CAPE COD HOSPITAL

**DON APPLICATION # CCHC-23122109-AM TABLE OF CONTENTS**

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## APPENDIX 4

### ORIGINAL DoN NOTICE OF APPROVAL

 The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619

CHARLES D. BAKER

Governor

KARYN E. POLITO

Lieutenant Governor

MARYLOU SUDDERS

Secretary

MARGRET R. COOKE

Commissioner

**Tel: 617-624-6000**

[**www.mass.gov/dph**](http://www.mass.gov/dph)

July 22, 2022

Crystal Bloom, Partner Husch Blackwell LLP

One Beacon Street, Suite 1320 Boston, MA 02108-3106

VIA electronic mail [Crystal.Bloom@huschblackwell.com](mailto:Crystal.Bloom@huschblackwell.com)

RE: Notice of Final Action DON Application # CCHC-22021416-HE Dear Attorney Bloom,

At their meeting of July 13, 2022, the Commissioner and the Public Health Council, acting together as the Department, voted pursuant to M.G.L. c.111, §25(c) and the regulations adopted thereunder, to approve the Determination of Need application filed by Cape Cod Healthcare, Inc. (Applicant) located at 27 Park Street, Hyannis, MA 02601 for a Substantial Capital Expenditure to construct a new facility that will consist of the following: (1) relocated and expanded medical

oncology department; (2) relocated radiation oncology department; (3) relocated medical/surgical unit consisting of 32 beds; and (4) shell space for future projects. This Notice of Final Action incorporates by reference the Staff Report, and the Public Health Council proceedings concerning this application, all of which are incorporated herein by reference.

This Determination of Need Application was reviewed pursuant to M.G.L. c. 111, § 25(c), and the regulatory provisions of 105 CMR 100.000 et seq. Based upon a review of the materials, the Department found that the Applicant has met each DoN factor with conditions and approves this Determination of Need application for a substantial capital expenditure for the Proposed Project of

$137,048,632.00. The total required Community Health Initiative (CHI) contribution is

$6,852,431.60.

In compliance with the provisions of 105 CMR 100.310 A (2) and (11) the Holder shall submit an acknowledgment of receipt to the Department (attached) and include a written attestation of participation or intent to participate in MassHealth.

In compliance with 105 CMR 100.310(A)(12), which requires a report to the Department, at a minimum on an annual basis, including the measures related to achievement of the DoN factors for a period of five years from completion of the Proposed Project, the Holder shall address its assertions with respect to all the factors.

Other Conditions to the DoN Condition 1 – CHI Contribution

1. Of the total required CHI contribution of $6,852,431.60
   1. $1,678,845.74 will be directed to the CHI Statewide Initiative
   2. $5,036,537.23 will be dedicated to local approaches to the DoN Health Priorities
   3. $137,048.63 will be designated as the administrative fee.
2. To comply with the Holder’s obligation to contribute to the Statewide CHI Initiative, the Holder must submit a check for $1,678,845.74 to Health Resources in Action (the fiscal agent for the CHI Statewide Initiative).
3. The Holder must submit the funds to HRiA within 30 days from the date of the Notice of Approval.
4. The Holder must promptly notify DPH (CHI contact staff) when the payment has been made.

Payment should be sent to:

Health Resources in Action, Inc., (HRiA) 2 Boylston Street, 4th Floor

Boston, MA 02116 Attn: Ms. Bora Toro

**Condition 2** – The Holder shall provide, in its annual report to the Department, the following outcome measures. These metrics will become part of the annual reporting on the approved DoN, required pursuant to 105 CMR 100.310(A)(12). Reporting will include a description of numerators and denominators.

OUTPATIENT MEDICAL ONCOLOGY QUALITY MEASURES

1. Patient Satisfaction: Patients that are satisfied with their care are more likely to seek additional treatment when necessary. CCH staff will review patient satisfaction scores from the Hospital Consumer Assessment of Healthcare Providers and Systems related to overall patient

satisfaction

* 1. Measure: Staff will review responses pertaining to registration, wait times, changing room privacy, facility navigation, staff communication, and personal needs. Response options include Very Poor, Poor, Fair, Good, and Very Good.

*Numerator:* # of responses with highest score; *Denominator:* Total # of responses

* 1. Baseline: 69.78% of patients responded with the highest score (“Top Box Score”)
  2. Projections: Year 1: 71%; Year 2: 73%; Year 3: 74%
  3. Monitoring: Results will be reviewed annually by oncology leadership.

