ground level at the building wall to the highest point of mansard, curvilinear, slanted, or flat roofs (including parapets), or to the mean level between the eaves and ridge of a gable, hip, or gambrel roof, as illustrated below.

DEC 17 2014

000052

DMC Group, LLC
52 Federal Road
Danbury, CT 06810
203-798-0104

Mr. David Palmer
Blue Sky Behavioral Health, LLC
52 Federal Road
Danbury, CT 06810

Dear Mr. Palmer:

DMC Group, LLC agrees to lease its property at 124 Franklin Street, Danbury, Connecticut 06810 to Blue Sky Behavioral Health, LLC for $5,000 per month during the application process and then upon State of Connecticut's approval of Blue Sky's application to establish a Mental Health Residential Living Center, DMC Group, LLC agrees to sell this property to Blue Sky Behavioral Health for the sum of $600,000.00.

If there is any further information that you require, please do not hesitate to contact me.

Sincerely,

Jose P. Boa

JPB/ch

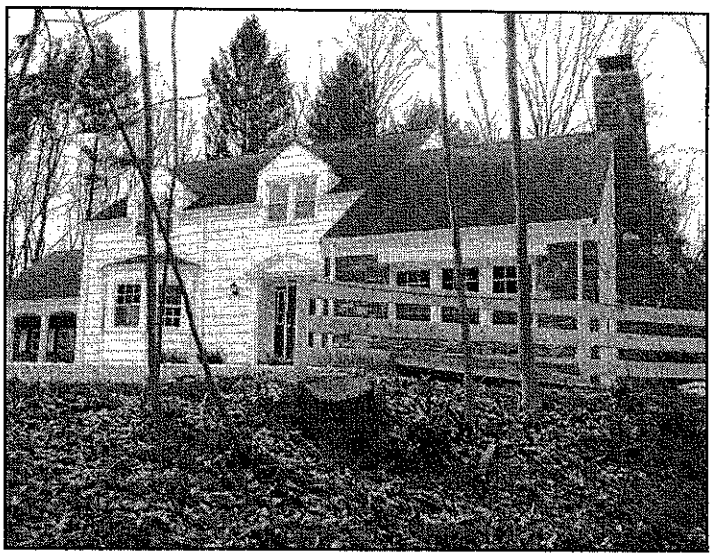
DEC 13 2012

Main File No. 11L04012

Subject Photo Page

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County FAIRFIELD	State CT	Zip Code 06811	
Lender	DAVID PALMER				

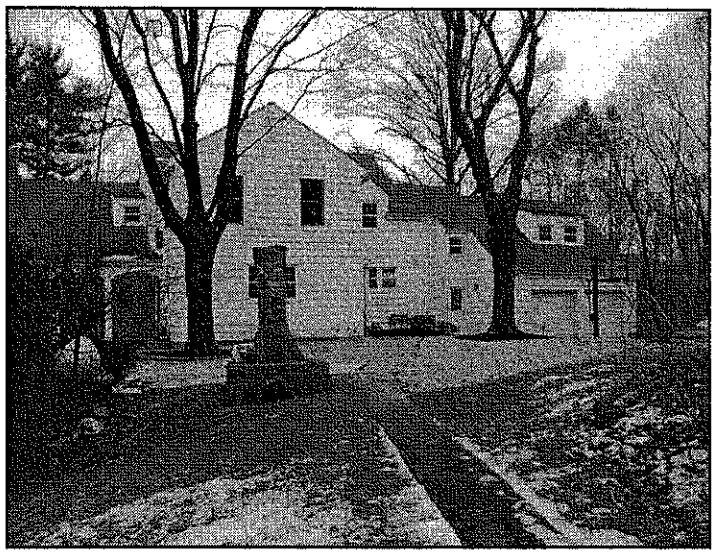
000053



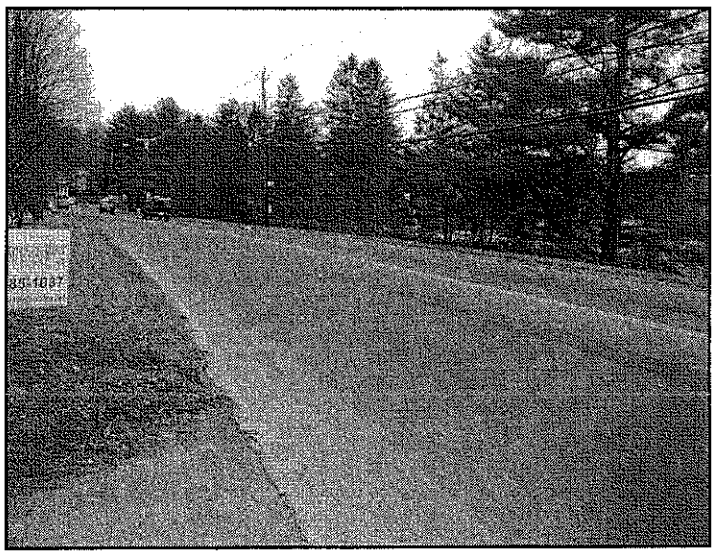
Subject Front

124 FRANKLIN STREET EXT

Sales Price	0
Gross Living Area	3,466
Total Rooms	9
Total Bedrooms	4
Total Bathrooms	4.1
Location	AVERAGE
View	RESIDENTIAL
Site	1.75 ACRE
Quality	GOOD
Age	72



Subject Rear



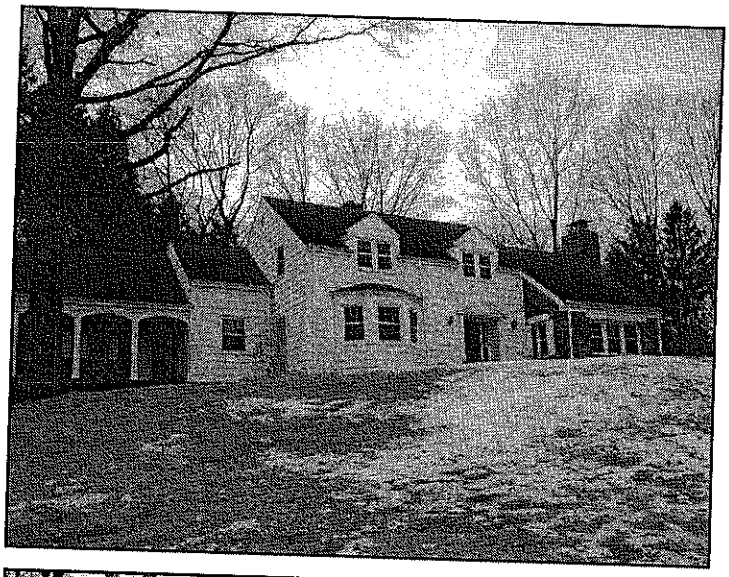
Subject Street

DEC 13 2012

Subject Photo Page

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County FAIRFIELD	State CT	Zip Code 06811	
Lender	DAVID PALMER				

000054



Subject Front

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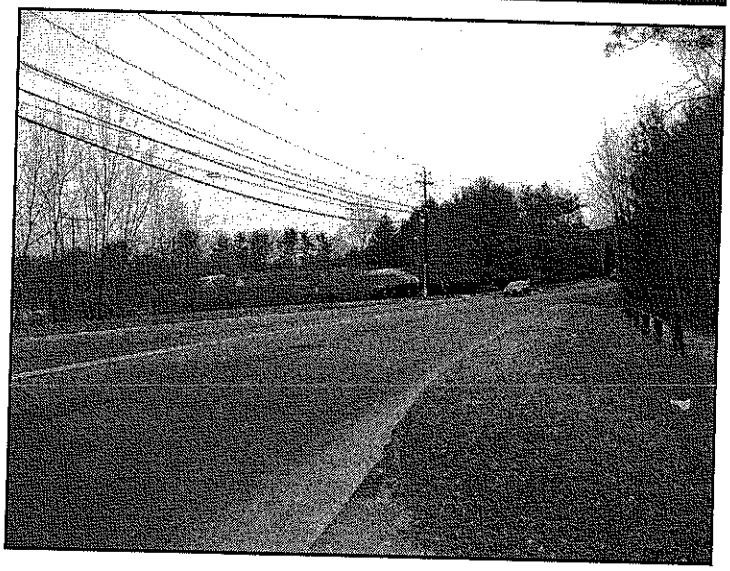
Quality	GOOD
Age	72

Subject Rear



Subject Street

DEC 17 2012

Uniform Residential Appraisal Report

File # 11L04012

The purpose of this summary appraisal report is to provide the lender/client with an accurate, and adequately supported, opinion of the market value of the subject property.

SUBJECT

Property Address 124 FRANKLIN STREET EXT | City DANBURY | State CT | Zip Code 06811

Borrower DAVID PALMER | Owner of Public Record DMC GROUP, LLC | County FAIRFIELD

Legal Description VOLUME 2180, PAGE 943 OF THE DANBURY LAND RECORDS

Assessor's Parcel # MAP G-13, LOT 30* | Tax Year 2011 | R.E. Taxes $ 5,963*

Neighborhood Name RIDGEWOOD COUNTRY CLUB | Map Reference 14860 | Census Tract 2108.00

Occupant ☐ Owner ☐ Tenant ☒ Vacant | Special Assessments $ 0 | ☐ PUD | HOA $ 0 ☐ per year ☐ per month

Property Rights Appraised ☒ Fee Simple ☐ Leasehold ☐ Other (describe)

Assignment Type ☐ Purchase Transaction ☐ Refinance Transaction ☒ Other (describe) PURCHASE DECISION

Lender/Client DAVID PALMER | Address 52 FEDERAL ROAD, DANBURY, CT

Is the subject property currently offered for sale or has it been offered for sale in the twelve months prior to the effective date of this appraisal? ☒ Yes ☐ No

Report data source(s) used, offering price(s), and date(s). MULTIPLE LISTING SERVICE #98520108. LISTED FOR SALE ON 11/09/2011 FOR $425,000. SOLD ON 05/22/2012 FOR $320,000.

CONTRACT

I ☐ did ☐ did not analyze the contract for sale for the subject purchase transaction. Explain the results of the analysis of the contract for sale or why the analysis was not performed. N/A

Contract Price $ 0 | Date of Contract N/A | Is the property seller the owner of public record? ☒ Yes ☐ No | Data Source(s) LAND RECORDS

Is there any financial assistance (loan charges, sale concessions, gift or downpayment assistance, etc.) to be paid by any party on behalf of the borrower? ☐ Yes ☒ No

If Yes, report the total dollar amount and describe the items to be paid. 0 $0;;

NEIGHBORHOOD

Note: Race and the racial composition of the neighborhood are not appraisal factors.

Neighborhood Characteristics				One-Unit Housing Trends				One-Unit Housing				Present Land Use %	
Location	☐ Urban	☒ Suburban	☐ Rural	Property Values	☐ Increasing	☒ Stable	☐ Declining	PRICE $ (000)	AGE (yrs)			One-Unit	100 %
Built-Up	☒ Over 75%	☐ 25-75%	☐ Under 25%	Demand/Supply	☐ Shortage	☒ In Balance	☐ Over Supply	135	Low	1		2-4 Unit	%
Growth	☐ Rapid	☒ Stable	☐ Slow	Marketing Time	☐ Under 3 mths	☒ 3-6 mths	☐ Over 6 mths	660	High	125		Multi-Family	%
Neighborhood Boundaries	NORTH: WEST KING STREET, EAST: ROUTE 39, SOUTH: INTERSTATE 84, WEST: NEW YORK STATE LINE.							425	Pred.	55		Commercial	%
												Other	%

Neighborhood Description SUBJECT PROPERTY IS LOCATED IN THE CENTRAL SECTION OF DANBURY. THE AREA IS COMPRISED OF SINGLE FAMILY RESIDENCES OF MIXED DESIGNS AND VARYING SIZES, WITH AVERAGE TO GOOD APPEAL. RETAIL AND SERVICE ESTABLISHMENTS AND MAJOR HIGHWAYS ARE WITHIN EASY DRIVING DISTANCE. RIDGEWOOD COUNTRY CLUB IS IN THE AREA.

Market Conditions (including support for the above conclusions) INTEREST RATES WHICH RANGE FROM 3.00% TO 6.25% ARE CONSIDERED AT AN ACCEPTABLE LEVEL AND CONTRIBUTE TO A STABLE MARKET. MARKET TIME HAS INCREASED AND VALUES HAVE DECREASED IN THE PAST YEARS DUE TO AN OVERALL ECONOMIC DECLINE CAUSED IN PART BY HIGH UNEMPLOYMENT & FORECLOSURES.

SITE

Dimensions 397.87 X 325.21 X 284.36 X 90.35 | Area 1.75 ACRE | Shape IRREGULAR | View RESIDENTIAL

Specific Zoning Classification (R-40) | Zoning Description SINGLE FAMILY, MINIMUM 40,000sf SITE

Zoning Compliance ☒ Legal ☐ Legal Nonconforming (Grandfathered Use) ☐ No Zoning ☐ Illegal (describe)

Is the highest and best use of subject property as improved (or as proposed per plans and specifications) the present use? ☒ Yes ☐ No If No, describe

Utilities	Public	Other (describe)		Public	Other (describe)	Off-site Improvements - Type	Public	Private
Electricity	☒	☐	Water	☐	☒ WELL/TYPICAL	Street ASPHALT	☒	☐
Gas	☐	☒ PROPANE	Sanitary Sewer	☐	☒ SEPTIC/TYPICAL	Alley NONE	☐	☐

FEMA Special Flood Hazard Area ☐ Yes ☒ No | FEMA Flood Zone X | FEMA Map # 09001C0138F | FEMA Map Date 06/18/2010

Are the utilities and off-site improvements typical for the market area? ☒ Yes ☐ No If No, describe

Are there any adverse site conditions or external factors (easements, encroachments, environmental conditions, land uses, etc.)? ☐ Yes ☒ No If Yes, describe

THERE WERE NO ADVERSE EASEMENTS OR CONDITIONS NOTED AT THE TIME OF THIS APPRAISAL OR IN THE DEED FOR THE SUBJECT PROPERTY. WELL AND SEPTIC SYSTEMS ARE TYPICAL TO THE AREA AND DO NOT HAVE AN ADVERSE AFFECT ON MARKETABILITY. SUBJECT SITE BORDERS ON INTERSTATE 84.

IMPROVEMENTS

General Description		Foundation		Exterior Description	materials/condition	Interior	materials/condition
Units	☒ One ☐ One with Accessory Unit	☐ Concrete Slab	☐ Crawl Space	Foundation Walls	CONC-BLK/AVG	Floors	HRDWD-TILE/GD
# of Stories	1	☒ Full Basement	☐ Partial Basement	Exterior Walls	WD SHNGLE/AVG	Walls	DRYWL-PLST/GD
Type	☒ Det. ☐ Att. ☐ S-Det./End Unit	Basement Area	1,116 sq.ft.	Roof Surface	ASPH SHINGL/AV	Trim/Finish	WOOD/GOOD
	☒ Existing ☐ Proposed ☐ Under Const.	Basement Finish	50 %	Gutters & Downspouts	ALUMINUM/AVG	Bath Floor	CERAMIC/GOOD
Design (Style)	COLONIAL	☒ Outside Entry/Exit	☐ Sump Pump	Window Type	DBLE HUNG/AVG	Bath Wainscot	PLASTER/GOOD
Year Built	1940	Evidence of	☐ Infestation	Storm Sash/Insulated	ALUMINUM/AVG	Car Storage	☐ None
Effective Age (Yrs)	15	☐ Dampness	☐ Settlement	Screens	YES/AVG	☒ Driveway	# of Cars 5
Attic	☒ None	Heating ☒ FWA	☐ HWBB ☐ Radiant	Amenities	☐ Woodstove(s) # 0	Driveway Surface	ASPHALT
☐ Drop Stair	☐ Stairs	☐ Other	Fuel GAS	☒ Fireplace(s) # 2	☐ Fence NONE	☒ Garage	# of Cars 2
☐ Floor	☐ Scuttle	Cooling	☒ Central Air Conditioning	☒ Patio/Deck PATIO	☒ Porch OPEN	☐ Carport	# of Cars 0
☐ Finished	☐ Heated	☐ Individual	☐ Other	☐ Pool NONE	☐ Other	☒ Att.	☐ Det. ☐ Built-in

Appliances ☒ Refrigerator ☒ Range/Oven ☒ Dishwasher ☐ Disposal ☒ Microwave ☐ Washer/Dryer ☐ Other (describe)

Finished area above grade contains: 9 Rooms 4 Bedrooms 4.1 Bath(s) 3,466 Square Feet of Gross Living Area Above Grade

Additional features (special energy efficient items, etc.). FIREPLACE IN LIVING ROOM & BASEMENT FAMILY ROOM, COVERED PORCHES, FINISHED BASEMENT OF GOOD QUALITY MATERIALS AND WORKMANSHIP.

Describe the condition of the property (including needed repairs, deterioration, renovations, remodeling, etc.). SUBJEC PROPERTY WAS PURCHASED IN POOR CONDITION AND REMODELED. WORK PERFORMED INCLUDE, BUT MAY NOT BE LIMITED TO: REMODELED KITCHEN AND BATHS, NEW FINISHED BASEMENT, NEW AND REFINISHED FLOORS, NEW INTERIOR PAINT, NEW ASPHALT DRIVEWAY, NEW SEPTIC SYSTEM. THE WORK PERFORMED APPEARS TO BE OF GOOD QUALITY MATERIALS AND WORKMANSHIP.

Are there any physical deficiencies or adverse conditions that affect the livability, soundness, or structural integrity of the property? ☐ Yes ☒ No If Yes, describe

Does the property generally conform to the neighborhood (functional utility, style, condition, use, construction, etc.)? ☒ Yes ☐ No If No, describe

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There are 21 comparable properties currently offered for sale in the subject neighborhood ranging in price from $ 161,900 to $ 489,900

There are 12 comparable sales in the subject neighborhood within the past twelve months ranging in sale price from $ 110,000 to $ 355,000

SALES COMPARISON APPROACH

FEATURE	SUBJECT	COMPARABLE SALE # 1		COMPARABLE SALE # 2		COMPARABLE SALE # 3	
Address	124 FRANKLIN STREET EXT DANBURY, CT 06811	6 CATALPA DR DANBURY, CT 06811		4 CHELSEA DR DANBURY, CT 06811		3 WOODSTONE CT DANBURY, CT 06811	
Proximity to Subject		2.64 MILES W		0.79 MILES W		1.98 MILES NW	
Sale Price	$ 0	$ 630,000		$ 586,000		$ 590,000	
Sale Price/Gross Liv. Area	$ sq.ft.	$ 186.83 sq.ft.		$ 157.95 sq.ft.		$ 182.55 sq.ft.	
Data Source(s)		MLS#98517350		MLS#98501105		MLS#98544089	
Verification Source(s)		TAX RECORDS		TAX RECORDS		TAX RECORDS	
VALUE ADJUSTMENTS	DESCRIPTION	DESCRIPTION	+(-) $ Adjustment	DESCRIPTION	+(-) $ Adjustment	DESCRIPTION	+(-) $ Adjustment
Sales or Financing Concessions		ArmLth Conv;0		ArmLth Conv;0		ArmLth Conv;0	
Date of Sale/Time		01/03/2012		03/05/2012		09/14/2012	
Location	AVERAGE	SUPERIOR	-31,500	SUPERIOR	-29,300	SUPERIOR	-24,500
Leasehold/Fee Simple	FEE SIMPLE	FEE SIMPLE		FEE SIMPLE		FEE SIMPLE	
Site	1.75 ACRE	1.60 ACRE		.92 ACRE	+29,300	1.57 ACRE	
View	RESIDENTIAL	RESIDENTIAL		RESIDENTIAL		RESIDENTIAL	
Design (Style)	COLONIAL	CAPE COD		COLONIAL		COLONIAL	
Quality of Construction	GOOD	GOOD		GOOD		GOOD	
Actual Age	72	9		12		13	
Condition	GOOD	GOOD		GOOD		GOOD	
Above Grade Room Count	Total 9 / Bdrms. 4 / Baths 4.1	Total 9 / Bdrms. 4 / Baths 3.1	+10,000	Total 9 / Bdrms. 4 / Baths 2.1	+20,000	Total 8 / Bdrms. 4 / Baths 2.1	+20,000
Gross Living Area	3,466 sq.ft.	3,372 sq.ft.	+2,800	3,710 sq.ft.	-7,300	3,232 sq.ft.	+7,000
Basement & Finished Rooms Below Grade	1,116 Sq.Ft. FINISHED	FULL UNFINISHED	+10,000	FULL UNFINISHED	+10,000	FULL FINISHED	
Functional Utility	AVERAGE	AVERAGE		AVERAGE		AVERAGE	
Heating/Cooling	HA/CENTRAL	HA/CENTRAL		HA/CENTRAL		HA/CENTRAL	
Energy Efficient Items	STANDARD	STANDARD		STANDARD		STANDARD	
Garage/Carport	2CAR GARAGE	2CAR GARAGE		2CAR GARAGE		2CAR GARAGE	
Porch/Patio/Deck	PRCHS, PATIO	PORCH, DECK	+2,500	PORCH, DECK	+2,500	PATIO	+5,000
FIREPLACES	2 FIREPLACES	1 FIREPLACE	+3,000	1 FIREPLACE	+3,000	1 FIREPLACE	+3,000
DAYS ON MARKET	N/A	64 DAYS	0	277 DAYS	0	52 DAYS	0
Net Adjustment (Total)		☐ + ☒ -	$ -3,200	☒ + ☐ -	$ 28,200	☒ + ☐ -	$ 10,500
Adjusted Sale Price of Comparables		Net Adj. 0.5 % Gross Adj. 9.5 %	$ 626,800	Net Adj. 4.8 % Gross Adj. 17.3 %	$ 614,200	Net Adj. 1.8 % Gross Adj. 10.1 %	$ 600,500

I ☒ did ☐ did not research the sale or transfer history of the subject property and comparable sales. If not, explain

My research ☒ did ☐ did not reveal any prior sales or transfers of the subject property for the three years prior to the effective date of this appraisal.

Data Source(s) LAND RECORDS

My research ☐ did ☒ did not reveal any prior sales or transfers of the comparable sales for the year prior to the date of sale of the comparable sale.

Data Source(s) LAND RECORDS

Report the results of the research and analysis of the prior sale or transfer history of the subject property and comparable sales (report additional prior sales on page 3).

ITEM	SUBJECT	COMPARABLE SALE #1	COMPARABLE SALE #2	COMPARABLE SALE #3
Date of Prior Sale/Transfer	05/22/2012			
Price of Prior Sale/Transfer	320,000			
Data Source(s)	LAND RECORDS	LAND RECORDS	LAND RECORDS	LAND RECORDS
Effective Date of Data Source(s)	11/27/2012	11/27/2012	11/27/2011	11/27/2012

Analysis of prior sale or transfer history of the subject property and comparable sales SUBJECT PROPERTY WAS ORIGINALLY PURCHASED ON 12/01/2006 FOR $880,000 AND FORECLOSED ON 09/06/2011. IT WAS PURCHASED AS A DISTRESSED SALE IN POOR CONDITION FOR $320,000 ON 05/22/2012 .

Summary of Sales Comparison Approach ALL SALES AND LISTINGS ARE CONSIDERED GOOD COMPARABLES AND PROVIDE A CLOSE RANGE OF VALUE. THEREFORE, EQUAL WEIGHT IS APPLIED TO ALL. A 5% LOCATION ADJUSTMENT IS APPLIED TO ALL SALES AS THEY ARE NOT LOCATED ALONG A MAJOR HIGHWAY (I-84). A 5% SITE ADJUSTMENT IS APPLIED TO SALE #2 FOR SMALLER SIZE AND LIMITED UTILITY. A $30 PER SQUARE FOOT ADJUSTMENT IS APPLIED TO THE DIFFERENCE IN GROSS LIVING AREA.

Indicated Value by Sales Comparison Approach $ 610,000

RECONCILIATION

Indicated Value by: Sales Comparison Approach $ 610,000 **Cost Approach (if developed) $** 612,989 **Income Approach (if developed) $** N/A

THE INCOME APPROACH IS NOT DEVELOPED DUE TO A LACK OF RENTAL DATA FOR RECENTLY TRANSFERRED SINGLE FAMILY DWELLINGS IN THE AREA FROM WHICH AN ESTIMATED MARKET RENT AND G.R.M. COULD BE DEVELOPED FOR THE SUBJECT. GREATEST WEIGHT IS APPLIED TO THE SALES COMPARISON APPROACH TO VALUE.

This appraisal is made ☒ "as is", ☐ subject to completion per plans and specifications on the basis of a hypothetical condition that the improvements have been completed, ☐ subject to the following repairs or alterations on the basis of a hypothetical condition that the repairs or alterations have been completed, or ☐ subject to the following required inspection based on the extraordinary assumption that the condition or deficiency does not require alteration or repair:

Based on a complete visual inspection of the interior and exterior areas of the subject property, defined scope of work, statement of assumptions and limiting conditions, and appraiser's certification, my (our) opinion of the market value, as defined, of the real property that is the subject of this report is $ 610,000 **, as of** 11/20/2012 **, which is the date of inspection and the effective date of this appraisal.**

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ADDITIONAL COMMENTS

• ENVIRONMENTAL

SUBSTANCES SUCH AS LEAD PAINT, ASBESTOS, UREA FORMALDEHYDE FOAM INSULATION, LEAKING UNDERGROUND OIL TANK, OTHER CHEMICALS,TOXIC WASTES, OR OTHER POTENTIALLY HAZARDOUS MATERIALS COULD, IF PRESENT, ADVERSELY AFFECT THE VALUE OF THE PROPERTY. UNLESS OTHERWISE STATED IN THIS REPORT, THE EXISTENCE OF HAZARDOUS SUBSTANCES OR CONDITIONS, WHICH MAY OR MAY NOT BE PRESENT ON OR IN THE PROPERTY, WAS NOT CONSIDERED BY THE APPRAISER IN THE DEVELOPMENT OF THE CONCLUSION OF FAIR MARKET VALUE.THE STATED VALUE ESTIMATE IS PREDICATED ON THE ASSUMPTION THAT THERE IS NO MATERIAL ON OR IN THE PROPERTY THAT WOULD CAUSE SUCH A LOSS IN VALUE. NO RESPONSIBILITY IS ASSUMED FOR ANY SUCH CONDITIONS, AND THE CLIENT IS INFORMED THAT THE APPRAISER IS NOT QUALIFIED TO DETECT SUCH SUBSTANCES, QUANTIFY THE IMPACT ON VALUES, OR DEVELOP THE REMEDIAL COST.

SCOPE OF APPRAISAL

THE INTENDED USER OF THIS APPRAISAL REPORT IS THE LENDER/CLIENT. THE INTENDED USE OF THIS APPRAISAL IS TO SUPPORT THE PURCHASE DECISION FOR SUBJECT PROPERTY; TO EVALUATE THE PROPERTY THAT IS THE SUBJECT OF THIS APPRAISAL FOR A MORTGAGE FINANCE TRANSACTION, SUBJECT TO THE STATED SCOPE OF WORK, PURPOSE OF THE APPRAISAL, REPORTING REQUIREMENTS OF THE APPRAISAL REPORT FORM, AND THE DEFINITION OF MARKET VALUE. NO ADDITIONAL INTENDED USER ARE IDENTIFIED BY THE APPRAISER.

WHEN PERFORMING THE INSPECTION OF THIS PROPERTY, A VISUAL INSPECTION WAS DONE IN ACCORDANCE WITH APPRAISAL GUIDELINES. THE INSPECTION IS NOT TECHNICALLY EXHAUSTIVE. THE INSPECTION DOES NOT OFFER WARRANTIES OR GUARANTEES OF ANY KIND.

IT IS ASSUMED THAT THERE ARE NO STRUCTURAL DEFECTS HIDDEN BY FLOOR OR WALL COVERINGS OR ANY OTHER HIDDEN OR UNAPPARENT CONDITIONS OF THE PROPERTY; THAT ALL MECHANICAL EQUIPMENT AND APPLIANCES ARE IN WORKING CONDITION; AND THAT ALL ELECTRICAL COMPONENTS AND THE ROOFING ARE IN GOOD CONDITION.

AT THE TIME OF INSPECTION, ALL UTILITIES WERE ON AND FUNCTIONAL.

USPAP DISCLAIMER

I HAVE PERFORMED NO SERVICES, AS AN APPRAISER OR IN ANY OTHER CAPACITY, REGARDING THE PROPERTY THAT IS THE SUBJECT OF THIS REPORT WITHIN THE THREE YEAR PERIOD IMMEDIATELY PRECEDING ACCEPTANCE OF THIS ASSIGNMENT.

IN THE APPRAISERS OPINION, A REASONABLE ESTIMATE OF "EXPOSURE TIME" FOR A PROPERTY OF SIMILAR VALUE AND WITH SIMILAR FEATURES TO THE SUBJECT WOULD BE IN THE RANGE OF 90-180 DAYS.

NEIGHBORHOOD PRICE RANGE

THE NEIGHBORHOOD PRICE RANGE REFLECTS HIGHS AND LOWS OF PREVAILING PRICES. THE PREDOMINANT PRICE IS THE NEIGHBORHOOD MODE (MOST FREQUENT OCCURRENCE). PRICES THAT ARE ABOVE OR BELOW THE PREDOMINANT ARE ALSO COMMON AND WOULD NOT INDICATE AN UNDER OR OVER IMPROVEMENT. THERE IS NO ADVERSE AFFECT WHEN AN ESTIMATE OF MARKET VALUE OCCURS ABOVE OR BELOW THE NEIGHBORHOOD MODE.

COST APPROACH

COST APPROACH TO VALUE (not required by Fannie Mae)

Provide adequate information for the lender/client to replicate the below cost figures and calculations.

Support for the opinion of site value (summary of comparable land sales or other methods for estimating site value) RECENT LAND SALES IN THE CITY OF DANBURY RANGE FROM $75,000 TO $425,000 DEPENDING ON LOCATION, SIZE, TOPOGRAPHY AND SOIL CONTENT.

ESTIMATED ☐ REPRODUCTION OR ☒ REPLACEMENT COST NEW

Source of cost data LOCAL CONTRACTOR

Quality rating from cost service AVG Effective date of cost data CURRENT

Comments on Cost Approach (gross living area calculations, depreciation, etc.)

THE AGE/LIFE METHOD IS USED TO DETERMINE ACCRUED DEPRECIATION.

OPINION OF SITE VALUE				=$ 150,000
DWELLING	3,466 Sq.Ft. @ $	120.00		=$ 415,920
	1,116 Sq.Ft. @ $	25.00		=$ 27,900
PORCHES, PATIO				=$ 20,000
Garage/Carport	441 Sq.Ft. @ $	50.00		=$ 22,050
Total Estimate of Cost-New				=$ 485,870
Less Depreciation	Physical 72,881	Functional	External	=$(72,881)
Depreciated Cost of Improvements				=$ 412,989
"As-Is" Value of Site Improvements				=$ 50,000
INDICATED VALUE BY COST APPROACH				=$ 612,989

Estimated Remaining Economic Life (HUD and VA only) 85 Years

INCOME

INCOME APPROACH TO VALUE (not required by Fannie Mae)

Estimated Monthly Market Rent $ X Gross Rent Multiplier = $ Indicated Value by Income Approach

Summary of Income Approach (including support for market rent and GRM) INCOME APPROACH IS NOT DEVELOPED DUE TO A LACK OF RENTAL DATA FOR RECENTLY TRANSFERRED SINGLE FAMILIES IN THE AREA FROM WHICH AN ESTIMATED G.R.M. COULD BE DEVELOPED.

PUD INFORMATION

PROJECT INFORMATION FOR PUDs (if applicable)

Is the developer/builder in control of the Homeowners' Association (HOA)? ☐ Yes ☐ No Unit type(s) ☐ Detached ☐ Attached

Provide the following information for PUDs ONLY if the developer/builder is in control of the HOA and the subject property is an attached dwelling unit.

Legal Name of Project

Total number of phases Total number of units Total number of units sold

Total number of units rented Total number of units for sale Data source(s)

Was the project created by the conversion of existing building(s) into a PUD? ☐ Yes ☐ No If Yes, date of conversion.

Does the project contain any multi-dwelling units? ☐ Yes ☐ No Data Source

Are the units, common elements, and recreation facilities complete? ☐ Yes ☐ No If No, describe the status of completion.

Are the common elements leased to or by the Homeowners' Association? ☐ Yes ☐ No If Yes, describe the rental terms and options.

Describe common elements and recreational facilities.

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This report form is designed to report an appraisal of a one-unit property or a one-unit property with an accessory unit; including a unit in a planned unit development (PUD). This report form is not designed to report an appraisal of a manufactured home or a unit in a condominium or cooperative project.

This appraisal report is subject to the following scope of work, intended use, intended user, definition of market value, statement of assumptions and limiting conditions, and certifications. Modifications, additions, or deletions to the intended use, intended user, definition of market value, or assumptions and limiting conditions are not permitted. The appraiser may expand the scope of work to include any additional research or analysis necessary based on the complexity of this appraisal assignment. Modifications or deletions to the certifications are also not permitted. However, additional certifications that do not constitute material alterations to this appraisal report, such as those required by law or those related to the appraiser's continuing education or membership in an appraisal organization, are permitted.

SCOPE OF WORK: The scope of work for this appraisal is defined by the complexity of this appraisal assignment and the reporting requirements of this appraisal report form, including the following definition of market value, statement of assumptions and limiting conditions, and certifications. The appraiser must, at a minimum: (1) perform a complete visual inspection of the interior and exterior areas of the subject property, (2) inspect the neighborhood, (3) inspect each of the comparable sales from at least the street, (4) research, verify, and analyze data from reliable public and/or private sources, and (5) report his or her analysis, opinions, and conclusions in this appraisal report.

INTENDED USE: The intended use of this appraisal report is for the lender/client to evaluate the property that is the subject of this appraisal for a mortgage finance transaction.

INTENDED USER: The intended user of this appraisal report is the lender/client.

DEFINITION OF MARKET VALUE: The most probable price which a property should bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller, each acting prudently, knowledgeably and assuming the price is not affected by undue stimulus. Implicit in this definition is the consummation of a sale as of a specified date and the passing of title from seller to buyer under conditions whereby: (1) buyer and seller are typically motivated; (2) both parties are well informed or well advised, and each acting in what he or she considers his or her own best interest; (3) a reasonable time is allowed for exposure in the open market; (4) payment is made in terms of cash in U. S. dollars or in terms of financial arrangements comparable thereto; and (5) the price represents the normal consideration for the property sold unaffected by special or creative financing or sales concessions* granted by anyone associated with the sale.

*Adjustments to the comparables must be made for special or creative financing or sales concessions. No adjustments are necessary for those costs which are normally paid by sellers as a result of tradition or law in a market area; these costs are readily identifiable since the seller pays these costs in virtually all sales transactions. Special or creative financing adjustments can be made to the comparable property by comparisons to financing terms offered by a third party institutional lender that is not already involved in the property or transaction. Any adjustment should not be calculated on a mechanical dollar for dollar cost of the financing or concession but the dollar amount of any adjustment should approximate the market's reaction to the financing or concessions based on the appraiser's judgment.

STATEMENT OF ASSUMPTIONS AND LIMITING CONDITIONS: The appraiser's certification in this report is subject to the following assumptions and limiting conditions:

1. The appraiser will not be responsible for matters of a legal nature that affect either the property being appraised or the title to it, except for information that he or she became aware of during the research involved in performing this appraisal. The appraiser assumes that the title is good and marketable and will not render any opinions about the title.

2. The appraiser has provided a sketch in this appraisal report to show the approximate dimensions of the improvements. The sketch is included only to assist the reader in visualizing the property and understanding the appraiser's determination of its size.

3. The appraiser has examined the available flood maps that are provided by the Federal Emergency Management Agency (or other data sources) and has noted in this appraisal report whether any portion of the subject site is located in an identified Special Flood Hazard Area. Because the appraiser is not a surveyor, he or she makes no guarantees, express or implied, regarding this determination.

4. The appraiser will not give testimony or appear in court because he or she made an appraisal of the property in question, unless specific arrangements to do so have been made beforehand, or as otherwise required by law.

5. The appraiser has noted in this appraisal report any adverse conditions (such as needed repairs, deterioration, the presence of hazardous wastes, toxic substances, etc.) observed during the inspection of the subject property or that he or she became aware of during the research involved in performing the appraisal. Unless otherwise stated in this appraisal report, the appraiser has no knowledge of any hidden or unapparent physical deficiencies or adverse conditions of the property (such as, but not limited to, needed repairs, deterioration, the presence of hazardous wastes, toxic substances, adverse environmental conditions, etc.) that would make the property less valuable, and has assumed that there are no such conditions and makes no guarantees or warranties, express or implied. The appraiser will not be responsible for any such conditions that do exist or for any engineering or testing that might be required to discover whether such conditions exist. Because the appraiser is not an expert in the field of environmental hazards, this appraisal report must not be considered as an environmental assessment of the property.

6. The appraiser has based his or her appraisal report and valuation conclusion for an appraisal that is subject to satisfactory completion, repairs, or alterations on the assumption that the completion, repairs, or alterations of the subject property will be performed in a professional manner.

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APPRAISER'S CERTIFICATION: The Appraiser certifies and agrees that:

1. I have, at a minimum, developed and reported this appraisal in accordance with the scope of work requirements stated in this appraisal report.

2. I performed a complete visual inspection of the interior and exterior areas of the subject property. I reported the condition of the improvements in factual, specific terms. I identified and reported the physical deficiencies that could affect the livability, soundness, or structural integrity of the property.

3. I performed this appraisal in accordance with the requirements of the Uniform Standards of Professional Appraisal Practice that were adopted and promulgated by the Appraisal Standards Board of The Appraisal Foundation and that were in place at the time this appraisal report was prepared.

4. I developed my opinion of the market value of the real property that is the subject of this report based on the sales comparison approach to value. I have adequate comparable market data to develop a reliable sales comparison approach for this appraisal assignment. I further certify that I considered the cost and income approaches to value but did not develop them, unless otherwise indicated in this report.

5. I researched, verified, analyzed, and reported on any current agreement for sale for the subject property, any offering for sale of the subject property in the twelve months prior to the effective date of this appraisal, and the prior sales of the subject property for a minimum of three years prior to the effective date of this appraisal, unless otherwise indicated in this report.

6. I researched, verified, analyzed, and reported on the prior sales of the comparable sales for a minimum of one year prior to the date of sale of the comparable sale, unless otherwise indicated in this report.

7. I selected and used comparable sales that are locationally, physically, and functionally the most similar to the subject property.

8. I have not used comparable sales that were the result of combining a land sale with the contract purchase price of a home that has been built or will be built on the land.

9. I have reported adjustments to the comparable sales that reflect the market's reaction to the differences between the subject property and the comparable sales.

10. I verified, from a disinterested source, all information in this report that was provided by parties who have a financial interest in the sale or financing of the subject property.

11. I have knowledge and experience in appraising this type of property in this market area.

12. I am aware of, and have access to, the necessary and appropriate public and private data sources, such as multiple listing services, tax assessment records, public land records and other such data sources for the area in which the property is located.

13. I obtained the information, estimates, and opinions furnished by other parties and expressed in this appraisal report from reliable sources that I believe to be true and correct.

14. I have taken into consideration the factors that have an impact on value with respect to the subject neighborhood, subject property, and the proximity of the subject property to adverse influences in the development of my opinion of market value. I have noted in this appraisal report any adverse conditions (such as, but not limited to, needed repairs, deterioration, the presence of hazardous wastes, toxic substances, adverse environmental conditions, etc.) observed during the inspection of the subject property or that I became aware of during the research involved in performing this appraisal. I have considered these adverse conditions in my analysis of the property value, and have reported on the effect of the conditions on the value and marketability of the subject property.

15. I have not knowingly withheld any significant information from this appraisal report and, to the best of my knowledge, all statements and information in this appraisal report are true and correct.

16. I stated in this appraisal report my own personal, unbiased, and professional analysis, opinions, and conclusions, which are subject only to the assumptions and limiting conditions in this appraisal report.

17. I have no present or prospective interest in the property that is the subject of this report, and I have no present or prospective personal interest or bias with respect to the participants in the transaction. I did not base, either partially or completely, my analysis and/or opinion of market value in this appraisal report on the race, color, religion, sex, age, marital status, handicap, familial status, or national origin of either the prospective owners or occupants of the subject property or of the present owners or occupants of the properties in the vicinity of the subject property or on any other basis prohibited by law.

18. My employment and/or compensation for performing this appraisal or any future or anticipated appraisals was not conditioned on any agreement or understanding, written or otherwise, that I would report (or present analysis supporting) a predetermined specific value, a predetermined minimum value, a range or direction in value, a value that favors the cause of any party, or the attainment of a specific result or occurrence of a specific subsequent event (such as approval of a pending mortgage loan application).

19. I personally prepared all conclusions and opinions about the real estate that were set forth in this appraisal report. If I relied on significant real property appraisal assistance from any individual or individuals in the performance of this appraisal or the preparation of this appraisal report, I have named such individual(s) and disclosed the specific tasks performed in this appraisal report. I certify that any individual so named is qualified to perform the tasks. I have not authorized anyone to make a change to any item in this appraisal report; therefore, any change made to this appraisal is unauthorized and I will take no responsibility for it.

20. I identified the lender/client in this appraisal report who is the individual, organization, or agent for the organization that ordered and will receive this appraisal report.

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21. The lender/client may disclose or distribute this appraisal report to: the borrower; another lender at the request of the borrower; the mortgagee or its successors and assigns; mortgage insurers; government sponsored enterprises; other secondary market participants; data collection or reporting services; professional appraisal organizations; any department, agency, or instrumentality of the United States; and any state, the District of Columbia, or other jurisdictions; without having to obtain the appraiser's or supervisory appraiser's (if applicable) consent. Such consent must be obtained before this appraisal report may be disclosed or distributed to any other party (including, but not limited to, the public through advertising, public relations, news, sales, or other media).

22. I am aware that any disclosure or distribution of this appraisal report by me or the lender/client may be subject to certain laws and regulations. Further, I am also subject to the provisions of the Uniform Standards of Professional Appraisal Practice that pertain to disclosure or distribution by me.

23. The borrower, another lender at the request of the borrower, the mortgagee or its successors and assigns, mortgage insurers, government sponsored enterprises, and other secondary market participants may rely on this appraisal report as part of any mortgage finance transaction that involves any one or more of these parties.

24. If this appraisal report was transmitted as an "electronic record" containing my "electronic signature," as those terms are defined in applicable federal and/or state laws (excluding audio and video recordings), or a facsimile transmission of this appraisal report containing a copy or representation of my signature, the appraisal report shall be as effective, enforceable and valid as if a paper version of this appraisal report were delivered containing my original hand written signature.

25. Any intentional or negligent misrepresentation(s) contained in this appraisal report may result in civil liability and/or criminal penalties including, but not limited to, fine or imprisonment or both under the provisions of Title 18, United States Code, Section 1001, et seq., or similar state laws.

SUPERVISORY APPRAISER'S CERTIFICATION: The Supervisory Appraiser certifies and agrees that:

1. I directly supervised the appraiser for this appraisal assignment, have read the appraisal report, and agree with the appraiser's analysis, opinions, statements, conclusions, and the appraiser's certification.

2. I accept full responsibility for the contents of this appraisal report including, but not limited to, the appraiser's analysis, opinions, statements, conclusions, and the appraiser's certification.

3. The appraiser identified in this appraisal report is either a sub-contractor or an employee of the supervisory appraiser (or the appraisal firm), is qualified to perform this appraisal, and is acceptable to perform this appraisal under the applicable state law.

4. This appraisal report complies with the Uniform Standards of Professional Appraisal Practice that were adopted and promulgated by the Appraisal Standards Board of The Appraisal Foundation and that were in place at the time this appraisal report was prepared.

5. If this appraisal report was transmitted as an "electronic record" containing my "electronic signature," as those terms are defined in applicable federal and/or state laws (excluding audio and video recordings), or a facsimile transmission of this appraisal report containing a copy or representation of my signature, the appraisal report shall be as effective, enforceable and valid as if a paper version of this appraisal report were delivered containing my original hand written signature.

APPRAISER

Signature
Name HORACIO CARDOZO
Company Name INTEGRITY REAL ESTATE E APPRAISERS
Company Address P.O. BOX 2451
SHELTON, CT 06484
Telephone Number (203) 610-3819
Email Address INTEGRITYR@SNET.NET
Date of Signature and Report 11/30/2012
Effective Date of Appraisal 11/20/2012
State Certification # RCG.0000107
or State License #
or Other (describe) State #
State CT
Expiration Date of Certification or License 04/30/2013

ADDRESS OF PROPERTY APPRAISED
124 FRANKLIN STREET EXT
DANBURY, CT 06811
APPRAISED VALUE OF SUBJECT PROPERTY $ 610,000
LENDER/CLIENT
Name
Company Name DAVID PALMER
Company Address 52 FEDERAL ROAD, DANBURY, CT
Email Address

SUPERVISORY APPRAISER (ONLY IF REQUIRED)

Signature
Name
Company Name
Company Address
Telephone Number
Email Address
Date of Signature
State Certification #
or State License #
State
Expiration Date of Certification or License

SUBJECT PROPERTY

☐ Did not inspect subject property
☐ Did inspect exterior of subject property from street
Date of Inspection
☐ Did inspect interior and exterior of subject property
Date of Inspection

COMPARABLE SALES

☐ Did not inspect exterior of comparable sales from street
☐ Did inspect exterior of comparable sales from street
Date of Inspection

Form 1004 — "WinTOTAL" appraisal software by a la mode, inc. — 1-800-ALAMODE

DEC 17 2012

Supplemental Addendum

Borrower/Client	DAVID PALMER			File No.	11L04012
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County	FAIRFIELD	State	CT Zip Code 06811
Lender	DAVID PALMER				

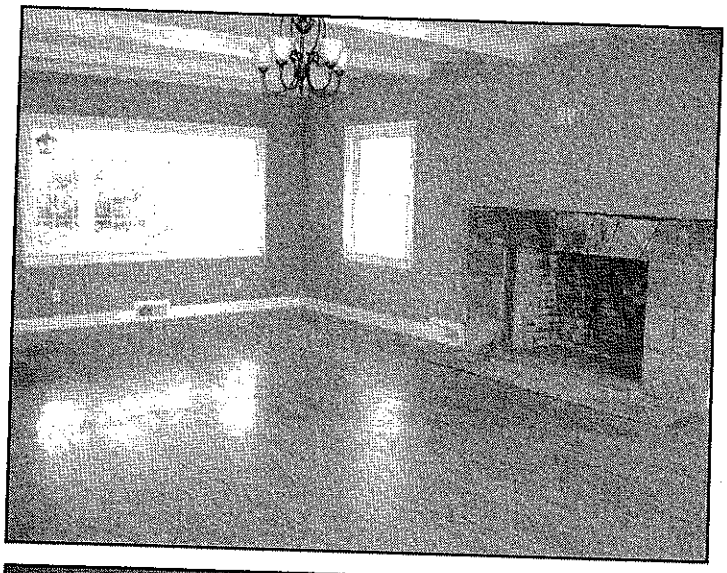
PROPERTY HISTORY

SUBJECT PROPERTY WAS PURCHASED AS A 2.893 ACRE PARCEL OF LAND WHICH WAS IMPROVED WITH SINGLE FAMILY RESIDENCE AND A 2-FAMILY DWELLING. THE PROPERTY WAS SUBDIVIDED TO SEPARATE THE TWO DWELLINGS AND ESTABLISH INDIVIDUAL PARCELS OF LAND FOR EACH DWELLING. AT THE TIME OF INSPECTION, THE ASSESSORS OFFICE OF CITY OF DANBURY HAD NOT ESTABLISHED THE INDIVIDUAL PARCEL ID'S NOR THE REAL ESTATE ASSESSMENT FOR EACH INDIVIDUAL PARCEL. THEREFORE, THE ASSESSOR PARCEL ID AND TAXES ARE BASED ON THE FORMER PROPERTY DESCRIPTION AND ASSESSMENT AND MAY BE SUBJECT TO CHANGE.

