.\_...,IA\\

ct><D•

{')JJ;

-/

o,pue1···

Massachusetts Department **of** Public Health

**Determination of Need** Affidavit **of Truthfulness and** Compliance **with Law and Disclosure Form 100.40S(B)**

Version: 7-6-17

September 28, 2021'

Application Number: *ACA-21092808--CL*

I

Original Application Date: t. *JP.iJt:crnm r* P'il, *tllH*

**Instructions:** Complete Information below. When complete check the box ''This document is ready to print:". This will date stamp and

lock the form. Print Form. Each person must sign and date the form. When all signatures have been collected, scan the document and e-mail to: **dph.don@state.ma.us**Include all attachments as requested.

Applicant Name: [Ascentria Care Alliance, Inc. (Laurel Ridge Rehabilitation and Skilled Care Center)

Application Type: conservation Long Term Care Project

Applicant's Business Type: Ci Corporation *('* Limited Partnership *('* Partnership *('* Trust *('* LLC *('* Other

Is the Applicant the sole member or sole shareholder of the Health Facility(ies) that are the subject of this Application? (i Yes *('* No

The undersigned certifies under the pains and penalties of perjury:

1. The Applicant is the sole corporate member or sole shareholder of the Health Facility[ies] that are the subject of this Application;
2. I have- 105 CMR 100.000, the Massachusetts Determination of Need Regulation;
3. I understand and agree to the expected and appropriate conduct of the Applicant pursuant to 105 CMR 100.800;
4. I have- this application for Determination of Need including all exhibits and attachments, and ~~certify that~~\* all of the information contained herein is accurate and true;
5. I have submitted the correct Filing Fee and understand it is nonrefundable pursuant to 105 CMR 100.405(8);
6. I have submitted the required copies of this application to the Determination of Need Program, and, as applicable, to all Parties of Record and other parties as required pursuant to 105 CMR 100.405(8);
7. I have caused, as required, notices of intent to be published and duplicate copies to be submitted to all Parties of Record, and all carriers or third-party administrators, public and commercial, for the payment of health care services with which the Applicant contracts, and with Medicare and Medicaid, as required by 105 CMR 100.405(C), et seq.;
8. I ~~have caused~~ \*\*proper notification and submissions to the Secretary of Environmental Affairs pursuant to 105 CMR

100.405(E) and 301 CMR 11.00; will be made if applicable.

1. If subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00, I have submitted such Notice of Material Change to the HPC - in accordance with 105 CMR 100.405(G);
2. Pursuant to 105 CMR 100.210(A)(3), I certify that both the Applicant and the Proposed Project are in material and substantial compliance and good standing with relevant federal, state, and local laws and regulations, as well as with all ~~previously issued~~ Notices of Determination of Need ~~and the terms andconditions attached therein~~\*\*\*·
3. I have- and understand the limitations on solicitation of funding from the general public prior to receiving a Notice of Determination of Need as established in 105 CMR 100.415;
4. I understand that, if Approved, the Applicant, as Holder of the DoN, shall become obligated to all Standard Conditions . pursuant to 105 CMR 100.310, as well as any aoolicable 0th .., Cnn,fainnc ,. N ,,,. ,.,.....L,\_ •*nr r•*·- •-- ---

**Laurel Ridge Rehabilitation** & **Skilled Care Center**

174 Forest Hills Street Jamaica Plain, MA 02130

..,.

\_,,,.

'.'"Berkshire Bank

53oslr / 21

'e

3804

Pay to the Order Of

$25,479.80

Twenty Five Thousand Four Hundred Seventy Nine Dollars and 80 Cents

DOLLARS

COMMONWEALTH OF MASSACHUSETTS POST OFFICE BOX 3538

BOSTON, MA 02241-3538

/? ,,.,.;s,"f."•.,...

<signature on file>

MEMO *DON*

'(it OF

-¥' ....,

**(f** 11

0 **r...1,.1,,,&** \.\

1

## Massachusetts Department of Public Health Determination of Need

Version: 7-6-17

## I i Affidavit of Truthfulness and Compliance

.... *i'*

OFI'

**with Law and Disclosure Form 1oo.40S(B)**

**Instructions:** Complete Information below. When complete check the box ''This document is ready to print:". This will date stamp and lock the form. Print Form. Each person must sign and date the form. When all signatures have been collected, scan the document and e-mail to: **dph.don@state.ma.us**Include all attachments as requested.

Application Number: ACA-21092808-CL

Original Application Date: *t,Je,,rrurw-1, Q'l> tUHJ*

***y***

;

Applicant Name: Ascentria Care Alliance, Inc.(Laurel Ridge Rehabilitation and Skilled Care Center)

Application Type: conservation Long Term Care Project

Applicant's Business Type: **Ci** Corporation ***r*** Limited Partnership ***r*** Partnership ***r*** Trust rLLC rother

Is the Applicant the sole member or sole shareholder of the Health Facility(ies) that are the subject of this Application? **Ci** Yes ***r*** No

!

|  |
| --- |
| The undersigned certifies under the pains and penalties of perjury:* 1. The Applicant is the sole corporate member or sole shareholder of the Health Facility[ies] that are the subject of this Application;

:2. I have105 CMR 100.000, the Massachusetts Determination of Need Regulation;1. I understand and agree to the expected and appropriate conduct of the Applicant pursuant to 105 CMR 100.800;
2. I have wdthis application for Determination of Need including all exhibits and attachments, anci **cecrii},\*rbar**all of the