1. Hospital Readmissions: This measure will monitor the rate of patients who receive non-routine inpatient care at the Hospital within 30 days of chemotherapy.
   1. Measure: The percent of Medical Oncology patients who are admitted within 30 days of receiving chemotherapy (number of patients admitted/number of chemotherapy patients within last 30 days). This is a rolling measure.

*Numerator:* # of patient admitted within 30 days of receiving chemotherapy; *Denominator:* # of patient receiving chemotherapy

* 1. Baseline: 5.6%
  2. Projections: Year 1: ≤5.0%; Year 2: ≤4.5%; Year 3: ≤3.9%
  3. Monitoring: Results will be reviewed annually by oncology leadership.

RADIATION ONCOLOGY QUALITY MEASURES

1. Patient Satisfaction: Patients that are satisfied with their care are more likely to seek additional treatment when necessary. CCH staff will review patient satisfaction scores from the Hospital Consumer Assessment of Healthcare Providers and Systems related to overall patient

satisfaction

* 1. Measure: Staff will review responses pertaining to registration, wait times, changing room privacy, facility navigation, staff communication, and personal needs. Response options include Very Poor, Poor, Fair, Good, and Very Good.

*Numerator:* # of responses with highest score; *Denominator:* Total # of responses

* 1. Baseline: 81.12% of patients responded with the highest score (“Top Box Score”)
  2. Projections: Year 1: ≥82%; Year 2: ≥83.5%; Year 3: ≥85%
  3. Monitoring: Results will be reviewed annually by oncology leadership.

INPATIENT CARDIAC MEDICAL-SURGICAL QUALITY MEASURES[[1]](#footnote-1)

1. Patient Satisfaction: Patients that are satisfied with their care are more likely to seek additional treatment when necessary. CCH staff will review patient satisfaction scores from the Hospital Consumer Assessment of Healthcare Providers and Systems specific to the hospital

environment.

* 1. Measure: Staff will review responses to “During this hospital stay, how often was the area around your room kept quiet at night?”. Response options include: Never, Sometimes, Usually, and Always

*Numerator:* # of responses with highest score; *Denominator:* Total # of responses

* 1. Baseline: 60% of patients responded with the highest score (“Top Box Score”).
  2. Projections: Year 1: 62%; Year 2: 64%; Year 3: 65%
  3. Monitoring: Scores are reviewed quarterly.

1. Fall Prevention: This measure will monitor the rate of patient falls resulting in injury.
   1. Measure: The number of patient falls with injury per 1000 acute patient days.

*Numerator:* # of patient falls with injury; *Denominator:* patient days/1000

* 1. Baseline: 0.29
  2. Projections: Year 1: 0; Year 2: 0; Year 3: 0
  3. Monitoring: The Department of Nursing will review falls data on a monthly basis.

1. Hospital Readmissions: This measure will monitor the rate of patients who are re-admitted to the Hospital within 30 days of discharge.
   1. Measure: The number of re-admissions/the number of discharges within a 30-day period. This is a rolling measure.

*Numerator:* # of patient admitted within 30 days; *Denominator:* # of patient discharges

* 1. Baseline: 0.7754
  2. Projections: Year 1: ≤1; Year 2: ≤1; Year 3: ≤1
  3. Monitoring: Scores are reviewed quarterly.

Ongoing compliance with the conditions and all terms of the DoN is, pursuant to the Regulation, a precondition to the filing of any future DoN by the Holder.

Sincerely,



Elizabeth Kelley

Director, Bureau of Health Care Safety and Quality

cc:

Stephen Davis, Division of Health Care Facility Licensure and Certification Daniel Gent, Division of Health Care Facility Licensure and Certification Rebecca Rodman, General Counsel’s Office

Samuel Louis, Office of Health Equity

Jennica Allen, Division of Community Health Planning and 68Engagement Elizabeth Maffei, Division of Community Health Planning and Engagement Katelyn Teague, Division of Community Health Planning and Engagement Elizabeth Almanzor, Center for Health Information Analysis

Katherine Mills, Health Policy Commission Eric Gold, Attorney General’s Office

Pavel Terpelets, MassHealth

Christopher King, Executive Office of Health and Human Services Tomaso Calicchio, Executive Office of Health and Human Services Hai Nguyen, Executive Office of Health and Human Services Karina Mejias, Executive Office of Health and Human Services Priscilla Portis, Executive Office of Health and Human Services

## APPENDIX 5 NOTICE OF INTENT





**APPENDIX 6 CHANGE IN SERVICE**

 Version DRAFT 6-14-17

**Massachusetts Department of Public Health**

**Determination of Need**

**Change in Service**

Application Number: CCHC-23122109-AM

Original Application Date: 02/02/2024

**Applicant Information:**

Applicant Name: Cape Cod Healthcare, Inc.