RECEIVED DEC 17 2012

Subject Interior Photo Page

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County FAIRFIELD	State CT	Zip Code 06811	
Lender	DAVID PALMER				

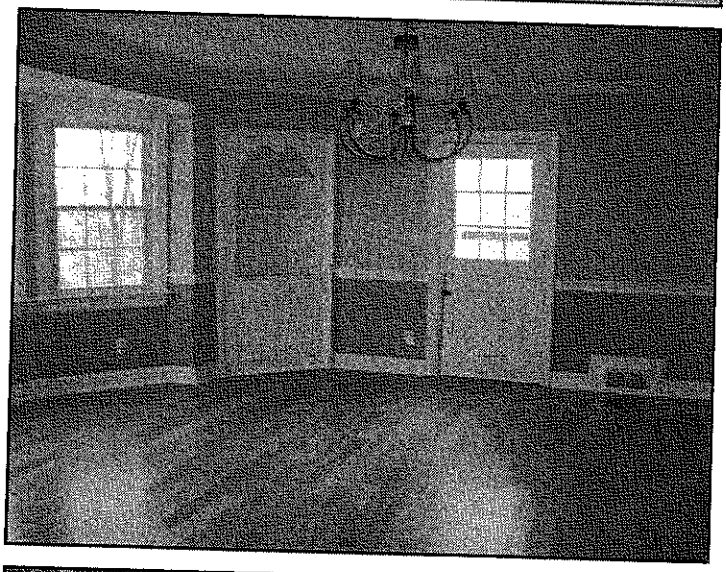


Subject Interior

124 FRANKLIN STREET EXT

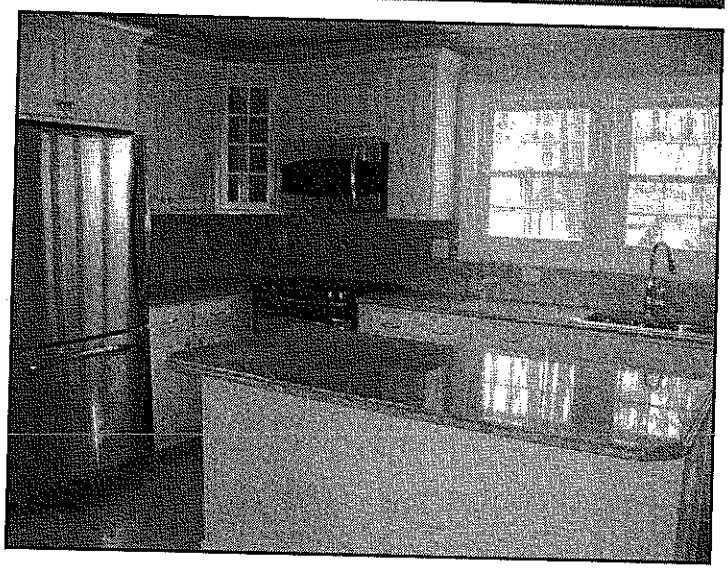
Sales Price	0
Gross Living Area	3,466
Total Rooms	9
Total Bedrooms	4
Total Bathrooms	4.1
Location	AVERAGE
View	RESIDENTIAL
Site	1.75 ACRE
Quality	GOOD
Age	72

LIVING ROOM



Subject Interior

DINING ROOM



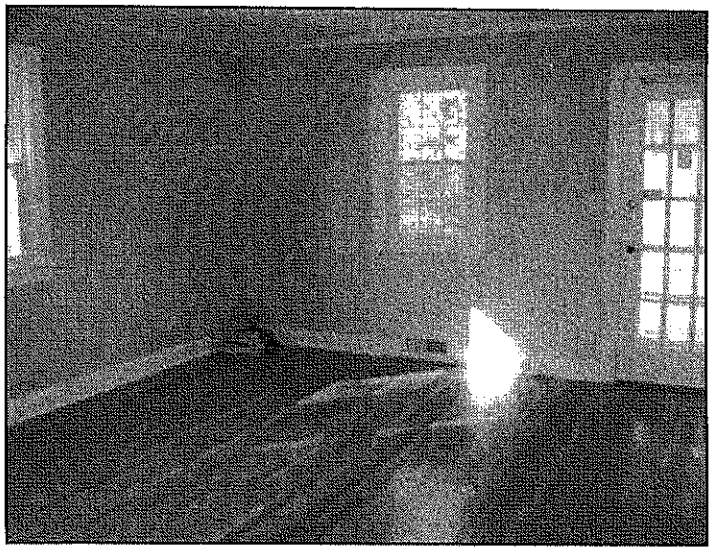
Subject Interior

KITCHEN

DEC 17 2012

Subject Interior Photo Page

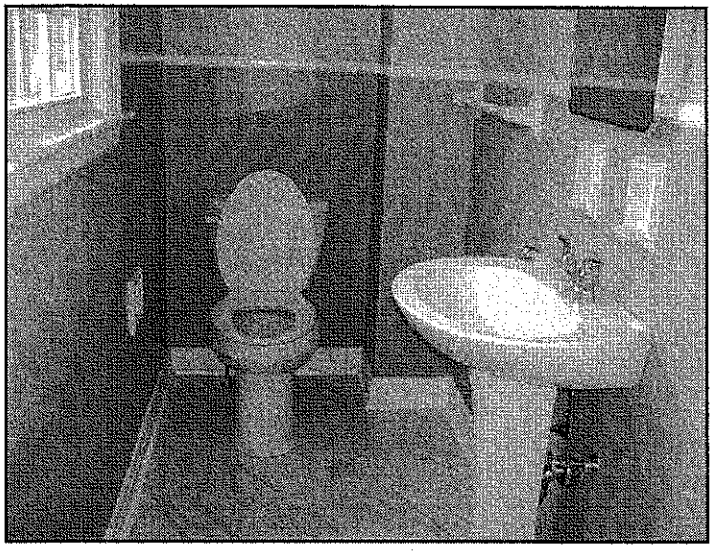
Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County FAIRFIELD	State CT	Zip Code 06811	
Lender	DAVID PALMER				



Subject Interior

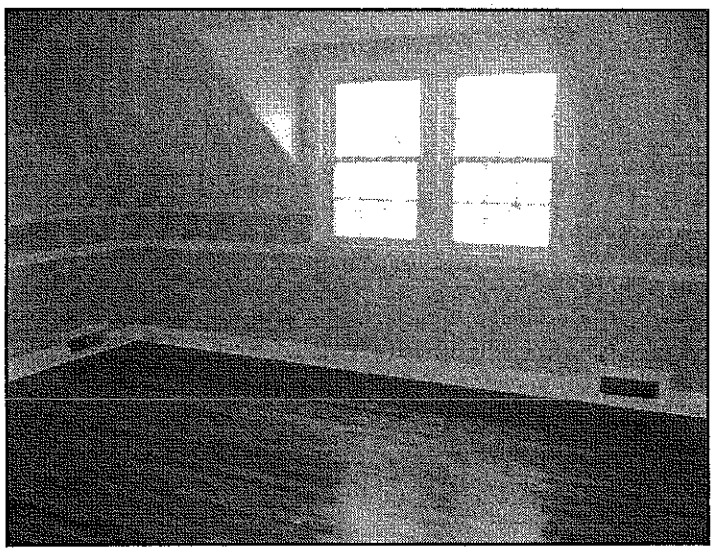
124 FRANKLIN STREET EXT

Sales Price	0
Gross Living Area	3,466
Total Rooms	9
Total Bedrooms	4
Total Bathrooms	4.1
Location	AVERAGE
View	RESIDENTIAL
Site	1.75 ACRE
Quality	GOOD
Age	72
	BEDROOM



Subject Interior

HALF BATH



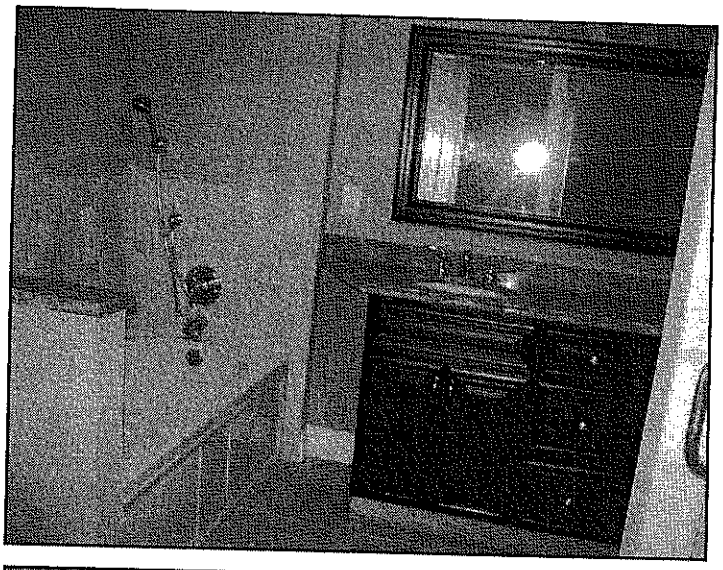
Subject Interior

BEDROOM

DEC 17 2012

Subject Interior Photo Page

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County FAIRFIELD	State CT	Zip Code 06811	
Lender	DAVID PALMER				

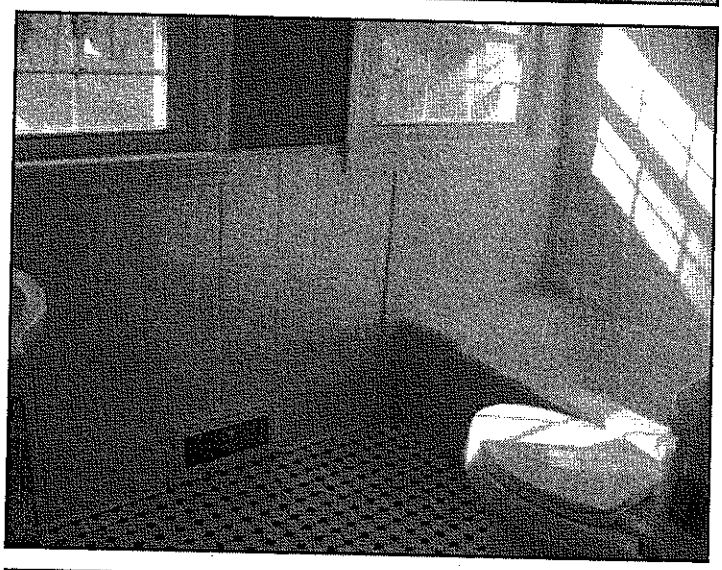


Subject Interior

124 FRANKLIN STREET EXT

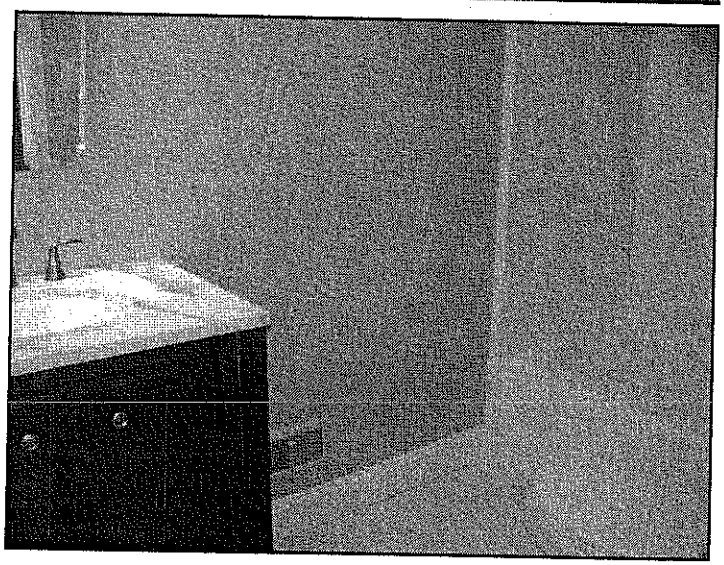
Sales Price	0
Gross Living Area	3,466
Total Rooms	9
Total Bedrooms	4
Total Bathrooms	4.1
Location	AVERAGE
View	RESIDENTIAL
Site	1.75 ACRE
Quality	GOOD
Age	72

BASEMENT BATH



Subject Interior

FULL BATH



Subject Interior

FULL BATH

DEC 17 2012

Subject Interior Photo Page

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County FAIRFIELD	State CT	Zip Code 06811	
Lender	DAVID PALMER				

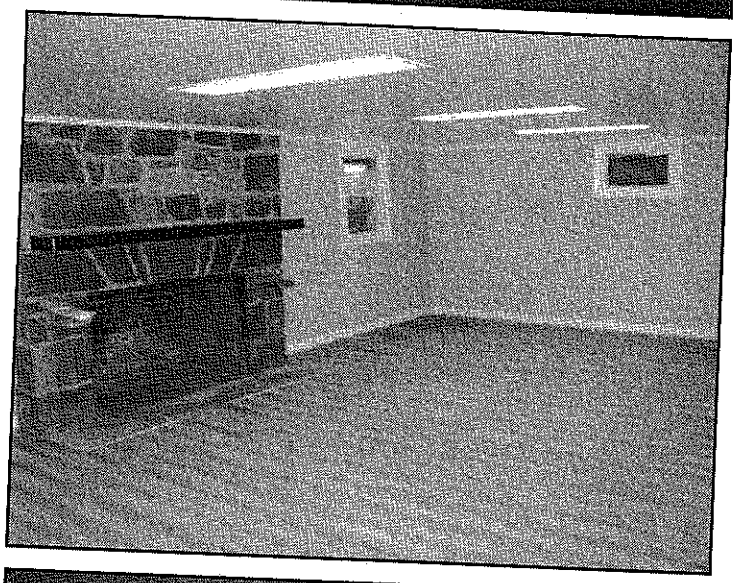
000065

Subject Interior

124 FRANKLIN STREET EXT

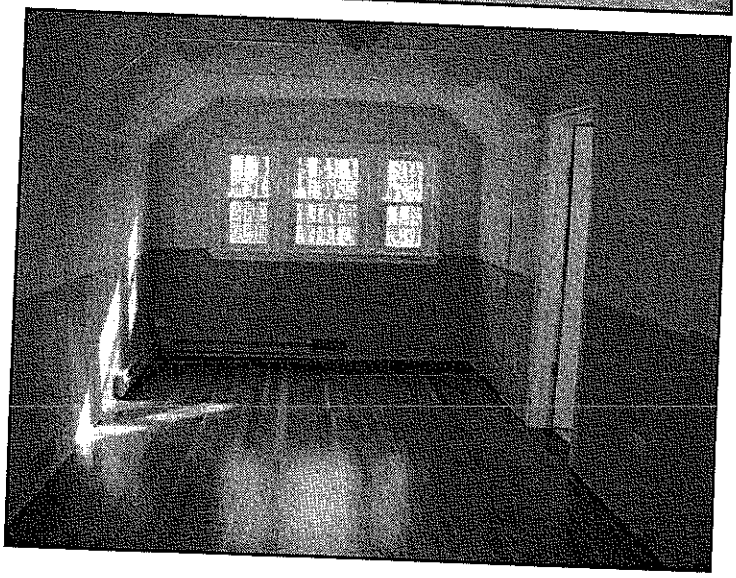
Sales Price	0
Gross Living Area	3,466
Total Rooms	9
Total Bedrooms	4
Total Bathrooms	4.1
Location	AVERAGE
View	RESIDENTIAL
Site	1.75 ACRE
Quality	GOOD
Age	72

STUDY



Subject Interior

BASEMENT FAMILY ROOM



Subject Interior

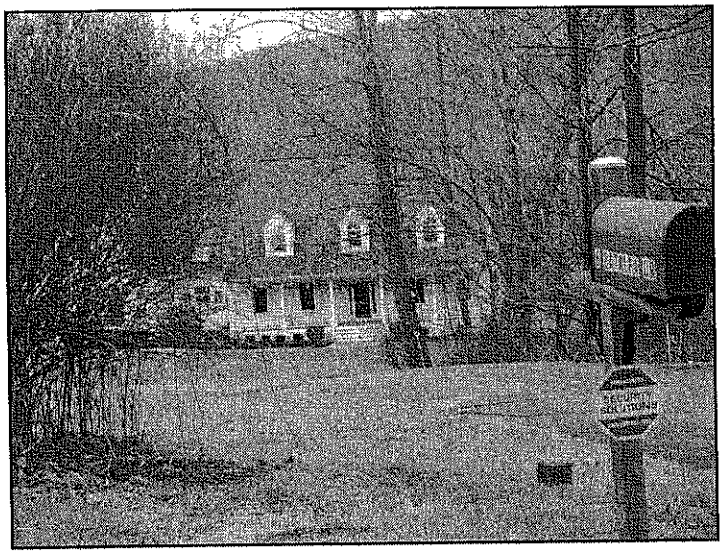
BEDROOM

DEC 17 2012

Comparable Photo Page

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County FAIRFIELD	State CT	Zip Code 06811	
Lender	DAVID PALMER				

000066



Comparable 1

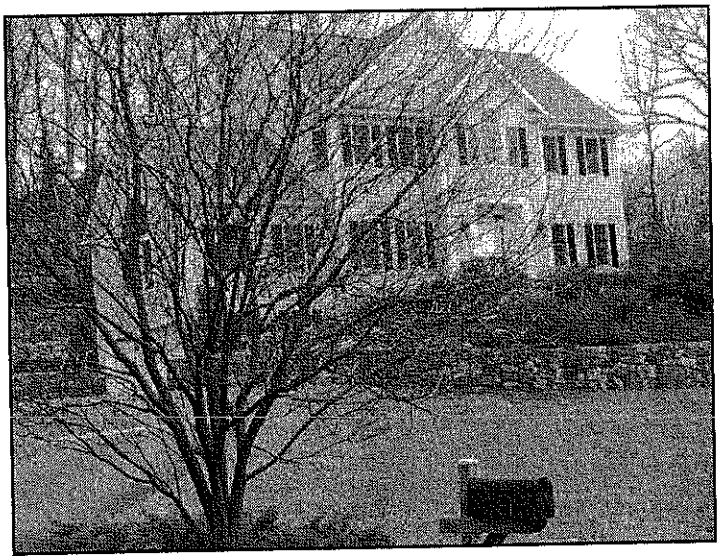
6 CATALPA DR

Prox. to Subject	2.64 MILES W
Sales Price	630,000
Gross Living Area	3,372
Total Rooms	9
Total Bedrooms	4
Total Bathrooms	3.1
Location	SUPERIOR
View	RESIDENTIAL
Site	1.60 ACRE
Quality	GOOD
Age	9

Comparable 2

4 CHELSEA DR

Prox. to Subject	0.79 MILES W
Sales Price	586,000
Gross Living Area	3,710
Total Rooms	9
Total Bedrooms	4
Total Bathrooms	2.1
Location	SUPERIOR
View	RESIDENTIAL
Site	.92 ACRE
Quality	GOOD
Age	12



Comparable 3

3 WOODSTONE CT

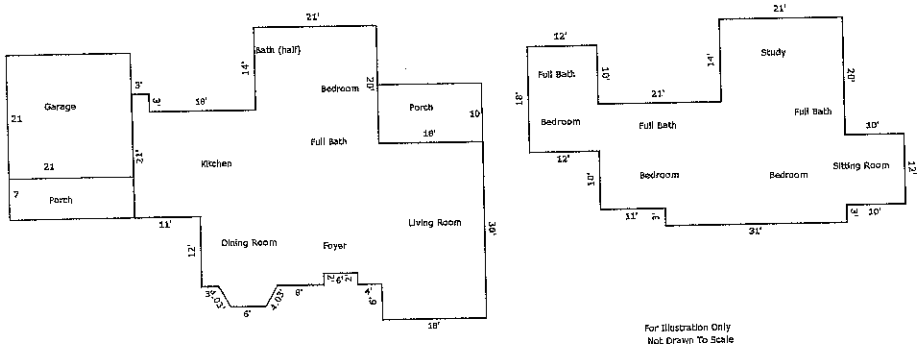
Prox. to Subject	1.98 MILES NW
Sales Price	590,000
Gross Living Area	3,232
Total Rooms	8
Total Bedrooms	4
Total Bathrooms	2.1
Location	SUPERIOR
View	RESIDENTIAL
Site	1.57 ACRE
Quality	GOOD
Age	13

DEC 17 2012

Building Sketch

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County	FAIRFIELD	State CT	Zip Code 06811
Lender	DAVID PALMER				

000067



TOTAL Sketch by a la mode, Inc.

Area Calculations Summary

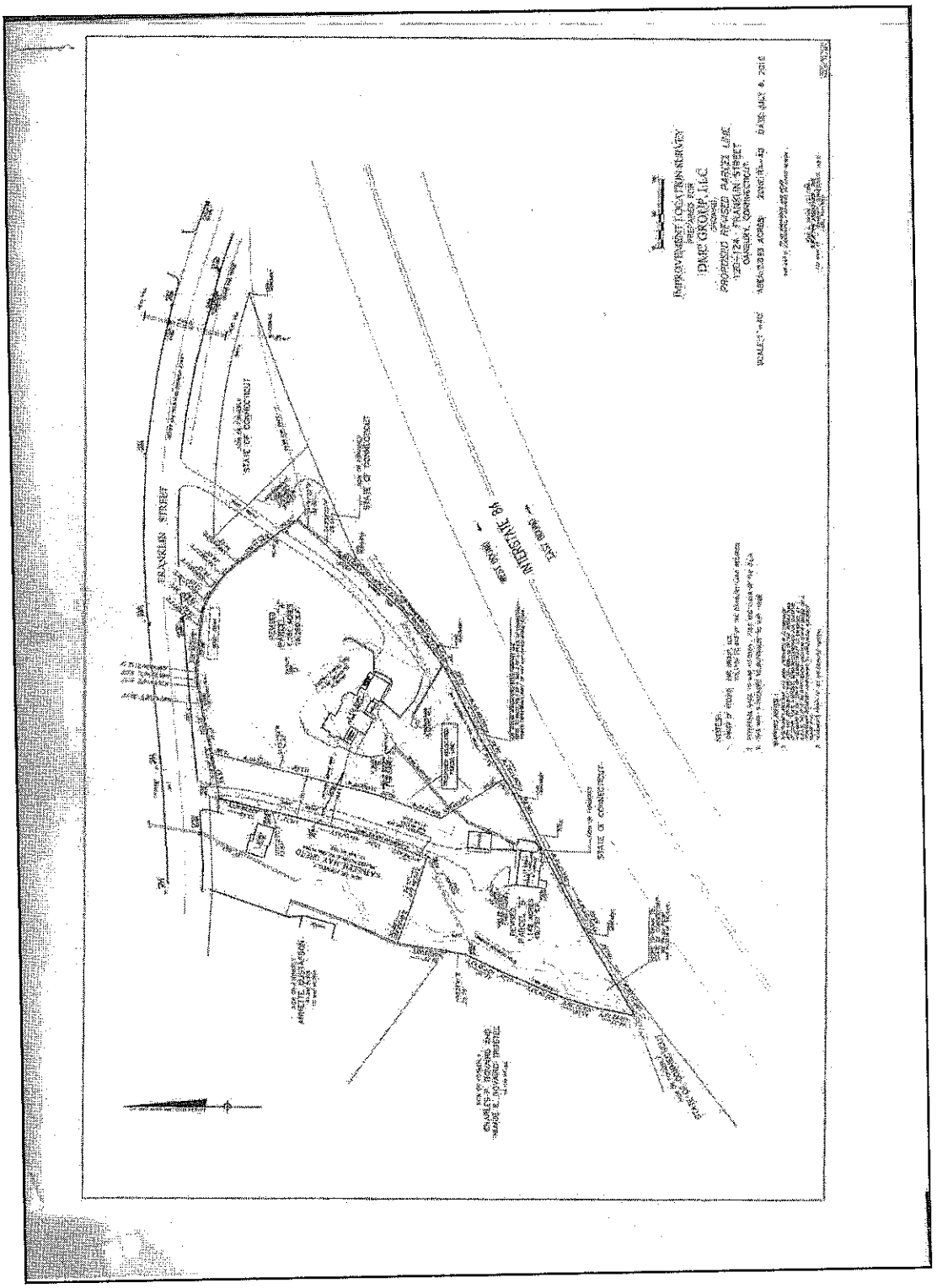
		Calculation Details	
Living Area			
First Floor	1987 Sq ft	30 × 18	= 540
		0.5 × 2 × 3.5	= 3.5
		0.5 × 3.5 × 2	= 3.5
		6 × 3.5	= 21
		21 × 14	= 294
		3 × 3	= 9
		18 × 11	= 198
		31 × 28	= 868
		2 × 21	= 42
		2 × 4	= 8
Second Floor	1479 Sq ft	12 × 10	= 120
		18 × 12	= 216
		21 × 14	= 294
		21 × 31	= 651
		18 × 11	= 198
Total Living Area (Rounded):	**3466 Sq ft**		

DEC 13 2012

Site Map

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County	FAIRFIELD	State CT	Zip Code 06811
Lender	DAVID PALMER				

000068

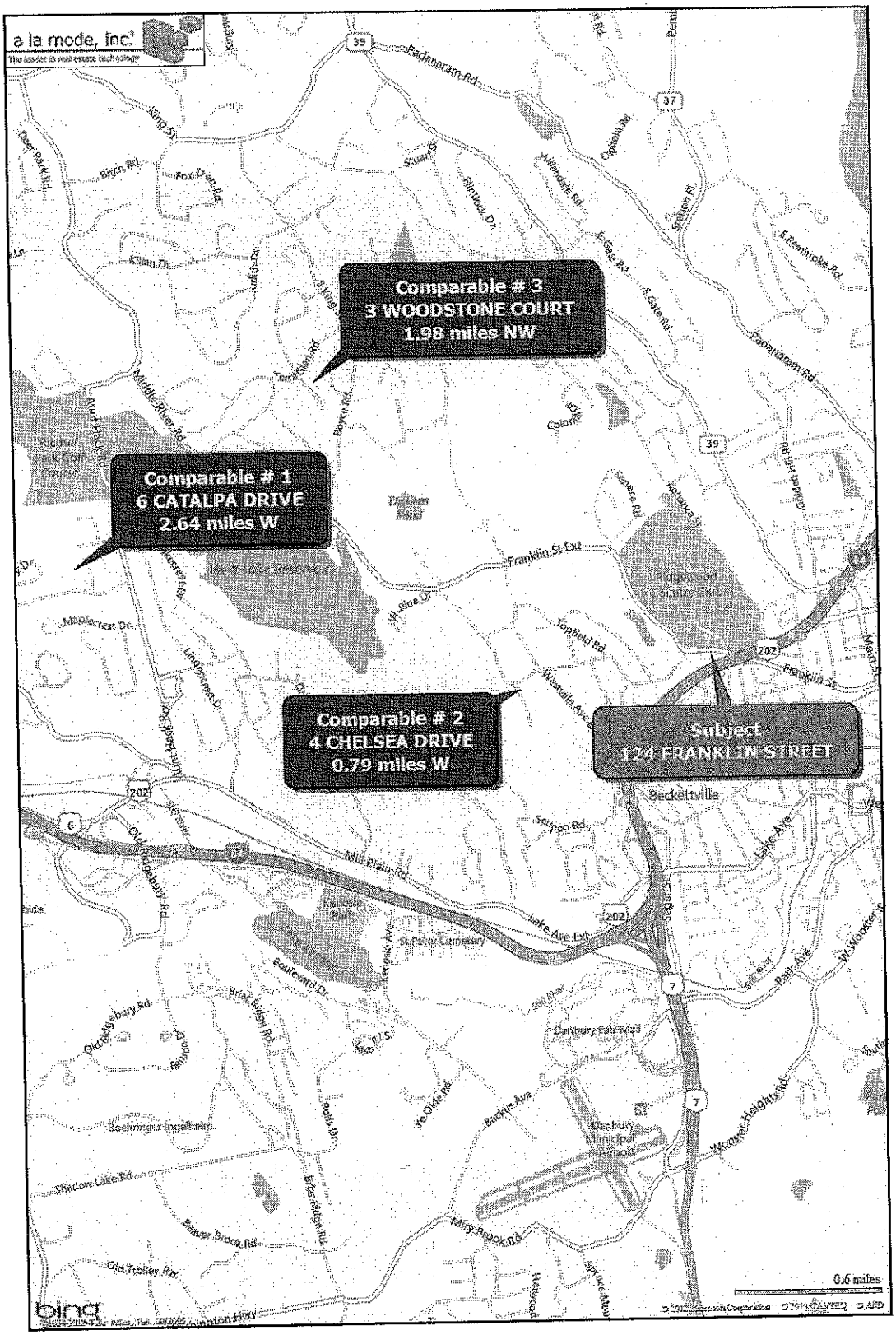


DEC 17 2012

Location Map

Borrower/Client	DAVID PALMER				
Property Address	124 FRANKLIN STREET EXT				
City	DANBURY	County FAIRFIELD	State CT	Zip Code 06811	
Lender	DAVID PALMER				

000069



Form MAP.LOC — "WinTOTAL" appraisal software by a la mode, inc. — 1-800-ALAMODE

DEC 17 2012

License/Certification

000070

STATE OF CONNECTICUT ✦ DEPARTMENT OF CONSUMER PROTECTION

Be it known that

HORACIO CARDOZO
P.O. Box 2451
Shelton, CT 06484

has been certified by the Department of Consumer Protection as a licensed

CERTIFIED GENERAL REAL ESTATE APPRAISER

License #RCG.0000107

Effective: 05/01/2012
Expiration: 04/30/2013

William M. Rubenstein, Commissioner

DEC 17 2012

NOD071

Appendix 6

DEC 17 2012

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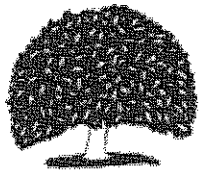

Connecticut State Office of Rural Health

Health care branching out to rural communities

- CT RURAL TOWNS
- CT RURAL HEALTH
- GRANTS
- CONFERENCES
- NEWS & EVENTS
- RESOURCES

CT RURAL HEALTH REPORT

Rural Community Health in Connecticut: Challenges and Opportunities
June 2006

- Download the Complete Report (PDF/4.33MB)
- View the Report Data (in HTML format). Includes data sources and downloadable spreadsheets of detailed data used in the assessment.

Project Summary

During March-June, 2006 CT-ORH commissioned research and data collection to (1) identify barriers to accessing healthcare services in rural Connecticut, (2) determine healthcare services available to Connecticut's rural residents and (3) support community efforts across rural Connecticut to improve the health status of residents. This report tells the "story" of rural health in Connecticut and provides data and tools that local healthcare providers, administrative bodies, and coalitions can use to address health issues facing Connecticut's rural areas. CT-ORH retained the firm of Holt, Wexler & Farnam, LLP (HWF) to assist in collecting and analyzing data in support of this project.

HWF assembled extensive health and related demographic data for this study for the 65 towns designated as rural by CT-ORH. The data is from numerous sources, with the intent to make it available to all rural health stakeholders. Data was compiled at the town level to the extent possible; some indicators however were only available at the county or state level. To examine the demographics, healthcare services, and health status of rural residents, rural Connecticut was divided into three zones based on location to facilitate examination of variances across rural areas. All indicators for which data is available at the town level are summarized by rural vs. non-rural areas and by three zones identified as the Northwest Region, the East Region, and the Connecticut River Valley. The conclusions regarding rural Connecticut have been drawn based upon data collected and summarized for the three regions.

Key Findings

The quantitative data revealed, and the interview data of opinion leaders confirmed the following three major themes about health status and health care services in rural Connecticut:

Disparities: In general, the economic health of rural residents remains stronger than non-rural residents. However, significant and growing numbers of individuals and families face substantial economic challenges and as a consequence, health challenges. Middle class families appear to enjoy solid access to healthcare systems. However, lower income - including retired elderly and families - experience a higher burden of health-related concerns.

Access to Healthcare: Two access issues present significant barriers to health care for a substantial subset of the rural population - cost and transportation. With respect to cost, availability of insurance coverage accepted by providers represents a limiting factor. Providers and consumers point out concerns especially for low-income populations in the areas of chronic disease management, oral health, and mental health. Transportation limitations prove equally significant. Getting to health appointments and especially to distant specialists has been identified as a significant challenge to maintaining health. Providers report a pattern of individuals who do not have access to transportation to see specialists for medical conditions often wait until their condition worsens and then rely on hospital emergency departments for services when their conditions become acute.

Capacity: The service system needs to increase its capacity to provide services in specific areas such as mental health, dental services, specialty services, and transportation services (or coordination). For example, a growing sentiment among providers exists that the current mental health prevention and treatment system can not address adequately the mental health service needs of the rural communities, particularly children,

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Headlines

Mental Health

- In Connecticut, during a single year, there are an estimated 600,000 adults with mental illness (including 135,000 with serious mental illness) and 85,000 children with serious emotional disturbance, yet it is estimated that only about half receive any form of public or privately funded treatment.[27]
- In 2004 DMHAS released a report synthesizing statewide priority services based on regional need. A consistent theme was expressed throughout all regional reports that the system (prevention, intervention, treatment, and recovery) is overburdened and under resourced. Through the collection of regional reports, the result commanded the recommendation of four (4) statewide identified needs; housing, service infrastructure, vocational and employment services and transportation.[28]
- DMHAS is in the early stages of planning for a Mental Health System Transformation grant that will guide investments in increasing the capacity of the mental health system to respond to community needs. [29]
- The State's Children's Mental Health System, Community KidCare, is jointly administered by DCF and DSS. KidCare Care Coordination data reveals that 710 Children statewide received care coordination services in fiscal year 2002-2003 (no breakout is available for rural areas). The capacity now exists to serve approximately 1200 children per year. There are waitlists for care Coordination due to unavailability of Care Coordination at the time of referral. 76% of these children live with one or both biological parents 62% of the children served have no current DCF involvement.
- Shortages of mental health services in rural areas have tangible effects. Children especially spend longer time periods in the emergency departments before finding placement. One rural health provider recounted an incident of a suicidal teenager waiting 72 hours in an emergency department to be placed.
- An estimated 9.5% of persons aged 18 and older in the Eastern service region (about 29,000 people) and 9.2% in the Northwestern service region (about 40,000) are estimated to have serious psychological distress (service regions include more than the similarly labeled rural areas) (Table 3.7).

[27] Report of the Governor's Blue Ribbon Commission on Mental Health, 2000

[28] Connecticut Department of Mental Health and Addiction Services, Reports on Statewide Priority Services: A Synthesis of Regional Needs, June 2004.

[29] http://www.dmhas.state.ct.us/transformation.htm

DEC 17 2012

Table 3.7 Serious Psychological Distress in Past Year among Persons Aged 18 or Older, by Service Region, Percentages (Annual Averages Based on 2002, 2003, and 2004 data)

Area	%	95% Confidence Interval
Connecticut	8.7	(7.38-10.29)
Eastern	9.5	(7.23-12.39)
North Central	9.2	(7.23-11.74)
Northwestern	9.2	(7.12-11.91)
South Central	8.0	(6.16-10.33)
Southwest	8.0	(5.96-10.56)

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004

Substance Abuse

- The rate of adult admissions for substance abuse in rural towns is less than half the rate in cities with over 50,000 population (Figure 3.10). Among rural areas, the rate is higher in the East.
- The Northeastern region identified the three highest needs to be addressed: (1) the need to reduce past month of alcohol use by high school students, (2) reduce underage liquor law violations, and (3) address driving under the influence.[30]
- According to the Connecticut Coalition to Stop Underage Drinking, Connecticut's average high school use is 28% above the national average.[31]
- The rate of admissions for substance abuse is lower in rural towns than the rest of the sate, and among rural areas, they are higher in the East (Figure 3.10). Table 3.8 estimates persons with substance dependence by the five state service regions.
- The rate of alcohol-related motor vehicle accidents and fatalities is far higher in rural towns than in the rest of the state (Figure 3.12)
- The rate of inpatient admissions for alcohol abuse is lower in the rural areas (Figure 3.11).

[30] Northeast Communities Against Substance Abuse. *Report to the Community.* Drug-Free Communities Support Grant. 2005.
[31] Northeast Communities Against Substance Abuse. *SPF-SIG Data Report.* 2005. Dayville,CT

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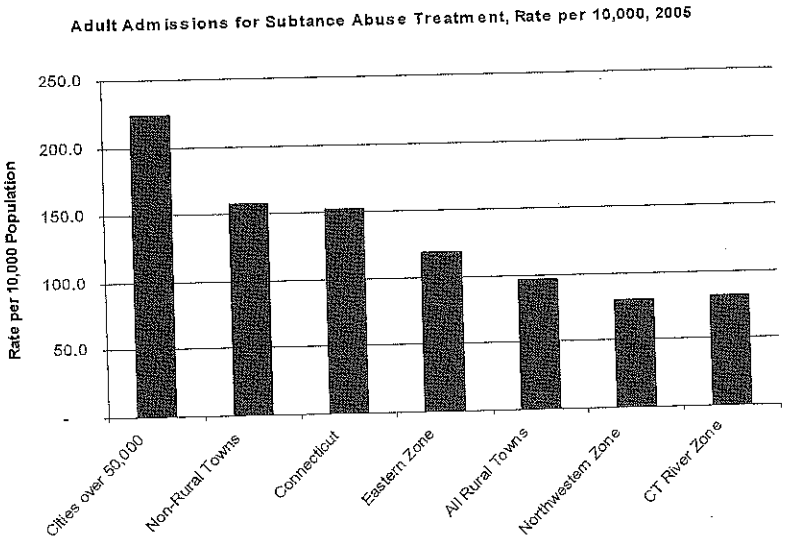
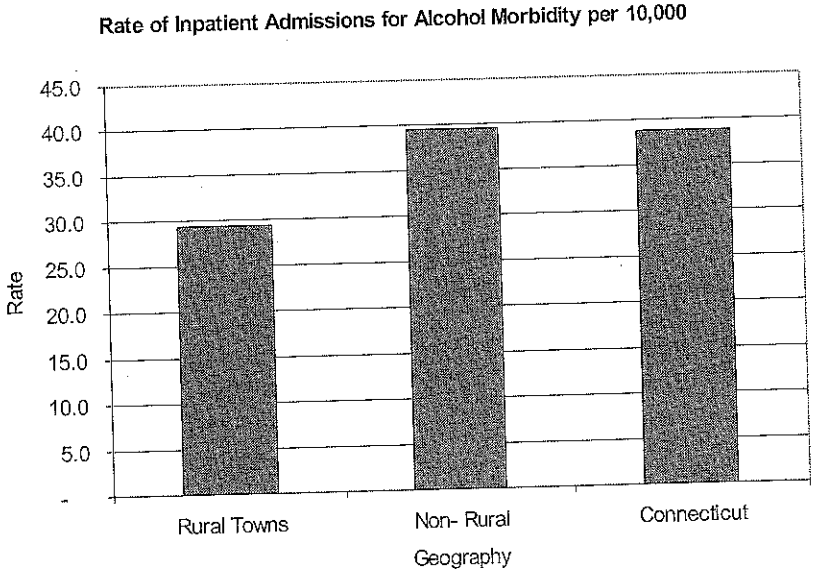
Figure 3.10



Source: DMHAS, Office of Health Care Access

Figure 3.11



Source: Connecticut Department of Transportation

DEC 17 2012

00007.6

Appendix 7

DEC 17 2012

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Connecticut Drug Treatment Centers, Alcohol Rehab Programs and AA and NA Meetings

GET HELP NOW
800-315-2056
Residential Inpatient - Drug Alcohol Detox - Interventions
Our Trained Addiction Treatment Counselors Can Help

Drug abuse statistics for Connecticut are significantly different than those for other states. For example, heroin is the most heavily abused drug in Connecticut, with 17,878 of 48,082 people surveyed admitting to heroin. The least abused drug in Connecticut? Methamphetamine, with only 128 of the 48,082 respondents admitting to having used that highly addictive drug. Of that number, 66.4% of meth users were male; 32.0% were female.
5,573 people admitted to cocaine use through methods of administration other than smoking. There were no figures available for the number of people who admitted to smoking cocaine.

The next lowest abuse drug was marijuana. Only 3,782 of those surveyed said they used marijuana. 80.3% of the users were male; 19.5% were female. Alcohol alone (in other words, the users only drank alcohol; they did not use or abuse other drugs) was used by 9,399; 9,290 of Connecticut residents admitted to using both alcohol and another drug.

As seen in previously-listed figures as well as in this paragraph, a higher number of males admit to substance abuse across the board (that is, including all drugs) than females. This has been noticed in survey reports from other states. Here is another example-76.0% of males admitted to alcohol consumption only (no other drug use or abuse) as opposed to only 23.7% of females. How many of the 48,082 sought treatment in the 171 available alcohol and drug treatment centers in Connecticut? This statistic is broken down into age groups, so a random selection was chosen for inclusion in this article.

The highest number of people who were admitted to substance abuse treatment centers were between the ages of 21-25 years, and they were seeking help for marijuana addiction. The highest number of people who entered treatment centers for meth addiction were between the ages of 26 and 30 years old.

The statistics are also divided up into racial categories of people who sought help at treatment centers. 76.6% of those who admitted to alcohol addiction were white; 30.2% of persons claiming Hispanic ethnicity entered treatment centers for help with heroin addiction. Those whose ethnicity was listed as African-American (40.7%) sought help at treatment centers for cocaine addiction.

Statistics are interesting to read, and they often provide very enlightening information. However, they may have the tendency to make one forget that the people on whom the statistics were compiled are much more than numbers. They are family members, from parents to adolescents, and even some grandparents (substance abuse addiction knows no age limit).

24/7 Addiction Help
1-800-559-9503

More

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000078

For some of these people, substance abuse addiction has led to a loss of income. For others, they saw a way of life that they had always known disappear, only to be replaced by a vastly different one, and not different in a good way. Others saw marriages end or other family relations severed or at the very least badly strained.
Others, however, saw loved ones determined to resume a normal lifestyle, which would include healing strained or broken relationships, once again becoming productive members of society, and in general becoming a new person-drug or alcohol free. It is for these people that Connecticut treatment centers are intended; they only have to take advantage of the services available at them.

When a person enters a Connecticut treatment center, he will not simply be a number. And while ethnicity, gender, and age, as well as other things that make that person the unique individual he is will be noticed and recognized, the treatment program will deal with that person as an individual, not as a member of an ethnic group, or someone who is a certain age. If necessary, treatment protocols will be adjusted to accommodate age-related physical problems or a person's cultural heritage and practices.

http://www.whitehousedrugpolicy.gov/drugfact/heroin/index.html
https://www.hopkins.edu/ftpimages/82/misc/misc_64477.pdf

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THE GOVERNOR'S Prevention Partnership

keeping kids safe, successful and drug free today for a stronger workforce tomorrow

Prescription Drug Abuse Among Youth: The Problem

Law enforcement, school administrators, prevention experts and treatment providers report a significant rise in youth prescription drug abuse rates in Connecticut. We know anecdotally that Connecticut treatment centers report a large increase in the number of youth admitted with opiate addictions that often began with prescription painkiller misuse. In addition, 20% of 12- to 17-year-olds nationally reported some abuse of prescription drugs in their lifetime[1]. While there is no way to know just from "use" statistics how much of the substance youth are taking, or whether they are (or will become) addicted, nationally, 15% of 12th graders reported using prescription drugs in 2007[2]. In Connecticut, we believe that the number of youth illegally using prescription drugs is greater than the percentage of those using cocaine and heroin combined, based on statistics culled from national averages and a 2007 Connecticut School Health Survey.

Both national surveys and the Connecticut Drug Enforcement Agency (DEA) support the concept of prescription painkillers as a "gateway" to illicit drug use – most often heroin. According to the 2006 National Survey of Drug Use and Health, in terms of individuals' first entry point into "illicit" drugs, the number of people trying pain medications (opioids) is greater than the number trying marijuana. Once the supply of prescription opioids is cut off, abusers often move on to heroin, since it is much cheaper ($20 for one day's worth of hits vs. up to $80 per prescription pills). Heroin is also readily available in the suburbs and has become the Connecticut DEA's top concern.

Between 1995 and 2002, ER mentions of prescription narcotics increased 300%, and treatment admissions for "opiates other than heroin" increased more than 200%. ER mentions of anxiety medications (benzodiazepenes) increased 38% during the same time period[3]. In Arizona, twice as many teens died from prescription-drug overdoses in 2006 than from methamphetamines, heroin and cocaine combined, according to the state health department. Drug-related deaths among children jumped 41 percent from 2006 to 2007. Here in Connecticut, treatment admissions due to opioid painkiller addiction have increased more than admissions for any other substance over the past several years. From 2003-2006, treatment of admissions of 18- to 24-year-olds increased by 18%, with heroin and other opioid painkillers largely responsible (admissions for younger youth are less common, but increasing)[4].

While opioid painkillers are the biggest problem, youth also abuse depressants to ease anxiety or aid sleep, and stimulants (most commonly prescribed for ADHD), as well. The Centers for Disease Control estimated in 2003 that 4.4 million children (ages 4 to 17) were diagnosed with ADHD, and of those, 2.5 million reported taking medication. Stimulants can produce euphoric effects when taken in high doses, and individuals who do not have ADHD often believe these drugs serve as "performance enhancers." As many as one in three 11- to 18-year-olds on ADHD medication report being

[1] Partnership Attitude Tracking Study, 2008
[2] Monitoring the Future, 2008
[3] www.streetdrugs.org
[4] Connecticut Department of Mental Health & Addiction Services

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approached to sell or trade their medication. While not the most common substance of abuse among college students, the abuse of prescription stimulants may be as prevalent as 15 to 20 percent of students, according to Amelia Arria, Ph.D., Senior Scientist at the Treatment Research Institute. Arria says that for some students, stimulant use is "sporadic," but a 2005 study in the *American Journal of College Health* found that even relatively infrequent illicit use of prescription stimulants is associated with increased likelihood of other substance abuse. Notably, the study showed that teens who reported illicit prescription stimulant use had significantly higher rates of alcohol and other drug use, including cocaine. A 2007 study of undergraduate students published in the journal *Pharmacotherapy* found that those students who began illicit prescription stimulant use in college were four times more likely to report three or more positive indicators on a standard drug abuse screening test than their peers who did not use stimulants[5].

When used to treat ADHD, "the benefits of medications like Ritalin or Adderall outweigh the risks, and can help bring someone who is completely unfocused and disorganized to a place where they're level with those who don't have this condition," explains Dr. Sam Glazer, an addiction psychiatrist in New York City and associate clinical professor at New York University. "But if they are used for performance enhancement...no one has asked about your family history, examined your health, and you could be prone to a heart arrhythmia or other serious conditions," he adds[6].

Why Prescription Drugs?

Youth have turned to prescription drugs for a variety of cultural reasons. First, there is a perception that drugs that may be prescribed under legal circumstances are "safer" than illicit substances; meanwhile, the use of other illicit drugs has decreased in recent years.

In addition, prescription drugs tend to be easily available in most homes. The Connecticut Department of Consumer Protection reports that when communities hold "take-back" programs for unused prescription medications, the majority of those turned in are prescription opioids. When not used as prescribed or turned back in, these drugs can frequently end up in the wrong hands. According to the Tennessee Medical Foundation, an estimated one quarter of all prescription opioids are diverted – either stolen, traded or improperly prescribed. When asked where they obtained misused prescription drugs, 56% of respondents reported that they obtained the medications free from someone they knew, and 15% reported buying or stealing them from someone they know[6]. One-third of 12- to 17-year-olds report obtaining prescription drugs in their own home[7].

Some trends that are specifically associated with prescription drug abuse among youth include college students taking stimulants as "performance enhancing" study drugs and "pharm" parties, which involve the mixing of medications and substances and/or taking unidentified medications, which could lead to dangerous synergistic effects.

[5] Drugfree.org
[6] 2006 National Survey of Drug Use and Health
[7] National Center on Addiction & Substance Abuse, 2008

Addiction

We should note that while not all youth who misuse prescription drugs are experiencing an immediate crisis, misuse can quickly lead to abuse, and, later, to dependence. In human development, behaviors that helped survival (eating and bonding with others) needed to be linked to feelings of pleasure so that humans would remember and repeat these behaviors. For this reason, the human brain has a "pleasure pathway," which is a reward center in the middle of the brain. A chemical called dopamine is released inside this reward center to make us feel happy, motivated and free of pain. Many prescription drugs block receptors that are meant to receive dopamine, which causes the dopamine to spill over, causing an intense, pleasurable sensation that can't be experienced naturally. The more receptors are blocked, the less dopamine the brain naturally produces. The brain thinks it doesn't need dopamine because the receptors are already "satisfied." Thus, the brain tells the body to keep taking the drug, but the more of the drug one takes, the less good it feels. This is called tolerance. Pretty soon, the brain stops producing dopamine altogether, but taking the drug has become a matter of survival to the brain, even though it no longer produces pleasure.

In terms of addiction, it is important to note that it could happen to anyone. Half of addicted people have no family history of addiction, and many people begin prescription drug addictions by "partying" or using the drug for a legitimate medical purpose (following surgery, etc.). As the human brain does not finish developing until about the age of 25, youth are even more susceptible to addiction than adults.

What Can We Do?

The Governor's Prevention Partnership, in partnership with the Connecticut Departments of Mental Health and Addiction Services and Consumer Protection and the Regional Action Councils, has taken the lead in developing an action plan to prevent youth prescription drug abuse in our communities. In 2008, this group launched the Connecticut Prescription Drug Abuse Task Force, comprised of over 15 major organizations and state agencies, and one major finding was the overwhelming need to raise awareness and educate the public and parents about the extent of the problem. The group developed and disseminated thousands of flyers, conducted speaking engagements and worked to increase media coverage. In 2009, through funding received from Purdue Pharma, The Partnership awarded 5 grants to Regional Action Councils for the purpose of increasing awareness and educating the public. Several of the RACs are including dissemination of public service announcements through the media as part of their plan. In early 2010, The Partnership and Regional Action Councils agreed to participate in a pilot program with the National Council on Patient Information and Education to field test and evaluate their Teen Influencer materials, which will be widely distributed through community meetings.

Since youth are influenced by many environmental factors, effective prevention must involve coordinated efforts. For maximum effectiveness, prevention resources should be allocated to educating/outreach to adults and to disposing of medication and restricting access. Fewer prevention resources should be allocated to "danger" messages aimed at youth.

Effective strategies for preventing youth prescription drug abuse are as follows:

- Parents and other adults who influence teen behavior (coaches, etc.)—talk to children/teens about misuse of prescription drugs in an open and honest way; lock up, monitor and dispose of medications in their own homes; get involved in community prevention efforts.

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- Schools—include information on prescription drugs and comprehensive prevention in their health curriculum; ensure that each student is able to connect with a caring adult and that staff are properly trained to intervene early; encourage student leadership on the issue; reach out and engage parents; conduct surveys to track student trends; enforce clear rules and policies.
- Communities—form coalitions to address the problem; provide trainings; conduct focus groups and needs assessments to measure the extent of the problem; advocate for law/policy change; conduct outreach programs.
- Statewide—pass and enforce appropriate laws and policies; implement prescription drug monitoring programs; devote adequate resources to prevention diversion; disseminate prevention messages in collaboration with the media, pharmaceutical companies, medical professionals and universities.

For more information on prevention of youth prescription drug abuse, visit The Governor's Prevention Partnership website at www.preventionworksct.org/rxinfo.