1information contained herein is accurate and true;1. I have submitted the correct Filing Fee and understand it is nonrefundable pursuant to 105 CMR 100.405(8);
2. I have submitted the required copies of this application to the Determination of Need Program, and, as applicable, to all Parties of Record and other parties as required pursuant to 105 CMR 100.405(8);
3. I have caused, as required, notices of intent to be published and duplicate copies to be submitted to all Parties of Record, and all carriers or third-party administrators, public and commercial, for the payment of health care services with which the Applicant contracts, and with Medicare and Medicaid, as required by 105 CMR 100.405((), et seq.;
4. I **~~have caused~~ \*\***proper notification and submissions to the Secretary of Environmental Affairs pursuant to 105 CMR

100.405(E) and 301 CMR 11.00; will be made if applicable.1. If subject to M.G.L.c. 6D, § 13 and 958 CMR 7.00, I have submitted such Notice of Material Change to the HPC - in accordance with 105 CMR 100.405(G);
2. Pursuant to 105 CMR 100.210(A)(3), I certify that both the Applicant and the Proposed Project are in material and substantial compliance and good standing with relevant federal, state, and local laws and regulations, as well as with all

**~~Previously issued~~** Notices of Determination of Need ~~and the terms and Conditions attached therein~~; \*\*\*:1. I have'8adand understand the limitations on solicitation of funding from the general public prior to receiving a Notice of Determination of Need as established in 105 CMR 100.415;
2. I understand that, if Approved, the Applicant, as Holder of the DoN, shall become obligated to all Standard Conditions pursuant to 105 CMR 100.310, as well as any applicable Other Conditions as outlined within 105 CMR 100.000 or that otherwise become a part of the Final Action pursuant to 105 CMR 100.360;
3. Pursuant to 105 CMR 100.705(A), I certify that the Applicant has Sufficient Interest in the Site or facility; and
4. Pursuant to 105 CMR 100.705(A), I certify that the Proposed Project is authorized under applicable zoning by-laws or ordinances, whether or not a special permit is required; or,
	1. If the Proposed Project is not authorized under applicable zoning by-laws or ordinances, a variance has been received to permit such Proposed Project; or,
	2. The Proposed Project is exempt from zoning by-laws or ordinances.
 |
| **Corporation:**Attach a copy of Articles of Organization/Incorporation, as amendedAngela Bovill *9/28/21* |
| CEO for Corporation Name:William MayoBoard Chair for Corporation Name: | Date/ <signature on file> *9/28/21*Signature:<signature on file> Date *1* |

·

* been infonned of the contents of

\*\* have been infonned that

••• issued in compliance with IOS CMR I00.000, the Massachusetts Detennination of Need regulation effective January 27, 2017 and amo:nded December 28, 20I8

**.4ffiti::n,it nf Tr, ,thf1 ,lnacc Acrontri, *r:uo* 411i::anro lnr /I ::um:.t Ririna Rah:1hil** 07/ nnnn **- q nm D::,no** 1 nf')

**BARRETT, HARRELL & FERRER LLC**

Via Email - Read Receipt Requested and Overnight UPS - Signature Requested September 29, 2021

Via E-Mail

Lara Szent-Gyorgyi, Director Determination of Need Program Department of Public Health 250 Washington Street

Boston, MA 02108

,,,-,

*II*

**RE: Ascentria Care Alliance, Inc. - Lutheran Home of Jamaica Plain, Inc. d/b/a Laurel Ridge Rehabilitation and Skilled Care Center Determination of Need Application# ACA-21092808- CL**

Dear Ms. Szent-Gyorgyi:

We write to provide you with additional documentation for the above-captioned Determination of Need ("DoN") Application submitted to your office electronically on September 28, 2021. Please find enclosed the original Affidavit of Truthfulness (Exhibit 1) and the filing fee (Exhibit 2) for the Ascentria Care Alliance, Inc. - Lutheran Home of Jamaica Plain, Inc. d/b/a Laurel Ridge Rehabilitation and Skilled Care Center DoN Application# ACA-21092808-CL.

We thank you for your assistance with this matter. Please do not hesitate to contact Amanda Beauregard, Esq. or me if you have any questions or require additional information.



Enclosure

cc: R. Rodman, Esq. dph.don@state.ma.us

EXHIBIT I

**Laurel Ridge Rehabilitation & Skilled Care Center Jamaica Plain, MAD2130**

# 3804

COMMON

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Invoice Number | Invoice Date | Description | Gross Amount | Discount Taken | Net Amount Paid |
| DON | 09/24/2021 | DON1-0: ¼,of-M€E)-·- | ·$2&,4T9,80 | $0.00 | $25,479.80 |
|  | $25,479.80 | $0.00 | $25,479.80 |

COMMONWEALTH OF MASSACHUSETTS 09/21/2021 3804

Laurel Ridge Rehabilitation & Skilled Care Center Jamaica Plain, MA02130

# 3804

COMMON

COMMONWEALTH OF MASSACHUSETTS 09/21/2021 3804

---· -,.--- -•-.--,--------

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Invoice Number | Invoice Date | Description | Gross Amount | Discount Taken | Net Amount Paid |
| DON | 09/24/2021 | DON (0.2% of MCE) | $25,479.80 | $0.00 | $25,479.80 |
|  | $25,479.80 | $0.00 | $25,479.80 |

EXHIBIT 2