Contact Person: Michael Bachstein

Title: Vice President of Facilities

Phone: 5088525225

E-mail: [MBachstein@capecodhealth.org](mailto:MBachstein@capecodhealth.org)

**Facility:**

Complete the tables below for each facility listed in the Application Form

1 Facility Name: Cape Cod Hospital

CMS Number: 220135

Facility Type: Freestanding Ambulatory Surgery capacity

**Change in Service:**

2.2 Complete the chart below with existing and planned service changes. Add additional services within each grouping if applicable.

| **Add/ Del Rows** |  | **Licensed Beds** | **Operating Beds** | **Change in Number of Beds (+/-)** | | **Number of Beds After Project Completion (calculated)** | | **Patient Days** | **Patient Days** | **Occupancy Rate for Operating Beds** | | **Average Length of Stay** | **Number of Discharges** | **Number of Discharges** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Existing | Existing | Licensed | Operating | Licensed | Operating | (Current/ Actual) | Projected | Current Beds | Projected | (Days) | Actual | Projected |
|  | **Acute** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Medical/ Surgical | 197 | 197 | 32 | 32 | 229 | 229 | 70,078 | 72,163 | 97% | 86% | 4.7 | 16,960 | 17,255 |
|  | Obstetrics (Maternity) |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Pediatrics |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Neonatal Intensive Care |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | ICU/CCU/SICU |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Acute | 197 | 197 | 32 | 32 | 229 | 229 | 70,078 | 72,163 | 97% | 86% | 4.7 | 16,960 | 17,255 |
|  | **Acute Rehabilitation** |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Rehabilitation |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | **Acute Psychiatric** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Adult |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Adolescent |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Pediatric |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Geriatric |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Total Acute Psychiatric |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | **Chronic Disease** |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Chronic Disease |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | **Substance Abuse** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Detoxification |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Short-term intensive |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Substance Abuse |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | **Skilled Nursing Facility** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Level II |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Level III |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Level IV |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Skilled Nursing |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |

Complete the chart below If there are changes other than those listed in table above.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Add/Del Rows** | **List other services if Changing e.g. OR, MRI, etc** | **Existing Number of Units** | **Change in Number +/-** | **Proposed Number of Units** | **Existing Volume** | **Proposed Volume** |
| +/- |  |  |  |  |  |  |

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Edit document then lock file and submit. Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the "E-mail submission to Determination of Need" button.

This document is ready to file? Yes

Date/Time Stamp: 02/01/2024 12:38 pm

Email Submission to Determination of Need

## APPENDIX 7 AFFILIATED PARTIES

 draft version 3-15-2017

**Massachusetts Department of Public Health**

**Determination of Need**

**Affiliated Parties**

Application Date: 02/02/2024

Application Number: CCHC-23122109-AM

**Applicant Information**

Applicant Name: Cape Cod Healthcare, Inc.

Contact Person: Michael Bachstein

Title: Vice President of Facilities

Phone: 5088625225

E-mail: [MBachstein@capecodhealth.org](mailto:MBachstein@capecodhealth.org)

**Affiliated Parties**

1.9 Affiliated Parties: List all officers, members of the board of directors, trustees, stockholders, partners, and other Persons who have an equity or otherwise controlling interest in the application.