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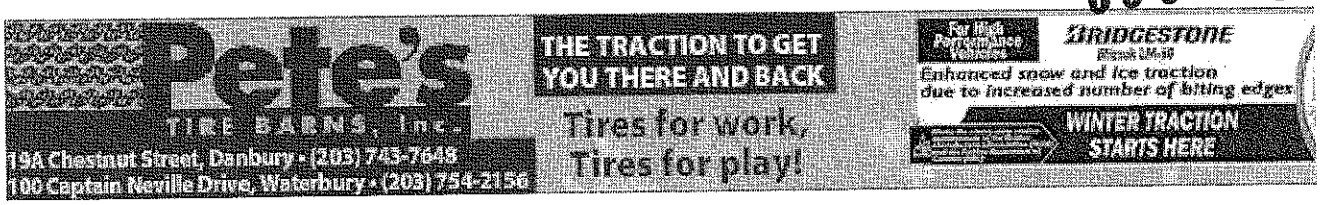


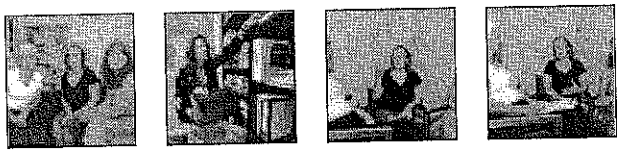
Prescription drug abuse in Danbury area is stealing lives

Nanci G. Hutson, Staff Writer

Published 2:03 p.m., Monday, August 16, 2010

VIEW: LARGER | HIDE 1 of 4 ◄ PREV NEXT ►

Pamela Walker, left, Liz Jorgensen, center, and Clare Gelissen all work at Insight Counseling in Ridgefield. Jorgensen is a private therapist who specializes in alcohol and substance abuse. Photo: Lisa Weir / The News-Times Freelance



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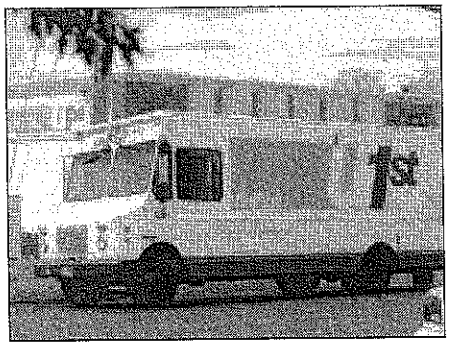
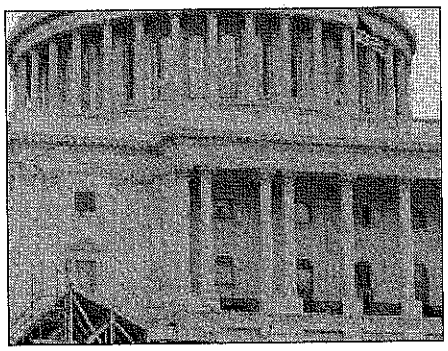


EPA probing toxic laundry emissions



Obama's 2nd inaugural a hot ticket

Poinsettias get ready to roll

This story originally appeared in the Sunday, August 15 print edition of The News-Times. Click here to subscribe.

Ridgefield substance abuse therapist Liz Jorgensen is shocked that no one has hit the panic button yet over the latest drug abuse trends.

Statistics indicate prescription drug overdoses are killing nice kids from nice families in well-to-do communities all over the country.

Prescription drug use in Connecticut now kills more people under the age of 34 than car crashes, Jorgensen said, quoting a national study of figures from 2006 released this year.

Nationwide, 45,000 are killed in car crashes; 39,000 die from prescription drug overdoses, according to the study.

"Why isn't everybody freaking out?" asked Jorgensen, who owns Insight Counseling and leads educational seminars and workshops on substance abuse. "It's terrifying."

Jorgensen's professional network and private practice indicate an increasing number of teens are dying from the scourge of prescription drugs, particularly opiates that mimic heroin. She said kids do not perceive the addictive danger of these drugs.

Jorgensen said some teens get hooked on heroin when the price of narcotic painkillers gets too high.

In recent months, Jorgensen said she has sent 30 of her patients under age 22 to in-patient treatment for opiate abuse. They all started using strong painkillers and then moved toward heroin as a cheaper alternative.

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One OxyContin pill -- a trademark version of the narcotic painkiller oxycodone -- costs about $80; a gram of cocaine is $50, and heroin is even cheaper at about $10 a bag, area experts said.

Jorgensen and other substance abuse specialists said opiates -- many found in bathroom cabinets and family medicine drawers -- are quite prevalent and accessible. Not only are they addictive, too often they can prove deadly when combined with other medications or alcohol.

The much-publicized death of a 17-year-old Newtown High School student, Danielle Jacobsen, just before her graduation ignited renewed concern about these troubling trends, according to area substance abuse specialists.

The investigation determined Jacobsen ingested a relatively unknown drug at a party in a Monroe condominium complex and early the next morning was found dead in a nearby pond.

Soon after news broke about Jacobsen's death, rumors started to circulate about teens who attend "pharm" parties, where unknown brands of prescription drugs are offered to guests.

Local substance abuse officials and police said they think that is relatively rare. Rather, they said, teens tend to sell or barter prescription drugs raided from family stashes, with some even stealing the drugs or altering medications they are able to buy over the counter.

"I don't think this `bowl thing' is exactly what it looks like," said Allison Fulton, executive director of the Housatonic Valley Coalition Against Substance Abuse. "But prescription drugs are out there.

Students don't just abuse narcotic painkillers, Fulton said.

She said she regularly hears of teens and young adults abusing attention deficit disorder and anti-anxiety drugs, as well as taking over-the-counter cough medications in higher doses than advised.

Cocaine is making a resurgence in some of the wealthier towns, and heroin use is clearly on the rise and readily available, she said.

Fulton also is highly concerned about underage drinking and marijuana use. She and others said that often is the beginning of drug exploration by teens and young adults. If not stopped early it can fuel addictions that lead them crave other drugs.

"It's pretty scary," Fulton said.

Newtown Parent Connection co-founder Dorrie Carolan said the availability of prescription drugs is cause for concern. In recent months, she has received calls about overdosing teens who ended up in emergency rooms and some in relapse after a period of sobriety.

Teens most vulnerable to these drugs tend to be those with lower self-esteem who are yearning for peer acceptance or approval, Carolan said.

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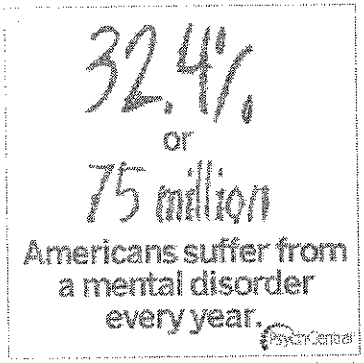
Mental Health Statistics

By JOHN M. GROHOL, PSYD
Founder & Editor-in-Chief (Google+ Profile)



May is Mental Health Month again, so it's also a good time to review the mental health statistics behind mental illness. Some of the statistics going around aren't entirely accurate, because they're based upon outdated web pages on the National Institute of Mental Health (NIMH) website. This misinformation is then propagated by well-meaning people and organizations, including NAMI and others. Sadly, the NIMH website is not as accurate or up-to-date as people like to think it is (I think that because it's a government resource, people just assume it's accurate and correct).

For instance, the NIMH Statistics page puts data into context of 2004 Census data. Well, it's 2010, not 2004, and we have more up-to-date Census data. Also according to the more recent NCS-R data, it's not really 1 in 4 Americans who could be diagnosed with a mental disorder in any given year — it's **1 in 3**!

According to the U.S. Census Bureau, in 2009 we had an estimated 307,006,550 people living in the U.S., approximately 75.5 percent of which are 18 or older. This translates to 231,789,945 adults. If we use the estimate of 26.2 percent of adults 18 or older who suffer from a diagnosable mental disorder in a given year, that translates into *60.7 million Americans*. But I think the "26.2 percent of adults" number is also inaccurate and not up-to-date.

According to the most recent prevalence data we have (from the NCS-R, Kessler et al 2005, which is based upon 9,282 subjects), the 12 month prevalence rate for any mental disorder or substance disorder is **32.4 percent.** Substance disorders — like alcoholism — are recognized in the rest of the world as a mental disorder, and indeed are included in the DSM-IV as such. So why the NIMH would leave those out of the estimate is beyond me.

So looking at these numbers with the latest data, we have nearly **1 in 3 Americans** who are suffering from a mental disorder in any given year, or *over 75 million people*.

Behind the Numbers

Let's break down the rates by category, as the NCS-R does:

	Women	Men	Both
Any Anxiety Disorder	23.4%	14.3%	19.1%
Any Mood Disorder	11.6%	7.7%	9.7%
Any Impulse-Control Disorder	9.3%	11.7%	10.5%
Any Substance Disorder	11.6%	15.4%	13.4%
Any Disorder	**34.7%**	**29.9%**	**32.4%**

As we can see, women are at a significantly greater risk for any anxiety disorder (more than double the risk for a specific phobia, like a fear of spiders, for panic disorder, and for post-traumatic stress disorder). They are also at slightly more risk for a mood disorder — especially for depression, where their rate is nearly double that of men's risk for depression.

Men are at greater risk for impulse-control disorders, but no disorder significantly stands out except conduct disorder (more than 4 times the risk). Men are at more risk for substance disorders across the board as well, with more than twice the risk for alcoholism and three times the risk for drug abuse.

Looking at lifetime prevalence rates is also interesting and quite eye-opening. For any mental disorder (including substance disorders), the lifetime prevalence rate is an astonishing **57.4 percent.** That's more than every 1 in 2 Americans. If you don't think mental illness will impact your life, you're sadly mistaken. If it doesn't hit you, it's going to hit someone you love or are close to.

References

Kessler, R.C., Chiu, W.T., Demler, O., Merikangas, K. R., Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62(6), 617-627.*

Kessler, R.C., Berglund, P.A., Demler, O., Jin, R., Merikangas, K.R., Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 62(6), 593-602.

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Appendix 8

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Connecticut 2010 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per1,000 population	6,833,040	24.47	21.94	59
Community Utilization per 1,000 population	6,496,649	23.63	20.86	58
State Hospital Utilization per 1,000 population	157,968	0.45	0.51	53
Other Psychiatric Inpatient Utilization per 1,000 population	385,299	0.24	1.40	44

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)	581,651	26.1%	36.3%	58
Employed (percent with Employment Data)	581,651	21.0%	19.0%	58

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	80.1%	71.1%	54

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	65.0%	62.1%	50

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	12,227	8.1%	9.2%	52
State Hospital Readmissions: 180 Days	27,198	14.3%	20.4%	53
State Hospital Readmissions: 30 Days: Adults	11,387	11.2%	9.3%	52
State Hospital Readmissions: 180 Days: Adults	25,339	19.0%	20.8%	53
State Hospital Readmissions: 30 Days: Children	839	0.5%	7.4%	29
State Hospital Readmissions: 180 Days: Children	1,857	2.8%	16.3%	29

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,173,695	82.8%	82.7%	57
Homeless/Shelter	137,909	5.3%	2.7%	54
Jail/Correctional Facility	88,500	0.7%	1.8%	53

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	75,091	9.5%	2.8%	41
Supported Employment	56,910	6.0%	2.1%	43
Assertive Community Treatment	62,473	-	2.2%	38
Family Psychoeducation	23,282	-	1.5%	19
Dual Diagnosis Treatment	64,243	13.0%	4.2%	27
Illness Self Management	167,530	-	9.1%	22
Medications Management	292,923	-	25.0%	19

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	18,032	8.7%	2.0%	29
Multisystemic Therapy	8,850	0.4%	1.4%	20
Functional Family Therapy	8,222	1.2%	1.8%	13

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	74.3%	71.2%	54
Child/Family Improved Social Connectedness	90.8%	84.6%	49

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CMHS Uniform Reporting System - 2010 State Mental Health Measures

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STATE: Connecticut

Basic Measures	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	86,093	24.47	6,835,040	21.94	59
Community Utilization per 1,000 population	83,127	23.63	6,496,649	20.86	58
State Hospital Utilization per 1,000 population	1,587	0.45	157,968	0.51	53
Medicaid Funding Status	46,638	56%	4,124,247	62%	56
Employment Status (percent employed)	9,262	21%	581,651	19%	58
State Hospital Adult Admissions	1,215	0.94	136,410	0.94	52
Community Adult Admissions	53,706	0.97	11,414,220	2.64	51
State Hospital LOS Discharged Adult patients (Median)	-	60 Days	-	55 Days	50
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	-	60 Days	-	73 Days	50
Percent of Client who meets SMI definition	-	67%	-	70%	56
Adults with Co-occurring MH/SA Disorders	-	34%	-	20%	51
Children with Co-occurring MH/SA Disorders	-	5%	-	5%	49

Basic Measures: Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	88.5%	84.8%	54
Quality/Appropriateness of Services	91.7%	88.0%	54
Outcome from Services	80.1%	71.1%	54
Participation in Treatment Planning	91.5%	79.5%	54
Overall Satisfaction with Care	92.3%	87.8%	54

Basic Measures: Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	96.1%	82.8%	49
Overall Satisfaction with Care	92.0%	82.9%	50
Outcome from Services	65.0%	62.1%	50
Participation in Treatment Planning	95.1%	87.4%	50
Cultural Sensitivity of Providers	97.9%	92.7%	49

Basic Measures: Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	58,684	82.8%	4,173,695	82.7%	57
Jail/Correctional Facility	521	0.7%	88,500	1.8%	53
Homeless or Shelter	3,770	5.3%	137,909	2.7%	54

Basic Measures: Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	60	8.1%	12,227	9.2%	52
State Hospital Readmissions: 180 Days	106	14.3%	27,198	20.4%	53
Readmission to any psychiatric hospital: 30 Days	1	0.5%	52,546	13.9%	31

Basic Measures: State Mental Health Finance (FY2008)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community MH *	$395,900,000	60.0%	$26,284,870,187	71.6%	51
SMHA Revenues from State Sources **	$585,600,000	93.2%	$15,437,575,310	42.3%	51
Total SMHA Expenditures	$659,400,000	-	$36,687,130,712	-	51

Developmental Measure	State Number	State Rate	U.S.	U.S. Rate	States
Percent Adults with SMI and Children with SED	44,446	51.6%	4,523,720	66.2%	58

Developmental Measure: Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	62,473	2.2%	38
Supported Housing	2,910	9.5%	75,091	2.8%	41
Supported Employment	1,841	6.0%	56,910	2.1%	43
Family Psychoeducation	-	-	23,282	1.5%	19
Integrated Dual Diagnosis Treatment	3,983	13.0%	64,243	4.2%	27
Illness Self-Management and Recovery	-	-	167,530	9.1%	22
Medications Management	-	-	292,923	25.0%	19

Developmental Measure: Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	1,189	8.7%	18,032	2.0%	29
Multisystemic Therapy	48	0.4%	8,850	1.4%	20
Functional Family Therapy	160	1.2%	8,222	1.8%	13

Developmental Measure: New Generation Medication	State Number	State Rate	U.S.	U.S. Rate	States
New Generation Meds: State Hospitals	-	-	12,232	67.52%	14
New Generation Meds: Community MH	-	-	51,143	34.74%	12
New Generation Meds: Total System	-	-	44,377	37.37%	10

Developmental Measure: Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	7,686	15.0%	35,334	7.0%	47
Juvenile Justice Contacts	24	9.1%	5,192	7.4%	41
School Attendance (Improved)	77	48.7%	6,989	37.1%	35

* Includes Other 24 -Hour expenditures for state hospitals.

** Revenues for state hospitals and community MH

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Mental Health Community Services Block Grant: 2010 State Summary Report

Connecticut

100090

State URS Contact Person
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Alfred.Bidorini@po.state.ct.us; Marilyn.Cloud@ct.gov

State Revenue Expenditure Data	Amount
FY 2008 Mental Health Block Grant Revenues	$5,000,000
FY 2008 SMHA Community MH Expenditures	$395,900,000
FY 2008 Per Capita Community MH Expenditures	$113.32
FY 2008 Community Percent of Total SMHA Spending	60.04%
FY 2008 Total SMHA Mental Health Expenditure	$659,400,000
FY 2008 Per Capita Total SMHA Mental Health Expenditures	$188.74

Statewide Mental Health Agency Data*

Measure	Number of Clients	Utilization Rate Per 1,000 Population
Total Clients Served by SMHA System	86,093	24.47
Clients Served in Community Settings	83,127	23.63
Clients Served in State Hospitals	1,587	0.45

Gender	Percent
Female	47.7%
Male	52.3%

Age	Percent
0 to 12	16.37%
13 to 17	15.49%
18 to 20	4.78%
21 to 64	58.38%
65 to 74	2.84%
75 and over	1.17%
Not Available	0.98%

Race/Ethnicity	Percent
American Indian or Alaska Native	0.3%
Asian	0.7%
Black or African American	17.0%
Native Hawaiian or Other Pacific Islander	0.1%
White	61.2%
Hispanic or Latino	23.3%
More Than One Race	1.1%
Not Available	19.6%

Living Situation (with Known Status)	Percent
Private Residence	82.75%
Foster Home	2.15%
Residential Care	4.28%
Crisis Residence	0.23%
Residential Treatment Center	0.58%
Institutional Setting	1.03%
Jail (Correctional Facility)	0.73%
Homeless (Shelter)	5.32%
Other	2.93%
Not Available	-

Employment With Known Status (Adults)	Percent
Employed	21.0%
Unemployed	59.4%
Not in Labor Force	19.6%

Medicaid Funding Status of Consumers	Percent
Medicaid Only	55.8%
Non-Medicaid	44.2%
Both Medicaid and Other Funds	-

Consumer Perception of Care: (Children/Adolescents)	Percent
Access to Services	96.11%
Overall Satisfaction with Care	92.04%
Outcome from Services	65.03%
Participation in Treatment Planning	95.12%
Cultural Sensitivity of Providers	97.89%

Consumer Perception of Care: (Adults)	Percent
Access to Services	88.5%
Quality/Appropriateness of Services	91.7%
Outcome from Services	80.1%
Participation in Treatment Planning	91.5%
Overall Satisfaction with Care	92.3%

Outcome Measures Developmental	Percent
Adults Arrested this Year	15.03%
Youth Arrested this Year	9.06%
Improved School Attendance	48.73%

Implementation of Evidence-Based Practices	Percent
Assertive Community Treatment	-
Supported Housing	9.5%
Supported Employment	6.0%
Family Psychoeducation	-
Integrated Dual Diagnosis Treatment	13.0%
Illness Self-Management and Recovery	-
Medications Management	-
Therapeutic Foster Care	8.7%
Multisystemic Therapy	0.4%
Functional Family Therapy	1.2%

Hospital Readmissions (Civil Status Patients)	Percent
State Hospital Readmissions: 30 Days	8.08%
State Hospital Readmissions: 180 Days	14.27%
Readmission to any psychiatric hospital: 30 Days	0.46%

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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* Based on 2010 URS data provided by US States and Territories per annual reporting guidelines.

The Community Mental Health Block Grant is administered by the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services

DEC 17 2012

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Access Domain: Demographic Characteristics of Persons Served by the State Mental Health Authority, FY 2010

Connecticut

000091

Demographics	Total Served: States n	Total Served: States %	Total Served: US n	Total Served: US %	Penetration Rates (per 1,000 population): State	Penetration Rates (per 1,000 population): Northeast	Penetration Rates (per 1,000 population): US	States Reporting
0-12	14,090	16.4%	963,830	14.1%	24.9	19.9	17.9	58
13-17	13,338	15.5%	843,342	12.3%	55.2	51.2	40.6	59
18-20	4,112	4.8%	339,200	5.0%	26.0	36.0	25.7	59
21-64	50,262	58.4%	4,355,499	63.7%	24.4	34.7	24.2	59
65-74	2,445	2.8%	193,375	2.8%	9.9	17.6	9.3	59
75 and over	1,004	1.2%	133,652	2.0%	4.2	17.1	7.7	57
Age Not Available	842	1.0%	6,142	0.1%	-	-	-	30
Age Total	86,093	100.0%	6,835,040	100.0%	24.5	31.1	21.9	59
Female	41,047	47.7%	3,514,476	51.4%	22.8	31.2	22.3	59
Male	44,997	52.3%	3,310,196	48.4%	26.2	31.0	21.5	59
Gender Not Available	49	0.1%	10,368	0.2%	-	-	-	32
Gender Total	86,093	100.0%	6,835,040	100.0%	24.5	31.1	21.9	59
American Indian/Alaskan Native	266	0.3%	75,357	1.1%	19.6	37.1	23.9	53
Asian	596	0.7%	84,946	1.2%	4.7	7.2	6.1	57
Black/African American	14652	17.0%	1,345,772	19.7%	40.0	47.7	33.9	54
Native Hawaiian/Pacific Islander	97	0.1%	13,679	0.2%	33.8	34.7	25.7	52
White	52720	61.2%	4,241,146	62.1%	17.8	23.8	17.4	58
Hispanic or Latino Race	*	*	109,369	1.6%	*	-	36.5	8
Multi-Racial	916	1.1%	158,693	2.3%	17.6	66.6	31.6	50
Race Not Available	16846	19.6%	806,078	11.8%	-	-	-	54
Race Total	86093	100.0%	6,835,040	100.0%	24.5	31.1	23.1	59
Hispanic or Latino Ethnicity	20,040	23.3%	794,226	12.1%	46.1	42.0	16.7	52
Not Hispanic or Latino Ethnicity	60,932	70.8%	5,060,600	77.4%	19.8	28.0	20.4	55
Ethnicity Not Available	5,121	5.9%	685,347	10.5%	-	-	-	42
Ethnicity Total	86,093	100.0%	6,540,173	100.0%	24.5	31.1	21.7	57

* Reported under Hispanic Origin.

Note:

Are Client Counts Unduplicated? Duplicated between Hospitals and Community; Duplicated Among Community Programs; Duplicated between children and adults

Number of States with Unduplicated Counts 43

This table uses data from URS/DIG Table 2a, Table 2b and from the US Census Bureau. All denominators use US Census data from 2009

US totals are calculated uniquely for each data element based on only those states who reported clients served.

Regional groupings are based on SAMHSA's Block Grant Regions.

State Notes:

Table 2a

Age	May be duplication between persons served in DMHAS and DCF systems for persons age 18 to 21 years old.
Gender	None
Race	For DMHAS, 84.1% (8,755) of "Race Not Available" represents clients race as "Other". For DCF: Of the 6,430 clients reported as "Race Not Available", DCF estimates that approximately 40% had no race reported and 60% were reported as being of "other race".
Overall	Unduplicated count for adults is across DMHAS system. Duplicated count for children between Hospitals and Community and among Community Programs.

Table 2b

Age	May be duplication between persons served in DMHAS and DCF systems for persons age 18 to 21 years old.
Gender	None
Race	For DMHAS, 84.1% (8,755) of "Race Not Available" represents clients race as "Other".
Overall	Unduplicated count for adults is across DMHAS system.

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DEC 17

Access Domain: Persons Served in Community Mental Health Programs by Age and Gender, FY 2010

Connecticut

000092

Demographic	Served in Community				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US				
	n	%	n	%	State	US	
Age 0-17	27,066	32.6%	1,796,838	27.7%	33.5	24.1	58
Age 18-20	3,855	4.6%	321,741	5.0%	24.4	24.4	58
Age 21-64	48,121	57.9%	4,097,038	63.1%	23.3	22.8	58
Age 65+	3,312	4.0%	275,755	4.2%	6.8	6.3	57
Age Not Available	773	0.9%	5,277	0.1%	-	-	25
Age Total	83,127	100.0%	6,496,649	100.0%	23.6	20.9	58
Female	40,071	48.2%	3,353,226	51.6%	22.3	21.2	58
Male	43,015	51.7%	3,133,898	48.2%	25.0	20.4	58
Gender Not Available	41	0.0%	9,525	0.1%	-	-	28
Total	83,127	100.0%	6,496,649	100.0%	23.6	20.9	58

Note:

US totals are based on states reporting.

This table uses data from URS/DIG Table 3.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age	None
Gender	None
Overall	For Community Services, 2,156 adult clients are served by DCF.

DEC 17 2012

Access Domain: Persons Served in State Psychiatric Hospitals by Age and Gender, FY 2010

Connecticut

Demographic	Served in State Psychiatric Hospitals				Penetration Rates (rate per 1,000 population)		States Reporting
	State		US				
	n	%	n	%	State	US	
Age 0-17	287	18.1%	11,966	7.6%	0.4	0.2	41
Age 18-20	50	3.2%	7,848	5.0%	0.3	0.6	53
Age 21-64	1,145	72.1%	130,786	82.8%	0.6	0.7	53
Age 65+	104	6.6%	7,349	4.7%	0.2	0.2	53
Age Not Available	1	0.1%	19	0.0%	-	-	7
Age Total	1,587	100.0%	157,968	100.0%	0.5	0.5	53
Female	490	30.9%	55,199	34.9%	0.3	0.4	53
Male	1,097	69.1%	102,713	65.0%	0.6	0.7	53
Gender Not Available	-	-	56	0.0%	-	-	11
Total	1,587	100.0%	157,968	100.0%	0.5	0.5	53

Notes:

US totals are based on states reporting.

This table uses data from URS/DIG Table 3.

US penetration rates are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Age	None
Gender	None
Overall	For Community Services, 2,156 adult clients are served by DCF.

DEC 17 2012

ACCESS DOMAIN: Persons Served by SMHA System through Medicaid and Other Funding Sources by Race, Gender, and Ethnicity, FY 2010

STATE: Connecticut

Demographic	State							US Averages							States Reporting
	Number Served				% Served			Number Served				% Served			
	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Total Served with Known Funding Status	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	Total Served with Known Funding Status	Medicaid Only	Non-Medicaid Only	Both Medicaid & Other	
Female	22,796	17,107	-	39,903	57%	43%	-	1,765,149	1,219,646	425,909	3,410,704	52%	36%	12%	56
Male	23,835	19,726	-	43,561	55%	45%	-	1,554,173	1,261,018	375,339	3,190,530	49%	40%	12%	56
Gender Not Available	7	40	-	47	15%	85%	-	3,089	4,850	588	8,527	36%	57%	7%	28
Total	46,638	36,873	-	83,511	56%	44%	-	3,322,411	2,485,514	801,836	6,609,761	50%	38%	12%	56
American Indian or Alaska Native	151	108	-	259	58%	42%	-	39,100	24,574	8,716	72,390	54%	34%	12%	52
Asian	207	381	-	588	35%	65%	-	43,939	28,045	9,416	81,400	54%	34%	12%	54
Black or African American	9,216	5,150	-	14,366	64%	36%	-	741,854	401,274	157,236	1,300,364	57%	31%	12%	52
Native Hawaiian or Other Pacific Islander	51	46	-	97	53%	47%	-	4,839	4,788	2,802	12,429	39%	39%	23%	48
White	27,117	24,520	-	51,637	53%	47%	-	1,920,245	1,659,858	525,193	4,105,296	47%	40%	13%	55
Hispanic or Latino	*	*	-	*	*	*	-	69,240	28,149	6,638	104,027	67%	27%	6%	7
More Than One Race	695	187	-	882	79%	21%	-	69,773	42,557	15,685	128,015	55%	33%	12%	45
Race Not Available	9,201	6,481	-	15,682	59%	41%	-	433,421	296,269	76,150	805,840	54%	37%	9%	52
Total	46,638	36,873	-	83,511	56%	44%	-	3,322,411	2,485,514	801,836	6,609,761	50%	38%	12%	56
Hispanic or Latino	13,167	6,249	-	19,416	68%	32%	-	382,868	266,926	123,926	773,720	49%	34%	16%	50
Not Hispanic or Latino	32,106	27,549	-	59,655	54%	46%	-	2,349,699	1,930,270	597,809	4,877,778	48%	40%	12%	52
Ethnicity Not Available	1,365	3,075	-	4,440	31%	69%	-	416,707	209,084	37,673	663,464	63%	32%	6%	39
Total	46,638	36,873	-	83,511	56%	44%	-	3,149,274	2,406,280	759,408	6,314,962	50%	38%	12%	54

* Reported under Hispanic Ethnicity.

Note:

This table uses data from DIG Tables 5a, and 5b (Hispanic Origin).

Duplication

Type of Medicaid Data Reported

Data based on Medicaid Eligibility, not Medicaid Paid Services.

State Notes

5a	Age	None
5a	Gender	None
5a	Overall	The row category "Both Medicaid and non-Medicaid" is DCF clients only. Data has been based on client's Medicaid status (DMHAS) and/or Medicaid reimbursability (DCF) of the given service that the client received.
5b	Overall	The row category "Both Medicaid and non-Medicaid" is DCF clients only. Data has been based on client's Medicaid status (DMHAS) and/or Medicaid reimbursability (DCF) of the given service that the client received.

DEC 17 2012

000094

Access Domain: Demographic Characteristics of Adults with SMI and Children with SED Served by the State Mental Health Authority, FY 2010

Connecticut

000095

Demographics	Total Served				Penetration Rates (per 1,000 population)			States Reporting
	States		US					
	n	%	n	%	State	Northeast	US	
0-12	6,487	14.6%	671,820	14.9%	11.5	12.1	12.5	56
13-17	6,515	14.7%	592,653	13.1%	27.0	28.5	28.5	58
18-20	1,739	3.9%	193,305	4.3%	11.0	15.3	14.6	58
21-64	27,500	61.9%	2,872,320	63.5%	13.3	17.4	16.0	58
65-74	1,535	3.5%	126,699	2.8%	6.2	8.7	6.1	58
75 and over	492	1.1%	64,761	1.4%	2.0	6.0	3.8	56
Age Not Available	178	0.4%	2,162	0.0%	-	-	-	22
Age Total	44,446	100.0%	4,523,720	100.0%	12.6	15.8	14.5	58
Female	22,635	50.9%	2,319,948	51.3%	12.6	15.7	14.7	58
Male	21,802	49.1%	2,198,389	48.6%	12.7	15.9	14.3	58
Gender Not Available	9	0.0%	5,383	0.1%	-	-	-	29
Gender Total	44,446	100.0%	4,523,720	100.0%	12.6	15.8	14.5	58
American Indian/Alaskan Native	128	0.3%	50,122	1.1%	9.4	16.3	15.9	52
Asian	295	0.7%	64,835	1.4%	2.3	4.3	4.6	54
Black/African American	7,153	16.1%	939,974	20.8%	19.5	27.5	23.7	53
Native Hawaiian/Pacific Islander	56	0.1%	10,351	0.2%	19.5	21.7	17.9	50
White	28,555	64.2%	2,719,273	60.1%	9.7	11.4	11.1	57
Hispanic or Latino Race	*	*	44,180	1.0%	*	-	0.9	7
Multi-Racial	537	1.2%	101,892	2.3%	10.3	28.0	19.1	47
Race Not Available	7,722	17.4%	593,093	13.1%	-	-	-	52
Race Total	44,446	100.0%	4,523,720	100.0%	12.6	15.8	14.5	58
Hispanic or Latino Ethnicity	10,173	22.9%	524,785	12.2%	23.4	23.7	10.8	51
Not Hispanic or Latino Ethnicity	32,661	73.5%	3,283,010	76.3%	10.6	14.1	12.7	54
Ethnicity Not Available	1,612	3.6%	497,786	11.6%	-	-	-	41
Ethnicity Total	44,446	100.0%	4,305,581	100.0%	12.6	15.8	13.8	56

* Reported under Hispanic Ethnicity.

State used Federal SMI Definition?	No
	DMHAS uses only diagnosis to determine SMI and does not include Level of Functioning.
Diagnoses included in State SMI definition	Dx codes: 295 and 296.
State used Federal SED Definition?	Yes

Note:
This table uses data from URS/DIG Table 14a, Table 14b and from the US Census Bureau. All denominators use US Census data from 2009
US totals are calculated uniquely for each data element based on only those states who reported clients served.

Regional groupings are based on SAMHSA's Block Grant Regions.

State Notes:

Table 14a	
Age	Ages 18-20 and 21-64 includes both DMHAS and DCF clients.
Gender	None
Race	None
Overall	None
Table 14b	
Age	Ages 18-20 and 21-64 includes both DMHAS and DCF clients.
Gender	None
Race	None
Overall	DMHAS uses only diagnosis (Dx) to determine SMI and does not include Level of Functioning. SMI Definition = Dx codes: 295 and 296.

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APPROPRIATENESS DOMAIN: NUMBER OF ADMISSIONS DURING THE YEAR TO STATE HOSPITAL INPATIENT AND COMMUNITY-BASED PROGRAMS, FY 2010

STATE: Connecticut

Setting	Demographic	State			US			Admission Rate		States Reporting
		Admissions During Year	Total Served At Start of Year	Total Served During Year	Admissions During Year	Total Served At Start of Year	Total Served During Year	State	US	
State Psychiatric Hospitals	Total	1,427	741	1,587	148,625	45,919	157,851	0.90	0.94	52
	Children	212	75	287	12,208	1,596	11,954	0.74	1.02	37
	Adults	1,215	666	1,299	136,410	44,320	145,869	0.94	0.94	52
	Age NA	-	-	1	7	3	1	-	7.00	3
Other Inpatient	Total	833	70	842	537,860	36,287	385,299	0.99	1.40	45
	Children	-	-	-	79,618	3,412	52,841	-	1.51	36
	Adults	833	70	838	456,445	32,842	330,740	0.99	1.38	43
	Age NA	-	-	4	1,797	33	72	-	24.96	6
Residential Treatment Centers	Total	62	101	101	46,426	10,017	33,689	0.61	1.38	38
	Children	49	76	75	20,231	5,420	18,766	0.65	1.08	37
	Adults	13	25	26	26,193	4,592	14,913	0.50	1.76	29
	Age NA	-	-	-	2	5	8	-	0.25	2
Community Programs	Total	75,651	46,455	83,127	19,831,459	3,302,826	5,998,424	0.91	3.31	51
	Children	21,945	9,219	27,066	8,413,716	926,701	1,676,159	0.81	5.02	51
	Adults	53,706	37,236	55,288	11,414,220	2,374,243	4,317,146	0.97	2.64	51
	Age NA	-	-	773	3,523	1,882	3,286	-	1.07	16

Note:

Admission Rate= number of admissions divided by total served during the year

US Admissions During Year uses data from states reporting data only. States are only included in "US Total Served" if they also reported data on admissions.

US Total Served During Year is calculated using data in URS/DIG Table 3.

This table uses data from URS/DIG Table3 and 6.

Table 3 State Notes:

Age	None
Overall	For Community Services, 2,156 adult clients are served by DCF.
Gender	None

Table 6 State Notes:

Hospital	None
Other Inpatient	None
Residential	Adults shown under Residential Treatment Centers are DCF clients only.
Community	Combines adults served by DMHAS (35,721) and DCF(1,151) for served at beginning of year and DMHAS (51,372) and DCF (2,334) for admissions during year.
Overall	Data are for 3/1/2009 to 2/28/2010 for adults due to implementation of two data systems.

DEC 17 2012

060969

APPROPRIATENESS DOMAIN: Length of Stays in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers for Children Settings, FY 2010

000097

STATE: Connecticut

Setting	Demographic	State						US						
		Length of Stay (Days)						Length of Stay (Days)						
		Discharged Clients		Resident Clients in Facility 1 year or less		Resident Clients in Facility more than 1 year		Discharged Clients		Resident Clients in Facility 1 year or less		Resident Clients in Facility more than 1 year		States Reporting
		Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	
State Hospitals	All	-	-	-	-	-	-	183	58	101	76	2,100	1,327	12
	Children	112	-	99	-	521	-	97	77	78	64	503	483	33
	Adults	220	60	162	60	2,032	318	186	55	94	73	1,974	1,239	52
	Age NA	-	-	-	-	-	-	-	-	163	163	812	812	1
Other Inpatient	All	-	-	-	-	-	-	60	9	43	27	852	686	7
	Children	-	-	-	-	-	-	20	13	27	21	804	706	28
	Adults	13	6	12	6	-	-	25	8	39	30	870	688	38
	Age NA	-	-	-	-	-	-	26	6	13	3	-	-	2
Residential Treatment Centers	All	-	-	-	-	-	-	175	133	122	119	514	458	7
	Children	171	85	197	98	662	331	183	150	138	118	642	528	33
	Adults	163	81	314	157	683	342	260	209	134	124	829	712	23
	Age NA	-	-	-	-	-	-	90	90	118	119	1,186	1,186	1

Note:

Resident clients are clients who were receiving services in inpatient settings at the end of the reporting period.

This table uses data from URS/DIG Table 6.

Table 6 State Notes:

Hospital	None
Other Inpatient	None
Residential	Adults shown under Residential Treatment Centers are DCF clients only.
Community	Combines adults served by DMHAS (35,721) and DCF(1,151) for served at beginning of year and DMHAS (51,372) and DCF (2,334) for admissions during year.
Overall	Data are for 3/1/2009 to 2/28/2010 for adults due to implementation of two data systems.

DEC 17 2012

Appropriateness Domain: Percent of Adults and Children Served Who Meet the Federal Definition for SMI/SED and Percent of Adults and Children Served Who Have Co-Occurring MH/AOD Disorders, FY 2010

000098

Connecticut

Adults and Children who meet the Federal Definition of SMI/SED	State	US Average	US Median	States Reporting
Percent of Adults served through the SMHA who meet the Federal definition for SMI	66.9%	69.5%	73.0%	56
Percent of Children served through the SMHA who meet the Federal definition for SED	48.8%	73.4%	76.0%	55

Co-occurring MH and Substance Abuse Consumers	State	US Average	US Median	States Reporting
Percent of Adults served through the SMHA who had a co-occurring MH and AOD disorder	34.0%	20.0%	19.0%	51
Percent of Children served through the SMHA who had a co-occurring MH and AOD disorder	5.0%	4.6%	4.0%	50
Percent of Adults served through the SMHA who met the Federal definitions of SMI who also have a substance abuse diagnosis	43.0%	24.4%	20.0%	50
Percent of Children served through the SMHA who met the Federal definitions of SED who also have a substance abuse diagnosis	5.0%	8.7%	5.0%	49

Note

This table uses data from URS/DIG Table 12.

State Notes

None

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APPROPRIATENESS DOMAIN: Living Situation of Consumers Served by State Mental Health Agency Systems, FY 2010

000099

STATE: Connecticut

Age Group	Setting	State			US			States Reporting
		Living Situation	Percent in Living Situation	Percent with Known Living Situation	Living Situation	Percent in Living Situation	Percent with Known Living Situation	
All Persons Served	Private Residence	58,684	70.3%	82.8%	4,173,695	69.3%	82.7%	57
	Foster Home	1,522	1.8%	2.1%	94,577	1.6%	1.9%	49
	Residential Care	3,036	3.6%	4.3%	193,495	3.2%	3.8%	53
	Crisis Residence	162	0.2%	0.2%	65,765	1.1%	1.3%	32
	Residential Treatment Center	410	0.5%	0.6%	14,884	0.2%	0.3%	44
	Institutional Setting	733	0.9%	1.0%	166,465	2.8%	3.3%	52
	Jail (Correctional Facility)	521	0.6%	0.7%	88,500	1.5%	1.8%	53
	Homeless (Shelter)	3,770	4.5%	5.3%	137,909	2.3%	2.7%	54
	Other	2,077	2.5%	2.9%	113,290	1.9%	2.2%	45
	Not Available	12,600	15.1%	-	977,797	16.2%	-	45
	Total	**83,515**	**100.0%**	**100.0%**	**6,026,377**	**100.0%**	**100.0%**	**59**
Children under age 18	Private Residence	22,200	80.9%	88.5%	1,178,251	72.9%	87.2%	56
	Foster Home	1,403	5.1%	5.6%	69,346	4.3%	5.1%	47
	Residential Care	311	1.1%	1.2%	18,611	1.2%	1.4%	43
	Crisis Residence	154	0.6%	0.6%	11,905	0.7%	0.9%	26
	Residential Treatment Center	342	1.2%	1.4%	13,134	0.8%	1.0%	42
	Institutional Setting	426	1.6%	1.7%	21,649	1.3%	1.6%	43
	Jail (Correctional Facility)	64	0.2%	0.3%	15,132	0.9%	1.1%	46
	Homeless (Shelter)	171	0.6%	0.7%	7,339	0.5%	0.5%	46
	Other	-	-	-	15,080	0.9%	1.1%	41
	Not Available	2,357	8.6%	-	266,696	16.5%	-	41
	Total	**27,428**	**100.0%**	**100.0%**	**1,617,143**	**100.0%**	**100.0%**	**57**
Adults over age 18	Private Residence	35,982	65.1%	79.4%	2,992,074	68.0%	81.0%	57
	Foster Home	119	0.2%	0.3%	24,804	0.6%	0.7%	45
	Residential Care	2,695	4.9%	6.0%	174,570	4.0%	4.7%	53
	Crisis Residence	8	0.0%	0.0%	53,806	1.2%	1.5%	31
	Residential Treatment Center	68	0.1%	0.2%	1,684	0.0%	0.0%	22
	Institutional Setting	307	0.6%	0.7%	144,717	3.3%	3.9%	52
	Jail (Correctional Facility)	456	0.8%	1.0%	73,305	1.7%	2.0%	53
	Homeless (Shelter)	3,588	6.5%	7.9%	130,498	3.0%	3.5%	54
	Other	2,069	3.7%	4.6%	97,991	2.2%	2.7%	45
	Not Available	10,022	18.1%	-	705,483	16.0%	-	45
	Total	**55,314**	**100.0%**	**100.0%**	**4,398,932**	**100.0%**	**100.0%**	**59**

This table uses data from URS/DIG Table 15.

State Notes:

None

DEC 17 2012

APPROPRIATENESS DOMAIN: Persons Who were Homeless by Age, Gender, Race, and Ethnicity, FY 2010

10 0 0 100

STATE: Connecticut

Demographic	Homeless or Living in Shelters				Percent of Total with Known Living Situation		States Reporting
	State		US		State	US	
	N	%	N	%	%	%	
Age 0 to 17	171	4.5%	7,339	5.3%	0.7%	0.5%	46
Age 18 to 64	3,517	93.3%	127,764	92.6%	8.2%	3.7%	54
Age 65+	71	1.9%	2,734	2.0%	2.8%	1.2%	52
Age Not Available	11	0.3%	72	0.1%	2.0%	1.5%	13
Age Total	**3,770**	**100.0%**	**137,909**	**100.0%**	**5.3%**	**2.7%**	**54**
Female	1,221	32.4%	54,595	39.6%	3.6%	2.1%	54
Male	2,541	67.4%	83,106	60.3%	6.8%	3.4%	54
Gender Not Available	8	0.2%	208	0.2%	26.7%	2.4%	18
Gender Total	**3,770**	**100.0%**	**137,909**	**100.0%**	**5.3%**	**2.7%**	**54**
American Indian or Alaska Native	16	0.4%	2,082	1.5%	7.0%	3.7%	47
Asian	13	0.3%	1,056	0.8%	2.8%	1.8%	45
Black or African American	1,104	29.3%	43,609	31.6%	9.0%	4.1%	51
Native Hawaiian or Other Pacific Islander	3	0.1%	398	0.3%	3.5%	4.0%	34
White	1,987	52.7%	75,456	54.7%	4.5%	2.3%	53
Hispanic or Latino	*	*	947	0.7%	*	1.7%	8
More Than One Race	7	0.2%	3,176	2.3%	0.8%	2.5%	42
Race Not Available	640	17.0%	11,185	8.1%	5.0%	2.5%	47
Race Total	**3,770**	**100.0%**	**137,909**	**100.0%**	**5.3%**	**2.7%**	**54**
Hispanic or Latino	775	20.6%	20,586	15.5%	3.2%	2.4%	49
Not Hispanic or Latino	2,898	76.9%	102,489	77.2%	6.5%	2.7%	50
Not Available	97	2.6%	9,721	7.3%	4.8%	3.6%	34
Ethnicity Total	**3,770**	**100.0%**	**132,796**	**100.0%**	**5.3%**	**2.7%**	**52**

* Reported under Hispanic ethnicity.

Note:

US totals are based on states reporting.

This table uses data from URS/DIG Table 15.

US totals are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

None

DEC 17 2012

Appropriateness Domain: Evidence-Based Practices Reported by SMHAs, FY 2010

Connecticut

Adult EBP Services	State		US		Penetration Rate: % of Consumers Receiving EBP/Estimated SMI		Measuring Fidelity		States Reporting
	EBP N	SMI N	EBP N	SMI N	State	US Average	State	US	
Supported Housing	2,910	30,574	75,091	3,077,350	9.5%	2.8%	Yes	4	41
Supported Employment	1,841	30,574	56,910	3,077,350	6.0%	2.1%	Yes	18	43
Assertive Community Treatment	-	-	62,473	3,077,350	-	2.2%	-	24	38
Family Psychoeducation	-	-	23,282	3,077,350	-	1.5%	-	3	19
Dual Diagnosis Treatment	3,983	30,574	64,243	3,077,350	13.0%	4.2%	Yes	12	27
Illness Self Management	-	-	167,530	3,077,350	-	9.1%	-	8	22
Medication Management	-	-	292,923	3,077,350	-	25.0%	-	3	19

Child/Adolescent EBP Services	State		US		Penetration Rate: % of Consumers Receiving EBP/Estimated SED		Measuring Fidelity		States Reporting
	EBP N	SED N	EBP N	SED N	State	US Average	State	US	
Therapeutic Foster Care	1,189	13,610	18,032	1,180,308	8.7%	2.0%	Yes	9	29
Multi-Systemic Therapy	48	13,610	8,850	1,180,308	0.4%	1.4%	Yes	11	20
Family Functional Therapy	160	13,610	8,222	1,180,308	1.2%	1.8%	Yes	8	13

Note:

US totals are based on states reporting.

This table uses data from URS/DIG Tables 16 and 17.

US averages are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.

State Notes:

Table 16: None
Table 17: IDDT data was run at a different time than Table 14A & B and thus the numbers do not match.

DEC 17 2012

000191

Outcomes Domain: Employment Status of Adult Mental Health Consumers Served in the Community by Age and Gender, FY 2010

Connecticut

Demographics	State				Employed as Percent of those in Labor Force		Employed as Percent of Known Employment Status		States Reporting
	Employed	Unemployed	In Labor Force*	With Known Employment Status**	State	US	State	US	
Age 18 to 20	315	927	1,242	1,581	25%	32%	19.9%	14.8%	58
Age 21 to 64	8,703	24,077	32,780	39,482	27%	37%	22.0%	20.0%	58
Age 65 and over	215	1,079	1,294	2,484	17%	31%	8.7%	7.5%	57
Age Not Available	29	87	116	498	25%	49%	5.8%	8.8%	13
Age TOTAL	9,262	26,170	35,432	44,045	26%	36%	21.0%	19.0%	58
Female	4,765	12,966	17,731	22,313	27%	37%	21.4%	19.1%	58
Male	4,488	13,195	17,683	21,708	25%	35%	20.7%	18.8%	58
Gender Not Available	9	9	18	24	50%	39%	37.5%	18.7%	28
Gender TOTAL	9,262	26,170	35,432	44,045	26%	36%	21.0%	19.0%	58

What populations are reported? All Clients Number of States Reporting All Clients: 29 Number of States Reporting Some Clients: 31

When is Employment Status Measured?	At Admission	At Discharge	Monthly	Quarterly	Other
CT	Yes	Yes	-	-	-
US	43	26	4	5	33

Note:

*In Labor Force is the sum of consumers employed and unemployed.

**With Known Employment Status is the sum of consumer employed, unemployed and not in labor force.

Consumers employed as a % of those in labor force uses adults employed and unemployed as the denominator.

Consumers employed as % of known employment status uses the sum of persons employed, unemployed and not in labor force as the denominator.

This table uses data from URS/DIG Table 4.

State Notes:

Age	None
Gender	None
Overall	DMHAS used most recent status on record (at admission or at discharge for all adults)

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DOH 00 2

Outcomes Domain: Employment Status of Adult Mental Health Consumers Served in the Community by Diagnosis, FY 2010

Connecticut

Diagnosis	State				Employed as a % of Labor Force		Employed as % of Known Employment Status		% of Consumers with Dx		States Reporting
	Employed	Unemployed	In Labor Force*	With Known Employment Status**	State	US	State	US	State	US	
Schizophrenia and Related Disorders	957	2,662	3,619	4,486	26.4%	23.2%	21.3%	8.1%	10.2%	14.5%	46
Bipolar and Mood Disorders	1,896	5,365	7,261	9,041	26.1%	35.4%	21.0%	17.8%	20.5%	44.0%	46
Other Psychoses	289	802	1,091	1,323	26.5%	20.0%	21.8%	9.8%	3.0%	2.8%	45
All other Diagnoses	3,391	9,805	13,196	16,370	25.7%	42.3%	20.7%	22.6%	37.2%	29.7%	45
No Diagnosis and Deferred Diagnosis	2,729	7,536	10,265	12,825	26.6%	37.8%	21.3%	14.6%	29.1%	9.0%	43
TOTAL	9,262	26,170	35,432	44,045	26.1%	36.1%	21.0%	17.3%	100.0%	100.0%	46

Note:

*In Labor Force is the sum of consumers employed and unemployed.

**With Known Employment Status is the sum of consumer employed, unemployed and not in labor force.

Consumers employed as a % of those in labor force uses adults employed and unemployed as the denominator.

Consumers employed as % of known employment status uses the sum of persons employed, unemployed and not in labor force as the denominator.

This table uses data for URS/DIG Table 4a.

State Notes:

Deferred Diagnosis = 28.6% (15,353) of 53,598.

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2010 CMHS Uniform Reporting System (URS) Output Tables

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000103

CONSUMER SURVEY RESULTS, FY 2010

STATE: Connecticut

Indicators	Children: State	Children: U.S. Average	States Reporting	Adults: State	Adults: U.S. Average	States Reporting
Reporting Positively About Access	96.1%	81.5%	49	88.5%	84.6%	54
Reporting Positively About Quality and Appropriateness				91.7%	88.3%	54
Reporting Positively About Outcomes	65.0%	62.1%	50	80.1%	72.0%	54
Reporting on Participation in Treatment Planning	95.1%	86.5%	50	91.5%	79.1%	54
Family Members Reporting High Cultural Sensitivity of Staff	97.9%	92.7%	49			
Reporting positively about General Satisfaction with Services	92.0%	81.6%	50	92.3%	88.0%	54

Note: U.S. Average Children & Adult rates are calculated only for states that used a version of the MHSIP Consumer Survey

This table uses data from URS/DIG Table 11.

