**Massachusetts Department of Public Health Determination of Need**

**Affidavit of Truthfulness and Compliance**

**with Law and Disclosure Form 100.405(8)**

Version: 7-6-17

Application Number: ACA-21092816-CLOriginal Application Date: September 28, 2021

**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**](mailto:dph.don@state.ma.us)Include all attachments as requested.

, . '

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

- -

Application Type: conservation Long\_ Term Care Project

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

Is the Applicant th&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 ~~read\*~~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 CM J00.800;
4. I have ~~read~~ \* this application for Determination of Need including all exhibits and attachments, and ~~certify that~~\* all of the

information 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(6);
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(6);

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(0, et seq.;

1. 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);

10. 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 ~~read~~\* 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;

1. I understand that, if Approved, the Applicant, as Holder of the DoN, shall become obligated to all Standard Conditions pursuant to 105 CMR 100.3 l0, as well as any applicable Other Conditions as outlined within 105 CMR 100.000 or that

THE KEY TO DOCUMENT SECURITY • HEAT ACTIVATED THUMB PRINT • ADDITIONAL SECURITY FEATURES INCLUDED • SEE BACK FOR DETAILS

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**Fair Havens, Inc.**

**dba Quaboag Rehabilitation and Skilled Care Center**

47 East Main Street

Berkshire **Bank**

53-7169/21'18

West Brookfield, MA 01585 -----

16629

- Twelve Thousand Two Hundred Twenty Three Dollars and 11 Cents

DATE

AMOUNT

$12,223.11 -

,Y TO THE ORDER

OF

COMMONWEAL TH OF MASSACHUSETTS POST OFFICE BOX 3538

BOSTON, MA 02241-3538

09/21/2021

*DON*

<signature on file>

**Massachusetts Department of Public Health Determination of Need**

**Affidavit of Truthfulness and Compliance**

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

Version: 7-6-17

**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**](mailto:dph.don@state.ma.us)Include all attachments as requested.

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

Application Type: conservation Long Term Care Project

Applicant's Business Type: **(i'** 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 have105 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 CMe) 00.800;
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.;

\*\* .

1. I **~~have caused~~\*\*** proper notification and submissions to the Secretary of Environmental Affairs pursuant to 105 CMR 100.405(E) and301 CMR 11.00; will be made if applicable.
2. 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);
3. 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 therein~~\*\*\*;
4. I have ~~read~~\* 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;

1. 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;
2. Pursuant to 105 CMR 100.705(A), I certify that the Applicant has Sufficient Interest in the Site or facility; and
3. 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 amended /

Angela **Bovill**

f;:;--:-------r----:: r------:---------

CEO for Corporation Name: Signature: <signature on file>

William Mayo <signature on file>

Board Chair for Corporation Name:

\* been informed oftbe contents of

•• have been informed that

9/28/21

Date

Date 9/28/21

\*\*\* issued in compliance with I05 CMR I00.000. the Massachusetts Determination of Need regulation effoctive January 27, 2017 und amended December 28, 2018

n ....,.,., , \_, ""t

**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

**RE: Ascentria Care Alliance, Inc. - Fair Havens, Inc. d/b/a Quaboag Rehabilitation and Skilled Care Center Determination of Need Application# ACA- 21092816-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. - Fair Havens, Inc. d/b/a Quaboag Rehabilitation and Skilled Care Center DoN Application # ACA- 21092816-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.

Sincerely,

<signature on file>

Kathleen Harell, Esq.

Enclosure

cc: R. Rodman, Esq. [dph.don@state.ma.us](mailto:dph.don@state.ma.us)

EXHIBIT 1

COMMON

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Invoice Number | Invoice Date | Description | Gross Amount | Discount Taken | Net Amount Paid |
| DON - Quaboag | 09/24/2021 | DON (0.2% of MCE) - ,--··•--r-·---,--.------,.--- -- """•·--•-~- ,, .---•-- | $12,223.11------ | $0.00 | $12,223.11 |
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EXHIBIT 2