| **Add/ Del Rows** | **Name (Last)** | **Name (First)** | **Mailing Address** | **City** | **State** | **Affiliation** | **Position with affiliated entity (or with Applicant)** | **Stock, shares, or partnership** | **Percent Equity (numbers only)** | **Convictions or violations** | **List other health care facilities affiliated with** | **Business relationship with Applicant** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| +/- | Lauf | MIchael | 2 Meadow Spring Drive E. | Sandwich | MA | Cape Cod Healthcare, Inc. | President and CEO, CCHC  CEO, Cape Cod Hospital |  |  | No | Cape Cod Hospital | Yes |
| +/- | Johnston | Alastari Bruce | 2141 Oyster Harbors | Osterville | MA | Cape Cod Healthcare, Inc. | Chairman |  |  | No |  | No |
| +/- | Devereaux | Robin | 15 Peace Pipe Road | Falmouth | MA | Cape Cod Healthcare, Inc. | Vice Chair |  |  | No |  | No |
| +/- | Ayer | Ramani | 22 Horseshoe Lane, North | South Orleans | MA | Cape Cod Healthcare, Inc. | Treasurer |  |  | No |  | No |
| +/- | Talerman | Robert A. | 34 Wild Goose Way | Centerville | MA | Cape Cod Healthcare, Inc. | Clerk |  |  | No |  | No |
| +/- | Jones | Michael G. | 65 Shady Lane | Hatchville | MA | Cape Cod Healthcare, Inc. | Co-Clerk |  |  | No |  | Yes |
| +/- | Adduci, M.D. | Alexander | 46 Greenwood Street | Sherborn | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No | Cape Cod Hospital | Yes |
| +/- | Capodilupo | Lawrence | 77 Geranium Drive | Chatham | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No |  | No |
| +/- | Gergyes, M.D. | Joseph | 104 Old Kings Road | Cotuit | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No | Falmouth Hospital | Yes |
| +/- | Tilton Gibson | Linda | 2139 Oyster Harbors | Osterville | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No |  | No |
| +/- | Hostetter, M.D. | John | 30 Marvin Circle | Falmouth | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No | Falmouth Hospital | Yes |
| +/- | Kennedy | Sharon | 40 Fort Hill Road East | Sandwich | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No |  | No |
| +/- | Mulchay, Jr. | Edward James | 2037 Oyster Harbors | Osterville | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No |  | No |
| +/- | Rudman, M.D. | Nathan T. | 48 Waterman Farm Road | Centerville | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No | Cape Cod Hospital | Yes |
| +/- | Vilsaint, M.D. | Kevin | 103 Pine Tree Drive | Centerville | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No | Cape Cod Hospital | Yes |
| +/- | Wilsterman M.D | Robert | 83 Cumloden Drive | Falmouth | MA | Cape Cod Healthcare, Inc. | Trustee |  |  | No | Falmouth Hospital | Yes |
| +/- |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

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Edit document then lock file and submit Keep a copy for your records. Click on the "Save" button at the bottom of the page. To submit the application electronically, click on the "E-mail submission to Determination of Need" button.

This document is ready to file? Yes

Date/time Stamp: 02/01/2024 10:16 am

E-mail submission to Determination of Need

## APPENDIX 8 ARTICLES OF ORGANIZATION

[https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Pat](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2014/0122/000532784/0374/000222600704_1.pdf) [h=CORP\_DRIVE1/2014/0122/000532784/0374/000222600704\_1.pdf](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2014/0122/000532784/0374/000222600704_1.pdf)

[https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Pat](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2013/1011/000486337/0084/020502697936_1.pdf) [h=CORP\_DRIVE1/2013/1011/000486337/0084/020502697936\_1.pdf](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2013/1011/000486337/0084/020502697936_1.pdf)

[https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Pat](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2011/0804/000355238/0005/020503446952_1.pdf) [h=CORP\_DRIVE1/2011/0804/000355238/0005/020503446952\_1.pdf](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2011/0804/000355238/0005/020503446952_1.pdf)

## APPENDIX 9 AFFIDAVIT

 Version: 7-6-17

**Massachusetts Department of Public Health**

**Determination of Need**

**Affidavit of Truthfulness and Compliance**

**with Law and Disclosure Form 100.405 (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**](mailto:dph.don@state.ma.us)Include all attachments as requested.

Application Number: CCHC-23122109-AM

Original Application Date: 2/2/2024

Applicant Name: Cape Cod Healthcare, Inc.

Application Type: Hospital/Clinic Substantial Capital Expenditure

Applicant's Business Type: Corporation

Is the Applicant the sole member or sole shareholder of the Health Facility(ies) that are the subject of this Application? Yes

Describe the role /relationship: Owner

|  |
| --- |
| 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~~ [been informed of the contents of] 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 ~~read~~ [been informed of the contents of] this application for Determination of Need including all exhibits and attachments, and ~~certify that~~ [have been informed 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(B); 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(B); 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~~ [have been informed that] 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. 9. 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~~ [issued in compliance with 105 CMR 100.00, the Massachusetts Determination of Need Regulation effective January 27, 2017 and amended December 28, 2018]; 11. I have ~~read~~ [been informed of the contents of] 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; 12. 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; 13. Pursuant to 105 CMR 100.705(A), I certify that the Applicant has Sufficient Interest in the Site or facility; and 14. 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  Michael K. Laui  CEO for Corporation Name: Signature: Date: 1-25-24  A. Bruce Johnston<Signature on File> 1-25-24  Board Chair for Corporation Name: Signature: Date |

**This document is ready to print:** unchecked **Date/Time stamp:** [blank]

1. These projections are limited to the care to be provided in the proposed cardiac medical-surgical inpatient unit. [↑](#footnote-ref-1)