Children/Family	State	U.S.
Type of Survey Used	YSS-F	YSS-F=41

Type of Adult Consumer Survey Used	28-Item MHSIP	Other MHSIP	Other Survey
state	Yes	-	-
U.S.	33	23	-

Sample Size & Response Rate	Children: State	Children: U.S.	States Reporting	Adults: State	Adults: U.S. Average	States Reporting
Response Rate	62.0%	44.5%	45	-	49.9%	47
Number of Surveys Attempted (send out)	700	133,003	43	-	239,783	46
Number of Surveys Contacts Made	-	110,954	41	-	190,201	45
Complete Surveys	436	41,002	47	11,867	107,182	52

Populations covered in survey	Children: State	Children: U.S.	Adults: State	Adults: U.S.
All Consumers	-	3	-	-
Sample	Yes	47	Yes	54

Sample Approach	Children: State	Children: U.S.	Adults: State	Adults: U.S.
Random Sample	Yes	18	-	13
Stratified Sample	-	12	-	17
Convenience Sample	-	14	Yes	18
Other Sample	-	5	-	7

Who is Sampled?	Children: State	Children: U.S.	Adults: State	Adults: U.S.
Current Clients	Yes	49	Yes	53
Former Clients	-	18	-	20

Populations included in sample: (e.g., all adults, only adults with SMI, etc.)	Children: State	Children: U.S.	Adults: State	Adults: U.S.
All Children or Adults Served	Yes	27	Yes	29
SMI Adults or SED Children	-	17	-	15
Persons Covered by Medicaid	-	9	-	8
Other	-	11	-	15

State Notes:
None

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OUTCOMES DOMAIN: Consumer Survey Results, by Race/Ethnicity FY 2010

STATE: Connecticut

Adult Consumer Survey Indicators: Reporting Positively About...

Race/Ethnicity	Access		Quality & Appropriateness		Outcomes		Participation In Tx Planning		General Satisfaction		Social Connectedness		Improved Functioning		States
	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	
Total	89%	85%	92%	88%	80%	71%	92%	80%	92%	88%	74%	71%	79%	72%	47
American Indian or Alaska Native	79%	40%	88%	85%	77%	71%	86%	77%	89%	85%	69%	74%	75%	72%	39
Asian	94%	85%	96%	87%	74%	73%	91%	80%	95%	88%	75%	74%	80%	75%	39
Black or African American	90%	98%	92%	88%	83%	76%	91%	82%	92%	89%	78%	76%	82%	76%	41
Native Hawaiian or Other Pacific Islander	88%	88%	80%	90%	82%	80%	88%	82%	96%	89%	71%	83%	77%	82%	30
White	88%	85%	91%	88%	79%	70%	92%	81%	92%	88%	73%	70%	78%	70%	41
Hispanic or Latino	91%	88%	95%	91%	83%	76%	93%	85%	95%	89%	78%	76%	82%	75%	38
More Than One Race	85%	81%	90%	84%	78%	68%	88%	77%	92%	85%	75%	67%	74%	67%	29
Not Available	89%	85%	93%	87%	82%	71%	92%	77%	93%	87%	77%	70%	81%	71%	42

Family of Children Survey Indicators: Reporting Positively About...

Race/Ethnicity	Access		General Satisfaction with Services		Outcomes		Participation In Tx Planning		Cultural Sensitivity of Staff		Social Connectedness		Improved Functioning		States
	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	State	US Average	
American Indian or Alaska Native	-	79%	-	80%	-	68%	-	81%	-	92%	-	85%	-	67%	33
Asian	-	76%	-	85%	-	66%	-	82%	-	91%	-	79%	-	72%	22
Black or African American	-	86%	-	85%	-	67%	-	87%	-	94%	-	88%	-	68%	36
Native Hawaiian or Other Pacific Islander	-	78%	-	83%	-	72%	-	86%	-	91%	-	91%	-	71%	20
White	-	81%	-	82%	-	64%	-	88%	-	93%	-	84%	-	65%	36
Hispanic or Latino	-	75%	-	80%	-	66%	-	82%	-	87%	-	80%	-	65%	32
More Than One Race	-	79%	-	79%	-	62%	-	86%	-	92%	-	83%	-	63%	24
Not Available	-	78%	-	80%	-	61%	-	84%	-	90%	-	81%	-	62%	36

Notes:

This table uses data from URS/DIG Table 11a.

State Notes:

None

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CT 10 67

Outcomes Domain: Change in Social Connectedness and Functioning, FY 2010

000106

Connecticut

Indicators	Children				Adults			
	State	US Average	US Median	States Reporting	State	US Average	US Median	States Reporting
Percent Reporting Improved Social Connectedness from Services	90.7%	84.6%	85.0%	49	74.3%	71.1%	70.7%	54
Percent Reporting Improved Functioning from Services	65.0%	64.4%	64.3%	50	78.9%	70.3%	71.1%	54

Note:

This table uses data from URS/DIG Table 9.

US State Averages and Medians are calculated only with states which used the recommended Social Connectedness and Functioning questions.

Adult Social Connectedness and Functioning Measures	State	US
Did you use the recommended new Social Connectedness Questions?	No	52
If No, what Measure did you use?	Recovery Domain	
Did you use the recommended new Functioning Domain Questions?	No	52
If No, what Measure did you use?	Recovery Domain	
Did you collect these as part of your MHSIP Adult Consumer Survey?	Yes	50

Children/Family Social Connectedness and Functioning Measures	State	US
Did you use the recommended new Social Connectedness Questions?	Yes	47
Did you use the recommended new Functioning Domain Questions?	Yes	47
Did you collect these as part of your YSS-F Survey?	Yes	45

State Notes:

None

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000107

Appendix 9

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000108

6 MENTAL HEALTH

Background

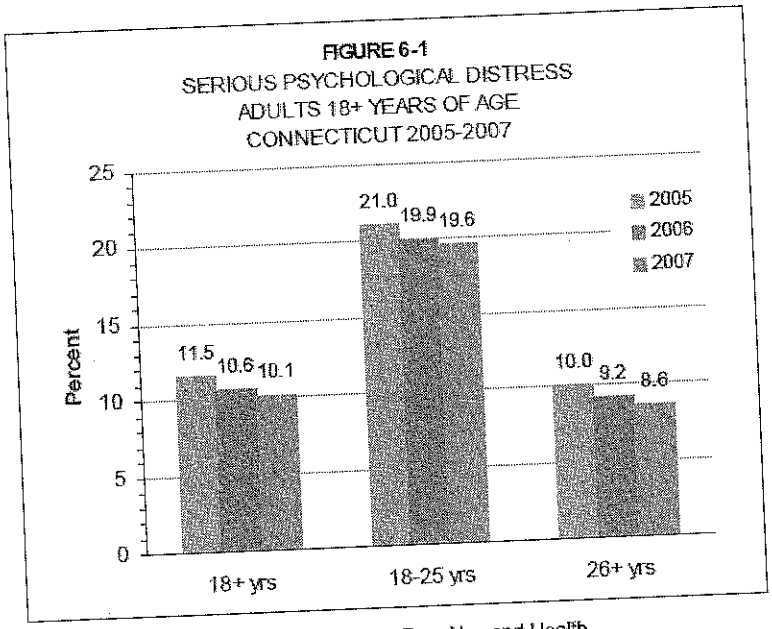
In 2007, one in three Americans 18 years of age and older had a diagnosable mental disorder.[1] The estimated lifetime prevalence was 57% for all mental disorders, 35% for substance use/abuse disorders, 31% for anxiety disorders, 25% for impulse-control disorders (e.g., attention deficit/hyperactivity disorder), and 21% for mood disorders (e.g., major depressive disorder, bipolar disorder).[2] These mental disorders account for more disability than any other diseases, including heart disease and cancer.[3] Major depression is the leading cause of disability and is responsible for more than two-thirds of suicides.[4]

In Connecticut in 2007, mental disorders, excluding alcohol and drug psychoses, accounted for 17,344 hospitalizations (488 per 100,000 population), with $332 million in total hospital charges. Adults 25-44 years of age accounted for 39% of these hospitalizations.[5]

Findings.

Serious Psychological Distress. Serious psychological distress (see *Tracking Data* for definition) is assessed only for persons over 17 years of age. From 2005 to 2007 (data from earlier years not comparable), serious psychological distress declined slightly among all age groups but was more than twice as common among young adults 18-25 years of age than among persons 26 years of age and older (Fig 6-1).

FIGURE 6-1
SERIOUS PSYCHOLOGICAL DISTRESS
ADULTS 18+ YEARS OF AGE
CONNECTICUT 2005-2007



Source: SAMHSA National Survey on Drug Use and Health

[1] Harvard School of Medicine. *National Comorbidity Survey Replication.* Table 2. 12-month prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort. http://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_12monthprevgenderxage.pdf. Accessed 2 February 2010. Diagnosable mental health disorders, as used here, include anxiety, mood, and impulse control disorders, and substance abuse, including tobacco disorders.

[2] Harvard School of Medicine. *National Comorbidity Survey Replication.* Table 1. Lifetime prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort. http://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_LTprevgenderxage.pdf. Accessed 2 February 2010.

[3] World Health Organization. 2005. *Promoting Mental Health: Concepts, Emerging Evidence, Practice.* Geneva: World Health Organization. http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf. Accessed 5 February 2010.

[4] U.S. Department of Health and Human Service, *Healthy People 2010.* Vol. 1, p. 36. http://www.healthypeople.gov/Document/pdf/uih/uih.pdf.

[5] Connecticut Department of Public Health. Connecticut Resident Hospitalizations, 2007. Table H-1AA. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397512. Accessed 8 February 2010.

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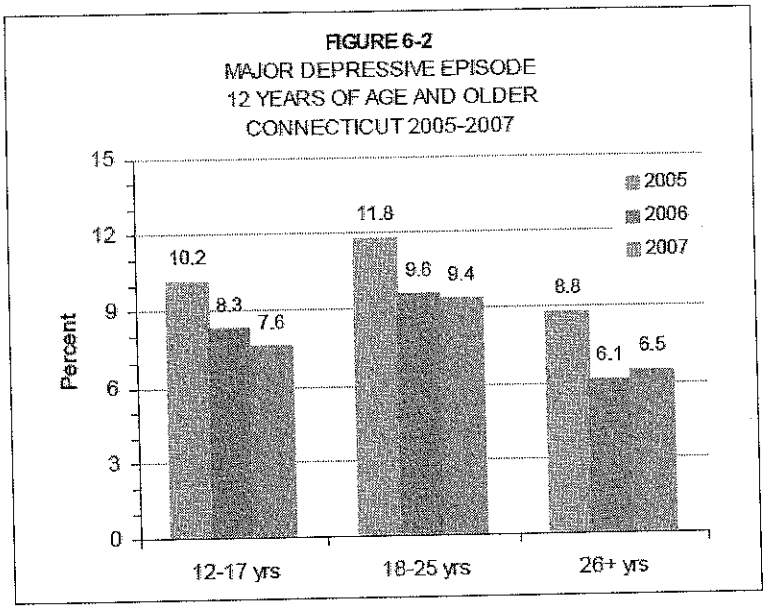
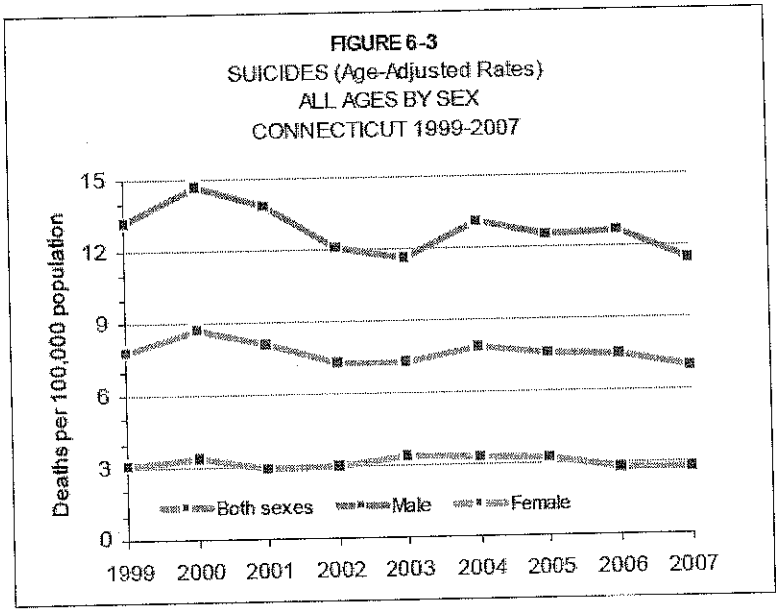
00109

Major Depressive Episodes. From 2005 to 2007, major depressive episodes declined among all age groups. Young adults 18-25 years of age and children 0-17 years of age consistently were more likely than adults 26 years of age and older to have a major depressive episode (Fig. 6-2).



Source: SAMHSA National Survey on Drug Use and Health

Suicide. Each year, 250 to 300 Connecticut residents take their own lives. In 2007, suicide was the second leading cause of death for males 15-19 and 25-34 years of age, the third for males 20-24 years of age, and ranked fourth for males 35-44 and 45-55 years of age.[6] Suicide also is often among the top five leading causes of death for children 10-14 years of age. From 1999 to 2007, the Connecticut suicide rate decreased overall and for both sexes (Fig. 6-3). Suicide rates for males consistently were about 4 times greater than those for females.



Source: Connecticut Death Registry (Registration Reports)

[6] Connecticut Department of Public Health, Health Information Systems and Reporting Section. 2007 Registration Report, Table 10. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598.

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4 ALCOHOL AND SUBSTANCE ABUSE

00.0 1110

Background

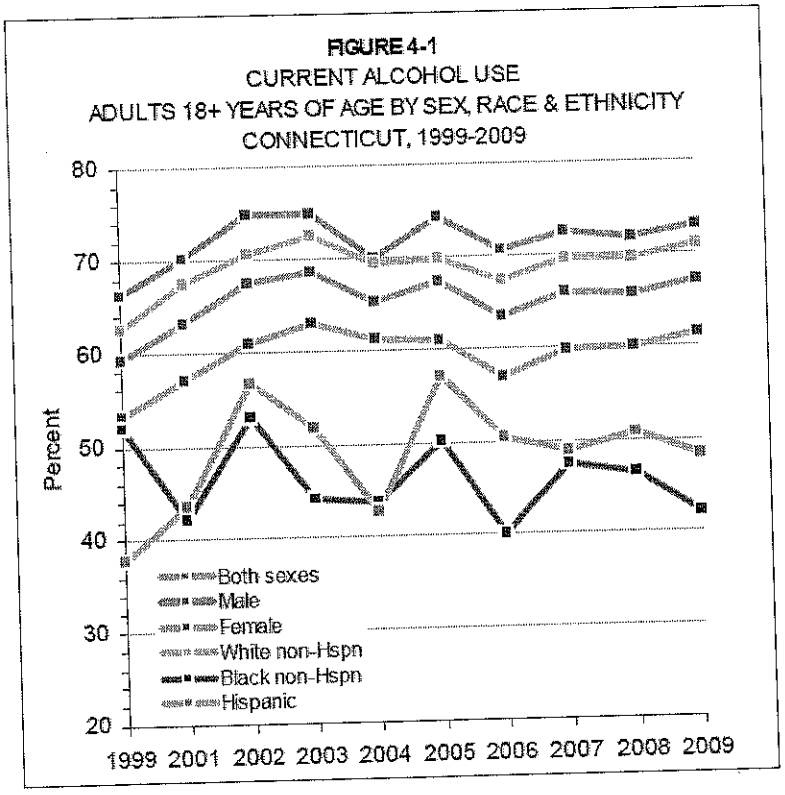
Alcohol, marijuana, tobacco, cocaine, heroin, and misused prescription drugs are the priority substances targeted for prevention efforts in Connecticut.[1] The use of alcohol and illicit drugs is associated with injury, illness, disability, lost productivity, death, and crime--including domestic violence, and it also can lead to serious chronic mental health problems.

Together, alcohol and drug abuse account for about 650 deaths and 5,000 hospitalizations among Connecticut residents each year.[2] In 2008, 40% of motor-vehicle-related fatalities were alcohol-related (BAC≥0.01%), and 33% involved alcohol-impaired drivers (BAC≥0.08%), and these percentages were about the same since 1998.[3] Inpatient hospitalizations for alcohol and drug abuse accounted for $77 million in hospital charges in 2007,[4] and underage drinking cost the state an estimated $621 million in 2005.[1]

Findings

Alcohol Use

Adults. Between 2001 and 2009, current alcohol use (at least one drink in past 30 days) increased among adults in all population groups except black non-Hispanics (Fig. 4-1). These changes were statistically



Source: Behavioral Risk Factor Surveillance System

[1] Connecticut Department of Mental Health and Addiction Services. *2009 Connecticut Strategic Prevention Framework State Epidemiological Profiles*. http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf. Accessed 01 Feb. 2010.

[2] Connecticut Department of Public Health. *2007 Registration Report*, Table 9 (provisional). Accessed 02 Feb. 2010.

[3] National Highway Traffic Safety Administration, National Center for Statistics and Analysis. Fatal Analysis Reporting System (FARS) Web-Based Encyclopedia. http://www-fars.nhtsa.dot.gov/States/StatesAlcohol.aspx. Accessed 05 Feb. 2010.

[4] Connecticut Department of Public Health. *2007 Hospitalization Report*, Table H-1AA. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397512&dphPNavCtr=%7C. Accessed 02 Feb. 2010.

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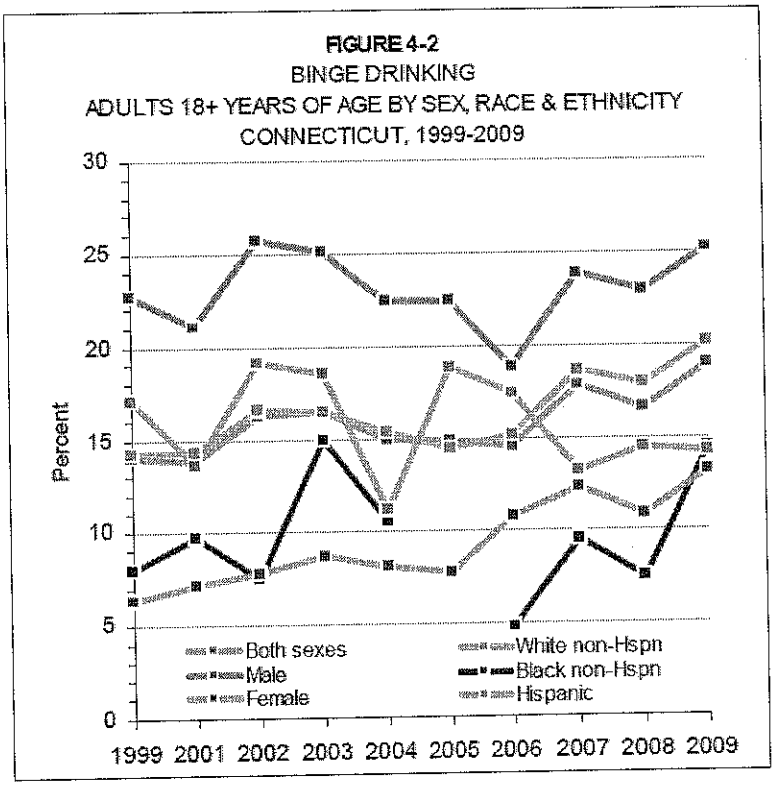
significant overall, for females, and for white non-Hispanics. In 2009, Hispanics and black non-Hispanics were significantly less likely than white non-Hispanics to drink alcoholic beverages, and women were significantly less likely to drink, compared to men. The proportion of white non-Hispanics who drank alcohol was nearly 70% greater than that of black non-Hispanics.

The definition of binge drinking changed in 2006, from five or more drinks on one or more occasions during the past month to five or more for men and four or more for women, so annual data are comparable from 1999-2005 and from 2006-2009, but not across the two intervals. During the most recent 4 years, binge drinking increased overall and among men and white non-Hispanics. Binge drinking decreased by 3.2 percentage points among Hispanics and increased by 9.6 percentage points among black non-Hispanics, but these changes were not statistically significant.(Fig. 4-2). In 2009, the prevalence of binge drinking was higher among white non-Hispanics compared to black non-Hispanics and Hispanics, but these differences were not significant. Men were significantly more likely than women to binge drink (91% greater prevalence).

FIGURE 4-2
BINGE DRINKING
ADULTS 18+ YEARS OF AGE BY SEX, RACE & ETHNICITY
CONNECTICUT, 1999-2009



Source: Behavioral Risk Factor Surveillance System
Note: Data not available for black non-Hispanics in 2005.

Adolescents. From 1997 to 2009, statistically significant decreases in alcohol use occurred overall and among male, female, and white non-Hispanic high school students (Fig. 4-3). In 2009, nearly half of all high school students reported drinking alcohol in the past 30 days. Binge drinking declined significantly for high school students overall, for males, and for white non-Hispanics since 1997 (Fig. 4-4). Differences in drinking and binge drinking by males and females were not statistically significant.

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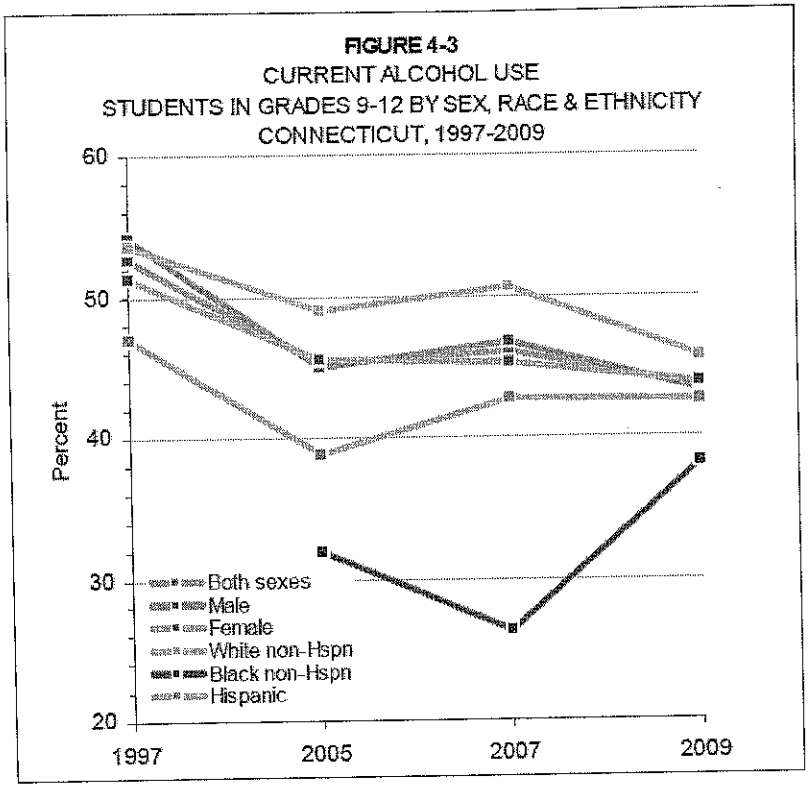
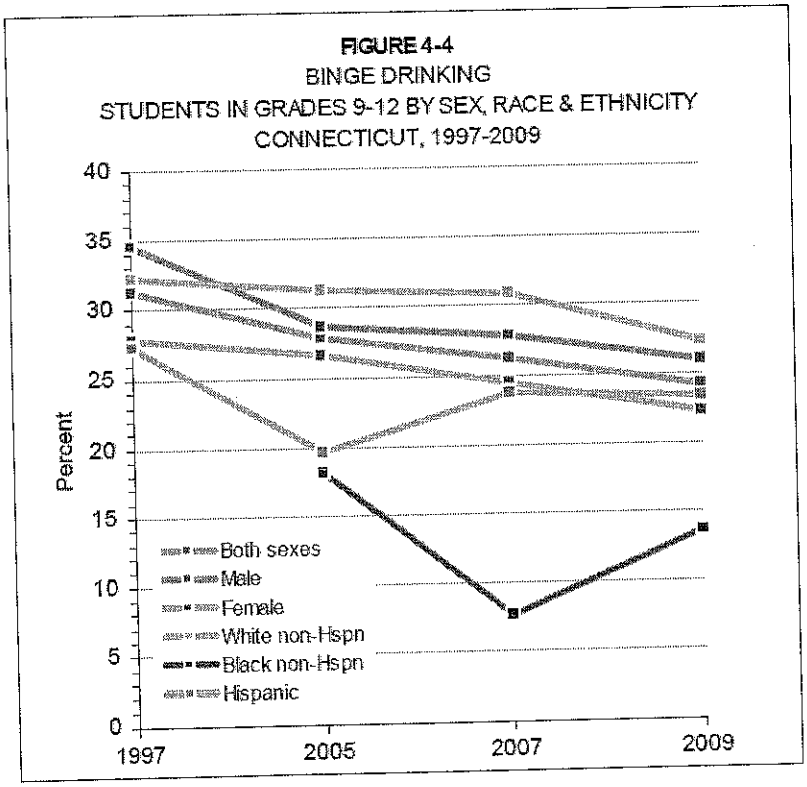
FIGURE 4-3
CURRENT ALCOHOL USE
STUDENTS IN GRADES 9-12 BY SEX, RACE & ETHNICITY
CONNECTICUT, 1997-2009



Source: Behavioral Risk Factor Surveillance System
Note: Data for black non-Hispanics not available in 1997.

FIGURE 4-4
BINGE DRINKING
STUDENTS IN GRADES 9-12 BY SEX, RACE & ETHNICITY
CONNECTICUT, 1997-2009



Source: Behavioral Risk Factor Surveillance System
Note: Data for black non-Hispanics not available in 1997.

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Appendix 10

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License Type:: Acupuncturist, Advanced Ankle Surgery Permit, Advanced Emergency Medical Technician, Advanced Practice Registered Nurse, Ambulatory Surgical Center

License Number:

Business Name/DBA:

First Name: Last Name:

Address:

City: State: Zip:

Specialty: Practice City:

Search Clear Form

Current Filters: License Type: Mental Health Residential Living

1 2 3

	Name	Credential	Credential Description	Credential Status	City	State	Zip Code	DBA
Detail	CENTER FOR HUMAN DEVELOPMENT-CONNECTICUT OUTREACH	MHRL.0000040	Mental Health Residential Living	ACTIVE	Hartford	CT	06106	CHD-CONNECTICUT OUTREACH: CROSSOVER
Detail	CENTRAL NAUGATUCK VALLEY HELP INC	MHRL.RLC0010	Mental Health Residential Living	ACTIVE	WATERBURY	CT	06708	ROGERS HOUSE
Detail	COMMUNITY MENTAL HEALTH AFFILIATES INC.	MHRL.0000043	Mental Health Residential Living	ACTIVE	New Britain	CT	06052	HIGHLANDS
Detail	COMMUNITY MENTAL HEALTH AFFILIATES INC.	MHRL.RLC0038	Mental Health Residential Living	ACTIVE	NEW BRITAIN	CT	06052	HARVEST HOUSE
Detail	COMMUNITY MENTAL HEALTHAFFILIATES INC.	MHRL.RLC0039	Mental Health Residential Living	INACTIVE	NEW BRITAIN	CT	06052	CENTRAL CONNECTICUT TRANSITIONAL LIVING CENTER
Detail	CONNECTION INC.	MHRL.0000047	Mental Health Residential Living	ACTIVE	New Haven	CT	06511	PARK STREET INN
Detail	CONNECTION INC.	MHRL.0000048	Mental Health Residential Living	ACTIVE	NEW HAVEN	CT	06511	DWIGHT HOUSE
Detail	CONTINUUM OF CARE INC	MHRL.RLC0013	Mental Health Residential Living	ACTIVE	NEW HAVEN	CT	06519	NEW HAVEN HALFWAY HOUSE
Detail	CONVERSION DATA	MHRL.RLC0005	Mental Health Residential Living	INACTIVE	DANBURY	CT	06810	INTERLUDE INC
Detail	CONVERSION DATA	MHRL.RLC0006	Mental Health Residential Living	INACTIVE	NEW BRITAIN	CT	06052	COMM. MH AFFILIATES INC/RUSSELL HOUSE

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12.99
81.98

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License Type: Acupuncturist
Advanced Ankle Surgery Permit
Advanced Emergency Medical Technician
Advanced Practice Registered Nurse
Ambulatory Surgical Center

License Number:

Business Name/DBA:

First Name: Last Name:

Address:

City: State: Zip:

Specialty: Practice City:

Search Clear Form

Current Filters: **License Type:** Mental Health Residential Living

1 2 3

	Name	Credential	Credential Description	Credential Status	City	State	Zip Code	DBA
Detail	CONVERSION DATA	MHRL.RLC0007	Mental Health Residential Living	INACTIVE	JEWETT CITY	CT	06351	RELIANCE HOUSE GROUP HOME
Detail	CONVERSION DATA	MHRL.RLC0011	Mental Health Residential Living	INACTIVE	TORRINGTON	CT	06790	BRIDGEWAY
Detail	CONVERSION DATA	MHRL.RLC0027	Mental Health Residential Living	INACTIVE	BRIDGEPORT	CT	06608	TRANSITIONAL LIVING CTR III
Detail	CONVERSION DATA	MHRL.RLC0033	Mental Health Residential Living	INACTIVE	BRIDGEPORT	CT	06604	TRANSITIONAL LIVING CENTER I
Detail	GILEAD COMMUNITY SERVICES INC.	MHRL.RLC0003	Mental Health Residential Living	ACTIVE	MIDDLETOWN	CT	06457-2612	GILEAD HOUSE I
Detail	GILEAD COMMUNITY SERVICES INC.	MHRL.RLC0004	Mental Health Residential Living	ACTIVE	MIDDLETOWN	CT	06457	GILEAD HOUSE II
Detail	GILEAD COMMUNITY SERVICES INC. - SCAP PROGRAM	MHRL.0000042	Mental Health Residential Living	ACTIVE	CLINTON	CT	06413	SHORELINE COMMUNITY APARTMENT PROGRAM
Detail	INSTITUTE HEALTH CARE INC.	MHRL.0000041	Mental Health Residential Living	INACTIVE	Hartford	CT	06106	TODD PROGRAM/BUCKINGHAM PROGRAM
Detail	KEYSTONE HOUSE INC	MHRL.RLC0016	Mental Health Residential Living	ACTIVE	NORWALK	CT	06850	ELMCREST TERRACE HALFWAY HOUSE
Detail	KEYSTONE HOUSE INC	MHRL.RLC0022	Mental Health Residential Living	ACTIVE	NORWALK	CT	06855	ST. JOHN STREET GROUP HOME

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License Type: Acupuncturist
Advanced Ankle Surgery Permit
Advanced Emergency Medical Technician
Advanced Practice Registered Nurse
Ambulatory Surgical Center

License Number: - -

Business Name/DBA:

First Name: Last Name:

Address:

City: State: Zip:

Specialty: Practice City:

Search Clear Form

Current Filters: **License Type:** Mental Health Residential Living

1 2 3

	Name	Credential	Credential Description	Credential Status	City	State	Zip Code	DBA
Detail	MENTAL HEALTH ASSOCIATION OF CONNECTICUT INC.	MHRL.RLC0028	Mental Health Residential Living	ACTIVE	WEST HARTFORD	CT	06119	ROBINSON HOUSE GROUP HOME
Detail	PARENTS' FOUNDATION FOR TRANSITIONAL LIVING INC.	MHRL.RLC0036	Mental Health Residential Living	ACTIVE	NEW HAVEN	CT	06511	PARENTS' FOUNDATION FOR TRANSITIONAL LIVING INC.
Detail	RECOVERY NETWORK OF PROGRAMS INC.	MHRL.RLC0026	Mental Health Residential Living	ACTIVE	BRIDGEPORT	CT	06604-3710	TRANSITIONAL LIVING CENTER II
Detail	RUSHFORD CENTER, INC.	MHRL.0000049	Mental Health Residential Living	ACTIVE	MERIDEN	CT	06450-3249	RUSHFORD CENTER, INC.
Detail	SOUND COMMUNITY SERVICES INC.	MHRL.0000045	Mental Health Residential Living	ACTIVE	NORWICH	CT	06360	SOUND COMMUNITY SERVICES, INC. - MICHAEL KERR RESPITE PROGRAM
Detail	ST. VINCENT DEPAUL MISSION OF WATERBURY INC.	MHRL.RLC0029	Mental Health Residential Living	ACTIVE	WATERBURY	CT	06705	CASA DE ROSA
Detail	TRANSITIONAL LIVING CENTER I	MHRL.RLC0035	Mental Health Residential Living	ACTIVE	BRIDGEPORT	CT	06608-1006	TRANSITIONAL LIVING CENTER I
Detail	UNITED SERVICES INC.	MHRL.0000046	Mental Health Residential Living	ACTIVE	Moosup	CT	06354	MILNER HOUSE
Detail	WELLSPRING FOUNDATION INC.	MHRL.RLC0037	Mental Health Residential Living	ACTIVE	BETHLEHEM	CT	06751	ANGELUS HOUSE

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Appendix 11

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Table 1: Projected Volume

Mental Health Residential Living center	Projected Volume (First 3 full operational FY's)			
	Current Year to Date	Year 1 Jan 1, 2013 - 12/31/13	Year 2 Jan 1, 2014 - 12/31/14	Year 3 Jan 1, 2015 - 12/31/15
Total Beds	N/A	6	6	6
Total Bed Days	N/A	2190	2190	2190
Projected Occupancy	N/A	83%	100%	100%
Projected Bed Days	N/A	1817.7	2190	2190
Projected Total Admissions	N/A	60.59	73	73

B) Table 1 Assumptions

1) Total beds-
Determined by the applicant in conjunction with the Planning and Zoning Department for Danbury (6).

2)Total bed days- Number of beds multiplied by 365 days in a year. (6x365)

3)Projected Occupancy-Estimated by the applicant

4)Projected bed days- Total available bed days multiplied by occupancy rate(year 1-2190x.83)=1817.7

5)Projected total admissions-Projected bed days divided by the average length of stay(30 days-estimated by applicant)-year 1-1817.7/30=60.59

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Appendix 12

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New Milford, Connecticut 06776
(H) 860-355-2558 / djpalmer@sbcglobal.net

DAVID J. PALMER

OBJECTIVE

Innovative, accomplished Professional seeking new challenge leading teams to achieve results that surpass business objectives.

HIGHLIGHTS OF QUALIFICATIONS

- Dedicated Management Professional with proven success conceptualizing and implementing business process improvements.
- Reduced operating costs 20% at *Ability Beyond Disability* through the development of alternatives for employee work schedules and overtime by initiating relationships with vendors and suppliers.
- Developed a best practices training manual for new and existing managers which reduced attrition, improved manager knowledge base, and facilitated employee communication.
- Created three volunteer and donation programs which provided residents with furniture, appliances, landscaping and maintenance services, and critical-care items.
- Chosen by senior management to lead the turnaround of five in-crisis homes; developed team-building exercises and made staffing changes which restored a positive household environment.
- Received the Outstanding Organization Award for two consecutive years in recognition of the development of cost saving measures and innovative resident programs.
- Technically proficient in Microsoft Word, Excel, PowerPoint, and Outlook, as well as Danic Tools and ExtendTime.

PROFESSIONAL EXPERIENCE

CEO, Blue Sky Behavioral Health, Danbury, CT Jan 2012-present

- Established a Substance abuse/mental health clinic as a new entity
- Responsible for all aspects of Day to day operations.

CEO, SLS Residential, Brewster, NY June 2007-Dec 2011

* Oversaw day to day operations of a residential mental health, substance abuse program.

SERVICES MANAGER, Ability Beyond Disability, Bethel, Connecticut, May 1996-June 2007

- Managed daily operations for nine residential sites with a budget of $6 million.
- Oversaw staff of four supervisors and 90 employees; provided recruiting, corporate training, and mentoring of new managers.
- Ensured homes were in compliance with the Department of Mental Retardation and Commission on Accreditation of Rehabilitation Facilities (CARF) licensing guidelines.
- Assisted the CEO and Director with program oversight, which included monitoring of contractual requirements and budgeted spending amounts.
- Prepared and delivered presentations on patient and facility status and needs to internal and external vendors, parents and guardians, and regulatory agencies.
- Researched and developed 20-year strategic plan for the organization based on expected population and the required facilities for their care; effort led to initiative to improve 75% of the organization's current facilities and to sell the remaining 25%.

GROUP HOME MANAGER, RMS, Kensington, Connecticut, May 2000-May 2005

- Managed 11 employees responsible for resident program development and provision of services for adults with disabilities.
- Responsible for all financial, medical, and programmatic records for residents; developed systems for vendor groups and analysis of all aspects of resident care.
- Prepared annual and semi-annual budget reports for vendor groups.
- Innovated in-house day program for residents which reduced staff and outside vendor costs.

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EDUCATION

BACHELOR OF BUSINESS ADMINISTRATION IN SUPERVISORY MANAGEMENT,
Western Connecticut State University, Danbury, Connecticut, 1991

- Received Teaching Certification for K-6 grades, 1995

KURT J. NESER

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Cell (845) 674-1859
kurtnes23@yahoo.com

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EDUCATION **Suny Albany, Albany, NY**
1999 - 2003 **BA – Psychology**

EXPERIENCE

2012-Present **Blue Sky Behavioral Health, Danbury, CT**
Risk Management Supervisor
- Responsible for compliance of state and federal regulations
- Created and updated policies and procedures in creation of new company
- Successfully spearheaded CARF certification

2012-Present **Life Assist, Brewster, NY**
Deputy Program Director
- Responsible for supervising all aspects of staff work performance
- Customer Service needs of clients
- Training of Staff
- Administrative duties

2004- 2011 **SLS HEALTH, Brewster, NY**
Risk Management Supervisor
- Started as a direct care staff and excelled from a Team Manager to Deputy Program Director to current position as Risk Management Supervisor
- Gained experience in directly managing up to 25 Staff Members
- Currently a certified PMT and CPR/First Aid Instructor
- Train and re-write new policies and procedures for programs
- Investigate incidents related to harm or potential of harm to clients
- Manage a system of incident data analysis used to identify trends and reduce future incidents
- Responsible for reporting of serious incidents to outside agencies
- Responsible for safety inspections of multiple sites and supervising needed repairs
- Responsible for review and maintenance of company policy incorporating three subdivisions of the company

SPECIAL SKILLS Type 40+ WPM. Proficient in MS Windows, Word, WordPerfect, Excel, Access, PowerPoint, Outlook, Member of Psi Chi National Honor Society for Psychology, lab experience in neurophysiology lab. Certified First Aid and CPR Trainer with the American Red Cross in Greater New York. Certified Instructor in Physical Management Training from PMT Associates. Experience in NYMRS reporting system for NY State

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DAVID GUREASKO-MOORE, PHD

CT LICENSED PSYCHOLOGIST # 2954
NEW YORK LICENSED PSYCHOLOGIST # 015968-1

6 WILDERNESS WEST RD
NEWTOWN, CT 06470
203 304-1044
SPGDPM@YAHOO.COM

EDUCATION

Lehigh University, Bethlehem, PA (APA Full Accreditation, NASP Approved)
Ph.D., School Psychology, May 2003

Lehigh University, Bethlehem, PA
Endorsement in Pediatric School Psychology, June 2001

Lehigh University, Bethlehem, PA
M.Ed., Human Development, May 1999

Muhlenberg College, Allentown, PA
B.A., Psychology, May 1997
Summa Cum Laude; Psychology Departmental Honors

EMPLOYMENT EXPERIENCE

Blue Sky Behavioral Health Clinic, Danbury, CT
Clinical Director, January 2012 - Present

Clinical Director for Blue Sky Behavioral Health Clinic. Work primarily with late adolescents and young adults with mental health and substance abuse issues. Conduct assessments, clinical interviews, individual and group therapy with clients. Supervise social workers, licensed professional counselor, and psychologist. Collaborate with other mental health providers in the community.

SLS Residential Clinic, Inc., Brewster, NY
Clinical Director, October 2009 – December 2011

Clinical Director for SLS Residential Clinic serving over eighty individuals with mental health needs. Ages range from late adolescence through geriatric population. Primary focus includes mood, anxiety, personality, and psychotic disorders. Responsibilities include supervising psychologists, psychiatrists, nursing staff, and social workers; providing staff training; leading clinical meetings; collaborating with the executive director and case managers; and consulting on company operations and policies. Additional responsibilities include organizing and attending psychiatric rounds, running therapeutic groups, serving on the Dialectical Behavior Therapy (DBT) team, and creating and monitoring clinical program goals.

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SLS Health, Inc., Brewster, NY
Psychotherapist, July 2003 – Present

Provide individual and group therapy to clients ranging from young adulthood to geriatric population. Utilize multiple paradigms, with a primary emphasis on cognitive behavioral and behavioral therapeutic modalities. In addition, work with families to provide family therapy and consultation. Conduct assessments of clients psychological and psychoeducational strengths and areas of need.

David Gureasko-Moore, PhD
Private Practice Psychotherapist, 2004 - Present

Private practice providing therapy to individuals with diverse diagnoses including mood disorders, PTSD, thought disorders, OCD, anxiety, learning issues, and personality disorders. Coordinate care with outside psychiatrists and other care providers. Provide family therapy and consultation. Perform assessments regarding both psychological and cognitive impairment. Utilize multiple modalities to provide an empathetic, caring, and collaborative approach to therapy.

SLS Residential Clinic, Inc., Brewster, NY
Deputy Clinical Director, November 2004 – October 2009

Provided oversight and supervision of the clinical services. Supervised therapists and case management staff, helping to provide consultation for clients with multiple needs ranging from mood related motivational issues to life skills training. In addition, some clients had co-morbid substance abuse diagnoses and/or personality disorders. Aided other therapists in working with families and clients to help develop plans that were least restrictive and promote the overall well being of the client.

Virginia Beach City Public Schools, Virginia Beach, VA
American Psychology Association (APA) Approved - Psychology Doctoral Internship
Doctoral Intern, Gifted Track, July 2002 – June 2003

Specialized internship with clinical and school psychology graduate students. Focused on serving both students within the general education setting and those attending schools for the gifted and talented. Responsibilities included assessment of individuals pre-school aged to early adulthood, diagnostic evaluations, and conducted learning, behavior, social and emotional assessments. Administered individual and group counseling to children, adolescents, and young adults. Conducted parent/teacher consultations, and developed workshops for this population. In addition, administered functional behavior assessments to develop interventions for individuals with behavior problems as well as facilitated parent training groups to promote prosocial skills in children and adolescents.

Lehigh University, Bethlehem, PA
National Institute of Mental Health (NIMH) Grant
Data Analyst, August 2001 – June 2002

Responsible for creating an extensive database using Statistical Program for the Social Sciences (SPSS). The database included information collected for an early intervention project targeting young children with AD/HD. This intervention study, Project Achieve, was a five year longitudinal investigation funded by NIMH. Additional responsibilities included data entry, maintenance and performing statistical analyses.

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Desales University, Center Valley, PA
University Professor, Fall 2001

Instructed two undergraduate level courses in Psychology: Introduction to Psychology and Behavior Modification. Classes were taught using a combination of instructional techniques including lecture, small group activities, group discussion, and application exercises. Instructor duties involved teaching course lectures, grading papers, projects, and examinations. Also met with students regarding projects and providing student mentoring.

Community Centered Therapy, Spring House, PA
Adolescent Counselor, September 1998-November 1999

Delivered therapeutic services to males youths, aged 12 through 18-years, who were placed on probation. Clients had committed violent crimes, sexual misconduct, or theft. Developed behavioral contracts and conducted individual counseling with clients to develop anger management and conflict resolution skills. Consulted with family members to help reduce familial stresses and encourage communication. Collaborated with probation officers to ensure that clients were exhibiting appropriate behavior in school and community settings.

Lehigh Support for Community Living, Bethlehem, PA
Program Manager, August 1997-August 1999

Provided services for adults with severe developmental disabilities living in a group home setting within the community. Integrated members into community activities and employment. Conducted functional behavioral assessments and developed functional behavior intervention plans linked to assessment results. Utilized task analyses and data-based decisions to teach functional life skills to members of the group home. Managed finances of members within the home

PUBLICATIONS

Gureasko-Moore, D.P., DuPaul, G.J., & Power, T. (2005). Stimulant treatment for Attention-Deficit/Hyperactivity Disorder: medication monitoring practices of school psychologists. *School Psychology Review, 34(2), 232-245.*

Volpe, R.J., Heick, P., & **Gureasko-Moore, D.P.** (2005). An agile model for monitoring the effects of stimulant medication in schools. *Psychology in the Schools, 42*, 509-523.

Angello, L. M., Volpe, R. J., Gureasko-Moore, S. P., **Gureasko-Moore, D. P.**, Nebrig, M. R., Ota, K., DiPerna, J. C. (2003). Assessment of attention deficit hyperactivity disorder: An evaluation of six published rating scales. *School Psychology Review, 32(2)*, 241-262.

Shapiro, E. S., DuPaul, G. J., Power, T., Gureasko, S. P., & **Moore, D. P.** (2000). Student perspectives on pediatric school psychology. *Communique,* 29(3), 6-7.

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PRESENTATIONS

Cass, A., **Gureasko-Moore, D.P.**, & Santoro, J. (2004). *Bad medicine for Wall Street: The impact of the war on alcohol use among financial advisors.* Poster session presented at the American Psychological Association Annual Convention, Honolulu, HI.

Moore, D.P. & DuPaul, G.J. (2001, April). *Increasing adherence to medication regimens of children using asthmatic inhalers.* Poster session presented at the National Association of School Psychologists Annual Convention, Washington, D.C.

Gureasko, S. P., & **Moore, D. P.** (2001, April). *Empirical analysis of social stories: Current research and future directions*. Poster session presented at the National Association of School Psychologists Annual Convention, Washington, D.C.

Moore, D.P., Volpe, R.J., & Kaufman, M. (2001, March). *Tutoring Services Survey.* Poster session presented at the Association of School Psychologist Of Pennsylvania Annual Convention, Harrisburg, PA.

DuPaul, G. J., Shapiro, E. S., Power, T. J., **et al.** (2000, March). *Pediatric school psychology: The students' perspectives*. Paper presentation at the Association of School Psychologists of Pennsylvania Annual Convention, Harrisburg, PA.

LEADERSHIP POSITIONS

- Clinical Director, Blue Sky Behavioral Health
- Incident Review Committee Co-Chair, SLS Health, Inc.
- Clinical Director, SLS Residential Clinic
- JCAHO Accreditation Clinical Committee Chair, SLS Health, Inc.
- Selected Trainee, U.S. Department of Education Leadership Training Grant in Pediatric School Psychology
- Student Representative, Project Advisory Committee, Pediatric School Psychology Leadership Training Grant

*** REFERENCES PROVIDED UPON REQUEST**

DEC 17 2012

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Hopewell Junction, NY 12533
(845) 221-5742
tangpd@gmail.com

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EDUCATION

New School University, New York, NY
M.A. in Pychology, 2008

JOHN JAY COLLEGE OF CRIMINAL JUSTICE, NEW YORK, NY
M.A. in Forensic Psychology, 2004
APA Division 41: American Psychology-Law Society

STATE UNIVERSITY OF NEW YORK AT STONY BROOK, STONY BROOK, N.Y.
B.A. in Psychology, 2002

EXPERIENCE

Life Assist Services, LLC, Danbury, CT
Director of Life Assist Services 2/12-present

- Coordinated day to day administrative operations of a community based housing/case management program.
- Attended weekly clinical meeting with clinical team with primary responsibility of identifying priority clients in order to facilitate how to best meet the needs of the patients.
- Reviewed and wrote policies for the behavioral component of the treatment program.
- Prepared a wide variety of written materials including monthly progress reports, weekly progress notes, incident reports, a life skills assessment and facility operations report.
- Collaborated with other mental health professionals in implementing and preparing treatment plans which included life skills, social skills, individual education programs, and vocational assessments and placement.
- Interviewed and prospective clients assessing suitability for the program.
- Interviewed and trained new hires.
- Instructed weekly training session for residential programs.
- Conducted tours with perspective clients as well as regulatory agencies.
- Coordinated the acquisition and maintenance of apartments and houses for clients in the community.

Supervised Lifestyles, Brewster, NY
Program Director 6/09-2/12

- Coordinated the day to day administrative operations of a private acute residential treatment facility.
- Attended weekly clinical meeting with the clinical team, with primary responsibility of identifying priority members in order to facilitate how to best meet the needs of the patients.
- Applied strong interpersonal skills and understanding of people and their behaviors while implementing the behavioral aspect of their treatment plan.
- Prepared a wide variety of written materials including monthly progress reports, weekly progress notes, incident reports, a life skills assessment and facility operations report.
- Reviewed and wrote policies for the behavioral component of the treatment program.
- Collaborated with other mental health professionals in implementing and preparing treatment plans which included life skills, social skills, individual education programs, and vocational assessments and placement.
- Maintained set standards set by CARF & NYSOMH for the care and treatment of patients in a mental health facility.
- Interviewed and trained new hires.
- Instructed weekly training session for residential programs.
- Conducted tours with perspective clients as well as regulatory agencies.

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- Coordinated, implemented and oversaw various therapeutic groups relating to patient's [illegible]
- Intervened on patients in crisis, using de-escalation techniques.

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Deputy Program Director 7/08-6/09

- Coordinated the day to day operations of multiple behavioral treatment programs including acute and post acute treatment with the Program Directors.
- Instructed weekly training session for residential programs.
- Observed and trained staff on a daily basis on policy adherence.
- Intervened on patients in crisis, using de-escalation techniques.

Team Manager 4/07-7/08

- Ensured company policies and procedures were followed and implemented.
- Ensured the clinical data records were accurately completed and information was transferred to the clinical team.
- Coordinated special needs of patients with the Program Director, Logistics Coordinator and Therapists.
- Ensured Activities Coordinators were trained in daily procedures, policy, and recreation room therapy.
- Lead daily shift meetings addressing daily operations and patient concerns.
- Intervened on dysfunctional members in crisis with relaxation, exercise and coaching techniques.

Activity Coordinator 8/05-4/07

- Implemented clinical orders and detailed instructions pertaining to the patients' treatment
- Recorded behaviors, activities, dysfunctions and medical information on a Clinical Data Record for the use of tracking patients' behaviors and trends.
- Wrote weekly progress notes on the patients.
- Lead therapeutic groups on self esteem, conflict resolution, and anger control.
- Mentored, supported and encouraged patients' positive behavior during their treatment stay.
- Intervened on dysfunctional members in crisis with relaxation, exercise and coaching techniques.

RESEARCH EXPERIENCE

JOHN JAY COLLEGE OF CRIMINAL JUSTICE, NEW YORK, N.Y.

Eyewitness Reliability

Research Assistant, 2003-2005

Objective: This study was designed to determine optimum techniques for eyewitness lineup construction and presentation as well as to study the techniques and phenomena of eyewitness identifications.

- Assisted in recruitment of subjects
- Assisted in writing of script used in experiment
- Executed certain aspects of study including running of subjects in computer-based paradigm and data collection

Malingering on the Rorschach

Research Assistant, 2003-2005

Objective: This study looked at the issue of malingering in the forensic context. The ability of the Rorschach to assess malingering was studied using an empirically validated instrument (MMPI-2, SIRS) to define malingering, honest responding, pathological and control groups.

- Collaborated on research design
- Executed all data management and statistical analyses
- Co-authored paper to be submitted for publication (2007)

STATE UNIVERSITY OF NEW YORK AT STONY BROOK, STONY BROOK, N.Y.

Marital and Family Violence

Research Assistant, 2001-2002

Objective: This study looked at issues of family discord including marital conflict and domestic violence. Couples were recruited via random digit dialing over the telephone and brought into the laboratory to

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discuss issues with staff psychologists. Through semi-structured
addressed and worked through.

- Recruited subjects via telephone
- Student stand-in: responsible for overseeing recruitment and acceptance of subjects
- Executed certain data management aspects including transcription of interviews and coding of data

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CLINICAL EXPERIENCE

METROPOLITAN CORRECTIONAL CENTER-NEW YORK, N.Y.

Student Extern, 2004

- Performed forensic evaluations for the courts including competency to stand trial, criminal responsibility, and psychological maturity evaluations
- Wrote semi-structured reports for the courts incorporating psychological tests data, information from outside sources (attorneys, probation officers, past treatment providers), and interview information as well as relevant laws
- Provided crisis intervention and follow-up care to clients (inmates) with major mental illnesses (e.g., schizophrenia and other psychotic disorders, mood disorders, personality disorders)
- Used various assessment instruments (e.g., MMPI-2, WAIS-III, CTONI) as well as scored and/or was exposed to various other instruments (e.g., Rorschach, Rey-15, TOMM, SIRS, Vineland ABS)
- Initiated and maintained contact with other treatment providers, including community service providers, attorneys, courts, and client families
- Maintained accurate client files, including obtaining information from various outside sources (e.g., courts, attorneys, hospitals, private psychiatrists.

Publications

Kucharski, L.T., Rosenfeld, B. & Tang, P.(2007). Detection of denial of psychiatric disorder with the MMPI-2: a study of criminal defendants. *International Journal of Forensic Mental Health Services.6,* 145-152.

References

Available upon request

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Appendix 13

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STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0428

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

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

Blue Sky Behavioral Health, LLC of Danbury, CT, d/b/a Blue Sky Behavioral Clinic is hereby licensed to maintain and operate a private freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Blue Sky Behavioral Clinic is located at 52 Federal Rd, Danbury, CT 06810 with:

David Palmer as Executive Director.

The service classification(s) and if applicable, the residential capacities are as follows:

Outpatient Treatment
Day or Evening Treatment
Chemical Maintenance Treatment

This license expires **December 31, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2012.

License revised to reflect:

Increase of Services Eff: 6/6/12

Jewel Mullen, MD, MPH, MPA
Commissioner

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STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0055

Mental Health Day Treatment Facility

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

Blue Sky Behavioral Health, LLC of Danbury, CT, d/b/a Blue Sky Behavioral Health Clinic is hereby licensed to maintain and operate a Mental Health Day Treatment Facility.

Blue Sky Behavioral Health Clinic is located at 52 Federal Rd, Danbury, CT 06810 with:

David Palmer as Executive Director,
David Moore, PhD as Director.

This license expires **March 31, 2016** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2012. INITIAL EFF: 6/6/12

Jewel Mullen, MD, MPH, MPA
Commissioner

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Appendix 14

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Table 2 Proposed Capital Expenditures/Costs

Medical Equipment Purchase	N/A
Imaging Equipment Purchase	N/A
Non-Medical Equipment Purchase	100,000
Land/Building Purchase lease	60,000
Construction/Renovation	N/A
Other Non-Construction (Specify)	N/A
Total Capital Expenditure	160,000
Medical Equipment Lease (Fair Market Value)	N/A
Imaging Equipment Lease (Fair Market Value)	N/A
Non-Medical Equipment Lease (Fair Market Value)	N/A
Fair Market Value of Space	5,000/month
Total Capital Cost	160,000
Capitalized Financing costs (Informational Purpose Only)	
Total capital Expenditure with Cap. Fin. Costs	160,000

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Appendix 15

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Department of the Treasury — Internal Revenue Service (99)

Form 1040 U.S. Individual Income Tax Return 2011

OMB No. 1545-0074 | IRS Use Only — Do not write or staple in this space.

For the year Jan 1 - Dec 31, 2011, or other tax year beginning , 2011, ending , 20

See separate instructions.

Your first name	MI	Last name	Your social security number
David	J	Palmer	
If a joint return, spouse's first name	MI	Last name	Spouse's social security number
Rory	E	O'Brien-Palmer	

Home address (number and street). If you have a P.O. box, see instructions. Apartment no.

3 Sand Rd

City, town or post office. If you have a foreign address, also complete spaces below (see instructions). State ZIP code

New Milford CT 06776

Foreign country name | Foreign province/county | Foreign postal code

▲ Make sure the SSN(s) above and on line 6c are correct.

Presidential Election Campaign

Check here if you, or your spouse if filing jointly, want $3 to go to this fund? Checking a box below will not change your tax or refund. ☐ You ☐ Spouse

Filing Status

Check only one box.

1 ☐ Single
2 ☒ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above & full name here. ►
4 ☐ Head of household (with qualifying person). (See instructions.) If the qualifying person is a child but not your dependent, enter this child's name here ►
5 ☐ Qualifying widow(er) with dependent child

Exemptions

6a ☒ **Yourself.** If someone can claim you as a dependent, **do not** check box 6a
b ☒ **Spouse**

Boxes checked on 6a and 6b: 2
No. of children on 6c who:
- lived with you: 2
- did not live with you due to divorce or separation (see instrs):
- Dependents on 6c not entered above:
- Add numbers on lines above ►: 4

c **Dependents:**

(1) First name Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child under age 17 qualifying for child tax cr (see instrs)
Shannon E Palmer		Daughter	☒
David J Palmer, Jr		Son	☒
			☐
			☐

If more than four dependents, see instructions and check here . . ► ☐

d Total number of exemptions claimed 4

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see instructions.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	226,392.
8a	**Taxable** interest. Attach Schedule B if required	8a	27.
b	**Tax-exempt** interest. **Do not** include on line 8a (8b)		
9a	Ordinary dividends. Attach Schedule B if required	9a	
b	Qualified dividends (9b)		
10	Taxable refunds, credits, or offsets of state and local income taxes	10	0.
11	Alimony received	11	
12	Business income or (loss). Attach Schedule C or C-EZ	12	
13	Capital gain or (loss). Att Sch D if reqd. If not reqd, ck here ► ☐	13	
14	Other gains or (losses). Attach Form 4797	14	
15a	IRA distributions (15a) b Taxable amount	15b	
16a	Pensions and annuities (16a) b Taxable amount	16b	
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E	17	
18	Farm income or (loss). Attach Schedule F	18	
19	Unemployment compensation	19	
20a	Social security benefits (20a) b Taxable amount	20b	
21	Other income	21	
22	Combine the amounts in the far right column for lines 7 through 21. This is your **total income** ►	22	226,419.

Adjusted Gross Income

23	Educator expenses	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	Health savings account deduction. Attach Form 8889	25	
26	Moving expenses. Attach Form 3903	26	
27	Deductible part of self-employment tax. Attach Schedule SE	27	
28	Self-employed SEP, SIMPLE, and qualified plans	28	
29	Self-employed health insurance deduction	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN ►	31a	
32	IRA deduction	32	
33	Student loan interest deduction	33	
34	Tuition and fees. Attach Form 8917	34	
35	Domestic production activities deduction. Attach Form 8903	35	
36	Add lines 23 through 35	36	
37	Subtract line 36 from line 22. This is your **adjusted gross income** ►	37	226,419.

Tax and Credits	38	Amount from line 37 (adjusted gross income)	38	226,419.
	39a	Check if: ☐ You were born before January 2, 1947, ☐ Blind. ☐ Spouse was born before January 2, 1947, ☐ Blind. **Total boxes checked** ► 39a		
Standard Deduction for – • People who check any box on line 39a **or** 39b or who can be claimed as a dependent, see instructions. • All others: Single or Married filing separately, $5,800 Married filing jointly or Qualifying widow(er), $11,600 Head of household, $8,500	b	If your spouse itemizes on a separate return or you were a dual-status alien, check here ► 39b ☐		
	40	**Itemized deductions** (from Schedule A) **or** your **standard deduction** (see instructions)	40	44,686.
	41	Subtract line 40 from line 38	41	181,733.
	42	**Exemptions.** Multiply $3,700 by the number on line 6d	42	14,800.
	43	**Taxable income.** Subtract line 42 from line 41. If line 42 is more than line 41, enter -0-	43	166,933.
	44	**Tax** (see instrs). Check if any from: a ☐ Form(s) 8814 b ☐ Form 4972 c ☐ 962 election	44	34,811.
	45	**Alternative minimum tax** (see instructions). Attach Form 6251	45	1,307.
	46	Add lines 44 and 45 ►	46	36,118.
	47	Foreign tax credit. Attach Form 1116 if required — 47		
	48	Credit for child and dependent care expenses. Attach Form 2441 — 48: 1,200.		
	49	Education credits from Form 8863, line 23 — 49		
	50	Retirement savings contributions credit. Attach Form 8880 — 50		
	51	Child tax credit (see instructions) — 51		
	52	Residential energy credits. Attach Form 5695 — 52		
	53	Other crs from Form: a ☐ 3800 b ☐ 8801 c ☐ — 53		
	54	Add lines 47 through 53. These are your **total credits**	54	1,200.
	55	Subtract line 54 from line 46. If line 54 is more than line 46, enter -0- ►	55	34,918.
Other Taxes	56	Self-employment tax. Attach Schedule SE	56	
	57	Unreported social security and Medicare tax from Form: a ☐ 4137 b ☐ 8919	57	
	58	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required	58	
	59a	Household employment taxes from Schedule H	59a	
	b	First-time homebuyer credit repayment. Attach Form 5405 if required	59b	
	60	Other taxes. Enter code(s) from instructions	60	
	61	Add lines 55-60. This is your **total tax** ►	61	34,918.
Payments If you have a qualifying child, attach Schedule EIC.	62	Federal income tax withheld from Forms W-2 and 1099 — 62: 40,018.		
	63	2011 estimated tax payments and amount applied from 2010 return — 63		
	64a	**Earned income credit (EIC)** — No — 64a		
	b	Nontaxable combat pay election ► 64b		
	65	Additional child tax credit. Attach Form 8812 — 65		
	66	American opportunity credit from Form 8863, line 14 — 66		
	67	First-time homebuyer credit from Form 5405, line 10 — 67		
	68	Amount paid with request for extension to file — 68		
	69	Excess social security and tier 1 RRTA tax withheld — 69: 156.		
	70	Credit for federal tax on fuels. Attach Form 4136 — 70		
	71	Credits from Form: a ☐ 2439 b ☐ 8839 c ☐ 8801 d ☐ 8885 — 71		
	72	Add lns 62, 63, 64a, & 65-71. These are your **total pmts** ►	72	40,174.
Refund	73	If line 72 is more than line 61, subtract line 61 from line 72. This is the amount you **overpaid**	73	5,256.
	74a	Amount of line 73 you want **refunded to you.** If Form 8888 is attached, check here ► ☐	74a	5,256.
Direct deposit? See instructions.	b	► Routing number 221172241 ► c Type: ☒ Checking ☐ Savings		
	d	► Account number 506003145		
	75	Amount of line 73 you want **applied to your 2012 estimated tax** ► 75		
Amount You Owe	76	**Amount you owe.** Subtract line 72 from line 61. For details on how to pay see instructions ►	76	
	77	Estimated tax penalty (see instructions) — 77		

Third Party Designee Do you want to allow another person to discuss this return with the IRS (see instructions)? ☒ **Yes.** Complete below. ☐ **No**

Designee's name ► Dawn R. Parker | Phone no. ► (860) 354-4150 | Personal identification number (PIN) ► 92999

Sign Here Joint return? See instructions. Keep a copy for your records.

Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Your signature	Date	Your occupation	Daytime phone number
		Group Home Manager	
Spouse's signature. If a joint return, both must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here (see inst)
		RN Supervisor	

Paid Preparer's Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☒ if self-employed	PTIN
Dawn R. Parker		12/14/2012		P00283242

Firm's name ► Dawn R. Parker, CPA & Associates — Firm's EIN ► 06-1607692

Firm's address ► 11B Prospect Hill Rd, New Milford, CT 06776 — Phone no. (860) 354-4150

Form **1040** (99) **U.S. Individual Income Tax Return** **2011** OMB No. 1545-0074 IRS Use Only - Do not write or staple in this space.

For the year Jan. 1-Dec. 31, 2011, or other tax year beginning , 2011, ending , 20 — See separate instructions.

Your first name and initial: JOSEPH	Last name: SANTORO	Your social security number:
If a joint return, spouse's first name and initial: JEANNE	Last name: SANTORO	Spouse's social security number:
Home address (number and street). If you have a P.O. box, see instructions: 9175 MISSISSIPPI RUN	Apt. no.	▲ Make sure the SSN(s) above and on line 6c are correct.
City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below: WEEKI WACHEE, FL 34613		Presidential Election Campaign: Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. ☐ You ☐ Spouse
Foreign country name	Foreign province/county	Foreign postal code

Filing Status Check only one box.

1 ☐ Single
2 ☒ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here. ▶
4 ☐ Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 ☐ Qualifying widow(er) with dependent child

Exemptions

6a ☒ **Yourself.** If someone can claim you as a dependent, do not check box 6a — Boxes checked on 6a and 6b: 2
b ☒ **Spouse**
c **Dependents:**

(1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child under age 17 qualifying for child tax credit
NICOLE SANTORO		DAUGHTER	

No. of children on 6c who:
- lived with you: 1
- did not live with you due to divorce or separation (see instructions):

Dependents on 6c not entered above:

If more than four dependents, see instructions and check here ▶ ☐

Add numbers on lines above ▶: 3

d Total number of exemptions claimed

Income — Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see instructions.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2		7	273,399.
8a	Taxable interest. Attach Schedule B if required		8a	11,424.
b	Tax-exempt interest. Do not include on line 8a	8b 233.		
9a	Ordinary dividends. Attach Schedule B if required		9a	13,075.
b	Qualified dividends	9b 1,919.		
10	Taxable refunds, credits, or offsets of state and local income taxes	STMT 2 STMT 3	10	0.
11	Alimony received		11	
12	Business income or (loss). Attach Schedule C or C-EZ		12	
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐		13	-3,000.
14	Other gains or (losses). Attach Form 4797		14	-10.
15a	IRA distributions	15a	b Taxable amount	15b	
16a	Pensions and annuities	16a 418,769.	b Taxable amount	16b	0.
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E		17	-118,634.
18	Farm income or (loss). Attach Schedule F		18	
19	Unemployment compensation		19	
20a	Social security benefits	20a	b Taxable amount	20b	
21	Other income. List type and amount: NOL CARRYOVER TO 2011 -12,003.		21	-12,003.
22	Combine the amounts in the far right column for lines 7 through 21. This is your **total income** ▶		22	164,251.

Adjusted Gross Income

23	Educator expenses	23		
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24		
25	Health savings account deduction. Attach Form 8889	25		
26	Moving expenses. Attach Form 3903	26		
27	Deductible part of self-employment tax. Attach Schedule SE	27		
28	Self-employed SEP, SIMPLE, and qualified plans	28		
29	Self-employed health insurance deduction	29		
30	Penalty on early withdrawal of savings	30		
31a	Alimony paid b Recipient's SSN ▶	31a		
32	IRA deduction	32	12,000.	
33	Student loan interest deduction	33		
34	Tuition and fees. Attach Form 8917	34		
35	Domestic production activities deduction. Attach Form 8903	35		
36	Add lines 23 through 35		36	12,000.
37	Subtract line 36 from line 22. This is your **adjusted gross income** ▶		37	152,251.

Form 1040 (2011) JOSEPH & JEANNE SANTORO

Tax and Credits	38	Amount from line 37 (adjusted gross income)		38	152,251.
	39a	Check if: ☐ You were born before January 2, 1947, ☐ Blind. ☐ Spouse was born before January 2, 1947, ☐ Blind. Total boxes checked ▶ 39a			
	b	If your spouse itemizes on a separate return or you were a dual-status alien, check here ▶ 39b ☐			
Standard Deduction for - • People who check any box on line 39a or 39b or who can be claimed as a dependent.	40	**Itemized deductions** (from Schedule A) or your **standard deduction** (see left margin)		40	104,779.
	41	Subtract line 40 from line 38		41	47,472.
	42	**Exemptions.** Multiply $3,700 by the number on line 6d		42	11,100.
	43	**Taxable income.** Subtract line 42 from line 41. If line 42 is more than line 41, enter -0-		43	36,372.
	44	Tax. Check if any from: a ☐ Form(s) 8814 b ☐ Form 4972 c ☐ 962 election		44	4,321.
	45	**Alternative minimum tax.** Attach Form 6251		45	0.
• All others: Single or Married filing separately, $5,800 Married filing jointly or Qualifying widow(er), $11,600 Head of household, $8,500	46	Add lines 44 and 45		46	4,321.
	47	Foreign tax credit. Attach Form 1116 if required	47		
	48	Credit for child and dependent care expenses. Attach Form 2441	48		
	49	Education credits from Form 8863, line 23	49		
	50	Retirement savings contributions credit. Attach Form 8880	50		
	51	Child tax credit (see instructions)	51		
	52	Residential energy credits. Attach Form 5695	52		
	53	Other credits from Form: a ☐ 3800 b ☐ 8801 c ☐	53		
	54	Add lines 47 through 53. These are your **total credits**		54	
	55	Subtract line 54 from line 46. If line 54 is more than line 46, enter -0-		55	4,321.
Other Taxes	56	Self-employment tax. Attach Schedule SE		56	
	57	Unreported social security and Medicare tax from Form: a ☐ 4137 b ☐ 8919		57	
	58	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required		58	
	59a	Household employment taxes from Schedule H		59a	
	b	First-time homebuyer credit repayment. Attach Form 5405 if required		59b	
	60	Other taxes. Enter code(s) from instructions		60	
	61	Add lines 55 through 60. This is your **total tax** ▶		61	4,321.
Payments	62	Federal income tax withheld from Forms W-2 and 1099	62	39,260.	
	63	2011 estimated tax payments and amount applied from 2010 return	63		
If you have a qualifying child, attach Schedule EIC.	64a	**Earned income credit (EIC)**	64a		
	b	Nontaxable combat pay election 64b			
	65	Additional child tax credit. Attach Form 8812	65		
	66	American opportunity credit from Form 8863, line 14	66		
	67	First-time homebuyer credit from Form 5405, line 10	67		
	68	Amount paid with request for extension to file	68		
	69	Excess social security and tier 1 RRTA tax withheld STMT 8	69	874.	
	70	Credit for federal tax on fuels. Attach Form 4136	70		
	71	Credits from Form: a ☐ 2439 b ☐ 8839 c ☐ 8801 d ☐ 8885	71		
	72	Add lines 62, 63, 64a, and 65 through 71. These are your **total payments** ▶		72	40,134.
Refund	73	If line 72 is more than line 61, subtract line 61 from line 72. This is the amount you **overpaid**		73	35,813.
	74a	Amount of line 73 you want **refunded to you.** If Form 8888 is attached, check here ▶ ☐		74a	35,813.
Direct deposit? See instructions.	b	Routing number ▶ c Type: ☐ Checking ☐ Savings ▶ d Account number			
	75	Amount of line 73 you want **applied to your 2012 estimated tax** ▶ 75			
	76	**Amount you owe.** Subtract line 72 from line 61. For details on how to pay, see instructions ▶		76	
Amount You Owe	77	Estimated tax penalty (see instructions) 77			

Third Party Designee Do you want to allow another person to discuss this return with the IRS (see instructions)? ☒ Yes. Complete below. ☐ No

Designee's name ▶ BRIAN M VARLEY CPA Phone no. ▶ 845-533-4690 Personal identification number (PIN) ▶ 06863

Sign Here Joint return? See instructions. Keep a copy for your records.

Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Your signature	Date	Your occupation	Daytime phone number
		PSYCHOLOGIST	347-672-7192
Spouse's signature. If a joint return, **both** must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here
		ADMINISTATOR	

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
BRIAN M VARLEY CPA		07/03/12		P00506863

Firm's name ▶ SCIALO REIMANN & ASSOCIATES CPA PC Firm's EIN ▶ 20-3863900

Firm's address ▶ 4 EXECUTIVE BOULEVARD SUFFERN, NY 10901 Phone no. 845-533-4690

Blue Sky Behavioral Health LLC
Profit & Loss
January through June 2012

000141

	Jan - Jun 12
Ordinary Income/Expense	
Income	
4005BlueSky. Revenue	468,634.00
Total Income	468,634.00
Expense	
5001BlueSky. Gross Payroll	246,718.79
5005BlueSky.1099 Payroll	37,125.00
5100BlueSky. FUTA	462.01
5101BlueSky. SUTA	6,446.87
5102BlueSky.Benefit	4,945.95
5103BlueSky. Disability Benefit	323.30
5105BlueSky. WC Ins.	-2,146.70
5107BlueSky.FICA	18,751.57
5108BlueSky.401K	281.51
5202BlueSky. General Insurance	8,563.00
6010BlueSky.Program Supplies	7,400.36
6020BlueSky. Prog.Purchased Ser	20,040.20
6200BlueSky.HousekeepingOffice	1,200.00
6221BlueSky.Maint Purchased Ser	1,800.00
6240BlueSky.Rent Expense	13,131.00
6250BlueSky.Automobile Expense	66.75
6260BlueSky.Legal Expenses	2,261.25
6270BlueSky. Accounting	6,420.00
6290BlueSky.Advertising/Marketi	17,312.27
6340BlueSky.Office Supplies	5,672.87
6341BlueSky.CreditCardFees	215.37
6410BlueSky. Utilities	987.98
8500BlueSky.Bank Fees	209.95
Total Expense	398,189.30
Net Ordinary Income	70,444.70
Other Income/Expense	
Other Income	
4007 Third Party Write Off	-2,794.00
Total Other Income	-2,794.00
Other Expense	
9999BlueSky.Suspended	-281.51
Total Other Expense	-281.51
Net Other Income	-2,512.49
Net Income	**67,932.21**

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Table 3: Patient Population Mix

	Current Year to Date	Year 1 Jan 1, 2013 - 12/31/13	Year 2 Jan 1, 2014 - 12/31/14	Year 3 Jan 1, 2015 - 12/31/15
Medicare	N/A	N/A	N/A	N/A
Medicaid				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers		75%	75%	75%
Uninsured (Self-Pay)		25%	25%	25%
Workers Compensation				
Total Non-Government		100%	100%	100%
Total Payer Mix		100%	100%	100%

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OUU 143

Appendix 16

DEC 17 2012

04/23/2010 10:21 FAX

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13. B1. 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 1-12 Projected W/out CON	FY 1-12 Projected Incremental	FY 1-12 Projected With CON	FY 12-24 Projected W/out CON	FY 12-24 Projected Incremental	FY 12-24 Projected With CON	FY 24-36 Projected W/out CON	FY 24-36 Projected Incremental	FY 24-36 Projected With CON
NET PATIENT REVENUE	0	0	908,850	908,850	0	1,204,500	1,204,500	0	1,314,000	1,314,000
Non-Government	0	0	0	$0	0		$0	0		$0
Medicare		0	0	$0	0		$0	0		$0
Medicaid and Other Medical Assistance	0		0	$0	0		$0	0		$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other [illegible]	0		908,850	908,850	0	1,204,500	1,204,500	0	1,314,000	1,314,000
[illegible]		0								$0
OPERATING EXPENSES		0	403,000	403,000	0	422,000	422,000	0	432,000	432,000
Salaries and Fringe Benefits	0	0		$0			$0	0	0	0 $0
Professional / Contracted Services	0	0	0	$0	0	0	$0 0	0	0	0 $0
Supplies and Drugs	0	0	20,000	$0 20,000	0	22,000	$0 22,000	0	24,000	24,000 $0
Bad Debts	0	0	10,000	$0 10,000	0	15,000	$0 15,000	0	20,000	20,000 $0
Other Operating Expense	0	0		$0	0	0	$0	0		$0
	$0	$0	$0	$0 145,000	$0	$0 156,000	$0 156,000	$0	$0 164,500	$0 164,500 $0
			145,000	$0			$0			$0
			578,000	$0 578,000	0	615,000	$0 615,000	0	640,500	640,500 $0
				$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
			330,850	330,850		589,500	589,500	0	673,500	673,500
				$0						$0
										$0
FTEs			10	10		10	10		10	10
			60.59	60.59		73	73		73	73

*Volume Statistics: (admissions)

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.

000 [redacted]

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Appendix 17

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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	Mental Health Residential Living Center									
Type of Unit Description:										
# of Months in Operation	12									
FY 2013	(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:	568,000			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare	0			$0	0	0		$0	$0	$0
Medicaid	0	$0		$0	0	0		$0	$0	$0
CHAMPUS/TriCare	0	$0		$0	0	0		$0	$0	$0
Total Governmental	0		0	$0	$0	$0	$0	$0	$0	$0
Private Pay	25%	500/day	1817.7	227,212			5000	222,212		
Commericial Insurers	75%	500/day $0	5	681,637 $0	0	0	5000	676,637 $0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovernment		$0	7	$0	$0	$0	$0	$0	568,000 $0	330,849 $0
Total All Payers	100%	$0	7	908,850 $0	$0	$0	10,000 $0	898,849 $0	568,000 $0	330,850 $0

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DEC 17 2012

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: Mental Health Residential Living Center
Type of Unit Description:
# of Months in Operation: 24 months

FY 2014

FY Projected Incremental Total Incremental Expenses: 600,000	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare				$0	0	0		$0	$0	$0
Medicaid		$0		$0	0	0		$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Private Pay	25%	$550/day	2190	301,125	0	0	2500	293,625		
Commericial Insurers	75%	$550/day	5	903,375	0	0	2500	$0	$0	$0
Uninsured		$0	2	$0	0	0		895,875	$0	$0
Total NonGovernment		$0	7	$0	$0	$0	$0	$0	600,000	$0
Total All Payers	100%	$0	7	1,204,500	$0	$0	5000	$0 1,189,500	$0 600,000	$0 589,500

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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	Mental Health Residential Living Center									
Type of Unit Description:										
# of Months in Operation	36									
FY 2015	(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:	620,500			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare	0			$0				$0	$0	$0
Medicaid	0	$0		$0				$0	$0	$0
CHAMPUS/TriCare	0	$0		$0				$0	$0	$0
Total Governmental	0		0	$0	0 $0	0 $0	10,000 $0	318,500 $0	620,500 $0	$0
Private Pay	25%	600/day	2190	328,500	0	0	10,000	975,500		
Commericial Insurers	75%	$0	5	985,500 $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	100%	$0	7	1,314,000 $0	0 $0	0 $0	20,000 $0	1294,000 $0	620,500 $0	673,500 $0

W:\CFAF\Certificate of Need\CY 2010 CON\Applications\10-31574\Financial Attachment II, Financial Attachment II

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Appendix 18

DEC 17 2018

Financial Attachment II supplemental info

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000150

1) FY 2013 (Year 1)

Expenses - staffing

Director	60,000
Assist Mgr	45,000
Coordinators 6(38K)	228,000
overnight (2) 35,000	70,000
	403,000

expenses - (building + misc)

Lease	60,000
maintenance	10,000
heat	13,000
electric	5000
phone	2000
insurance	25,000
supplies	20,000
	165,000

Expenses = 403,000 + 165,000 = 568,000

Total expenses = 403,000 + 165,000 = $568,000

FY 2013 (Year 1)

Rev - 500/day X 6 beds X 365/days X .83 = 908,850

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2) FY 2014 (Year 2)

000151

Expenses - Staffing)

Director -	62,000
Asst mgr -	46,000
Coordinators (6) 40K	240,000
overnight (2) 37K	74,000
	$422,000

Expenses - building/misc

lease	62,000
Maintenance	13,000
heat	15,000
electric	6500
phone	2500
insurance	26,000
food/supplies	31,000
~~supplies~~	22,000
	$178,000

Total Exp -
422,000 + 178,000 =
600,000

FY 2014 (Year 2 Rev)

$550/day X (6) beds X 365 days X 10% =
$1,204,500

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3) FY 2015 (Year 3)

000152

expenses - staffing

Directer	63,000
Asst mgr	47,000
Coordinators 6(41K)	246,000
overnight 2 (38K)	76,000
	432,000

expenses - building + misc

lease	64,000
Maintenance	15,000
heat	16,000
electric	7500
phone	3000
insurance	27,000
food	32,000
supplies	24,000
	188,500

expenses - 432,000 + 188,500 = $620,500

FY 2015 (Year 3 revenue)

600/day X 6 beds X 365 days = 1,314,000

DEC 17 2012

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 18, 2013

VIA FAX ONLY

David Palmer
Chief Executive Officer
Blue Sky Behavioral Health, LLC
52 Federal Road
Suite 2A
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 12-31811-CON
Blue Sky Behavioral Health, LLC
Establish a Mental Health Residential Living Center in Danbury

Dear Mr. Palmer:

On December 21, 2012, the Office of Health Care Access ("OHCA") received your initial Certificate of Need application filing on behalf of Blue Sky Behavioral Health, LLC ("Applicant") for the establishment of a mental health residential living center in Danbury, with an associated capital cost of $400,000.

OHCA has reviewed the CON application pursuant to Section 19a-639a(c) and requests the following additional information:

1. On page 7 of the CON Application the proposed location of the clinic is related to the DMHAS (Department of Mental Health and Addiction Services) Region 5 which includes towns located in Litchfield County as well as Fairfield County. Also on page 7, the population of Fairfield County is discussed in relation to the socioeconomic viability of the area. Other than Region 5 towns and Danbury, list any other Fairfield County towns that the Applicant considers part of its primary service area.

2. Please provide specific details and methodology on how the Applicant determined that Region 5 and additional towns within one hour's drive of the clinic would be the service area for the proposed services located in Danbury.

3. Regarding where the proposed patient population is currently being served, please complete the following table:

Provider Name	Address	Town	State

4. On page 8 of the CON Application the Applicant states that "people in Danbury and surrounding towns have asked Blue Sky Clinic staff a total of 144 times for residential referrals". Provide a breakdown of the origination of the 144 residential referrals (i.e. patients, private practitioners, social workers, self-referral, etc.).

5. Provide an explanation as to why some of the Mental Health Residential Living licenses listed on pages 114-116 of the CON application are referred to as "inactive".

6. How will the proposed services not duplicate the services of the other Mental Health Residential Living providers in the Applicant's service area?

7. Explain how the Applicant will serve a Medicare and/or Medicaid Patient? If the proposed facility receives a referral for a Medicare or Medicaid patient or a patient under age 18 or over age 65, how will these referrals be handled?

8. Explain the Applicant's qualifications to provide the proposed level of residential services.

9. The Applicant is projecting total admissions of 60.59 for year one, 73 for year 2 and 73 for year 3, respectively. Provide details as to the source of your projected number of clients (i.e. majority of clients coming from where, do you have any relationships with any other providers for referral patterns, the assumptions/calculation in determining the need for a 6 bed facility for adults 18-64 years of age and self-pay or commercial insured, etc.).

10. The Applicant indicates on page 118 that the Projected Occupancy (83% in year 1, 100% in years 2 and 3) is "Estimated by the applicant." Provide further explanation and support for this estimation.

11. The Applicant indicates on page 118 that the total beds proposed is "Determined by the applicant in conjunction with the Planning and Zoning Department for Danbury." Is the Applicant basing the number of beds for this proposal on capacity of the physical plant or is the six beds based on the need for this level service and the projected patient base (commercially insured or self-pay adults under age 65) in the area? Provide the exact calculation used to arrive at the need for six beds to serve this patient population base.

12. The Applicant indicates on page 118 that the estimated average length of stay is 30 days. Provide further discussion and support for this estimation.

13. Provide further details regarding the 10 FTEs that will serve the proposed facility:

    - Are the 10 FTEs that will serve the proposed facility also employees of the other Blue Sky facility and will they split time between sites?
    - What are the "Coordinators" and "Overnight" staff listed on page 150 of the CON Application.
    - Are these social workers, licensed therapists, etc.?

14. Provide the policies and procedures that will be utilized in relation to the proposal. Explain the quality assurance program. What level of staff will be responsible for quality assurance on-site.

15. Please resubmit Financial Attachment I in a more legible format and also submit another Financial Attachment I for Blue Sky Behavioral Health Clinic with, without and incremental statement of the proposed facility.

16. Please resubmit pages 146-148 of the CON application. The new forms must be completed in the exact format that OHCA has prescribed (the For-Profit Form). Please make sure that all numbers are clear and legible.

17. Will the proposed rate $500/day be the same for all payers, including self-pay? Does the Applicant have a sliding-fee scale?

18. The Applicant does not appear to be differentiating between gross revenue and net revenue in Appendices 16 and 17. Year one Non-Government Net Patient Revenue of $908,850 is based on a rate of $500.00 per day X 1817.7 units (patient days). Is the Applicant making the assumption in the financial projections that the commercial payers will be paying the full published rate without any contractual allowances? Please explain further and demonstrate using information from current Blue Sky operations.

19. On page 142 of the CON Application, the Applicant provided the following patient population mix table:

Table 3: Patient Population Mix

	Current FY	FY 2013	FY 2014	FY 2015
Medicare*	*n/a*	*n/a*	*n/a*	*n/a*
Medicaid*	*n/a*	*n/a*	*n/a*	*n/a*
CHAMPUS & TriCare	*n/a*	*n/a*	*n/a*	*n/a*
Total Government	*n/a*	*n/a*	*n/a*	*n/a*
Commercial Insurers*	*n/a*	75%	75%	75%
Uninsured	*n/a*	25%	25%	25%
Workers Compensation	*n/a*	*n/a*	*n/a*	*n/a*
Total Non-Government	**n/a**	**100%**	**100%**	**100%**
Total Payer Mix	**n/a**	**100%**	**100%**	**100%**

Please provide a detailed explanation of all assumptions used in the derivation/calculation of the projected patient population mix. Is the projected payer mix for the proposed service the same as the actual payer mix for the Applicant's other licensed services?

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. 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 preceding it. Please begin your submission using Page 178 and reference "Docket Number: 12-31811-CON." Submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7035.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

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

TRANSMISSION OK

TX/RX NO	3254
RECIPIENT ADDRESS	912039422693
DESTINATION ID	
ST. TIME	01/18 14:35
TIME USE	01'04
PAGES SENT	5
RESULT	OK

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

FAX SHEET

TO: DAVID PALMER

FAX: 203 942 2693

AGENCY: BLUE SKY BEHAVIORAL HEALTH, LLC

FROM: PAOLO FIDUCIA

DATE: 1/18/13 TIME: 1:30 PM

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: 12-31811-CON
COMPLETENESS LETTER

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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JAN 29 2013
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HEALTH CARE ACCESS

JAN 27 2013

Blue Sky Behavioral Health, LLC
Docket Number 12-31811-CON

Responses to OHCA Questions

1) On page 7 of the CON Application, the proposed location of the clinic is related to DMHAS Region 5 which includes towns located in Litchfield County as well as Fairfield County. Also on page 7, the population of Fairfield County is discussed in relation to the socioeconomic viability of the area. Other than Region 5 towns in Danbury, list any Fairfield County towns that the Applicant considers part of its primary service area.

Response
The applicant was referring to two County's that the proposed location site is either located in(Fairfield County) or located very close to(Litchfield County). These County's were mentioned by the Applicant as they are socioeconomically very viable and within a short commute to the proposed location. The Applicant considers the entire State of Connecticut as a potential referral source as well the entire State of New York as the city of Danbury borders New York State.

2) Please provide specific details and methodology on how the Applicant determined that Region 5 and additional towns within one hour's drive time of the clinic would be the service are of the proposed services in Danbury.

Response
The Applicant was attempting to demonstrate that Region 5 and additional town's within a 1 hour's drive time of the proposed site would offer a wealth of potential opportunities for referrals. The Applicant recognizes that the entire State of Connecticut is a potential referral source , the State of New York due to its proximity is a referral source as well as any State in the United States as the Mental Health Residential Living Center would have a website offering its services.

3) Regarding where the proposed patient population is currently being served, please complete.

Response

The proposed patient population is being serviced by the following Mental Health Residential Living Centers n Connecticut.

000179

JAN 27 2013

Robinson House
96-98 South Quaker Lane
West Hartford, CT

Parents Foundation for Transitional Living
100 Broadway Street
New Haven, CT

Transitional Living Center Li
964 Iranistan Ave
Bridgeport,CT

Rush Ford Center
883 Paddock Ave
Meriden, CT

Sand Community Service
401 Thames River PI
Norwich, CT

Casa de Rosa
86 Midland Rd
Waterbury, CT

Transitional Living Center
964 Iranistan Ave
Bridgeport, CT

Milner House
249 Main Street
Moosup, CT

Angelus House
234 Wake Road
Bethlehem, CT

CHD- CT Outreach Crosssover
248 Laurel Street
Hartford,CT

Rogers House
900 Watertown Ave
Waterbury, CT

Highlands

0180

JAN 27 2013

33 Highland Street
New Britain, CT

Harvest House
5 Harvest Street
New Britain,CT

Central CT Living Center
31 Highland St
New Britain, CT

Park Street Inn
51 Park Street
New Haven CT

Dwight House
282 Dwight Street
New Haven, CT

New Haven Halfway House
1 Grand Ave
New Haven, CT

Interlude
60 West Street
Danbury, CT

Comm MH Affiliates
36 Russell Street
New Britain, CT

Reliance House Group Home
64 S. Main Street
Jewitt City, CT

Bridgeway
36 Main Street
Torrington, CT

Transitional Living Center III
655 Park Ave
Bridgeport, CT

Transitional Living Center I
964 Iranistan Ave
Bridgeport, CT

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Gilead House
681 saybrook Rd
Middletown, CT

Shoreline Apartment Program
36 Shoreline Rd
Clinton, CT

Todd Program
36 Elm Street
Hartford, CT

Elmcrest Terrace
36 Silvermine Rd
Norwalk, CT

St. John Street Group Home
4 John Street
Norwalk, CT

4) On page 8 of the CON Application, the Applicant states that 'people in Danbury and surrounding towns have asked Blue Sky Clinic staff a total of 144 times for residential referrals'. Provide a breakdown of the origination of the referrals.

Response

The breakdown of the referrals is as follows:
Patients- 8
Private Practioners-28
Hospitals-44
Other Providers- 50
Self Referred-14

5) Provide an explanation as to why some of the Mental Health Residential Living licenses listed on pages 114-116 of the CON Application are referred to as 'inactive'.

JAN 27 2013

Response

These Mental Health Living Centers still had a valid and current license but for a variety of unique reasons asked the State of Connecticut to put their license on hold and not be operational for a period of time. When they are ready to resume operations they then must contact the State of Connecticut to not be listed as 'inactive'.

6) How will the proposed services not duplicate the services of other Mental Health Residential Living providers in the Applicant's service area?

Response

The proposed services offered at the proposed site would be unique in nature when compared to other Mental Health Residential Living Centers in Connecticut. The following areas would be different in nature when in comparison to other facilities in the State:

1) Higher educational training- The direct care staff (other than overnights) would all have a minimum 4 year college degree and that degree would preferably be in the health care field. Other programs in the State have a minimum requirement of a high school diploma. Applicant contends that this higher level of education makes its direct care unique in comparison to direct care staff at other programs whose staff have only a high school diploma.

2) Life Skills groups taught at facility by direct care staff- Direct care staff at the proposed facility would be involved in teaching non clinical course offerings to the residents at the proposed facility. These groups would include offerings such as: budgeting, current events, writing workshop, public speaking, job hunting skills and time management.

3) Transportation to: Alcoholics Anonymous, Narcotics Anonymous, church, volunteer sites to volunteer, and work if resident is working in community.

4) Additional classes on:cooking, art, yoga, meditation and tai chi will be offered as well. It is the Applicant's belief, that the previously mentioned offerings make their program distinctly unique from other Residential Mental Health Living Center providers in the State of Connecticut.

5) The vast majority of Mental Health Residential Living Centers also only provide for room and board and some basic support helping those attending to find clinical resources such as: a psychiatrist, a therapist, and groups to attend. Thos program is run in conjunction with the clinical program so that there is not only communication between the two programs but also continuity of care existing that helps get the individual the best care possible. This type of coordination is not the similar model that the previously mentioned Mental Health Residential Living Centers follow.

JAN 27 2013

7) Explain how the Applicant will serve a Medicare/Medicaid patient. If the proposed facility receives a referral for Medicaid or Medicare patient or a patient under 18 or over 65, how will these referrals be handled?

Response

The proposed facility would only treat individuals between the ages of 18-64 who are either private insurance or private pay. Individuals who are Medicaid/Medicare or under 18 or over 65 would be referred by Blue Sky Clinical staff to an appropriate location that could assist them with their respective needs.

8) Explain the Applicant's qualifications to provide the proposed level of residential services.

Response

The Applicant's qualifications are as follows:
* 11 years working for Ability Beyond Disability as Service Manager responsible for the oversight of 10 physically/mentally challenged individuals with a minimum of 6 residents at each location. Responsible for overseeing house manager, all aspects of programming and service planning, budgeting, staff discipline, licensure. All programs supervised were CARF(Commission on Accredidation Rehabilitation Facilities) accredited programs.

* 4 years working for SLS Residential as CEO. 52 bed psychiatric/ substance abuse facility. Supervised all aspects of program .

* Past year(2012) part owner and CEO of Blue Sky Behavioral Health Clinic in Danbury. Blue Sky Clinic was CARF accredited for the maximum term (3 years) in 2012.

9) The Applicant is projecting total admissions of 60.59 for year 1, 73 for year 2 and 73 for year 3. Provide details as to the source of the projected number of clients i.e. where they are coming from., do you have relationships with other providers, the assumption/calculation in determining the need for a 6 bed facility for adults 18-64 years of pay or commercial assured.

Response
First, let's look at the demand for services within the United States as a whole and then the demand for services in Connecticut.

JAN 27 2013

According to a 2006 report, the health care system in CT is not equipped to handle the demand for services(See CON pg 8). The report further notes that mental health and substance abuse issues are becoming the most prevalent issues that effect the general population and this trend is expected to continue in the future(See CON page 8).The US Census Bureau estimates that ther are 307,006,550 people living in the United States)See CON page 9) Of that number 231,789,945 are between the target ages the Applicant has for his facility:18-64. Of this number, it is estimated that 26.2% suffer from a diagnosable mental illness or substance abuse disorder(See CON page 9).
Looking at Connecticut data, it is estimated that 600,000 adults suffer with mental disorders(See CON page 9). The CT rate for co-occurring disorders is 34%. In 2006 alone, 292 people in CT died from suicide(See CON page 9). According to NAMi, suicide is almost always the result of untreated mental illness. NAMI further states that Connecticut's public mental illness system provides only 24.5% of services to adults with serious mental illness.
Substance abuse stats are also not favorable in Connecticut as well. Since stats were kept, CT has been in the top 10 states for illicit drug use(See CON page 9).According to the Department of Health and Human Services, the number of facilities that were equipped to help treat substance abuse patients declined between 2002 and 2009(See CON page 9).

According to a Healthy CT 2010 Report, mental disorders accounting for 17,344 hospitilizations and 332 million in charges(See CON page 10). In 2012, Victoria Ventri a CT healthcare advocate stated at a meeting that the number of prevention and treatment programs for mental health and substance abuse within Connecticut are undersized in comparison to the current need fort services(See CON page 10).

The above mentioned information, paints a clear picture of the given need for mental health and substance abuse services in the United States as well as Connecticut. Combined with this need is also a shortage of given services. The Applicant's proposed for profit facility would receive no funding from the State of Connecticut. This means it would take nothing away from the funding received by other non profit providers in Connecticut.

Secondly, Blue Sky Clinic already has established referral relationships between a number of other providers in the area. Referrals have come to Blue Sky from the following providers over the past year: High Watch Farm, Silver Hill Hospital, Institute of Living, Bristol Hospital, Four Winds Hospital, Putnam Hospital, Middlesex Hospital, Hackensack Hospital, Summit Oaks and the Carrier Clinic.

The Above information points out not only the need for the types of services offered by the Applicant in Connecticut, but also the ability of the proposed service location to generate referrals to fill the 6 beds.

10) The Applicant indicates on page 118 that the projected occupancy(83% in year 1, 100% in year 2 and 3) is estimated by the Applicant. Provide further explanation to support this estimation.

JAN 27 2013

Response

The estimation firstly is supported by the Applicant's ability between 2007-2012 when he was CEO of SLS Residential, to have filled at any given time at least 90% of the 52 available beds that he was responsible for. Secondly, the existing referral network that The Applicant already has in place for Blue Sky Clinic(See response 9) potentially provides a wealth of referrals to the proposed program. Thirdly, as mentioned on Page 8 of the CON, the Applicant's Clinic has received 144 inquires for residential care. These referrals were unsolicited and no advertising was done for them. If advertising and other marketing methods are utilized by the Applicant to solicit referrals there would exist the possibility of an even higher number of referrals than the 144 referrals that were unsolicited for residential services.

11) The Applicant indicates on page 118 that the total beds proposed is determined by the Applicant in Conjunction with the Planning and Zoning Department for Danbury. Is the Applicant basing the number of beds on the capacity of the physical plant or are the 6 beds based on the need for this level of service in the area?

Response

The Applicant is basing the 6 beds on the level of need. As has been previously stated in response 9, there exists within Connecticut a very high demand for the type of services that the Applicant is proposing. Although the need is high, the comparable services offered to fill this need within the State of Connecticut is inadequate. Realizing this need within Connecticut, the Applicant is proposing a small intimate setting to help provide treatment. The Applicant's proposal of a 6 bed facility helps fill a very small portion of the extensive need for services within the State.

12) The Applicant indicates on page 118 that the estimated length of stay is 30 days. Provide furtherf discussion as to this estimation.

Response

To clarify, the minimum length of stay would be 30 days in the proposed facility. The Applicant's experience in working with the proposed population has demonstrated that 30 days is the minimum time needed to address the complex issues that referrals come with. The company's agreement with potential intakes would also indicate that 30 days would be the minimum length of stay. The Applicant also works with insurance companies in providing appropriate communication to demonstrate the need for at least 30 days of coverage. The Applicant experience in this field has demonstrated to him that the average length of stay is approximately 60-90 days. The 30 day number was utilized by the Applicant for consistency in the discussion and calculations due to it being the one constant(everyone would be at facility at least 30 days).

13) Provide further details regarding the 10 FTE's that will serve at the proposed facility.

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Response

The 10 FTE's are not employees of the Clinic. They will not be splitting time between the 2 sites. The 10 employees would work only at the proposed facility. None of the mentioned staff are therapists or social workers or licensed professional in any way. The Coordinators are college educated direct care staff that would directly with the residents. There would also be a Director of the facility who would be responsible for day to day operations and report directly to the CEO. The overnight position is an awake individual who would be in the facility during the overnight hours and would be a support to residents during the overnight shift if additional assistance for anything is needed.

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14. Provide the policies and procedures that will be utilized in relation to the proposal. Explain the quality assurance program. What level of staff will be responsible for quality assurance on-site?

Response

Listed Below is an outline with some brief descriptions of the policies and procedures to be used for the Blue Sky Residential Program:

Administrative

Accreditation

- Describes with whom the Blue Sky Residential program is accredited.

Admission Criteria and Process

- Describes the criteria by which a potential client must meet to be admitted and the process by which a client would be admitted

Blue Sky Residential Consent to Receive Service

Consent for information documents

- Describes that Blue Sky Residential requests consent for release of information and the form associated with

  Authorization to release Information Form

Discharge Policy

- Describes the criteria and procedure associated with discharging a client from the program

Ethics Code & Prohibition of Fraud, Waste & Abuse

Governance

- escribes the governing body of program and explains authority designation

Legal Compliance

- Describes legal entities by which the program is in compliance with such as state licensing agencies.

Mission Statement

Program Description: Blue Sky Residential

- description of the Blue Sky Residential Program including some of the services offered by the program.

Reasonable Accommodation

- escribes how the company may grant accommodations to clients and staff with special needs based on company resources.

Referral to other Facilities

- Describes that the organization will make efforts to refer clients to more appropriate facilities if the client does not meet the criteria or requirements for the Blue Sky Residential program

Responding to legal entities

- Describes the process by which employees should respond to requests by legal entities.

Risk Management

- Describes how the company avoids exposure to risk across the various aspects of the company

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Confidentiality

Confidentiality Awareness Training Policy

- Describes the policy that the company trains employees on the importance and awareness of information regarding clients that should be kept confidential

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Confidentiality Awareness Training Procedure

Confidentiality Policy

- Describes the company's confidentiality policy and the employee form associated with it.

Confidentiality of Health Information Form

Patient's Right to Access Personal Health Information Policy

Patient's Right to Access Personal Health Information Procedure

Patient's Right to Restrict Health Information Policy

Facility

Property Audits

- Describes the process by which the property has monthly internal inspections for purposes of health and safety as well as and external inspection by in an independent organization.

Property Damage

- Describes that client are responsible for damage to property

Fiscal

Accounting service

- Describes that Blue Sky Residential contracts a CPA to review fiscal management on a quarterly basis.

Budget

Budget Preparation

Client Fund Policy

- Describes how clients may allow Blue Sky Residential to manage funds for personal use. Client funds are kept separate from company funds

Fees for Service

- Describes how rates for services are established and put into a financial agreement with the client.

Fiscal: Cash Management

- Describes who is responsible for handling funding within the organization

Fiscal: Record Keeping

Fiscal: Report Access

- Describes who is allowed access to fiscal information within the organization.

Health and Safety

De-escalation Intervention (DEI) Policy

- Describes policy and procedure for staff to follow to de-escalate a potential behavioral situation involving a client

Emergency / Disaster Management Plan

Emergency / Disaster Plan Activation Evaluation Form

Emergency Phone Numbers

Emergency Procedures (Auto Accidents)

Health and Safety Review

Infection Control Plan

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Infection Control Plan Review

Pet Policy

Sale and Use of Tobacco Products

Security and Safety of Clients and Staff

Staff safety protocol for responding to crisis in the community

Human Resources

Cultural diversity

Disciplinary Action and Termination

Employee compensation and annual evaluation

Employee Grievance Policy

Employee Screening Process

Ethical Values

Ethical Violations

HR: Anti-Discrimination

HR: Attendance

HR: Cultural Competency Plan

HR: Professionalism

Human Resource Practices

Employee Cell Phone Use/Personal Electronic Device Use

Employee Substance Abuse

Employment At Will

Exceptional Performance and Commitment

Excessive Absences / Tardiness

Federal employment standards

Overtime

Recruitment and Retention

Staff Attendance

Time Off Requests

Volunteers: Hiring, Training and Supervision

Job Posting

Employee Monthly Performance Report

Managerial Levels of authority

Modification of the Staffing Pattern

Personnel Records

Photo Identification (Staff)

Professionalism

Promotion Eligibility

Sexual Harassment

Staffing Roster – Case management

Verification of Applicant Information/ Professional Credentialing

Human Resources-Training

First Aid and CPR Training

Safety Company Vehicles

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Assertiveness Training

Basic Training

Child Abuse Reporting

Generic Detailed Instruction

Infection Control Training

Initial Staff Training

Ongoing Training

Values and Attitudes: Orientation to Service Delivery

Information Services

Computer and Password usage

Data Backup

Employee Technology Use

Internet Usage

Medical

Medication Self Administration

- Describes policy and procedures by which a client administers their medication

Over the counter medication

Client Policies

Blue Sky Client Rights and Responsibilities

Community, Providers, Support Services and Groups

Client Grievance Policy

Grievance Form

Programmatic

Blue Sky Residential Orientation

Client Dining and Meal Preparation

Information Distribution

- Describes the process by which information pertinent to client day to day care is communicated throughout the organization

Procedure for transporting clients

Residential On-Duty Policy

- Describes the process by which administrative staff can be contacted in case of need outside of regular business hours

Quality Measures

Accessibility Plan

- Identifies potential barriers to client service delivery and coordinates a plan to eliminate or accommodate for described barriers.

Annual policy review

- Describes how is responsible for reviewing the programs policy and procedure on an annual basis

Case record Confidentiality and Maintenance

Incidents and Events: Reporting Investigation and Follow up

Case Record Content

Client Input

Data Collection

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Grievance Review Process

Outcome Evaluations for Performance Improvement

Post Discharge Survey Consent Form

Target Behavior Tracking System

Treatment Effectiveness

Record and Service Plan Quality Assurance Review

Quality Assurance Review Form

Service Plan

Blue Sky Residential Service Plan

Service Plan Review

Vocational Rehabilitation Services

Vocational Rehabilitation Services

Blue Sky Residential will incorporate various quality measures to monitor and improve its service delivery. Client input would be routinely acquired through satisfaction surveys, post discharge outcome surveys, solicitation of suggestions from clients and a general open door policy. This client input would then be used to improve service delivery where applicable. Internal audits of the physical plant, client records and service plans help to monitor compliance with established policy and procedure. External audits of the physical plant and fiscal records help to further establish compliance with policy and procedure and general health and safety. Target Behavior Tracking and monitoring progress notes and service plans assist in assessing client symptom reduction and goal achievement. All staff would be somewhat responsible for on-site quality assurance with the ultimate responsibility falling to the Program Director, Risk Management and CEO.

15)

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense an without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Mental Health Residential Living Center

Description	FY Actual Results	FY 1-12 Projected W/out CON	FY 1-12 Projected Incremental	FY 1-12 Projected With CON	FY 12-24 Projected W/out CON	FY 12-24 Projected Incremental
NET PATIENT REVENUE						
Non-Government	$0	$0	$908,850	$908,850	$0	$1,204,500
Medicare	$0	$0	$0	$0		
Medicaid and Other Medical Assistance	$0	$0	$0	$0		
Other Government	$0	$0	$0	$0		
Total Net Patient Patient Revenue	$0	$0	$908,850	$908,850	$0	$1,204,500
Other Operating Revenue						
Revenue from Operations	$0	$0	$908,850	$908,850	$0	$1,204,500
OPERATING EXPENSES						
Salaries and Fringe Benefits	$0	$0	$403,000	$403,000	$0	$422,000
Professional / Contracted Services	$0	$0		$0		
Supplies and Drugs	$0	$0	$20,000	$20,000		$22,000
Bad Debts	$0	$0	$10,000	$10,000		$15,000
Other Operating Expense	$0	$0	$145,000	$145,000		$156,000
Subtotal	$0	$0	$578,000	$578,000	$0	$615,000
Depreciation/Amortization	$0	$0		$0		
Interest Expense	$0	$0		$0		
Lease Expense	$0	$0		$0		
Total Operating Expenses	$0	$0	$578,000	$578,000	$0	$615,000
Income (Loss) from Operations	$0	$0	$330,850	$330,850	$0	$589,500
Non-Operating Income				$0		
Income before provision for income taxes	$0	$0	$330,850	$330,850	$0	$589,500

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Provision for income taxes						
Net Income	$0	$0	$330,850	$330,850	$0	$589,500
Retained earnings, beginning of year		$0	$0	$0	$0	$330,850
Retained earnings, end of year	$0	$0	$330,850	$330,850	$0	$920,350
FTEs	0	0	10	10		10
			60.59	60.59		73

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics fo

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id volume statistics

FY 12-24 Projected With CON	FY 24-36 Projected W/out CON	FY 24-36 Projected Incremental	FY 24-36 Projected With CON
$1,204,500	$0	$1,314,000	$1,314,000
$0			$0
$0			$0
$0			$0
$1,204,500	$0	$1,314,000	$1,314,000
$1,204,500	$0	$1,314,000	$1,314,000
$422,000		$432,000	$432,000
$0			$0
$22,000		$24,000	$24,000
$15,000		$20,000	$20,000
$156,000		$164,500	$164,500
$615,000	$0	$640,500	$640,500
$0			$0
$0			$0
$0			$0
$615,000	$0	$640,500	$640,500
$589,500	$0	$673,500	$673,500
$0			$0
$589,500	$0	$673,500	$673,500

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$589,500	$0	$673,500	$673,500
$330,850	$0	$920,350	$920,350
$920,350	$0	$1,593,850	$1,593,850
10		10	10
73		73	73

or any existing services which will change due to the proposal.

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13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense an without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description clinic	FY Actual Results	FY 1-12 Projected W/out CON	FY 1-12 Projected Incremental	FY 1-12 Projected With CON	FY 12-24 Projected W/out CON	FY 12-24 Projected Incremental
NET PATIENT REVENUE						
Non-Government	$0	$0	$2,955,375	$2,955,375	$0	$3,100,000
Medicare	$0	$0	$0	$0		
Medicaid and Other Medical Assistance	$0	$0	$0	$0		
Other Government	$0	$0	$0	$0		
Total Net Patient Patient Revenue	$0	$0	$2,955,375	$2,955,375	$0	$3,100,000
Other Operating Revenue						
Revenue from Operations	$0	$0	$2,955,375	$2,955,375	$0	$3,100,000
OPERATING EXPENSES						
Salaries and Fringe Benefits	$0	$0	$1,020,000	$1,020,000	$0	$1,050,000
Professional / Contracted Services	$0	$0		$0		
Supplies and Drugs	$0	$0	$75,000	$75,000		$80,000
Bad Debts	$0	$0	$20,000	$20,000		$20,000
Other Operating Expense	$0	$0	$150,000	$150,000		$160,000
Subtotal	$0	$0	$1,265,000	$1,265,000	$0	$1,310,000
Depreciation/Amortization	$0	$0		$0		
Interest Expense	$0	$0				
Lease Expense	$0	$0	$80,000	$80,000		$85,000
Total Operating Expenses	$0	$0	$1,345,000	$1,345,000	$0	$1,395,000
Income (Loss) from Operations	$0	$0	$1,610,375	$1,610,375	$0	$1,705,000
Non-Operating Income				$0		
Income before provision for income taxes	$0	$0	$1,610,375	$1,610,375	$0	$1,705,000

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id volume statistics

FY 12-24 Projected With CON	FY 24-36 Projected W/out CON	FY 24-36 Projected Incremental	FY 24-36 Projected With CON
$3,100,000	$0	$3,300,000	$3,300,000
$0			$0
$0			$0
$0			$0
$3,100,000	$0	$3,300,000	$3,300,000
$3,100,000	$0	$3,300,000	$3,300,000
$1,050,000		$1,070,000	$1,070,000
$0			$0
$80,000		$85,000	$85,000
$20,000		$20,000	$20,000
$160,000			$0
$1,310,000	$0	$1,175,000	$1,175,000
$0			$0
$0			$0
$85,000		$90,000	$90,000
$1,395,000	$0	$1,265,000	$1,265,000
$1,705,000	$0	$2,035,000	$2,035,000
$0			$0
$1,705,000	$0	$2,035,000	$2,035,000

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$1,705,000	$0	$2,035,000	$2,035,000
$1,610,375	$0	$3,315,375	$3,315,375
$3,315,375	$0	$5,350,375	$5,350,375
15		10	10

or any existing services which will change due to the proposal.

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10)

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the**

Type of Service Description: Mental Health Residential Living Center
Type of Unit Description:
# of Months in Operation: 12 months

FY 2013	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt
FY Projected Incremental Total Incremental Expenses:	**$568,000**						
Total Facility by Payer Category:							
Medicare	$0			$0			
Medicaid	$0	$0		$0			
CHAMPUS/TriCare	$0	$0		$0			
Total Governmental			0	$0	$0	$0	$0
Commericial Insurers	75% 500/day		1,818	$681,637			$5,000
Uninsured-private pay	25% 500/day			$0			$5,000
Total NonGovernment		$0	1,818	$681,637	$0	$0	$10,000
Total All Payers	100%	$0	1,818	$908,850	$0	$0	

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proposal in the following reporting format:

(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
$0	$0	$0
$0	$0	$0
$0	$0	$0
$0	$0	$0
$222,212	$568,000	($345,788)
$676,637	$0	$676,637
$898,849		$330,849
$898,849	$568,000	$330,849

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12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the**

Type of Service Description: Mental Health Residential Living Center
Type of Unit Description:
# of Months in Operation: 24 Months

FY ___2014_____	(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY Projected Incremental		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt
Total Incremental Expenses:	**$600,000**			Col. 2 * Col. 3			
Total Facility by Payer Category:							
Medicare	$0			$0			
Medicaid	$0	$0		$0			
CHAMPUS/TriCare	$0	$0		$0			
Total Governmental			0	$0	$0	$0	$0
Commericial Insurers	75%	550/day	2,190	$301,125			$7,500
Uninsured-private pay	25%	550/day		$903,375			$7,500
Total NonGovernment		$0	2,190	$1,204,500	$0	$0	$15,000
Total All Payers	100%	$0	2,190	$1,204,500	$0	$0	

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proposal in the following reporting format:

(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
$0	$0	$0
$0	$0	$0
$0	$0	$0
$0	$0	$0
$293,625	$600,000	($306,375)
$895,875		$895,875
$1,189,500		$589,500
$1,189,500	$600,000	$589,500

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12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the**

Type of Service Description Mental Health Residential Living Center
Type of Unit Description:
# of Months in Operation 36

FY ___2015__	(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY Projected Incremental		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt
Total Incremental Expenses:	**$620,500**			Col. 2 * Col. 3			
Total Facility by Payer Category:							
Medicare	$0			$0			
Medicaid	$0	$0		$0			
CHAMPUS/TriCare	$0	$0		$0			
Total Governmental			0	$0	$0	$0	$0
Commericial Insurers	75% 600/day		2,190	$328,500			$10,000
Uninsured-private pay	25% 600/day			$985,500			$10,000
Total NonGovernment		$0	2,190	$1,314,000	$0	$0	$20,000
Total All Payers	100%	$0	2,190	$1,314,000	$0	$0	

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proposal in the following reporting format:

(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
$0	$0	$0
$0	$0	$0
$0	$0	$0
$0	$0	$0
$318,500	$620,500	($302,000)
$975,500		$975,500
$1,294,000		$673,500
$1,294,000	$620,500	$673,500

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Provision for income taxes	$0	$0	$1,610,375	$1,610,375	$0	$1,705,000
Net Income		$0	$1,610,375	$1,610,375	$0	$1,610,375
		$0	$0	$0	$0	$3,315,375
Retained earnings, beginning of year	$0	$0	$1,610,375	$1,610,375		
Retained earnings, end of year	0	0	15	15		15
FTEs						

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics fo

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17) Will the proposed $500/day be the same for all payers, including self pay?Does the Applicant have a sliding fee scale.?

Response
No, the proposed $500/day fee will not be the same for all payers. The Applicant used the $500/day fee as an average rate that would be charged by Blue Sky. The Applicant chose this rate from his years of experience in the health care field. This fee includes both room and board and also clinical services. The Applicant understands that all private payers and insurers may not be able to pay $500/day. The Applicant will work with these individuals whenever possible to agree on a different rate. The Applicant's experience also tells that him that some insurers pay more than $500/day for the Residential and Clinical aspect of services. The Applicant felt that the higher payments they received combined with the lower payments they receive would make an average rate of approximately $500/day.

18) The Applicant does not appear to be differentiating between gross and net revenue. Is the Applicant making the assumption that the commercial payers will be paying the full published amounts without any allowances?

Response
The Applicant is making the assumption that the average rate that they will receive for services will be $500/day. Some insurers may be higher and some insurers may be lower but the average rate will be $500/day. The Applicant has years of experience dealing with insurance companies and most often the rate is a back and forth negotiation between the organization and the insurer. The rate would start above $500 for the insurer and through negotiation would not typically go below the Applicant's base rate. Of course, there are always exceptions to each situation where the rate will be lower for an admission under special circumstances but the Applicant needs the $500/day level as a benchmark to set rates.

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19) Please provide all assumptions used in the calculation of the patient population mix.

Response

The 75% insurers and 25% private pay mix for the proposed service is calculated directly from the Applicant's other licensed services. The Applicant has seen this payer mix consistently over its last year of operation and believes that it is a reasonable assumption to make that the payer mix will remain fairly constant despite the new services being offered.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

February 28, 2013 VIA FAX ONLY

David Palmer
Chief Executive Officer
Blue Sky Behavioral Health, LLC
52 Federal Road
Suite 2A
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 12-31811-CON
Blue Sky Behavioral Health, LLC
Establish a Mental Health Residential Living Center in Danbury

Dear Mr. Palmer:

On January 29, 2013, the Office of Health Care Access ("OHCA") received your Completeness Letter responses in the Certificate of Need ("CON") application filing of Blue Sky Behavioral Health, LLC ("Applicant") for the establishment of a mental health residential living center in Danbury, with an associated capital cost of $400,000.

OHCA has reviewed the Completeness Letter Responses and requests the following additional information pursuant to General Statutes §19a-639a(c):

1. Please explain in detail how the Applicant determined the clear public need to establish and operate this specific level of care in Danbury.

2. Please explain in detail and provide evidence/calculations on how the Applicant determined the need for the proposed service was a 6 bed facility and not, for example, a 4, or 8, or 12 bed facility.

3. Regarding the breakdown of the origination of referrals provided on page 181 of the Completeness Response letter, please address the following:

    - Provide letters that would support the proposed services from the referring providers.

    - Provide the number of patients that the existing providers (private practioners-28, Hospitals-44, other providers-50) would send to the proposed facility to be treated and for what specific type of diagnosis/treatment.

4. On page 182 of the Completeness Responses the Applicant states that "this program is run in conjunction with the clinical program so that there is not only communication between the two programs but also continuity of care existing that helps get the individual the best care possible." Please address the following:

    - Provide the number of patients currently being treated at Blue Sky Behavioral Health Clinic that will utilize the proposed facility.

    - Provide the financial and volume impact of this proposal on the existing Blue Sky Behavioral Health Clinic.

5. On page 206 of the Completeness Responses the Applicant states that "the $500/day fee includes both room and board and also clinical services." Will the charges for staying at the proposed facility include the clinical services that will be provided by the other licensed services at the existing Blue Sky Behavioral Health Clinic?

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. 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 preceding it. Please begin your submission using Page 178 and reference "Docket Number: 12-31811-CON." Submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7035.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

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

TRANSMISSION OK

TX/RX NO	3306
RECIPIENT ADDRESS	912039422693
DESTINATION ID	
ST. TIME	02/28 14:59
TIME USE	00'40
PAGES SENT	3
RESULT	OK

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

FAX SHEET

TO: DAVID PALMER

FAX: 203 942 2693

AGENCY: BLUE SKY BEHAVIORAL HEALTH, LLC

FROM: PAOLO FIDUCIA

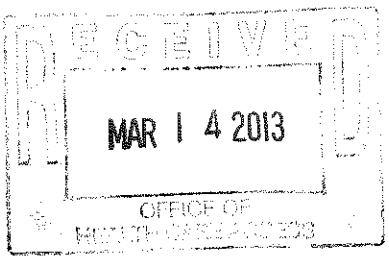
DATE: 2/28/13 TIME: 2 PM

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: 12-31811-CON
2nd COMPLETENESS LETTER

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Blue Sky Behavioral Health, LLC
Docket Number 12-31811-CON



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Responses to OHCA Questions

1) Please explain how the Applicant determined the clear public need to establish and operate this level of care in Danbury.

Response

The need for this level of care in Danbury involves the growth of Danbury, and the growth of Danbury Hospital and Western Connecticut State University. All of these areas would potential be referral sources to the proposed 6 bed facility. According to the 2010 Census, the population of Danbury reached 80,893, which equates to a growth rate of 7.4% since the last Census(See Con Page 7). In fact, Danbury's population growth was more than any other area in Fairfield County(the county where Danbury is located)(See Con page 7). The population base of Fairfield County is 925,899 and correspondingly has the highest per capita income in the Connecticut-$82,558(See Con page 7). The Applicant believes that with the growth of the area also comes the potential of opportunities.

According to the 2010 Census data for Danbury, 61%(49,344 people) are between the ages of 18-64(Blue Sky's target market). According to the National Institute of Mental Health(NIMH), 32.4% of Americans(1 in 3) have a diagnosable mental health disorder(See Con page 9). Using the population of Danbury between 18-64 (49,344), this would mean 15987 people living in Danbury have a diagnosable mental health disorder. According to CMHS data for 2010, Connecticut has a 34% rate for co-occurring disorders(See Con page 9). This would mean of the 15,987 people with a diagnosable mental health disorder, 5435 would also have a co-occurring disorder.

Danbury Hospital and Western Connecticut State University also represent a potential need for Blue Sky to help fill. Danbury Hospital has begun construction on a 150 million dollar addition to add 300,000 square feet to its current location(See Con page 7). Danbury Hospital has already merged with New Milford Hospital and Norwalk Hospital over the past year to provide a uniform healthcare system from New Milford down to Norwalk. Danbury Hospital has realized the growth of the area now and moving forward and also the fact that with the growth of the area comes the increase demand for medical services. Blue Sky already has a relationship with Danbury Hospital (See Con page 7) and this relationship could potentially lead to referrals for residential services to Blue Sky from Danbury Hospital.

Another potential source of referrals to the new proposed site would be Western Connecticut State University(WCSU). WCSU located in Danbury has a population of

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6407 students. According to SAMSHA, 1 in 5 college students have a mental healthy issue. Taking WCSU's population of 6407 students, this would translate to 1281 students. Of this 1281 students, it is reasonable to assume that a percentage of this number woulod be appropriate for and seek residential services. Blue Sky would be able to the need for behavioral services.

Clearly there continues to be a potential demand for services in the City of Danbury. Blue Sky's proposal of a 6 bed facility is a step in the right direction to offer residential services to those in Danbury and surrounding towns in need of these services.

2) Explain how the Applicant determined the need for the proposed service was a 6 bed facility and not a 4, 8 or 12 bed facility.

Response

The Applicant believes that the demand is more than 4, 8, or even 12 beds. This potential demand is clearly described in question #1 above. The Applicant chose the number of 6 beds because of Danbury zoning regulations. For those locations that allow a similar use in Danbury , a maximum of 6 beds are permitted for this type of use. It is the Applicant's desire to have a facility to fill the maximum demand for services in 1 location at this time. Should the business have high demand and that demand is over 50% of current capacity for over 6 months in a given calendar year, the Applicant would consider another location in Danbury.

3) Regarding the breakdown of the origination of referrals provided on page 181 of the Completeness letter, please address:
***Letters that would support the proposed services.**

***Provide the number of patients that existing providers would send to the proposed facility to be treated and for what type of diagnosis./treatment.**

Response

Please see Appendix for letters that would support the proposed services. As far as the question regarding the number of patients that existing providers would have sent it is impossible to quantify. In the period of time that the Applicant kept these records(private practiioners-28, Hospitals-44, and other providers-50 was the number of inquiries that Blue Sky Clinic received. Of this number, all would have to be interviewed and their cases reviewed and discussed by the clinical team(psychiatrist, Clinic Director and Clinicians) before approval or denial of the individual could take place. So, it is impossible to say of these numbers recorded, how many potential patients would be appropriate for admission. Additionally, more intakes from each of these referral sources potentially could be recorded providing that they successfully sent an admission to Blue Sky. The Applicant's experience in this field over the years has shown him that once a referral source has successfully sent a facility an intake they are much more likely to

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continue sending future referrals to this organization because they are a proven commodity, rather than looking at sending a referral to a completely new referral source. Te majority of the people that were referred to Blue Sky over this time period were as follows:mood disorders,dual diagnosis(mental health and substance abuse issues), borderline personality disorders and anxiety disorders. This cross section referrals sent to Blue Sky is fairly consistent.

4) On page 182 of the completeness responses, the Applicant states 'this program is run in conjunction with the clinical program so that there is a continuity of care that exists between the two programs that helps the individual get the best care possible'. Please address:
*** Provide the number of patients currently being treated at Blue Sky Clinic that would utilize the proposed facility.**
*** Provide the financial and volume impact of this proposal on existing Blue Sky Clinic.**

Response
Of the 70 people that are currently being treated at Blue Sky Clinic, approximately 10 would be appropriate to utilize the proposed facility.Please see Appendix for Financial and Volume impact on existing Blue Sky Clinic.

5) On page 206 of the completeness letter, the Applicant states that the ' $500/day fee includes room and board and clinical services'. Will the charges for staying at proposed facility include the clinical services that will be provided by the other licensed services at the Blue Sky Clinic?

Response
Yes, the charges for staying at the proposed facility will include all clinical services that will be provided by other licensed professionals at Blue Sky Clinic.

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Appendix

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SHAWN T. PRICHARD, Ph.D.
Licensed Psychologist
23 Parkway Street
Katonah, N.Y., 10536

03 March, 2013

To: Whom this concerns
From: Shawn Prichard, Ph.D.
Licensed Psychologist
Re: Blue Sky Behavioral Health

I am a Psychologist in Private Practice located in Katonah, N.Y. and out of my home office in New Milford, CT. I am writing this letter in support of Blue Sky Behavioral Health's application to establish an Adult Residential facility in Danbury, CT. I primarily treat adolescents and young adults with mental health and/or substance abuse problems, and these patients are generally from the Westchester County, N.Y., and Fairfield and Litchfield County's, CT.

Over the last several years of practice I have had more than a dozen young adult patients that needed longer term residential care, but I have unfortunately had no good local options to refer these patients to. I have had to arrange placements in Vermont, Georgia, Colorado, Utah, California, Florida, and Washington, among other states, due to the spate of appropriate Residential Programs in New York and Connecticut. Other than the Institute for Living in Hartford, CT., and Wellspring in Bethlehem, CT., there are no other residential programs in Connecticut that are members of the American Residential Treatment Association (ARTA).

I fully endorse the need for more Residential Programs in the state of Connecticut, particularly the application of Blue Sky Behavioral Health. Approval of Blue Sky Behavioral Health's application would be a step in the right direction of addressing the needs of the underserved population of Connecticut adults that need longer term Residential Treatment. If you have any questions, please feel free to contact me at 347-672-7197.

Shawn Prichard, Ph.D.
Licensed Psychologist

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Associated Psychotherapists of Western Connecticut
Kimberly S. Sharpe
72 North Street – Suite 201
Danbury, Ct. 06810

March 10, 2013

To whom it may concern:

I support the application of Blue Sky Behavioral Health, LLC with the Department of Public Health Office of Health Care Access for the establishment of a 6 bed mental health residential living center in Danbury, Ct. As a health care professional in this area for the last roughly 15 years I have seen an increased day to day need for this type of service in Danbury, Ct. Particularly, in light of recent events in Sandy Hook, Ct. on 12-14-2012 I have seen an increased need for mental health care in this area.

The establishment of this facility would be a step in the right direction for making it possible for individuals who need this type of housing to get the professional level of care and support they need. I have made referrals to Blue Sky Behavioral Health's clinic over the last year (the most recent being just this week) and have found them to be both professional and competent.

If I may be of further assistance in this matter, please do not hesitate to contact me.

Sincerely,

Kimberly S. Sharpe, MA, LADC
203-778-2824

15)

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense an without, incremental to and with the CON proposal in the following reporting format:

Mental Health Residential Living Center

Total Facility:	FY Actual Results	FY 1-12 Projected W/out CON	FY 1-12 Projected Incremental	FY 1-12 Projected With CON	FY 12-24 Projected W/out CON	FY 12-24 Projected Incremental
Description						
NET PATIENT REVENUE					$0	$1,204,500
Non-Government	$0	$0	$908,850	$908,850		
Medicare	$0	$0	$0	$0		
Medicaid and Other Medical Assistance	$0	$0	$0	$0		
Other Government	$0	$0	$0	$0		
Total Net Patient Patient Revenue	$0	$0	$908,850	$908,850	$0	$1,204,500
Other Operating Revenue					$0	$1,204,500
Revenue from Operations	$0	$0	$908,850	$908,850		
OPERATING EXPENSES					$0	$422,000
Salaries and Fringe Benefits	$0	$0	$403,000	$403,000		
Professional / Contracted Services	$0	$0		$0		$22,000
Supplies and Drugs	$0	$0	$20,000	$20,000		$15,000
Bad Debts	$0	$0	$10,000	$10,000		$156,000
Other Operating Expense	$0	$0	$145,000	$145,000	$0	$615,000
Subtotal	$0	$0	$578,000	$578,000		
Depreciation/Amortization	$0	$0		$0		
Interest Expense	$0	$0		$0		
Lease Expense	$0	$0		$0		
Total Operating Expenses	$0	$0	$578,000	$578,000	$0	$615,000
Income (Loss) from Operations	$0	$0	$330,850	$330,850	$0	$589,500
Non-Operating Income				$0		
Income before provision for income taxes	$0	$0	$330,850	$330,850	$0	$589,500

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Provision for income taxes	$0	$0	$330,850	$330,850	$0	$589,500
Net Income		$0	$0	$0	$0	$330,850
Retained earnings, beginning of year	$0	$0	$330,850	$330,850	$0	$920,350
Retained earnings, end of year						
FTEs	0	0	10	10		10
			60.59	60.59		73

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics fo

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ıd volume statistics

FY 12-24 Projected With CON	FY 24-36 Projected W/out CON	FY 24-36 Projected Incremental	FY 24-36 Projected With CON
$1,204,500	$0	$1,314,000	$1,314,000
$0			$0
$0			$0
$0			$0
$1,204,500	$0	$1,314,000	$1,314,000
$1,204,500	$0	$1,314,000	$1,314,000
$422,000		$432,000	$432,000
$0			$0
$22,000		$24,000	$24,000
$15,000		$20,000	$20,000
$156,000		$164,500	$164,500
$615,000	$0	$640,500	$640,500
$0			$0
$0			$0
$0			$0
$615,000	$0	$640,500	$640,500
$589,500	$0	$673,500	$673,500
$0			$0
$589,500	$0	$673,500	$673,500

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$589,500	$0	$673,500	$673,500
$330,850	$0	$920,350	$920,350
$920,350	$0	$1,593,850	$1,593,850
10		10	10
73		73	73

or any existing services which will change due to the proposal.

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13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense an without, incremental to and with the CON proposal in the following reporting format:

Total Facility: clinic	FY Actual Results	FY 1-12 Projected W/out CON	FY 1-12 Projected Incremental	FY 1-12 Projected With CON	FY 12-24 Projected W/out CON	FY 12-24 Projected Incremental
Description					$0	$3,100,000
NET PATIENT REVENUE	$0	$0	$2,955,375	$2,955,375		
Non-Government	$0	$0	$0	$0		
Medicare	$0	$0	$0	$0		
Medicaid and Other Medical Assistance	$0	$0	$0	$0		
Other Government	$0	$0	$2,955,375	$2,955,375	$0	$3,100,000
Total Net Patient Patient Revenue						
		$0	$2,955,375	$2,955,375	$0	$3,100,000
Other Operating Revenue	$0					
Revenue from Operations					$0	$1,050,000
OPERATING EXPENSES	$0	$0	$1,020,000	$1,020,000		
Salaries and Fringe Benefits	$0	$0		$0		$80,000
Professional / Contracted Services	$0	$0	$75,000	$75,000		$20,000
Supplies and Drugs	$0	$0	$20,000	$20,000		$160,000
Bad Debts	$0	$0	$150,000	$150,000	$0	$1,310,000
Other Operating Expense	$0	$0	$1,265,000	$1,265,000		
Subtotal	$0	$0		$0		$85,000
Depreciation/Amortization	$0	$0			$0	$1,395,000
Interest Expense	$0	$0	$80,000	$80,000		
Lease Expense	$0	$0	$1,345,000	$1,345,000	$0	$1,705,000
Total Operating Expenses						
	$0	$0	$1,610,375	$1,610,375		
Income (Loss) from Operations				$0		
		$0	$1,610,375	$1,610,375	$0	$1,705,000
Non-Operating Income	$0					
Income before provision for income taxes						

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id volume statistics

FY 12-24 Projected With CON	FY 24-36 Projected W/out CON	FY 24-36 Projected Incremental	FY 24-36 Projected With CON
$3,100,000	$0	$3,300,000	$3,300,000
$0			$0
$0			$0
$0			$0
$3,100,000	$0	$3,300,000	$3,300,000
$3,100,000	$0	$3,300,000	$3,300,000
		$1,070,000	$1,070,000
$1,050,000			$0
$0		$85,000	$85,000
$80,000		$20,000	$20,000
$20,000			$0
$160,000	$0	$1,175,000	$1,175,000
$1,310,000			$0
$0			$0
$0		$90,000	$90,000
$85,000	$0	$1,265,000	$1,265,000
$1,395,000			
	$0	$2,035,000	$2,035,000
$1,705,000			
			$0
$0	$0	$2,035,000	$2,035,000
$1,705,000			

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$1,705,000	$0	$2,035,000	$2,035,000
$1,610,375	$0	$3,315,375	$3,315,375
$3,315,375	$0	$5,350,375	$5,350,375
15		10	10

or any existing services which will change due to the proposal.

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10)

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the**

Type of Service Description Mental Health Residential Living Center
Type of Unit Description:
# of Months in Operation 12 months

FY 2013 FY Projected Incremental Total Incremental Expenses: $568,000	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt
Total Facility by Payer Category:							
Medicare	$0			$0			
Medicaid	$0	$0		$0			
CHAMPUS/TriCare	$0	$0		$0			
Total Governmental			0	$0	$0	$0	$0
Commericial Insurers	75% 500/day		1,818	$681,637			$5,000
Uninsured-private pay	25% 500/day			$0			$5,000
Total NonGovernment		$0	1,818	$681,637	$0	$0	$10,000
Total All Payers	100%	$0	1,818	$908,850	$0	$0	

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proposal in the following reporting format:

(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
$0	$0	$0
$0	$0	$0
$0	$0	$0
$0	$0	$0
$222,212	$568,000	($345,788)
$676,637	$0	$676,637
$898,849		$330,849
$898,849	$568,000	$330,849

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12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the**

Type of Service Description: Mental Health Residential Living Center
Type of Unit Description:
# of Months in Operation: 24 Months

FY 2014	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt
FY Projected Incremental Total Incremental Expenses:	**$600,000**						
Total Facility by Payer Category:							
Medicare		$0		$0			
Medicaid		$0	$0	$0			
CHAMPUS/TriCare		$0	$0	$0			
Total Governmental			0	$0	$0	$0	$0
Commericial Insurers		75% 550/day	2,190	$301,125			$7,500
Uninsured-private pay		25% 550/day		$903,375			$7,500
Total NonGovernment			$0 2,190	$1,204,500	$0	$0	$15,000
Total All Payers		100%	$0 2,190	$1,204,500	$0	$0	

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proposal in the following reporting format:

(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
$0	$0	$0
$0	$0	$0
$0	$0	$0
$0	$0	$0
$293,625	$600,000	($306,375)
$895,875		$895,875
$1,189,500		$589,500
$1,189,500	$600,000	$589,500

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12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the**

Type of Service Description Mental Health Residential Living Center
Type of Unit Description:
# of Months in Operation 36

FY ___2015__ FY Projected Incremental	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt
Total Incremental Expenses:	$620,500						
Total Facility by Payer Category:							
Medicare	$0			$0			
Medicaid	$0	$0		$0			
CHAMPUS/TriCare	$0	$0		$0			
Total Governmental			0	$0	$0	$0	$0
Commericial Insurers	75% 600/day		2,190	$328,500			$10,000
Uninsured-private pay	25% 600/day			$985,500			$10,000
Total NonGovernment		$0	2,190	$1,314,000	$0	$0	$20,000
Total All Payers	100%	$0	2,190	$1,314,000	$0	$0	

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proposal in the following reporting format:

(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
$0	$0	$0
$0	$0	$0
$0	$0	$0
$0	$0	$0
$318,500	$620,500	($302,000)
$975,500		$975,500
$1,294,000		$673,500
$1,294,000	$620,500	$673,500

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Provision for income taxes	$0	$0	$1,610,375	$1,610,375	$0	$1,705,000
Net Income		$0	$0	$0	$0	$1,610,375
Retained earnings, beginning of year	$0	$0	$1,610,375	$1,610,375	$0	$3,315,375
Retained earnings, end of year	0	0	15	15		15
FTEs						

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics fc

MAR 1 3 2013

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 11, 2013 VIA FAX ONLY

David Palmer
Chief Executive Officer
Blue Sky Behavioral Health, LLC
52 Federal Road
Suite 2A
Danbury, CT 06810

RE: Certificate of Need Application; Docket Number: 12-31811-CON
Blue Sky Behavioral Health, LLC
Establish a Mental Health Residential Living Center in Danbury
Notification Deeming the CON Application Complete

Dear Mr. Palmer:

This letter is to inform you that, pursuant to Section 19a-639a(d) of the Connecticut General Statutes, the Office of Health Care Access ("OHCA") has determined that the above-referenced application has been deemed complete as of **April 11, 2013**. The date of April 11, 2013, also begins the ninety-day review period of the application.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7015.

Sincerely,

Paolo Fiducia
Associate Health Analyst

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

TRANSMISSION OK

TX/RX NO	3434
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DESTINATION ID	
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TIME USE	00'27
PAGES SENT	2
RESULT	OK

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

FAX SHEET

TO: DAVID PALMER

FAX: 203 942 2693

AGENCY: BLUE SKY BEHAVIORAL HEALTH

FROM: PAOLO FIDUCIA

DATE: 4/11/13 **TIME:** 1:30 PM

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: 12-31811-CON

NOTIFICATION DEEMING CON APPLICATION COMPLETE

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 11, 2013

David Palmer, CEO
Blue Sky Behavioral Health, LLC
52 Federal Road, Suite 2A
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 12-31811-CON
Blue Sky Behavioral Health, LLC
Proposal to Establish a Mental Health Residential Living Center in Danbury

Dear Mr. Palmer,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Blue Sky Behavioral Health, LLC ("Applicant") on April 11, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant:	Blue Sky Behavioral Health, LLC
Docket Number:	12-31811-CON
Proposal:	Proposal to Establish a Mental Health Residential Living Center in Danbury, with an associated capital expenditure of $400,000

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: May 8, 2013

Time: 10:00 a.m.

Place: Department of Public Health, Office of Health Care Access
410 Capitol Avenue, Third Floor Hearing Room
Hartford, CT 06134

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in *The News Times* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: PF:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 11, 2013 Requisition # 41748

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 **Saturday, April 13, 2013.** 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 Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:PF:lmg

The News Time **April 11, 2013**
Notice of Public Hearing, Docket Number 12-31811-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	Blue Sky Behavioral Health, LLC
Town:	Danbury
Docket Number:	12-31811-CON
Proposal:	Proposal to Establish a Mental Health Residential Living Center, with an associated capital expenditure of $400,000
Date:	May 8, 2013
Time:	10:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 3, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3435
RECIPIENT ADDRESS	912039422693
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ST. TIME	04/11 17:17
TIME USE	00'44
PAGES SENT	5
RESULT	OK

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

FAX SHEET

TO: **DAVID PALMER**

FAX: **(203) 942-2693**

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

FROM: **PAOLO FIDUCIA**

DATE: **4/11/13** **TIME:**

NUMBER OF PAGES: **5**
(including transmittal sheet

Comments: DN: 12-31811-CON Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Thursday, April 11, 2013 4:15 PM
To: Greer, Leslie
Subject: Re: Hearing Notice 12-31811-CON

Good day!

Thanks so much for your ad submission.
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From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Thursday, April 11, 2013 4:07 PM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice 12-31811-CON

Please run the attached hearing notice in The News Times by 4/13/13. For billing purposes, refer to requisition 41748. In addition, please submit me a "proof of publication" for my records.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: April 15, 2013

RE: Certificate of Need Application; Docket Number: 12-31811-CON
Blue Sky Behavioral Health, LLC
Proposal to Establish a Mental Health Residential Living Center

---

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 16, 2013

VIA FAX ONLY

David Palmer
Chief Executive Officer
Blue Sky Behavioral Health, LLC
52 Federal Road
Suite 2A
Danbury, CT 06810

RE: Certificate of Need Application; Docket Number: 12-31811-CON
Blue Sky Behavioral Health, LLC
Proposal to Establish a Mental Health Residential Living Center in Danbury

Dear Mr. Palmer:

The Office of Health Care Access ("OHCA") will hold a public hearing on Wednesday, May 8, 2013, at 10:00 a.m. at the Department of Public Health, Office of Health Care Access, Third Floor Hearing Room, 410 Capitol Avenue, Hartford, regarding the Certificate of Need ("CON") application identified above. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. The Applicant's prefiled testimony must be submitted to OHCA no later than **12:00 p.m., on Friday, May 3, 2013.**

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find OHCA's attachment outlining the suggested discussion points to prepare for the hearing.

Please contact Paolo Fiducia at (860) 418-7035, if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted, Esq.
Hearing Officer

ISSUES

for Public Hearing:

Certificate of Need Application, Docket Number: 12-31811-CON

Blue Sky Behavioral Health, LLC

Proposal to Establish a Mental Health Residential Living Center in Danbury

Please be fully prepared to discuss the following:

1. The need for Blue Sky Behavioral Health, LLC to establish a mental health residential living center in Danbury.
2. How the Applicant plans to attract clients to the proposed location.
3. The origin of the projected clients.

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3438
RECIPIENT ADDRESS	912039422693
DESTINATION ID	
ST. TIME	04/16 13:55
TIME USE	00'39
PAGES SENT	4
RESULT	OK

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

FAX SHEET

TO: DAVID PALMER

FAX: 203 942 2693

AGENCY: BLUE SKY BEHAVIORAL HEALTH, LLC

FROM: PAOLO FIDUCIA

DATE: 4/16/13 **TIME:** 1:45 pm

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: 12-31811-CON

PRE-FILE TESTIMONY LETTER

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

52 Federal Road
Danbury CT 06810
203-300-5055
203-942-2693
blueskyrecovery.com

BlueSky Behavioral

RECEIVED
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Fax

To: Paolo ~~Fiducia~~ Fiducia From: David Palmer

Fax: 860-418-7053 Pages: 4

Phone: Date:

Re: Prefile testimony cc:

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• Comments:

***** Confidential Communication

Prefile Testimony
Blue Sky Behavioral Health, LLC
12-31811-CON

RECEIVED
APR 2 4 2013

The proposal is for a 6 bed Mental Health Residential Living Center in Danbury, Connecticut. This facility would be operated by Blue Sky Behavioral Health, LLC which established a Clinic in Danbury in January 2012. There are only 29 Mental Health Residential Living Centers in Connecticut(Con page 10). Of these 29, only 4 are in the Region 5 area in which Blue Sky is located and only 2 are listed as active and both of those are in Waterbury which is over 30 minutes away from Danbury by car(Con page 10).

Need for such a facility

There are a number of reasons why the need for such a facility exists. The first reason involves the growth of the city of Danbury and with this growth in population also correspondingly increases the potential need for mental health and substance abuse services. According to the 2010 Census, the population of Danbury reached 80,893 which is a 7.4% growth rate since the last Census(Con page 7). Danbury's growth was more than any other area in Fairfield County(the County where Danbury is located). The population of Fairfield County is 925,899 and this County has the highest per capita income- $82,558(Con page 7). The target population that the facility intends to treat is between the ages of 18-64.(Con page 192). According to the 2010 Census information for Danbury, 61%(49,344 people) are between the ages of 18-64(Con page 9). According to the National Institute of Mental Health(NIMH), 32.4% of Americans(1 in 3) have a diagnosable mental health disorder.(Con page 9). Using the population of Danbury between 18-64(49,344), this would mean that 15,987 people living in Danbury have a diagnosable mental health disorder. According to CMHS data for 2010, Connecticut has a 34% rate for co-occurring disorders(Con page 9). This would mean that of the 15,987 people with a diagnosable mental health disorder in Danbury, 5435 would also have a co-occurring disorder.

The second reason that such a facility is needed in Danbury is to complement the growth of Danbury Hospital and offer its patients a potential Residential program to attend should they need one. Danbury Hospital has also recognized the current and future growth needs of the Danbury area. To meet these needs they have merged with New Milford Hospital and Norwalk Hospital to extend their area of service. Danbury Hospital has also begun construction on a 150 million dollar expansion to better serve this increased need(Con page 7). All 3 hospitals have psychiatric units which could potentially refer people to Blue Sky's programs. Blue Sky also already has established a relationship with Danbury Hospital for admissions when clients its services need to be admitted (Con page 7).

A third reason for the proposed facility to be located in Danbury is the close proximity to Western Connecticut State University(WCSU) a local college which is also located in Danbury. Enrollment at WCSU shows a steady increase and this increase is expected to continue(Con page 7). With this college population also comes the potential need for services offered by Blue Sky. College students have an increased incidence in mental health and substance abuse issues(Con page 7). Each year, 1 in 5 American students have a mental health issue, which translates to 54 million people(Con page 7). SAMSHA also

reports that substance abuse is also a major issue on college campuses.(Con page 7). 46.6% of all treatment admissions for college students are alcohol related. Blue Sky would be available to offer treatment avenues fort any students attending WCSU and allow them to potentially still remain in school while receiving necessary services from Blue Sky.

A fourth reason why the facility makes sense involves the overall need for mental health and substance abuse services in the United States. In 2009,the Census Bureau estimated that there were 307,006,550 people living in the United States(Con page 9). Of that number, 75.5% are 18 and older. This translates to 231,789,945 people. It is estimated that 26.2% of adults between these ages of 18-64 suffer from a diagnosable mental health or substance abuse disorder, which translates to 60.7 million people(Con page 9). Mental health and substance abuse issues have a large economic impact on families, communities, health care cost and lost productivity(Con page 9). Not only does Blue Sky work with individual from Connecticut, but 25% of its client base of approximately 65 come from States other than Connecticut. So, Blue Sky is not only servicing the needs of Connecticut, but also 25%(or approximately 16) people come to Blue Sky from States other than Connecticut to receive services. So, there is a 'bigger picture' concept that Blue Sky can also potentially continue to help people who need its services from other States.

How the Applicant plans to attract clients to the proposed location

There are a number of ways that Blue Sky will look to attract people to the proposed location. The first way involves adding to its existing website and detailing the services offered at the new location. Blue Sky also would pay for 'ad words' on the website that would direct users on the internet to its services. When people would put in key words like 'residential treatment' for example, Blue Sky's program would have a prominent place in the listings presented and offer a better opportunity of being looked at as a potential provider. The second way that Blue Sky can attract clients would be by direct mail. Blue Sky has lists of people and organizations that have referred to the company in the past and also lists of new referrals to which mailings can take place. The hope is that some of these people and organizations that receive mailings will in turn send referrals to Blue Sky.

The third way to help attract clients to Blue Sky would be to utilize a marketing staff member. This staff would help coordinate marketing efforts including visiting organizations with marketing materials and making presentations to clinical teams. This marketing person would be the 'face' of the program visiting both new organizations and organizations that have sent referrals to Blue Sky before.

The last major area of referrals would be by providers who have referred people to Blue Sky in the past. Blue Sky is regularly getting referrals from providers. Some of the providers who do so are: High Watch Farm, Silver Hill Hospital, Institute of Living, Bristol Hospital, Four Winds Hospital, Putnam Hospital, Middlesex Hospital, Hackensack Hospital, Summit Oaks, and the Carrier Clinic.

The origin of projected clients

Clients to the proposed program would come from the following sources:
1) Home environment
2) Hospital
3) Residential or similar program
4)In network insurance carriers
5)Employee Assistance programs/ Human Resource Departments

In conclusion, the previously mentioned points highlight the need to grant the application for a 6 bed Mental Health Living in Danbury to Blue Sky Behavioral Health. This proposal helps the established need for such services in the Danbury area as well as Connecticut. Furthermore, the Mental Health Residential Living Center is private pay and private insurance so it does not affect the already limited resources that the State provides as well as not affecting the two providers of similar services 30 plus minutes away in Waterbury. I respectfully ask that OHCA grants the application under consideration for Blue Sky Behavioral Health, LLC for the establishment of a 6 bed Mental Health Residential Living Center in Danbury.

Respectfully yours,

David Palmer
CEO/Blue Sky Behavioral Health, LLC

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3463
RECIPIENT ADDRESS	912039422693
DESTINATION ID	
ST. TIME	05/07 10:34
TIME USE	00'55
PAGES SENT	5
RESULT	OK

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

FAX SHEET

TO: DAVID PALMER

FAX: 2039422693

AGENCY: BLUE SKY BEHAVIORAL HEALTH LLC

FROM: PAOLO FIDUCIA

DATE: 5/7/13 **Time:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:

Information for tomorrow's hearing regarding Docket Number 12-31811-CON.

PLEASE PHONE Barbara K. Oleiarz IF THERE ARE ANY TRANSMISSION

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 12-31811-CON

Blue Sky Behavioral Health, LLC

Proposal to Establish a Mental Health Residential Living Center in Danbury

May 8, 2013, at 10:00 a.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (10 minutes)

III. OHCA's Questions

IV. Closing Remarks

VIII. Public Hearing Adjourned

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Blue Sky Behavioral Health, LLC**

DOCKET NUMBER: **12-31811-CON**

PUBLIC HEARING: **May 8, 2013 at 10:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room Hartford, Connecticut**

EXHIBIT	DESCRIPTION
A	Letter from the Applicant dated December 6, 2012 enclosing the CON application under Docket Number 12-31811, received by OHCA on December 21, 2012. (150 pages)
B	OHCA's letter to the Applicant dated January 18, 2013 requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31811. (4 pages)
C	Applicant's responses to OHCA's letter of January 18, 2013, dated January 27, 2013, in the matter of the CON application under Docket Number 12-31811, received by OHCA on January 29, 2013. (28 pages)
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F	OHCA's letter to the Applicant dated April 11, 2013 deeming the application complete as of April 11, 2013 in the matter of the CON application under Docket Number 12-31811. (1 page)
G	OHCA's request for legal notification in *The News Times* and OHCA's Notice to the Applicant of the public hearing scheduled for May 8, 2013 in the matter of the CON application under Docket Number 12-31811, dated April 11, 2013. (4 pages)

H	OHCA's letter dated April 15, 2013 designating Kevin Hansted as hearing officer in the matter of the CON application under Docket Number 12-31811. (1 page)
I	OHCA's letter to the Applicant dated April 16, 2013 requesting prefile testimony and discussion questions in the matter of the CON application under Docket Number 12-31811. (3 pages)
J	Letter from the Applicant enclosing prefile testimony dated April 24, 2013 in the matter of the CON application under Docket Number 12-31811, received by OHCA on April 24, 2013. (4 pages)

Directions to the Office of Health Care Access

From I-91 North or South and from East of the River:

In Hartford take I-84 westbound. Exit at Asylum Street, exit 48.

At the signal at the bottom of the ramp, make a gradual right, staying to the left of the fork in the road.

At the first light, take an immediate left onto Broad Street.

Travel on Broad Street to the light at the first four-way intersection; take a right onto Capitol Avenue. OHCA (tan brick building at 410 Capitol Avenue) is two blocks down on the right.

* Pass 410 and enter in the driveway between 410 and 450 Capitol Avenue. Turn right into the parking lot behind the building and proceed to the Security building in the lot. You will be directed to available parking.

From the West:

Take I-84 East to Capitol Avenue, Exit 48B. Bear right on the exit ramp. At the end of the ramp, turn right onto Capitol Avenue. OHCA is 3 blocks down on the right (tan brick building at 410 Capitol Avenue).

Proceed from * above

Directions to Forest and Sisson (Lot C) for visitor shuttle service:

From I-91 (north or south) and from east of the river

In Hartford, take I-84 west. Take Exit 46, Sisson Avenue. At the end of the exit ramp, turn left at the signal light onto Sisson Avenue. Take your first left onto **Capitol Ave. Take your first left onto Forest Street. The parking lot is on your left and is labeled State of Connecticut. A shuttle bus to take you to our offices will either be waiting, or will appear in a few minutes.**

From the West

Take I-84 East to Exit 46, Sisson Avenue. At the end of the exit ramp, turn left at the light onto Sisson Avenue. Take you first left onto **Capitol Avenue. Take your first left onto Forest Street. The parking lot is on your left and is labeled State of Connecticut. A shuttle bus to take you to our offices will either be waiting, or will appear in a few minutes**

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Blue Sky Behavioral Health, LLC**

DOCKET NUMBER: **12-31811-CON**

PUBLIC HEARING: **May 8, 2013 at 10:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 12-31811-CON

Blue Sky Behavioral Health, LLC

Proposal to Establish a Mental Health Residential Living Center in Danbury

May 8, 2013, at 10:00 a.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (10 minutes)

III. OHCA's Questions

IV. Closing Remarks

VIII. Public Hearing Adjourned

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Blue Sky Behavioral Health, LLC

DN: 12-31811-CON

Hearing Date: May 8, 2013

Time: 10:00 a.m.

Proposal: Establish a Mental Health Residential Living Center

OHCA Exhibit #	Description
1	Letter of support from Insurance company. within 30 days of today.
2	
3	
4	
5	

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

May 8, 2013
10:00 a.m.

Docket Number: 12-31810-CON
Blue Sky Behavioral Health, LLC
Establish a Mental Health Residential Living Center

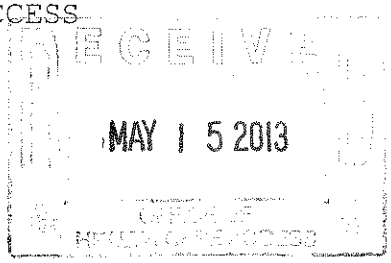
PRINT NAME	Phone	Fax	Representing Organization
David Moore, PhD	203 300-5055 x261		Blue Sky
David Palmer	203 300-5055 ext 206		Blue Sky

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



BLUE SKY BEHAVIORAL HEALTH, LLC
APPLICATION TO ESTABLISH A MENTAL HEALTH
RESIDENTIAL LIVING CENTER IN DANBURY, CONNECTICUT

DOCKET NO. 12-31811-CON

MAY 8, 2013

10:00 A.M.

410 CAPITOL AVENUE
HARTFORD, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

HEARING RE: BLUE SKY BEHAVIORAL HEALTH, LLC
MAY 8, 2013

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Blue Sky Behavioral Health, LLC, held at 410 Capitol Avenue, Hartford, Connecticut, on May 8, 2013 at 10:00 a.m. . . .

HEARING OFFICER KEVIN HANSTED: Good morning, everyone. This public hearing before the Office of Health Care Access, identified by Docket No. 12-31811-CON, is being held on May 8, 2013 to consider Blue Sky Behavioral Health, LLC's application to establish a mental health residential living center in Danbury, Connecticut.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I've been designated by Commissioner Jewel Mullen of the Department of Public Health to serve as the Hearing Officer for this

matter.

The staff members assigned to assist me in this case today are Paolo Fiducia and Kimberly Martone. The hearing is being recorded by Post Reporting Services.

Following the hearing, I will issue a proposed final decision, in accordance with Connecticut General Statutes, Section 4-179.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

The Applicant, Blue Sky Behavioral Health, LLC, has been designated as a party in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in this case. All documents have been identified in the Table of the Record for reference purposes. Mr. Fiducia?

MR. PAOLO FIDUCIA: Yes. We have Exhibits A through J.

HEARING OFFICER HANSTED: Does staff any additional exhibits?

MR. FIDUCIA: No.

HEARING OFFICER HANSTED: No? Do you have

any objections?

MR. DAVID PALMER: No, not at all.

HEARING OFFICER HANSTED: Thank you. At this time, I would ask any of the individuals here that will be testifying on behalf of the Applicant to please stand, raise your right hand, and be sworn in.

(Whereupon, the parties were sworn.)

HEARING OFFICER HANSTED: Thank you. And the first time you speak today, please state your full name for the record and adopt any written testimony you've filed with the office. Thank you. At this time, you may proceed.

MR. PALMER: Okay. My name is David Palmer. I'm the Applicant. I'm the CEO of Blue Sky Behavioral Health. Do you want to state your name?

DR. DAVID MOORE: My name is Dr. David Moore. I'm the Clinic Director and a psychologist with Blue Sky Behavioral Health.

HEARING OFFICER HANSTED: Thank you. And, Mr. Palmer, you've submitted some pre-filed testimony?

MR. PALMER: Correct.

HEARING OFFICER HANSTED: And do you adopt that on the record today?

MR. PALMER: Yes, I do.

HEARING OFFICER HANSTED: Thank you. You may proceed with your testimony.

MR. PALMER: Okay. Good morning, everyone.

HEARING OFFICER HANSTED: Good morning.

MR. PALMER: Thank you for entertaining the application for a residential mental health living center in Danbury, Connecticut.

I just wanted to backtrack for a minute and say that, when over a year ago Blue Sky Behavioral Health got a clinic license and proceeded to establish a clinic in Danbury, Connecticut, it was part of the original CON application at that point that made mention that we also were looking potentially, within a year or two, to also establish a residential site in Danbury, Connecticut, as well, so I just wanted to give a little bit more of a broader overview, that this is a part of our long-term goal to be in the Danbury area.

We think that there's definitely a niche in the market in Danbury, and definitely think there is a need for this service in the State of Connecticut.

Also, unfortunately, the tragic incidents that happened at Newtown, I think, at least for me, what that really said was, you know, there was such a focus on

gun control legislation and everything, and, unfortunately, I think, through all this, what really got pushed aside -- again, let me just backtrack.

Newtown is only about 20 minutes outside of where Danbury is located and the clinic is located. What really I think got kind of pushed aside in this whole discussion is just the need for mental health services offered in the State of Connecticut, as well as throughout the U.S.

Also, not only mental health services available, but the ease of these mental health services to be available. Unfortunately, although we might not know all the things about the shooter that was involved, certainly he would seem to have benefited from some type of, you know, intense mental health services that were offered in the state.

That being said, I think there certainly are a number of reasons that this facility makes sense in the City of Danbury. One, as I mentioned on the pre-filed testimony, is just the growth of the Danbury, Connecticut area.

Danbury is very much in a unique situation. It's right on the border with New York State, so that certainly is something that certainly people can

be drawn from that area, but, also, Danbury is an area that has grown since the last census 7.4 percent, so of any county in Fairfield County it's grown the most.

Also, combined with that is certainly there is a relative affluent population that lives in this area. Certainly, these individuals that live in this area or of any area of the state certainly would have a little bit more opportunity to pay for these services, either with private pay or the ability to have insurance to pay for these services.

Also, in this area there's actually the target population is 18 to 64. The Danbury area certainly has a tremendous number of people in that area in that population group, and I also wanted to mention Danbury Hospital.

When Blue Sky Behavioral Health actually got the clinic license, we had to establish a relationship with Danbury Hospital. Certainly, if we have anyone in crisis, Danbury Hospital is the first organization that we try to get.

We actually have a pre-screening with them, and we're able to push people past the emergency room and actually get to speak to the doctors to potentially get them admitted.

Danbury Hospital we've worked very closely with them over the last year. We have a relationship with them. They're part of the Danbury health network, and they've actually, over this last year, since we've actually been with Blue Sky Behavioral Health, the clinic established in Danbury, they've actually taken over New Milford Hospital, and they've also taken over Norwalk Hospital, so from New Milford all the way down to Norwalk, that whole network is Danbury Hospital.

We certainly look at Danbury Hospital as being a potential referral source to us. They actually have been a referral source to Blue Sky Behavioral Health at this point, and, certainly, when we have people that are in a crisis situation at the clinic, certainly Danbury Hospital is, you know, certainly a facility that we refer to.

A third possible referral source, which makes sense in this area, is Western Connecticut State University. Now Western Connecticut State University, of course, is part of the Connecticut State University system.

Their population has certainly grown and continues to grow over the last number of years, and, certainly, college students it's well-documented that

college students with either mental health or substance abuse issues, you know, certainly, it's rather prevalent, as the documentation proposes, or whatever, not only in the State of Connecticut, but, also, throughout the Connecticut states.

What I think our facility would certainly offer is the ability for people to not only attend college, but, also, potentially to also go to a residential facility and be at that residential facility and receive treatment while still attending college, so there would be no disruption of services for these people, or whatever, in residential treatment.

Thirdly, you know, another potential source is just, if you look at over all of the United States, certainly, in the United States, you know, there are tremendous need for residential treatment facilities, or whatever.

Approximately, 25 percent of our population that attends our clinic actually is from other states, and I think that's a key thing to point out, or whatever.

Certainly, we serve not only the needs of Connecticut, but there certainly are people in other states that, for whatever reason, do not offer the

services that the Blue Sky Clinic offers and certainly come to Blue Sky Clinic.

Now what Blue Sky Clinic would offer, presently offers is the ability for individuals to get comprehensive help in their mental health, their substance abuse issues, but this residential program would offer, as I said in the CON application, a continuity of care, so, basically, or whatever, individuals are coming into to Blue Sky Clinic, but, also, or whatever, there's the continuity of care with the residential treatment program.

We're not talking about a large residential treatment program. We're talking about six people in this residential treatment program. It's a small type enclave of people, and I think, with this smaller enclave of people what we're looking to do, or whatever, is we're looking to give specialized care for these individuals.

Certainly, or whatever, you know, there's a residential component. That component is also tied directly into the individuals receiving clinical services.

And we'd also like to say, or whatever, how do you plan to attract people to the State of

Connecticut, or to this residential facility? Certainly, there are a number of ways that we can do this. One is what we already do at present, but we would increase the budget for this. It's something called AdWords, and, basically, or whatever, what you do is you go through Google or one of the other search terms, or whatever, companies, or whatever, and you pay for specific terms.

So it could be like mental health residential facility in Connecticut, or mental health facility, or treatment in Connecticut, and you pay for these AdWords, so when people type into the computer and type in Google, or whatever, and they're looking for places, Blue Sky is one of the -- if not the first place, one of the first places that go up, and it kind of sets people to know that Blue Sky Clinic is and Blue Sky Residential is also in this area.

One of the other areas that we certainly would receive referrals from would be the other providers. As I mention on here, or whatever, certainly, High Watch Farm, Silver Hill, Institute of Living, Bristol Hospital, Four Winds Hospital, Putnam Hospital.

These are a handful of the places that Blue Sky Clinic actually presently receives referrals from. We certainly expect -- these facilities have

referred to us over the last year. We still intend for them to continue to refer to us, and it's a reciprocal relationship.

Again, providers do not refer to you if they feel that the services that you're offering are not up to their standards of care, and I think that, over the last year that we've been in existence, Blue Sky Clinic, I certainly think that, you know, we've done a very good job of just establishing ourselves within the City of Danbury and starting to make a name for ourselves for treatment.

One of the other areas that we'd be looking to to track people, or whatever, certainly, through e-mail, and not only through e-mail blast, but, also, through direct marketing, through direct mail to other providers in the area and families, as well.

Certainly, we would be hiring another marketing person, or whatever, to help market Blue Sky, its residential treatment program, because, certainly, I think part of what we need to do, or whatever, is we need to, you know, attract -- again, the people that we're looking to attract are between the ages of 18 and 64.

The origin, as I mention on here, the origin of the projected clients would be for the home

environment. Again, a key thing is Danbury Hospital, Norwalk Hospital, as well as New Milford Hospital. These individuals in many cases, or whatever, they go through the psychiatric wings of these hospitals.

They might stay a couple of days, maybe a week, two weeks, or whatever, then they get discharged. In many cases, or whatever, these individuals, you know, go back to their home environment, and, in many cases, that's not the best environment for them to be in.

It would be better suited for them to go to a residential treatment program, where they could get the specialized care.

Many times, the source of their actual dysfunction is this home environment, so that would be one area.

Also, or whatever, you know, hospitals, as I mentioned before, hospitals would be a direct referral source. A similar residential network, like I mentioned before, Silver Hill Hospital, High Watch Farm, they certainly can give us referrals, in-network insurance carriers.

Again, insurance carriers, once you are a licensed facility and once you get in-network, you know, these insurance carriers do refer people to the facility.

Also, employee assistance programs, many organizations have employee assistance programs, and they certainly have a network of organizations that they utilize within not only the State of Connecticut, but other states, as well.

Dave, did you have anything to offer?

DR. MOORE: I just wanted to add really quickly, from a clinical standpoint, what I've seen is somewhat of a revolving door at times in the ERs, and, so, when I talk to the crises teams, the crisis team, when I speak with clinicians at the ER, what their frustration a lot of times is that they'll say to me, look, I know that this person came in, and they were suicidal initially, but they're saying all the right things, so they cannot stay at the hospital right now.

I know they're going to be back tomorrow. I'm aware of that. That's very likely, but I just can't admit them, and, lo and behold, the person is back.

I speak with these clinicians, and they're wonderful, and they're working very hard, but they're frustrated, because there isn't sort of a middle placement.

It goes hospital, and it goes to, then, either partial IOP or outpatient programming. It's

excellent programming, but, many times, the client just goes back into the environment, which it's highly, highly triggering, and they don't have the ability to deal with it, and, so, they go to a partial program maybe for a day or two, and then they stop going, they have the same triggers, and they end up back in the hospital.

And, so, what we're looking to do is find some of this middle spot to help people be able to deal with these significant issues in their life, mental health and addiction issues, and having a safe place to do it and safe area to do it.

The other issue is, many times, if it's a trauma client, they're going back into an environment in which the trauma is happening, and, so, it's a way to kind of pull them away from that for a while and create a real plan for their future.

And, so, that's where I see it as a clinician being a huge benefit, and there's just nothing in Danbury to offer that, and, so, it's just over and over I'm talking with the hospital, and they're kind of like, yeah, I know your frustration, I know that you'd love to get them admitted, but that's a band aid, and they're saying the right things not to get admitted, and we wish there was another option, but either they're

going home, or they're going to go to a shelter, or maybe a random friend's house.

So that's just the one part that I wanted to add on to what David was saying, that I think it's a real, real need within the Danbury community and would be a real wonderful support for clients with mental health issues and addiction issues.

MR. PALMER: The last point that I just wanted to make is I think that, as the CON application, the information that I submitted, there was well over 100 people in the year 2012 that just mentioned to -- when they came into Blue Sky Behavioral Health, they either contacted us via phone or other sources, or whatever, and they asked for residential treatment. Do you offer residential treatment? Do you know where we can find residential treatment?

So I just wanted to make that point, or whatever, that -- and this number has only continued to grow. Not only in 2012 there were over 100 people, in 2013, shortly after the tragedy that happened in Newtown, we got bombarded with well over 100 phone calls, or whatever, from people that were looking for residential treatment.

I think that was very eye-opening to

families, or whatever, knowing that they might have some children in the house and not wanting their children, their child to do something like the terrible things that happened in Newtown.

I think that's certainly, you know, not only the recent incident that happened in Newtown, but, also, before this, you know, there has been a tremendous outpouring in the public for, you know, when they see Blue Sky Clinic, do you offer residential services, as well? I think that's been the next thing that people have mentioned.

HEARING OFFICER HANSTED: Okay. Thank you, both. We just have a few questions. Do you want to start?

MR. FIDUCIA: Yes. Paolo Fiducia. Besides all the reasons that you mentioned already in your opening statement for the need, I mean, is there anything else that you can say why there's a need for residential services and not other type of service?

MR. PALMER: Well I think I, with what I provided, I think that's the majority of need. I think that, you know, I think, if you look at just -- if you look at the sheer numbers of people that are between 18 and 64 just in the Greater Danbury area with potentially

mental health, potential mental health issues, and if you look at the population of the United States between 18 and 64, which they say the estimates are about 26.2 percent of people in that area have mental health issues, I think, you know, the numbers are out there to basically support.

We're not talking about filling, you know, like a 100-bed facility, or whatever, or a multiple-bed facility. We're talking about six beds in the Greater Danbury area, and I think that's, you know, I think that the population stats, not only in the Greater Danbury area, but, also, if you look in New York State and the surrounding towns to Danbury, or whatever, certainly, I think attest to the fact that there are the need for these types of services out there.

MS. KIMBERLY MARTONE: All right. Kind of putting aside the statistics --

MR. PALMER: Sure.

MS. MARTONE: What about your experience? You had just talked about residential and how it's kind of in between the emergency room and the IOP and PHP, so why this residential setting? What is the residential setting going to provide for these patients, as opposed to, as you just stated, going to the IOP and PHP? That's

what I'm kind of looking for, the need for this specific residential service.

MR. PALMER: Sure. I think, as David mentioned before, or whatever, the residential piece serves a niche, that, you know, certainly, IOP doesn't -- the people that go in residential, they need more of a concentrated effort. They need more services directed that are specific and concentrated to the things that they need.

They need to be in a residential facility that's 24-hour staffed, where they can get the kind of support that they need. Unfortunately, what happens, as Dave was touching on before, it's a revolving door.

People are at home, and they start to decompensate. In many cases, or whatever, unfortunately, people have mental health issues, or whatever, they have co-occurring issues, where they try to treat the mental health issues, or whatever, with some type of substance abuse, so that kind of gets into a co-occurring disorder.

What happens is it's a revolving door, as David mentioned, of going to the hospital, staying for a brief period of time, saying the right things, not being suicidal or anything else, and being released to home environment, and it's just a revolving door that

continues to go around.

And I think what the residential facility offers is offers very specific concentrated efforts, and it's a realization that these families and these individuals have of, look, I need help. I cannot get to the next stage of my life.

I need a facility that's 24-hour staffed, that can get very concentrated care to treat the specific things that brought me here in the first place, and I think that IOP does not offer that.

It's intensive outpatient, but you get intensive for a couple of hours, and then that's it. This is a 24-hour facility that's staffed with people that are very skilled in working with these individuals.

They have a concentrated clinic throughout the day, they have staff that work on programming throughout the day, and they offer the services that they need to focus specifically on what brought them there in the first place.

I think IOP is well-intentioned, and it might serve a specific population, but what we're proposing is to fill six beds in the Danbury area for people that are specifically in need of more concentrated services than IOP offers.

MS. MARTONE: Okay. Do you have any --

DR. MOORE: May I add to that a little bit?

MS. MARTONE: Yes. Do you have any documentation, based on your experiences at all? I know you've had discussions with the hospitals, but I'm trying to kind of quantify it. Do you have any other supporting documentation on that? Like did you track any other referrals that you were given by phone or anything?

DR. MOORE: Yeah. I believe they track the numbers of actually referrals and people asking for residential.

MS. MARTONE: Okay.

DR. MOORE: I think, in terms of -- and if you look at, also, some of the other residential facilities, such as Well Spring, they frequently, when even they tried to refer to them, at times, they have waiting lists.

The other issue would be with Silver Hill actually has a wonderful DBT program, it's a 30-day DBT program, it's residential, it has staffing, but it's extraordinarily expensive, and they don't take private insurance.

And, so, some of the actual facilities

have the limitations of just the costs are just too high, but I think the residential, what it provides that not just having partial provides, so it has 24/7, as David mentioned, so there's people there, because, a lot of times, people, who got into the hospital and then need partially, they're after the hospital or going into the ER, are just not quite ready to sort of deal with the impulsive reactivity that they are manifesting, because of what got them in there in the first place.

They can adjust medications, and that will certainly help, but they need someone there to sort of direct them in the right direction.

Partial IOP tend to not be on weekends, whereas residential is on weekends, and, so, there's support on weekends. They need structure, because the structure tends to just be lacking within -- often within the home environments. Not always, but I think that's identifying with the hospital staff.

For example, is this somebody, who is going back to a highly unstructured environment? They need consistency, in which the residential provides, and then, also, helps to make sure that they're actually going to go to the partial programming.

If you look at it, and I don't have the

statistics, but the amount of time that people actually stay within partial IOP programs, particularly with co-occurring disorders, tends to be pretty low, and I don't know the numbers off the top of my head, but that is a consistent problem, in which, you know, you have people that just sort of kind of leave after two days, or five days, because they relapse and decide not to come back at that point.

I think that those are really, really important factors in why residential is that sort of middle ground that's necessary.

MS. MARTONE: Okay, thank you.

HEARING OFFICER HANSTED: And when you talk about 24-hour staffing, who would comprise the staffing?

MR. PALMER: Well the staffing at the residence are actually -- we go a step higher than what a great many facilities offer in the State of Connecticut.

Everyone would have to at least have a four-year college degree. In many type of residential programs, or whatever, what's needed is just years of experience, or whatever, and just a high school diploma, so I think we certainly want to raise the bar with that, or whatever, and certainly have individuals, or whatever,

who have a four-year college degree in a similar field.

These are individuals that would be -- it actually would be comprised of there would be two ends of the week, so, for example, or whatever, one end of the week would be the Sunday through Wednesday team that we call them, or whatever, and this would be even a team with not only a team manager on that team, but it would also be with several staff on that team, or whatever, that would work on that team, or whatever.

Basically, what would happen is there would be a team that would be like 8:00 in the morning until approximately 3:00 in the afternoon, then there would be a second shift that would come in from 3:00 to 11:00, and, then, also, there would be overnights that would be at the facility, or whatever, from 11:00 in the morning until 8:00 the next morning.

Now, on Wednesday, there would be overlap shifts, but the same thing, or whatever. There would be a Wednesday through Saturday team that was first shift, there would be a second shift, and there would be an overnight that would be third shift.

HEARING OFFICER HANSTED: But are these counselors, social workers, or as long as you have a four-year college degree?

MR. PALMER: No. These would be counselors at the facility, yes.

HEARING OFFICER HANSTED: Okay and what kind of certification would they have for counseling?

MR. PALMER: Well I think the wrong thing to call them, I think, in thinking about it would be counselors, or whatever. These are individuals that are staff and staff on board. They're basically individuals that would be -- what would call them, Dave, instructors?

DR. MOORE: Yeah. They're not counselors. They're not licensed staff.

MR. PALMER: They're not licensed staff. This isn't clinical staff. These are staff, or whatever, that are specifically there to assist the members with like daily living skills, or whatever, helping the individuals, or whatever.

Again, staff would be doing all the cooking, or whatever. The individuals would be helping with the cooking, any of the work that would be done around the house or laundry, or whatever. Again, daily life skills would also be taught at the facility, or whatever.

There certainly would be some time, or whatever, for the individuals to participate in different

types of exercise, or whatever. These would be in a sense people that, yes, they have a four-year degree, but they're not offering the type of skills, or whatever, that would be certainly run at the clinic.

HEARING OFFICER HANSTED: Okay, so, let me just give you a scenario.

MR. PALMER: Sure.

HEARING OFFICER HANSTED: Someone with a mental health disorder is a resident and let's say midnight has some sort of a mental health episode that needs attention.

MR. PALMER: Sure.

HEARING OFFICER HANSTED: What happens?

MR. PALMER: Well what would happen in that situation was, again, the staff would, of course, be trained, or whatever, on -- there would be certainly thorough training, or whatever, from the clinical staff, or whatever, about warning signs. There certainly would be protocol, or whatever.

In this particular situation, or whatever, what would happen, or whatever, is, if the staff would use their particular judgment in situations, somebody severely decompensates, or whatever, always in these types of situations 9-1-1 would be called, or whatever,

and the person would be transported to the local hospital for evaluation.

HEARING OFFICER HANSTED: Okay.

MR. PALMER: Again, the staff there would not be offering any type of clinical services, or trying to self-diagnose the person, or whatever.

If a person decompensates and would need to be evaluated, that would be something, or whatever, that, again, staff of the residence could not do that. That would be somebody that would have to be -- they would be transported to the local hospital.

That, I must say, or whatever, would be at -- that would be no different than any other facility in the State of Connecticut, the majority of other facilities in the State of Connecticut.

If you look at Well Spring, if you look at High Watch Farm, if you look at Institute of Living, people decompensate on grounds and would certainly show the signs of needing to be evaluated by a clinical professional, then 9-1-1 would be called, and those people would be transported to the hospital for evaluation.

HEARING OFFICER HANSTED: Okay, so, what I'm trying to differentiate is the difference between

what you're proposing and the current extended treatment program you offer. Can you differentiate that for me? I know the extended treatment program involves a rental apartment, presumably, but, beyond that difference, what's going to be the benefit to the resident?

MR. PALMER: The benefit is the individuals that are in, that are in the residential program, the benefit is these are individuals, who need more intensive treatment. They need more intensive care.

These are individuals, or whatever, who could not exist if they were -- they would not do as well if they were in an intensive, and ETP-type program, or whatever, in a rental program, where they need 24-hour structure.

There's a difference between people, who just need -- who need -- if you look at the symptoms, there's a difference in the symptomatic symptoms of people, who need 24-hour care versus somebody, who just needs, you know, minimal care, or whatever, who live in their own apartment, or whatever, and attend a clinic.

These are individuals, who need more intensive care. Left at their own devices, they might get involved in substance abuse, left at their own devices, where they might be wandering around the

community.

These are individuals, who need more intensive care. They need 24-hour supervision. These are people, who have, in many cases, or whatever, again, past history of where Dr. Moore and I work, many of these people have failed in other programs, or whatever.

Maybe they failed in IOP. Maybe they failed in other residential treatment programs. Maybe they failed in less-structured programs, but what happens is we get notifications. We still, from the insurance carriers right now.

The insurance carriers that we have right now still ask us, or whatever, let us know do you have residential? Let us know when you have residential. There's such a need, not only in the State of Connecticut, but in the United States, for places that offer residential 24-hour care.

As I noted on the CON, if you go back a couple of years, or whatever, the number of programs that offer residential in the State of Connecticut has not increased. If anything, it's decreased. That number has decreased. The staff support, the number has decreased.

I think the population of Connecticut certainly has decreased. In the Danbury area, it's

increased, so I think the individuals that are in this program they need the structured 24-hour care.

In this line of work, they're structured. They do not need to be hospitalized at this point, or whatever, but IOP doesn't fit their bill, or whatever. Living at home doesn't fit their bill, but they need that in between that fits the bill, or whatever.

ETP doesn't fit their bill, because they need the structured 24-hour care.

HEARING OFFICER HANSTED: Right. I understand that. I guess what I'm still struggling with is, you know, the fact that you don't have any documentation of this purported need, and that's what I need, for lack of a better term.

Is there any documentation you can provide me from let's say the insurance companies writing you, saying, you know, do you offer this residential care service? There is a need for this, and we're looking for placements. Do you have anything like that that you can provide to me?

MR. PALMER: Well I provided that in the CON documentation. I mean I'm a little taken aback at this point, because I provided that in the CON documentation, with the fact, or whatever, I said there

were 145, you know, 145 requests in the year 2012, and I went through the whole list of insurance carriers, with various family members, or whatever, who are looking for residential care at Blue Sky Behavioral Health, and I listed that in the CON documentation.

HEARING OFFICER HANSTED: No, and I appreciate that. What I'm looking for is some sort of direct letter from an insurance company, or a hospital, or someone else that I can document the application.

MR. PALMER: What I gave OHCA, and I was told that the application was complete, was I gave several letters, or whatever, attesting to the fact that this facility is needed in the State of Connecticut, and it would be beneficial in the Danbury area.

I wasn't asked, specifically, to provide from insurance companies. I gave the documentation from insurance -- from records from insurance companies. I mean I wasn't, not to sound -- I don't mean to disregard anything you're saying, but I certainly would have provided something if I was asked from insurance companies to provide.

HEARING OFFICER HANSTED: Well you still can. You still can. I can order it as a late file. If you're willing to provide that to me, I'll order it as a

late file to be filed by a certain date.

MS. MARTONE: Mr. Moore, you had mentioned that you did have tracking of some of your referrals that you just spoke of.

DR. MOORE: Yeah. We have tracked, in terms of numbers, in terms of how the request of people saying we're looking for residential.

MS. MARTONE: That's what you mean?

DR. MOORE: Yes.

MS. MARTONE: What you already supplied?

DR. MOORE: Yes.

MS. MARTONE: Nothing different?

MR. PALMER: We already supplied in the CON application, yes.

MS. MARTONE: Okay. I didn't know if you had something additional to that.

MR. PALMER: No. No.

MS. MARTONE: Okay.

HEARING OFFICER HANSTED: So could you provide me something from several different insurance companies that would support the need for this facility?

MR. PALMER: I could certainly look into that, yes.

HEARING OFFICER HANSTED: Okay. Okay.

I'll order that. That will be Late File No. 1. I understand this is -- you'll probably need some time dealing with the insurance companies. I'll leave that open to you. How long do you think you'd need to provide that?

MR. PALMER: I would think within a month. I would think, to be on the fair side and side of safety, I could say within a month.

HEARING OFFICER HANSTED: Okay. All right, so, I'll order that within 30 days from today's date.

MR. PALMER: Okay. I mean, I'm sorry. If I thought I needed to provide it before, I would have.

HEARING OFFICER HANSTED: No, that's fine. I mean this is a standard procedure, ordering a late file, so that's not an issue. Do you have any more questions?

MR. FIDUCIA: The other question would be, if you're getting any referrals for any uninsured or Medicaid, how would you deal with that?

MR. PALMER: I think I touched on that briefly in the CON application. Unfortunately, we're dealing with private pay and private insurance, so that would be something we would refer those individuals to

other providers in the area that could assist them.

On the positive side of things, or whatever, with this proposal, we wouldn't be taking any resources away that are already limited within the State of Connecticut. Budgets with most cities and towns are very tight. Certainly, the State of Connecticut is no different.

We wouldn't be taking any of the resources that are sparse right now within the State of Connecticut. We would just be working on private insurance and private pay model.

MS. MARTONE: Just so you know, our concern is that, you know, as health care reform rolls out and more people go on Medicaid, you know, as a State agency, we need to understand and make sure that there's access to services for Medicaid patients.

MR. PALMER: Sure.

MS. MARTONE: So that's why we're asking. We do want to make sure that they have access equal to private pay patients, as well.

DR. MOORE: And there are facilities, there are other facilities in Danbury that provide, you know, the types of service, like partial IOP, outpatient, that do accept those.

Unfortunately, there are very few residential facilities that accept Medicaid and Medicare. We have referred, actually, at times out of state, because of that, tri-county and other places that do accept that, because it's just few and far between, unfortunately.

MS. MARTONE: Okay, but would your facility be willing at some point to provide services to Medicaid clients?

DR. MOORE: I'm not sure. From my standpoint, I'm not sure if it would be something that would be possible, economically valuable or not, so I think it has to do with --

MR. PALMER: You have to look at the whole logistics of something like that. Certainly, what we've done with the clinic, and I certainly see no difference in what we would do with the residential, is, certainly, we'd certainly take on some cases that are pro bono, as well.

MS. MARTONE: Okay.

HEARING OFFICER HANSTED: Anything further? Do you have anything further? Okay. OHCA has no further questions. Just for the record, are there any persons, other than the Applicants, who wish to provide

any testimony or public comment here today? Let the record reflect that there are none.

With that, I will adjourn this hearing. Thank you, both.

MR. PALMER: Okay, thank you.

DR. MOORE: Thank you very much.

(Whereupon, the hearing adjourned at 10:47 a.m.)

HEARING RE: BLUE SKY BEHAVIORAL HEALTH, LLC
MAY 8, 2013

AGENDA

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CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

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In witness whereof I have hereunto set my hand and do so attest to the above, this 13th day of May, 2013.

Paul Landman
President

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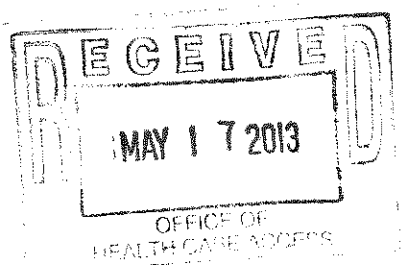
To: Paolo Fiducia
From: David Palmer
Re: 12-31811-CON



Paolo,
I have included the following:
1)Letter from Danbury Hospital
2) Letter from Catherine Roche
3)Letter from Mark Braunsdorf
4)Email from Vincent Delguidice
5)Letter from Pomco that Blue Sky Clinic is in network
6) Letter from Blue Cross that we are in network
7)Letter from Magellan that we are in network
8) Letter from MHN that we are in network
9) Letter from Value options that are in Network

Trying to get letters from insurance companies is extremely difficult. The care managers who generally refer to us are not willing to draft such a letter as it is not something they normally do. The matter is referred to legal but it could take months with no resolution. With this in mind, I have provided letters attesting to the fact that we are already in network with the mentioned providers and that getting into their plan for residential involves filling out paperwork and being accepted by them. Due to the fact that we are already in network for the Clinic makes the process for approval and being sent referrals much easier than if we weren't already in network.

Sincerely,

David Palmer
CEO -Blue Sky Behavioral Health

WESTERN CONNECTICUT MEDICAL GROUP
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

Psychiatry

152 West Street
Danbury, CT 06810-6361
Phone 203.791.5140
Fax 203.798.9200
WesternConnecticutMedicalGroup.org

May 9, 2013

To whom it may concern.

We are aware that Blue Sky Behavioral Health is looking to establish a Mental Health Residential Living Center in Danbury, Connecticut. As a hospital in Danbury with psychiatric services, we support Blue Sky's establishing residential care in our community and would refer patients in need of residential services to Blue Sky.

Sincerely,

Charles Herrick, M.D.
Chairman, Department of Psychiatry
Danbury Hospital
Western Connecticut Medical Group

CH/mhd

Catherine J Roche, LMFT
23 Valley View Rd
Newtown, CT 06470

To Whom It May Concern,

We are aware that Blue Sky Behavioral Health is looking to establish a Mental Health Residential Living Center in Danbury, Connecticut. As a provider in the Danbury Area, we would be interested in the option of referring clients in need of residential services to Blue Sky. This Service is needed for our area.

Sincerely,

Catherine Roche, LMFT

203-426-8535

Suzy O'Neil

From: Mark S. Braunsdorf, PhD [msbraunsdorf@gmail.com]
Sent: Monday, May 13, 2013 10:35 AM
To: Suzy O'Neil
Subject: Letter of reference

To Whom It May Concern:

I am aware that Blue Sky Behavioral Health is looking to establish a mental health residential living center in Danbury Connecticut, As a psychologist who has made several referrals to Blue Sky with positive results, I would be interested in referring clients in need of residential services to Blue Sky.

Should you have any questions, please contact me.

Sincerely,

Mark S. Braunsdorf, PhD
Psychologist

--
Mark S. Braunsdorf, PhD
Consulting Psychologist & Executive Coach
Sent from Gmail Mobile

Suzy O'Neil

From: Delguidice, Vincent [Vincent.Delguidice@valueoptions.com]

Sent: Monday, May 13, 2013 10:15 AM

To: 'Suzy O'Neil'

Subject: RE: letter to assist with BlueSky's application for mental health Residential / BLUESKY BEHAVIORAL H, EALTH (705009) @@

Ref # 05132013-6935083-01

Suzy,

Good morning. Your facility is not yet credentialed and contracted for residential services. I will submit a request to have the needed credentialing materials emailed to you from our operations staff. You should receive these within 7-10 business dates. Once the credentialing materials are completed, returned, reviewed and approved and the residential services are contracted, any ValueOptions member who calls looking for residential services in the Danbury, CT area will be referred to your facility.

All the best,

Vincent DelGuidice.

Manager, Northeast Provider Relations

ValueOptions Inc.

Latham, New York

Phone: 518.220.8666

Fax: 855.524.6068

Email: vincent.delguidice@valueoptions.com

Please be advised that I will be out of the office on the following dates.

Monday, 13 May 2013 – from 12:00pm to 3:30pm

Tuesday, 14 May 2013 – all day

Wednesday, 15 May 2013 – all day

POMCO GROUP

2425 JAMES STREET
SYRACUSE, NY 13206
CLAIMS MAILING ADDRESS
PO BOX 6329
SYRACUSE, NY 13217
315 432 9171
800 934 2459
315 437 9466 FAX
WWW.POMCOGROUP.COM
BENEFITS MANAGEMENT
EM RISK MANAGEMENT
COMMERCIAL SERVICES
BENEFITS CONSULTING

May 09, 2012

Blue Sky Behavioral Health LLC
52 Federal Rd
Danbury, CT 06810
Attn: Billing Manager

Dear Billing Manager:

POMCO is pleased to inform you that effective 5/1/2012 you have been accepted into our Participating Provider Network. Enclosed you will find a copy of your executed Participating Provider Agreement along with a provider manual.

POMCO will only use your Tax Identification Number for claims processing purposes. As a result of this, no additional provider number will be assigned.

We invite you to visit our website at **www.pomcogroup.com** for important information relating to POMCO and at **www.benefitsoft.com** where you can view claims status, check eligibility, and access resources in our document library.

Our Customer Service Department is also available to assist you with benefit, eligibility, or claims status inquiries. Customer Service Representatives may be reached at 1-800- 766-2687 from 8:30 a.m. through 5:00 p.m. EST Monday through Friday. Client specific toll free numbers are located on the enrollee's ID card and in the enclosed information manual.

Sincerely,

Evelyn Arias
Credentialing
Network Development

Enclosures

ANTHEM BLUE CROSS AND BLUE SHIELD

EMPIRE HMO/POS AMENDMENT

THIS EMPIRE HMO/POS AMENDMENT is between **ANTHEM HEALTH PLANS, INC.** doing business as Anthem Blue Cross and Blue Shield ("Anthem BC&BS") for itself and as agent for each of its Affiliates and **CONTRACTED PROVIDER** (defined herein) and is made and entered into as of **January 1, 2013** (the "Effective Date").

WHEREAS, Anthem BC&BS for itself and as agent for its Affiliates entered into a participation agreement with Contracted Provider (defined herein) for the provision of Covered Services to Members (including all prior amendments, the "Agreement") and;

WHEREAS, Anthem BC&BS and Contracted Provider desire to extend Contracted Provider's participation to include Empire Blue Cross and Blue Shield of New York ("Empire") commercial, non-gatekeeper HMO and POS Products, Programs and Plans ("Empire Plans").

NOW, THEREFORE, in consideration of the mutual promises herein, the parties agree as follows

1. Defined Terms. Except as otherwise set forth herein, defined terms shall have the meanings set forth in the Agreement. For purposes of this Empire HMO/POS Amendment, the term "Contracted Provider" shall mean the provider that has entered into the Agreement and whose signature appears below.

2. Empire Plans. As of the Effective Date, Contracted Provider agrees to render Covered Services to Members of the following Empire Plans, all in accordance with the terms and conditions of the Agreement:

- Direct HMO
- Direct POS
- DirectShare^{SM} POS

Compensation for Covered Services rendered to such Members shall be at the Rates set forth in the Agreement for BlueCare HMO/POS Products, Programs and Plans (except MediBlue^{SM}), subject to individual Member payment responsibility.

3. Standard Clauses Appendix. As of the Effective Date, the Standard Clauses Appendix, attached hereto and incorporated herein by reference, is hereby made a part of the Agreement. In the event of any conflict between the terms and conditions of the Standard Clauses Appendix and the terms and conditions of the Agreement with respect to Members of Empire Plans, the terms and conditions of the Standard Clauses Appendix shall govern.

4. Confirmation of Agreement. Except as amended by this Empire HMO/POS Amendment, the Agreement and all prior amendments and exhibits thereto, remains in full force and effect in accordance with its terms.

The remainder of this page is intentionally left blank.

EXECUTED

MAGELLAN BEHAVIORAL HEALTH, INC.
FACILITY AND PROGRAM PARTICIPATION AGREEMENT

THIS AGREEMENT (the "Agreement"), effective 24 day of August, 20 12, is by and between **MAGELLAN BEHAVIORAL HEALTH, INC.**, for itself and on behalf of its Affiliates ("Magellan") and Blue Sky Behavioral Health, LLC ("Facility").

WHEREAS, Magellan or an Affiliate of Magellan, has contracted with one or more health insurance programs and/or employers to provide mental health and/or substance abuse treatment services to Members covered by Benefit Plans sponsored or issued by Payors, as defined in this Agreement; and

WHEREAS, Facility is licensed under the laws of the state of CT to provide inpatient and/or residential or outpatient mental health and substance abuse treatment services and is interested in contracting with Magellan to provide these services for the benefit of health insurance program members and individuals covered by the employer's benefit plans; and

WHEREAS, Magellan and Facility mutually desire to preserve and enhance patient dignity;

NOW, THEREFORE, in consideration of the premises, promises and mutual covenants contained herein and other good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually covenanted and agreed by and between the parties hereto as follows:

SECTION 1
Definitions

Affiliate: A Person that, now or hereafter, directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with Magellan, Magellan Health Services, Inc., Green Spring Health Services, Inc., Merit Behavioral Care Corporation, Human Affairs International, Inc., and/or CMG Health, Inc. For the purposes hereof, the term "Affiliate" shall include "New Affiliate" unless the context otherwise requires.

Affiliate Contract: A contract in effect between the Facility and a New Affiliate prior to the date on which the New Affiliate became an Affiliate of Magellan.

Benefit Plan: A health insurance program's or employer's written benefit plan which contains the terms and conditions of coverage.

Coinsurance: The percent of covered expense for which the Member is responsible in accordance with the terms of the Benefit Plan.

Control: The term "control" (including the terms "controlling," "controlled by," and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise.

Copayment: The amount charged to Members at the time services are rendered in accordance with the terms of the Benefit Plan.

Covered Services: The outpatient and/or inpatient mental health and/or substance abuse treatment services ordered by a Participating Provider and authorized by Magellan pursuant to Member's Benefit Plan and rendered at Facility.

PARTICIPATING PROVIDER AGREEMENT

This Agreement is made by and between the provider named on the signature page of this Agreement ("Provider") and Managed Health Network, Inc. ("MHN, Inc."), and its Affiliates identified in Addendum A to this Agreement. The effective date of this Agreement is set forth on its signature page.

RECITALS

A. Provider is a duly licensed and certified individual, medical group, independent practice association, ancillary service or institutional health care provider whose field of practice is indicated on the signature page of this Agreement.

B. MHN, Inc. and its Affiliates identified on Addendum A (referred to collectively herein as "MHN") arrange for or administer the provision of mental health and substance abuse services and supplies.

C. MHN desires to enter into this Agreement to arrange for Provider to render Covered Services to Enrollees pursuant to this Agreement.

D. Provider desires to enter into this Agreement to render Covered Services to Enrollees pursuant to this Agreement.

NOW THEREFORE, it is agreed as follows:

1. Definitions. The defined terms set forth in this Section below are those words that are capitalized in this Agreement and its addenda.

1.1 Affiliate. A company in which MHN, Inc. or any parent or subsidiary corporation of MHN, Inc., owns 51% or more of the voting stock.

1.2 Agreement. This contract, including all appendices hereto, any policies and procedures referenced herein, rules or regulations issued pursuant to this contract, and all applicable state or federal requirements that are required to be incorporated as part of the Agreement.

1.3 Benefit Plan. The obligation of MHN, Inc. and/or an Affiliate to pay for, provide, arrange for or administer Covered Services, provider networks, administrative or other related services pursuant to a written agreement between an employer or other entity or an individual and MHN, Inc. or an Affiliate. The Benefit Plans covered under this Agreement include, but are not limited to, any of the following lines of business of MHN, Inc. or an Affiliate: (a) MHN, Inc. and Affiliates: (b) the employee assistance plan ("EAP") business described in Addendum B (Individual Providers Only); (c) the behavioral health care business described in Addendum C; (d) the health maintenance organization ("HMO") business described in Addendum D; (e) the Medicare Supplement and Medicare Select business described in Addendum E; (f) the Medicare Advantage business described in Addendum F; (g) the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS/TRICARE") business described in Addendum G; (h) the preferred provider organization ("PPO"), exclusive provider organization ("EPO") and indemnity insurance business underwritten by Health Net Life Insurance Company ("HNL"), Standard Security Life Insurance Company of New York ("SSLIC") and other insurance carriers described in Addendum H; (i) the administrative services only ("ASO") business described in Addendum I; (j) the Medi-Cal business described in Addendum J; (k) the Medicaid business described in Addendum K; (l) all "other" lines of business of MHN, Inc. or an Affiliate described in Addendum L; (n) the New Jersey business of MHN described in Addendum N; (o) the New Jersey Medicaid business of MHN and Affiliates described in Addendum O; and (u) the Department of Veterans Affairs Programs described in Addendum U.

1.4 Coordination of Benefits. The allocation of financial responsibility between two or more Payors of health care services, each with legal duty to pay for Covered Services provided to an Enrollee at the same time.

EFFECTIVE DATE. This Agreement is effective on OCTOBER 15, 2012

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement on the effective date specified above.

BLUE SKY BEHAVIORAL HEALTH	MANAGED HEALTH NETWORK, INC. AND AFFILIATES
Notices: All notices shall be addressed as follows:	
Address:	Address:
52 Federal Rd Ste 2A	P.O. Box 10086
Danbury, CT 06810	San Rafael, CA 94912
E-mail: NMilligram@BlueSkyBH.com	Professional.Relations@MHN.com
TEL: (203) 300-5055 ext 111	TEL: (800) 541-3353
FAX: (203) 942-2693	FAX: (415) 257-1467
(Authorized Signature)	(Authorized Signature)
Nancy Milligram	Dena Maddox
(Print Name)	
Title: Administrative Asst	Title: Vice President, Professional Relations
Date: 10/5/2012	Date:

Federal Tax ID#: 300503871

Signature Above is binding for all applicable lines of business defined in the Addenda of this Agreement.

Attn Provider Groups: Roster of Individual Practitioners included under this Agreement must be attached for participation.

VALUEOPTIONS®
Innovative Solutions. Better Health.

Provider NPI #: 1831462165

05/22/2012

NANCY MILLIGRAM
BLUESKY BEHAVIORAL HEALTH
52 FEDERAL RD STE 2A
DANBURY CT 06810-6162

RE: WELCOME LETTER

Dear Provider:

We are pleased to welcome your organization as a participating provider in the ValueOptions® provider network.

Enclosed is an executed copy of your ValueOptions® Provider Agreement. Your effective date with ValueOptions® is 05/22/2012. You have been approved for the following ValueOptions® networks: ValueOptions Commercial Non-HMO, Great West Health Plan, & GHI/Emblem Health Network.

Please refer to the ValueOptions® Provider Handbook to review our policies and procedures, clinical criteria, and information about treating ValueOptions® members. The Handbook can be found at www.valueoptions.com. If you are unable to access the Internet or if there is any way we can be of assistance, please feel free to contact our National Provider Line at (800) 397-1630, between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday.

We look forward to a working with you in a mutually rewarding relationship.

Sincerely,
Facility Credentialing Manager

Provider Number:705009
PC12 - Facility Welcome Letter
COST CODE 301-0188

ValueOptions® continues to make changes to comply with provisions of Federal Mental Health Parity (FMHP). To learn more about the changes ValueOptions® is making in terms of FMHP, please visit:
http://www.valueoptions.com/providers/Files/pdfs/Mental_Health_Parity_FAQ.pdf

To: Paolo Fiducia
From: David Palmer
Re: 12-31811-CON

Paolo,
I have included the following:
1)Letter from Danbury Hospital
2) Letter from Catherine Roche
3)Letter from Mark Braunsdorf
4)Email from Vincent Delguidice
5)Letter from Pomco that Blue Sky Clinic is in network
6) Letter from Blue Cross that we are in network
7)Letter from Magellan that we are in network
8) Letter from MHN that we are in network
9) Letter from Value options that are in Network

Trying to get letters from insurance companies is extremely difficult. The care managers who generally refer to us are not willing to draft such a letter as it is not something they normally do. The matter is referred to legal but it could take months with no resolution. With this in mind, I have provided letters attesting to the fact that we are already in network with the mentioned providers and that getting into their plan for residential involves filling out paperwork and being accepted by them. Due to the fact that we are already in network for the Clinic makes the process for approval and being sent referrals much easier than if we weren't already in network.

Sincerely,

David Palmer
CEO -Blue Sky Behavioral Health

Catherine J Roche, LMFT
23 Valley View Rd
Newtown, CT 06470

To Whom It May Concern,

We are aware that Blue Sky Behavioral Health is looking to establish a Mental Health Residential Living Center in Danbury, Connecticut. As a provider in the Danbury Area, we would be interested in the option of referring clients in need of residential services to Blue Sky. This Service is needed for our area.

Sincerely,

Catherine Roche, LMFT

203-426-8535

WESTERN CONNECTICUT MEDICAL GROUP
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

Psychiatry

152 West Street
Danbury, CT 06810-6361
Phone 203.791.5140
Fax 203.796.9200
WesternConnecticutMedicalGroup.org

May 9, 2013

To whom it may concern,

We are aware that Blue Sky Behavioral Health is looking to establish a Mental Health Residential Living Center in Danbury, Connecticut. As a hospital in Danbury with psychiatric services, we support Blue Sky's establishing residential care in our community and would refer patients in need of residential services to Blue Sky.

Sincerely,

Charles Herrick, M.D.
Chairman, Department of Psychiatry
Danbury Hospital
Western Connecticut Medical Group

CH/mhd

Suzy O'Neil

From: Mark S. Braunsdorf, PhD [msbraunsdorf@gmail.com]
Sent: Monday, May 13, 2013 10:35 AM
To: Suzy O'Neil
Subject: Letter of reference

To Whom It May Concern:

I am aware that Blue Sky Behavioral Health is looking to establish a mental health residential living center in Danbury Connecticut, As a psychologist who has made several referrals to Blue Sky with positive results, I would be interested in referring clients in need of residential services to Blue Sky.

Should you have any questions, please contact me.

Sincerely,

Mark S. Braunsdorf, PhD
Psychologist

--
Mark S. Braunsdorf, PhD
Consulting Psychologist & Executive Coach
Sent from Gmail Mobile

Suzy O'Neil

From: Delguidice, Vincent [Vincent.Delguidice@valueoptions.com]

Sent: Monday, May 13, 2013 10:15 AM

To: 'Suzy O'Neil'

Subject: RE: letter to assist with BlueSky's application for mental health Residential / BLUESKY BEHAVIORAL H, EALTH (705009) @@

Ref # 05132013-6935083-01

Suzy,

Good morning. Your facility is not yet credentialed and contracted for residential services. I will submit a request to have the needed credentialing materials emailed to you from our operations staff. You should receive these within 7-10 business dates. Once the credentialing materials are completed, returned, reviewed and approved and the residential services are contracted, any ValueOptions member who calls looking for residential services in the Danbury, CT area will be referred to your facility.

All the best,

Vincent DelGuidice.

Manager, Northeast Provider Relations

ValueOptions Inc.

Latham, New York

Phone: 518.220.8666

Fax: 855.524.6068

Email: vincent.delguidice@valueoptions.com

Please be advised that I will be out of the office on the following dates.

Monday, 13 May 2013 – from 12:00pm to 3:30pm

Tuesday, 14 May 2013 – all day

Wednesday, 15 May 2013 – all day

POMCO GROUP

2425 JAMES STREET
SYRACUSE, NY 13206
CLAIMS MAILING ADDRESS
PO BOX 6329
SYRACUSE, NY 13217
315 432 9171
800 934 2459
315 437 9466 FAX
WWW.POMCOGROUP.COM
BENEFITS MANAGEMENT
EM RISK MANAGEMENT
COMMERCIAL SERVICES
BENEFITS CONSULTING

May 09, 2012

Blue Sky Behavioral Health LLC
52 Federal Rd
Danbury, CT 06810
Attn: Billing Manager

Dear Billing Manager:

POMCO is pleased to inform you that effective 5/1/2012 you have been accepted into our Participating Provider Network. Enclosed you will find a copy of your executed Participating Provider Agreement along with a provider manual.

POMCO will only use your Tax Identification Number for claims processing purposes. As a result of this, no additional provider number will be assigned.

We invite you to visit our website at **www.pomcogroup.com** for important information relating to POMCO and at **www.benefitsoft.com** where you can view claims status, check eligibility, and access resources in our document library.

Our Customer Service Department is also available to assist you with benefit, eligibility, or claims status inquiries. Customer Service Representatives may be reached at 1-800- 766-2687 from 8:30 a.m. through 5:00 p.m. EST Monday through Friday. Client specific toll free numbers are located on the enrollee's ID card and in the enclosed information manual.

Sincerely,

Evelyn Arias
Credentialing
Network Development

Enclosures

EXECUTED

MAGELLAN BEHAVIORAL HEALTH, INC.
FACILITY AND PROGRAM PARTICIPATION AGREEMENT

THIS AGREEMENT (the "Agreement"), effective 24 day of August, 20 12, is by and between **MAGELLAN BEHAVIORAL HEALTH, INC.**, for itself and on behalf of its Affiliates ("Magellan") and Blue Sky Behavioral Health, LLC ("Facility").

WHEREAS, Magellan or an Affiliate of Magellan, has contracted with one or more health insurance programs and/or employers to provide mental health and/or substance abuse treatment services to Members covered by Benefit Plans sponsored or issued by Payors, as defined in this Agreement; and

WHEREAS, Facility is licensed under the laws of the state of CT to provide inpatient and/or residential or outpatient mental health and substance abuse treatment services and is interested in contracting with Magellan to provide these services for the benefit of health insurance program members and individuals covered by the employer's benefit plans; and

WHEREAS, Magellan and Facility mutually desire to preserve and enhance patient dignity;

NOW, THEREFORE, in consideration of the premises, promises and mutual covenants contained herein and other good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually covenanted and agreed by and between the parties hereto as follows:

SECTION 1
Definitions

Affiliate: A Person that, now or hereafter, directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with Magellan, Magellan Health Services, Inc., Green Spring Health Services, Inc., Merit Behavioral Care Corporation, Human Affairs International, Inc., and/or CMG Health, Inc. For the purposes hereof, the term "Affiliate" shall include "New Affiliate" unless the context otherwise requires.

Affiliate Contract: A contract in effect between the Facility and a New Affiliate prior to the date on which the New Affiliate became an Affiliate of Magellan.

Benefit Plan: A health insurance program's or employer's written benefit plan which contains the terms and conditions of coverage.

Coinsurance: The percent of covered expense for which the Member is responsible in accordance with the terms of the Benefit Plan.

Control: The term "control" (including the terms "controlling," "controlled by," and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise.

Copayment: The amount charged to Members at the time services are rendered in accordance with the terms of the Benefit Plan.

Covered Services: The outpatient and/or inpatient mental health and/or substance abuse treatment services ordered by a Participating Provider and authorized by Magellan pursuant to Member's Benefit Plan and rendered at Facility.

VALUEOPTIONS®
Innovative Solutions. Better Health.

Provider NPI #: 1831463165

05/22/2012

NANCY MILLIGRAM
BLUESKY BEHAVIORAL HEALTH
52 FEDERAL RD STE 2A
DANBURY CT 06810-6162

RE: WELCOME LETTER

Dear Provider:

We are pleased to welcome your organization as a participating provider in the ValueOptions® provider network.

Enclosed is an executed copy of your ValueOptions® Provider Agreement. Your effective date with ValueOptions® is 05/22/2012. You have been approved for the following ValueOptions® networks: ValueOptions Commercial Non-HMO, Great West Health Plan, & GHI/Emblem Health Network.

Please refer to the ValueOptions® Provider Handbook to review our policies and procedures, clinical criteria, and information about treating ValueOptions® members. The Handbook can be found at www.valueoptions.com. If you are unable to access the Internet or if there is any way we can be of assistance, please feel free to contact our National Provider Line at **(800) 397-1630**, between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday.

We look forward to a working with you in a mutually rewarding relationship.

Sincerely,
Facility Credentialing Manager

Provider Number:705009
PC12 - Facility Welcome Letter
COST CODE 301-0188

ValueOptions® continues to make changes to comply with provisions of Federal Mental Health Parity (FMHP). To learn more about the changes ValueOptions® is making in terms of FMHP, please visit:
http://www.valueoptions.com/providers/Files/pdfs/Mental_Health_Parity_FAQ.pdf

ANTHEM BLUE CROSS AND BLUE SHIELD

EMPIRE HMO/POS AMENDMENT

THIS EMPIRE HMO/POS AMENDMENT is between **ANTHEM HEALTH PLANS, INC.** doing business as Anthem Blue Cross and Blue Shield ("Anthem BC&BS") for itself and as agent for each of its Affiliates and **CONTRACTED PROVIDER** (defined herein) and is made and entered into as of **January 1, 2013** (the "Effective Date").

WHEREAS, Anthem BC&BS for itself and as agent for its Affiliates entered into a participation agreement with Contracted Provider (defined herein) for the provision of Covered Services to Members (including all prior amendments, the "Agreement") and;

WHEREAS, Anthem BC&BS and Contracted Provider desire to extend Contracted Provider's participation to include Empire Blue Cross and Blue Shield of New York ("Empire") commercial, non-gatekeeper HMO and POS Products, Programs and Plans ("Empire Plans").

NOW, THEREFORE, in consideration of the mutual promises herein, the parties agree as follows

1. Defined Terms. Except as otherwise set forth herein, defined terms shall have the meanings set forth in the Agreement. For purposes of this Empire HMO/POS Amendment, the term "Contracted Provider" shall mean the provider that has entered into the Agreement and whose signature appears below.

2. Empire Plans. As of the Effective Date, Contracted Provider agrees to render Covered Services to Members of the following Empire Plans, all in accordance with the terms and conditions of the Agreement:

- Direct HMO
- Direct POS
- DirectShare^{SM} POS

Compensation for Covered Services rendered to such Members shall be at the Rates set forth in the Agreement for BlueCare HMO/POS Products, Programs and Plans (except MediBlue^{SM}), subject to individual Member payment responsibility.

3. Standard Clauses Appendix. As of the Effective Date, the Standard Clauses Appendix, attached hereto and incorporated herein by reference, is hereby made a part of the Agreement. In the event of any conflict between the terms and conditions of the Standard Clauses Appendix and the terms and conditions of the Agreement with respect to Members of Empire Plans, the terms and conditions of the Standard Clauses Appendix shall govern.

4. Confirmation of Agreement. Except as amended by this Empire HMO/POS Amendment, the Agreement and all prior amendments and exhibits thereto, remains in full force and effect in accordance with its terms.

The remainder of this page is intentionally left blank.

IN WITNESS WHEREOF, the parties have executed this Empire HMO/POS Amendment as of the Effective Date.

BLUE SKY BEHAVIORAL HEALTH, LLC
(Contracted Provider Name)

By: [signature]

Title: Administrator

Date: 10/15/12

300503871
(Contracted Provider Tax ID Number)

1851463165
(Contracted Provider NPI)

ANTHEM HEALTH PLANS,
for itself and as agent for Affiliates

By: _____
Bernadette Kelleher
Vice President,
Provider Engagement and Contracting

Date: _____

PARTICIPATING PROVIDER AGREEMENT

This Agreement is made by and between the provider named on the signature page of this Agreement ("Provider") and Managed Health Network, Inc. ("MHN, Inc."), and its Affiliates identified in Addendum A to this Agreement. The effective date of this Agreement is set forth on its signature page.

RECITALS

A. Provider is a duly licensed and certified individual, medical group, independent practice association, ancillary service or institutional health care provider whose field of practice is indicated on the signature page of this Agreement.

B. MHN, Inc. and its Affiliates identified on Addendum A (referred to collectively herein as "MHN") arrange for or administer the provision of mental health and substance abuse services and supplies.

C. MHN desires to enter into this Agreement to arrange for Provider to render Covered Services to Enrollees pursuant to this Agreement.

D. Provider desires to enter into this Agreement to render Covered Services to Enrollees pursuant to this Agreement.

NOW THEREFORE, it is agreed as follows:

1. Definitions. The defined terms set forth in this Section below are those words that are capitalized in this Agreement and its addenda.

1.1 Affiliate. A company in which MHN, Inc. or any parent or subsidiary corporation of MHN, Inc., owns 51% or more of the voting stock.

1.2 Agreement. This contract, including all appendices hereto, any policies and procedures referenced herein, rules or regulations issued pursuant to this contract, and all applicable state or federal requirements that are required to be incorporated as part of the Agreement.

1.3 Benefit Plan. The obligation of MHN, Inc. and/or an Affiliate to pay for, provide, arrange for or administer Covered Services, provider networks, administrative or other related services pursuant to a written agreement between an employer or other entity or an individual and MHN, Inc. or an Affiliate. The Benefit Plans covered under this Agreement include, but are not limited to, any of the following lines of business of MHN, Inc. or an Affiliate: (a) MHN, Inc. and Affiliates: (b) the employee assistance plan ("EAP") business described in Addendum B (Individual Providers Only); (c) the behavioral health care business described in Addendum C; (d) the health maintenance organization ("HMO") business described in Addendum D; (e) the Medicare Supplement and Medicare Select business described in Addendum E; (f) the Medicare Advantage business described in Addendum F; (g) the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS/TRICARE") business described in Addendum G; (h) the preferred provider organization ("PPO"), exclusive provider organization ("EPO") and indemnity insurance business underwritten by Health Net Life Insurance Company ("HNL"), Standard Security Life Insurance Company of New York ("SSLIC") and other insurance carriers described in Addendum H; (i) the administrative services only ("ASO") business described in Addendum I; (j) the Medi-Cal business described in Addendum J; (k) the Medicaid business described in Addendum K; (l) all "other" lines of business of MHN, Inc. or an Affiliate described in Addendum L; (n) the New Jersey business of MHN described in Addendum N; (o) the New Jersey Medicaid business of MHN and Affiliates described in Addendum O; and (u) the Department of Veterans Affairs Programs described in Addendum U.

1.4 Coordination of Benefits. The allocation of financial responsibility between two or more Payors of health care services, each with legal duty to pay for Covered Services provided to an Enrollee at the same time.

EFFECTIVE DATE. This Agreement is effective on OCTOBER 15, 2012

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement on the effective date specified above.

BLUE SKY BEHAVIORAL HEALTH

MANAGED HEALTH NETWORK, INC. AND AFFILIATES

Notices: All notices shall be addressed as follows:

Address: 52 Federal Rd Ste 2A
Danbury, CT 06810

E-mail: NMilligram@blueskybh.com

TEL: (203) 300-5055 ext 111

FAX: (203) 942-2693

Jenny Milligram
(Authorized Signature)

Jenny Milligram
(Print Name)

Title: Administrative Asst

Date: 10/5/2012

Address: P.O. Box 10086
San Rafael, CA 94912

Professional.Relations@MHN.com

TEL: (800) 541-3353

FAX: (415) 257-1467

(Authorized Signature)

Dena Maddox

Title: Vice President, Professional Relations

Date:

Federal Tax ID#: 300503871

Signature Above is binding for all applicable lines of business defined in the Addenda of this Agreement.

Attn Provider Groups: Roster of Individual Practitioners included under this Agreement must be attached for participation.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 29, 2013 VIA FACSIMILE ONLY

David Palmer
Chief Executive Officer
Blue Sky Behavioral Health, LLC
52 Federal Road
Suite 2A
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 12-31811-CON
Blue Sky Behavioral Health, LLC
Establish a Mental Health Residential Living Center in Danbury
Closure of the Public Hearing

Dear Mr. Palmer:

On May 17, 2013, the Office of Health Care Access ("OHCA") received the information requested by OHCA as a late file submission from the public hearing held in this matter on May 8, 2013. With the receipt of the late file submission, the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please feel free to contact Paolo Fiducia at (860) 418-7035.

Sincerely,

Kevin Hansted, Esq.
Hearing Officer

KH:pf

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

TRANSMISSION OK

TX/RX NO	3502
RECIPIENT ADDRESS	912039422693
DESTINATION ID	
ST. TIME	05/29 13:55
TIME USE	00'25
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 29, 2013

VIA FACSIMILE ONLY

David Palmer
Chief Executive Officer
Blue Sky Behavioral Health, LLC
52 Federal Road
Suite 2A
Danbury, CT 06810

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If you have any questions regarding this matter, please feel free to contact Paolo Fiducia at (860) 418-7035.

Sincerely,

JCC SCHOOLBOY/ SCHOOLGIRL CLASSIC

Amy Mortensen/For The News-Times

Ridgefield's Kurt Steidl (31) controls the ball during a game last season. Steidl will play in the 52nd annual Schoolboy/ Schoolgirl Classic Sunday at the Jewish Community Center in Bridgeport.

Steidl ready for another test

By Mike Cardillo

BRIDGEPORT — If you're lucky enough to be a talented basketball player, then you're always looking to play against the best.

That's, in part, how you get better.

It'd be hard to find more senior basketball talent on display than Sunday afternoon when the Jewish Community Center hosts its 52nd annual Schoolboy/Schoolgirl Classic.

"It's a lot of talented kids here, so you just want to come here and play with them," Stratford's Bernard Brantley said Thursday night. "Maybe you'll take a couple moves off of them."

The Classic tips off Sunday at 1:30 with the girls game, featuring state stars from the East vs. West followed by the boys game where the Connecticut all-stars face a very talented New Jersey squad. The team from the Garden State features numerous Division I-bound talent and will be coached by the legendary Bob Hurley, who's won more than 1,000 games in charge of St. Anthony High in Jersey City.

Notre Dame-Fairfield's Vin Laczkoski will coach the Connecticut boys.

"It's kind of like the last high school thing," said Ridgefield's Kurt Steidl. "It's great competition."

The Vermont-bound Steidl added to his resume, earning Gatorade Player of the Year honors earlier this month.

"I was pretty surprised," he said. "I knew I'd been nominated but I didn't think I was going to win it."

At the JCC Classic Steidl will get a chance to play alongside his former AAU teammate, Schadrac Casimir of Trinity Catholic, one more time. Casimir, the Hearst Connecticut Boys Basketball MVP, announced earlier this week he'll attend a year of prep school at South Kent after he graduates in June.

Casimir had Division I offers, including Sacred Heart and Hofstra, but felt he needed a postgraduate year.

"I think I needed another year on and off the court to mature, to get bigger and stronger," he said. "I need to be more of a leader, be more vocal."

Prep school is something on the minds of both Brantley and

See Steidl on B3

NCAA HOCKEY CHAMPIONSHIP: YALE VS. QUINNIPIAC; TODAY; 7 P.M. (ESPN)

Connecticut on ice

Gene J. Puskar/Associated Press

Yale right wing Andrew Miller (17) slips the puck between the legs of UMass Lowell goalie Connor Hellebuyck (37) in front of defenseman Chad Ruhwedel (3) for the winning goal during overtime of an NCAA Frozen Four college hockey semifinal Thursday in Pittsburgh,. Yale won 3-2 and will face in-state rival Quinnipiac today for the national title.

Rivals Quinnipiac, Yale meet for national hockey championship

By Michael Fornabaio

Championship
Today (ESPN)

- Yale (21-12-3) vs. Quinnipiac (30-7-5), 7 p.m.
- Game day. **B5**
- Hartzell: No Hobey Baker, but title would be better. **B5**

PITTSBURGH — They know each other well, but when they last met, they were going in different directions.

Quinnipiac had a disappointing loss in the ECAC semifinals, but was still the No. 1 team in the nation. Yale didn't score a goal all weekend in the ECAC's version of the Frozen Four, shut out by Quinnipiac in the consolation game, and was left to watch the CCHA final to see if they'd play on.

Have they both ever played on.

The War on Whitney reaches its peak Saturday night at Consol Energy Center when the Bobcats and Bulldogs play for the NCAA championship, their fourth meeting of the season.

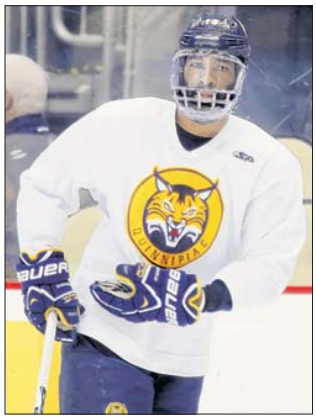
"I think the fact it's a rivalry game is kind of irrelevant right now," said Quinnipiac junior forward Jordan Samuels-Thomas of Windsor, Conn., the only Connecticut native on either team.

"Both teams are competing for a national championship. That's what comes first. They are our rivals, and I don't think anyone thinks other than that, but this is about winning a national championship."

They met twice in February in the ECAC regular season. Quinnipiac won 6-2 at Ingalls Rink, then 4-1 at High Point Solutions Arena in Hamden.

"During an NCAA tournament game, first of all, what happened in the regular season, in the playoffs, doesn't really matter at this

See Yale on B5



Keith Srakocic/Associated Press

Quinnipiac's Jordan Samuels-Thomas skates during practice at the Frozen Four Friday in Pittsburgh. Quinnipiac plays Yale tonight in the championship game.

Samuels-Thomas big presence on the ice

PITTSBURGH — In the Quinnipiac locker room, Jordan Samuels-Thomas does his best to keep a low profile. Forget about wanting to be the center of attention. He doesn't pull pranks, doesn't joke around. In fact, there are times when he barely makes a sound.

"I just sit there and keep my head down," he says.

On the ice, however. That's a different story.

"He plays big man hockey," defenseman Zach Davies said.

At 6-foot-4, Samuels-Thomas, who was born in West Hartford and grew up in Windsor, is almost impossible to hide. And that's fine. His role is to be in the middle of it all. Just look toward the net, that's usually where you'll find the player his teammates call Gator.

"He's this quiet guy but when he gets onto the ice he just turns into beast mode," forward Kevin Bui said. "And when he's in beast mode, we call him Gator."

CHRIS ELSBERRY

It was Gator that set the tone Thursday night and helped carry Quinnipiac into tonight's NCAA championship match-up against Yale, scoring on the power play just 1:47 into the game and adding an assist when linemate Ben Arnt buried the rebound of Samuels-Thomas' initial shot as the Bobcats rolled over St. Cloud State 4-1 and set up a fourth meeting with the Bulldogs.

"Jordan's a high-end offensive player," Bobcats coach Rand Pecknold said. "I thought he was dominant in that first period, the best player on the ice. He really gave us a start with those first two. He was big and strong and St. Cloud ... they didn't know what hit them. He was a huge reason why we won the game."

Huge indeed.

"When I'm on the ice, there's no hiding," he said. "I'm a pretty big guy and I need to play that way for my team

See Samuels-Thomas on B5

YANKEES 5, ORIOLES 2

Yankees turn triple play in victory over sloppy Orioles

ASSOCIATED PRESS

NEW YORK — The Yankees turned a triple play at home for the first time in 45 years, Adam Jones dropped Vernon Wells' fly ball while blowing a bubble for a tiebreaking three-run error and New York beat the Baltimore Orioles 5-2 Friday night for its fourth straight win.

Baltimore started the eighth with two singles off CC Sabathia (2-1), and Manny Machado hit a sharp low liner that second baseman Robinson Cano.

Cano tossed it to shortstop Jayson Nix for the forceout at second. Nick Markakis, thinking the ball was going to be caught by Cano, got trapped in a rundown between second and third base.

Third baseman Kevin Youkilis tagged Markakis and then threw to first baseman Lyle Overbay when Machado ranged too far off the bag. Overbay then threw to Cano, who tagged Machado, setting off a smiling celebration by New York.

The Yankees had last turned a triple play on April 23, 2010, at Oakland. They hadn't accomplished the feat in the Bronx since June 3, 1968, against Minnesota.

With the score 2-2 in the seventh, the Yankees had loaded the bases on two walks — one intentional — and a hit batter. Wells hit a long fly ball that Jones — a Gold Glove center fielder — ranged back for. On the warning track, Jones turned, raised his glove and blew a pink bubble. He closed his glove a bit early, and the ball bounced away clearing the bases.

In the first meeting between the teams since the Yankees eliminated the Orioles in Game 5 of the division series,

SPORTS

Yale Bulldogs vs. Quinnipiac Bobcats

WHAT: NCAA Division I men's hockey national championship
WHEN: Saturday, 7 p.m.
WHERE: Consol Energy Center, Pittsburgh
ON THE AIR: ESPN, WQUN-AM 1220, WYBC-AM 1340
RECORDS: Yale 21-12-3; Quinnipiac 30-7-5
ALL-TIME SERIES: Quinnipiac leads 10-5-2, including 3-0 this year
LAST MEETING: Quinnipiac won 3-0 in the ECAC tournament consolation game, March 23 in Atlantic City, N.J.
ABOUT THE BULLDOGS: After being shut out twice in the ECAC tournament, Yale has won three games in the NCAA tournament — two in overtime, including Thursday's 3-2 win over UMass Lowell — to reach its first national final. ... Sr. RW Andrew Miller (17 goals-22 assists-39 points) scored the winner Thursday, giving himself a breakaway and deking to his backhand; a first-period assist tied him with Bob Brooke for the school record with 113. ... LW Kenny Agostino leads the team at 17-23-40. ... G Jeff Malcolm has a .915 save percentage and a 2.33 goals-against average.
ABOUT THE BOBCATS: The ECAC regular-season champions have been No. 1 in the polls for most of the second half of the season, also reaching their first final. ... Sr. G Eric Hartzell, a Hobey Baker Award finalist, made 33 saves in Thursday's semifinal against St. Cloud State. He has a .934 save percentage and a 1.53 goals-against in front of a defense corps that includes four seniors. ... Jr. RW Jordan Samuels-Thomas (17-12-29) had a goal and an assist in the first six minutes Thursday. ... Sr. C Jeremy Langlois (13-18-31, 100 career points) leads the team in scoring with soph. LW Matthew Peca (15-15-30) right behind.

— MICHAEL FORNABAIO

QUINNIPIAC

Hard work pays off for Hartzell

By Michael Fornabaio

PITTSBURGH — As soon as he saw Eric Hartzell as a junior in 2011, new Quinnipiac goalie coach Steve Valiquette had an idea of what the big goalie could be.

That was an NHL goalie, let alone a star in college.

"My initial impression was 'holy... this guy can play," said Valiquette, editing himself but making the emotion clear.

"It was the way he carried himself, his mind, and his practice habits. Most college kids don't understand how important training is on the ice."

Hartzell did. Valiquette moved on, but he and Hartzell worked out in Bridgeport at the Wonderland of Ice last summer, early in the morning, three times a week.

The work paid off. Hartzell posted a brilliant senior season, has helped the Bobcats into Saturday's national title game against Yale, and was a finalist for the Hobey Baker Award as college hockey's top player.

St. Cloud State forward Drew LeBlanc won the award Friday night and later signed with the Chicago Black Hawks. Boston College forward Johnny Gaudreau was the other finalist.

"I worked really hard over junior year and all summer with Steve Valiquette," Hartzell said. "He really helped me identify who I was as a goaltender. I wasn't really sure.

"He helped me keep my mind in one place at one time."

Legs bouncing, Hartzell looked more nervous in a suit waiting for the announcement Friday night than he has in the NCAA tournament.

He has been in goal for all 30 of the Bobcats' wins, starting all but one game. His 1.53 goals-against average and .934 save percentage rank third and eighth in the nation, helping Quinnipiac lead the nation in team defense, with an experienced defense corps led by assistant coach Reid Cashman, and on the penalty kill.

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Yale to face rival Quinnipiac

Continued from B1

point," said Yale senior forward Antoine Laganiere, who'll be one of the premier college free agents come Sunday. "It's one-and-done. It's a whole new time.

"If we ... get a lot of pucks low and get to rebounds and get some traffic in front of the goalie, we'll be successful."

They'll need traffic to disrupt Eric Hartzell.

The Bobcats' senior goalie has stood out all season. He was a finalist for the Hobey Baker Award, which was awarded Friday night to St. Cloud State senior forward Drew LeBlanc.

Quinnipiac has 10 seniors in the lineup, four of them on a strong defense corps, and depth throughout the lineup.

But the Bulldogs have come back strong from their late-season disappointment. The top line of Kenny Agostino, Andrew Miller and Jesse Root has scored clutch goals, and senior goalie Jeff Malcolm has made big saves.

"I think the details in our game and our individuals are better now than they were the last time we faced them," Yale coach Keith Allain said.

Quinnipiac coach Rand Pecknold sees more confidence in the Bulldogs now than in Atlantic City, a team playing at a higher level.

Defenseman Zack Currie, the Bobcats' captain, agreed.

"Our approach doesn't change," Currie said. "We've played some very good lines, some very good teams and some very good players."

They took different routes from Whitney Avenue to Pittsburgh, where one or the other will be the first champion from the ECAC in 24 years.

Yale needed Notre Dame to beat Michigan in the CCHA final just to get in; as the fourth seed in the West Regional in Grand Rapids, Mich., they knocked off favored Minnesota and North Dakota before toppling another favorite, UMass Lowell.

Quinnipiac shook off a slow start against Canisius as the top seed in the tournament, beating Union and then St. Cloud State to find a familiar foe awaiting.

"It doesn't matter who we're going to play," Pecknold said. "We could play the Montreal Canadiens (Saturday) night and we're going to play the same way. We've got to tweak things a little bit and make some small adaptations to shut down Yale in certain situations, but ultimately we have to play our game."

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Samuels-Thomas a big presence

Continued from B1

and if I want to play at the next level."

Those National Hockey League aspirations came early. First from his father, Cliff Thomas, who put Jordan on skates just after he started to walk. Power-skating lessons came next and soon, Jordan was playing in house hockey leagues in Windsor and Newington. But the sport soon became his passion after Jordan watched the 1992 movie, the Mighty Ducks.

"That movie came out a little after I started playing and it was something that made me love the game even more," he said. "I was a big Boston Bruins fan, too, a big Ray Bourque fan. My dad was really pro-active, getting me to play. We had (Hartford) Whalers season tickets the year before they moved (1996-97). My dad was huge in getting me into the sport."

Samuels-Thomas spent a season in the United States Hockey League with the Waterloo Black Hawks before accepting a scholarship to Bowling Green University. He had been interested in Quinnipiac and Yale but the Falcons were the first team to express interest and hockey players tend to be fiercely loyal. So Samuels-Thomas headed to Ohio and led Bowling Green in goals and assists his first two seasons before things there started becoming unsettled.

"I had gone through three sets of coaching staffs in my first two years," Samuels-Thomas said. "I led the team in scoring but I didn't think I was learning anything new. I want to play in the NHL and I thought it was time for me to go somewhere else, a place with more stability and I found that here at Quinnipiac."

And Samuels-Thomas learned quickly. Having to sit out last season as a transfer, he spent hours in the weight room, getting stronger. He spent hours on the ice skating after practice, getting faster. Whatever he needed to do to make that NHL dream get a little clearer, Samuels-Thomas did it.

"When he first came here, he had to work on his defense and his compete level," Pecknold said. "Give him credit, he's really worked at that and become a complete player."

His goal against St. Cloud was his team-leading 17th of the season, and his 12 assists stand him second overall in scoring, two points behind Jeremy Langlois.

"Jordan is a big body presence on the ice," said defenseman Dan Federico. "In practice, he's one of the hardest guys to take the puck from. His line, with Bryce (Van Brabant) and Ben (Arnt), they cycle the puck well and you never really know what he's going to do, shoot or pass. He's very hard to defend."

And his presence off the ice?

"He's a pretty quiet guy," said Zach Davies.

"Pretty reserved," added Arnt. "and pretty laid back."

"He's had some interesting hairdos," noted Federico. "He's had a Mohawk, he's had dreads. He's had some interesting hair."

On Friday, Samuels-Thomas sported a normal looking "do," the aftermath, he says, of an early season head shaving to benefit cancer.

"I'm probably going to go back to the Mohawk," he said. "I haven't had the chance to do anything with it so I'm just letting it get rough."

And the beard?

"That's serious," he said. "I'm just setting the tone. It's hockey."

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MASTERS

Day leads at Masters; 14-year-old makes cut

ASSOCIATED PRESS

AUGUSTA, Ga. — Jason Day is out front midway through the Masters.

Fortunately for Guan Tianlang, the leader didn't sink one last putt Friday.

Guan, a 14-year-old from China, became the youngest player to make the cut in PGA Tour history, despite taking a one-stroke penalty on the 17th hole for slow play.

Apparently the first ruling of its kind in the Masters' 77-year history, it gave the eighth-grader no margin for error if he wanted to play on the weekend.

Day charged to the lead and was in position to knock out Guan — and everyone else at 4 over, including defending champ Bubba Watson — when he stood over a 12-foot putt at the 17th hole. When the ball slid by the right side of the hole, Guan could breathe a little easier.

Then, when Day's approach at the 18th rolled back toward the front of the green, it was clear Guan would reach another milestone — two more rounds in the first major of the year. He already was the youngest player in Masters history.

Day, an Australian, shot a 4-under 68 that gave him a 6-under 138 total, good enough for a one-stroke lead over Fred Couples and first-round co-leader Marc Leishman.

Day

Guan

Tiger Woods had a share of the top spot until a tough finish knocked him back. He struck the flagstick at No. 15, sending the ball careening back into the water. Only a brilliant little pitch on the do-over allowed him to save bogey at a hole where he should have had a good chance for a birdie. Then, on 18, Woods misjudged the distance just a bit on the approach, wound up on the back tier of the green and three-putted for another bogey.

He finished at 71 and three shots back at 141, a score that easily could have been two or three shots lower.

"I really played well," Woods said. "The score is not indicative of quite how well I played."

Everyone within 10 shots of the lead will be back on Saturday.

That includes a youngster who's on quite a field trip.

Guan just needs to speed things up a bit.

Fred Ridley, the club's competition committee chairman, said Guan's threesome was first warned for being too far behind the group ahead of them at the 10th hole. The teenager went on the clock two holes later — an official imposes a 40-second time limit to play a stroke — and gave Guan his first warning at No. 13.

"In keeping with the applicable rules, he was penalized following his second shot on the 17th hole when he again exceeded the 40-second time limit by a considerable margin," Ridley said in a statement.

That turned what would have been a par into a bogey. Guan finished at 75 and 148 overall.

"I respect the decision," Guan said. "This is what they can do."

The last player to be penalized for slow play at a major was Gregory Bourdy at the 2010 PGA Championship at Whistling Straits. No one could find a record of anyone getting penalized in such a way at Augusta National.

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PUBLIC NOTICES

PUBLIC NOTICE

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	Blue Sky Behavioral Health, LLC
Town:	Danbury
Docket Number:	12-31811-CON
Proposal:	Proposal to Establish a Mental Health Residential Living Center, with an associated capital expenditure of $400,000
Date:	May 8, 2013
Time:	10:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 3, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone(860) 418-7001.

PUBLIC NOTICES

INVITATION TO BID

Sealed Bids will be received by the Purchasing Agent of the City of Danbury at the Purchasing Agent's Office, City Hall, Danbury, CT until 10:00 A.M. on:

Tuesday, April 23, 2013 for:
Bid #04-12-13-05 "Flange Kits and Associated Hardware – Public Utilities"

Thursday, April 25, 2013 for:
Bid #04-12-13-07 "Trailer Mounted Portable Traffic Signal – Engineering Department"

Tuesday, April 30, 2013 for:
Bid #03-12-13-02 "Heating Fuel – Public Buildings"
Bid #03-12-13-01 "Motor Fuels – City Departments & Agencies"

Tuesday, May 7, 2013 for:
Bid #04-12-13-06 "Chemicals - Water Department"

Specifications for both the bids may be obtained at the Purchasing Agent's Office, City Hall, 155 Deer Hill Avenue, Danbury, CT 06810, (203) 797-4571.

The City of Danbury is an equal opportunity and affirmative action purchaser, and bids from all vendors, including those from enterprises owned by minorities and women, are encouraged.

The City of Danbury reserves the right to accept or reject any or all Bids, and unless specified otherwise, to award the contract within thirty working days to the Bidder deemed to be for the best interest of the City of Danbury.

Dated: April 11, 2013

Charles J. Volpe, Jr., CPPB
Purchasing Agent
City of Danbury

Notice To Bidders

Notice is hereby given that The New Milford Public Schools is soliciting bids for the equipment, materials, supplies, and or services listed below.

Bid Specifications may be obtained at:
Laura Olson, Director of Special Education
NEW MILFORD PUBLIC SCHOOLS
50 East Street
New Milford, CT 06776

Bid#	Description
E-2013-04-25	School-Based OT & PT Services

Due Date: Friday, May 10, 2013

Sealed bids are to be returned to the address listed above where they will be opened and read aloud publicly at times set forth in the respective specification package.

PUBLIC NOTICES

LEGAL NOTICE

At the regular meeting held on March 20, 2013, the Planning Commission of the City of Danbury made the following decision:

APPROVED PER REVISED RESOLUTION to E.W. Batista Family LP –Application for Revised Special Exception/Revised Site Plan Approval to allow uses generating over five hundred (500) vehicle trips per day in the C-CBD Zone – 2-12 Main St. & 155 South St. (#J15045, #J15046, & #J15048) - SE #587.

Arnold E. Finaldi Jr., Chairman

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 1, 2013

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 12-31811-CON
Blue Sky Behavioral Health, LLC	**Establish a Mental Health Residential Living Center in Danbury**

To:

David Palmer
Chief Executive Officer
Blue Sky Behavioral Health, Inc.
52 Federal Road
Suite 2A
Danbury, CT 06810

Dear Mr. Palmer:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter, as provided by Section 19a-638, C.G.S. On August 1, 2013, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:pf

Department of Public Health
Office of Health Care Access

Final Decision

Applicant: **Blue Sky Behavioral Health, LLC**
52 Federal Road
Suite 2A, Danbury, CT 06810

Docket Number: **12-31811-CON**

Project Title: **Establish a Mental Health Residential Living Center in Danbury, Connecticut**

Project Description: Blue Sky Behavioral Health, LLC ("Applicant") is proposing the establishment of a mental health residential living center in Danbury, Connecticut with an associated capital cost of $160,000.

Procedural History: The Applicant published notice of its intent to file the Certificate of Need ("CON") application in the *News-Times* on November 11, 12 and 13, 2012. On December 21, 2012, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project. On April 11, 2013, OHCA deemed the CON application complete.

On April 11, 2013, the Applicant was notified of the date, time and place of the public hearing. On April 14, 2013, a notice to the public announcing the hearing was published in the *News-Times*. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat") § 19a-639a, a public hearing regarding the CON application was held on May 8, 2013.

Commissioner Jewel Mullen designated Attorney Kevin T. Hansted as the hearing officer in this matter. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the General Statutes) and Conn. Gen. Stat. § 19a-639a. The public hearing record was closed on May 29, 2013.

Findings of Fact

1. The Applicant is a for-profit Connecticut limited liability company, and a health care facility or institution as defined by Conn. Gen. Stat. § 19a-639, that is proposing the establishment of a 6 bed Mental Health Residential Living Center at 124 Franklin Street, Danbury, Connecticut. Ex. A., p. 7.

2. A Mental Health Residential Living Center is a facility which provides a supervised, structured and supportive group living arrangement which includes psychosocial rehabilitative services and may also provide assistance in obtaining community services to persons in need of mental health services. Ex. A., p. 7.

3. The Applicant currently holds Mental Health Day Treatment Facility and Facility for the Care or Treatment of Substance Abusive or Dependent Persons licenses and provides these services at 52 Federal Road, Danbury, Connecticut ("Blue Sky Clinic"). Ex. A., p. 13.

4. The Applicant proposes to provide services to residents of the following towns that comprise Region 5 as defined by the State of CT, Department of Mental Health Services ("DMHAS"):

Barkhamsted	Goshen	Newtown	Southbury
Beacon Falls	Hartland	Norfolk	Thomaston
Bethel	Harwinton	North Canaan	Torrington
Bethlehem	Kent	Oxford	Warren
Bridgewater	Litchfield	Prospect	Washington
Brookfield	Middlebury	Redding	Waterbury
Canaan	Morris	Ridgefield	Watertown
Cheshire	Naugatuck	Roxbury	Winchester
Colebrook	New Fairfield	Salisbury	Wolcott
Cornwall	New Hartford	Sharon	Woodbury
Danbury	New Milford	Sherman	

Ex. A, p. 8.

5. The Applicant states that the Danbury area was selected for the proposed residential facility, in part, because it will allow for the unification and coordination of mental health and substance abuse counseling and treatment offered at the existing Blue Sky Clinic in Danbury for the residents of its proposed residential treatment facility. Ex. A, p. 8.

6. The Applicant testified that the proposed residential treatment facility would also add to the continuity of care for individuals being treated at the Blue Sky Clinic. Transcript of May 8, 2013 Public Hearing ('Tr."), Testimony of David Palmer, Chief Executive Officer, Blue Sky Behavioral Health, LLC. p. 10.

7. The populations to be served by the proposed facility are adults ages 18-64 with a primary diagnosis of a behavioral health disorder, or potentially a secondary diagnosis of substance abuse (co-occurring disorder). Ex. A, p. 9.

8. According to the National Institute of Mental Health ("NIMH"), 26.2% of adults in the United States age 18 and older suffer from a diagnosable mental health or substance abuse disorder in a given year. Ex. A, p. 9.

9. According to The Connecticut State Office of Rural Health, during a single year, there are an estimated 600,000 adults in Connecticut with mental illness (including 135,000 with serious mental illness), yet it is estimated that only about half receive any form of public or privately funded treatment. Ex. A, p. 73.

10. The Applicant reports that 58.3% of the people treated in the State of Connecticut with a diagnosable mental health disorder are between the ages of 18 and 64. Ex. A, p. 10.

11. In Fiscal Year ("FY") 2012, there were 417,009 discharges from acute care hospitals in Connecticut. Persons age 18 and older with a behavioral health diagnosis, including mental health disorders and alcohol and drug abuse, accounted for 28,012 of those discharges. In FY 2012, there were 56,780 discharges age 18 and older in Region 5 with 4,111 with a behavioral health diagnosis. CT Department of Public Health Office of Health Care Access Acute Care Hospital Inpatient Discharge Database.

12. The majority of referrals to the proposed residential treatment facility would originate from the Danbury area. Currently, the Blue Sky Clinic has relationships with other providers in the area, including Danbury and New Milford Hospitals. Blue Sky Clinic has received referrals from Mountainside Treatment Center, High Watch Recovery Center and Silver Hill Hospital, a Hospital for Mentally Ill Patients. Tr. Testimony of David Palmer, p. 11.

13. The Applicant will build upon these existing relationships and expects to receive residential treatment program referrals from these providers. Tr. Testimony of David Palmer, p. 12.

14. The Applicant also identified Western Connecticut State University ("WCSU"), located in Danbury, as a potential source of referrals, based upon recent studies that have shown that substance abuse is a growing problem among college students. Ex. E, p. 192.

15. According to the Substance Abuse and Mental Health Services Administration ("SAMHSA"), college students have an increased incidence of mental health and substance abuse issues. 46.6 % of all substance abuse treatment admissions for college students are alcohol related. Ex. A, p. 7.

16. According to SAMSHA, 1 in 6 college students have a mental health issue. The Applicant assumes that 1,281 of WCSU's 6,407 students may have a mental health issue and that a percentage of these students would be appropriate for and seek residential services. Ex. E, p. 193.

17. The Applicant testified that emergency room clinicians have expressed frustration at the lack of intermediate facilities available for those patients presenting at the emergency room with mental health issues who are not appropriate to be admitted to the hospital. Tr. Testimony of Dr. David Moore, Clinical Director and Psychologist, Blue Sky Behavioral Health, LLC. pp. 14-15.

18. The proposed residential treatment facility will serve as a "middle placement" for individuals not admitted to a hospital, but needing more behavioral health services than currently offered by existing partial intensive outpatient or outpatient programs. Tr. Testimony of Dr. David Moore, pp. 14-15.

19. The proposed residential treatment facility will be staffed 24-hours a day in a structured environment so that patients will get the kind of continuous support they need in a program that offers more concentrated services than are currently available. Tr. Testimony of David Palmer, pp. 19-20.

20. The Applicant will provide the following services at the proposed residential treatment facility: budgeting group, exercise group, art therapy, music therapy, vocational job hunting group, current events group, yoga group, and transportation to church, Narcotics Anonymous and Alcoholics Anonymous, if necessary. Ex. A, p. 11.

21. There are two other residential treatment facilities in Region 5, both located in Waterbury -- Central Naugatuck Valley Help, Inc. and St. Vincent DePaul Mission of Waterbury, both approximately 30 miles from Danbury. Ex. A, pp. 10-11; Mapquest.

22. The effect of the proposed residential treatment facility on the existing providers will be minimal. According to the Applicant, the services it proposes to offer are more comprehensive than services currently offered at other area facilities. Ex. A, p. 11.

23. The Applicant is projecting the following total admissions for FYs 2013, 2014, 2015:

Table 1: Projected Total Admissions for FYs 2013, 2014, 2015

Mental Health Residential Living Center	FY 2013	FY 2014	FY 2015
Total Beds	6	6	6
Total Bed Days	2190	2190	2190
Projected Occupancy	83%	100%	100%
Projected Bed Days	1817.7	2190	2190
Projected Total Admissions	60.59	73	73

Ex. A, p. 118.

24. The Applicant projects the following payments: $500/day per bed for FY 2013, $550/day per bed for FY 2014 and $600/day per bed for FY 2015. Ex. A, pp. 150-152.

25. The Applicant projects the following operating revenue, expenses and earnings for the proposed residential facility:

Table 2: Residential Treatment Facility Financial Projections by Fiscal Year*

	FY 2013**	FY 2014***	FY 2015****
Total Revenue from Operations	$908,850	$1,204,500	$1,314,000
Total Expenses from Operations	$578,000	$615,000	$640,500
Earnings before Taxes	$330,850	$589,500	$673,500

* Based on fiscal year ending Dec 31.
**Total Revenue from Operations ($500/day x 6 beds x 365 days x 83% = $908,850).
*** Total Revenue from Operations ($550/day x 6 beds x 365 days x 100% = $1,204,500).
**** Total Revenue from Operations ($600/day x 6 beds x 365 days x 100% = $1,314,000).
Ex. A, pp. 150-152.

26. The total capital cost for the proposal is $160,000 and will be financed by David Palmer and Joe Santoro, who are the current owners of the Blue Sky Clinic. Ex. A, pp. 13, 135

27. The proposed residential treatment facility will have a patient population mix of 25% private pay and 75% commercial insurance. The Applicant based this patient mix on the experience at the Blue Sky Clinic. Ex. C, p. 201.

28. The Applicant assumes that since it is only accepting private pay and commercial insurance, it would not take funding away from other providers who are not-for-profit, since they are not serving the same population. Ex. C., p. 184.

29. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any policies and standards not yet adopted as regulations by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

30. This CON application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2).

31. The Applicant has established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).

32. The Applicant has satisfactorily demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).

33. The Applicant has satisfactorily demonstrated that its proposal would improve the accessibility of health care delivery in the region and it has satisfactorily demonstrated a potential improvement in quality through an expanded continuum of care. (Conn. Gen. Stat. § 19a-639(a)(5)).

34. The Applicant has shown that there would be no change to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6)).

35. The Applicant has satisfactorily identified the population to be served by this proposal and has satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7)).

36. The historical utilization in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).

37. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing behavioral health services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services, 288 Conn. 790 (2008).*

Blue Sky Behavioral Health, LLC is proposing the establishment of a 6 bed Mental Health Residential Living Center at 124 Franklin Street in Danbury, Connecticut. *FF1.* The Applicant currently operates a day treatment facility, Blue Sky Behavioral Health Clinic ("Blue Sky Clinic"), in Danbury. *FF3.* The Applicant is proposing the provision of residential behavioral health services to adults between the ages of 18 and 64 who are not admitted to a hospital but are in need of more structured, concentrated behavioral health services than are currently offered at existing programs in the area. *FF 19&20.*

The Applicant will locate the residential treatment facility in Danbury, in part, to unify and coordinate mental health and substance abuse counseling and treatment offered at the existing Blue Sky Clinic in Danbury for the residents of its proposed residential treatment facility. In turn, the proposed residential treatment facility will also provide continuity of care for individuals being treated at the Blue Sky Clinic. *FF 5&6.*

The majority of referrals to the proposed residential treatment facility will originate from the Danbury area. The Blue Sky Clinic currently has relationships with other health care providers in the area, including Danbury and New Milford Hospitals, and has received referrals from Mountainside Treatment Center, High Watch Recovery Center and Silver Hill Hospital. *FF 13.* The Applicant will build upon these relationships and expects to receive residential treatment referrals from these providers. *FF 14.* In addition, the Applicant also expects to receive referrals from Western Connecticut State University, since recent studies indicate an increased incidence of mental health and substance abuse issues among college students. *FF 15-17.*

The proposed residential treatment facility will be staffed 24-hours a day and will offer the traditional treatments for its behavioral health clients such as budgeting group, exercise group, art therapy, music therapy, vocational job hunting group, current events group, yoga group, and transportation to church Narcotics Anonymous and Alcoholics Anonymous, if necessary. *FF 20&21.* The closest providers of similar services are located in Waterbury and are approximately 30 miles from the proposed location. *FF 22.* Since there are no providers in the Danbury area offering a similar level of services, the effect of the proposed residential treatment facility on existing providers will be minimal. *FF 23.*

The total capital cost associated with the proposal is $160,000, which will be funded by the current owners of the Blue Sky Clinic. *FF 27.* The Applicant projects that the proposed residential treatment facility will realize net operating gains in each of the first three years of operations. *FF 28.* All proposed clients will either have private insurance or will self-pay, mirroring that of the Blue Sky Clinic. *FF 28&29.*

The addition of a residential treatment component to the overall Blue Sky Clinic service line will allow for a continuum of care for the target population. Therefore, OHCA finds that the Applicant has satisfactorily demonstrated clear public need for this service and that its proposal will improve the quality and accessibility of health care delivery in the Danbury area by offering an additional level of supportive, continuous residential service not currently available.

The Applicant's volumes, and the financial projections upon which the operating gains are based, appear to be reasonable. Therefore, OHCA finds that this proposal is financially feasible.

ORDER

Based upon the foregoing Findings of Fact and Discussion, the Certificate of Need application of Blue Sky Behavioral Health, LLC for the establishment of a 6 bed Mental Health Residential Living Center at 124 Franklin Street in Danbury, Connecticut, with an associated capital cost of $160,000, is hereby **APPROVED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

8/1/2013
Date

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

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*** TX REPORT ***
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