

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,



Kathleen Harrell, Esq.

Enclosure

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

EXHIBIT 1



Massachusetts Department of Public Health

Determination of Need

Affidavit of Truthfulness and Compliance

with Law and Disclosure Form 100.405(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 Include all attachments as requested.

Application Number: ACA-21092816-CL Original Application Date: September 28, 2021

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

Application Type: Conservation Long Term Care Project

Applicant's Business Type: ☒ 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? ☒ 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 CMR 100.800;
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;
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~~^{**} 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;
11. 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;
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,
 - a. 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,
 - b. The Proposed Project is exempt from zoning by-laws or ordinances.

Corporation:

Attach a copy of Articles of Organization/Incorporation, as amended

Angela Bovill

CEO for Corporation Name:

Signature: [Signature]

Date: 9/28/21

William Mayo

Board Chair for Corporation Name:

Signature: [Signature]

Date: 28 Sep 21

* been informed of the contents of

** have been informed that

*** issued in compliance with 105 CMR 100.000, the Massachusetts Determination of Need regulation effective January 27, 2017 and amended December 28, 2018

EXHIBIT 2

COMMONWEALTH OF MASSACHUSETTS

09/21/2021

16629

[illegible]

COMMON

COMMONWEALTH OF MASSACHUSETTS

09/21/2021

16629

[illegible]

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

Fair Havens, Inc.
dba Quaboag Rehabilitation and Skilled Care Center
47 East Main Street
West Brookfield, MA 01585

Berkshire Bank
53-7169/2118

16629

Twelve Thousand Two Hundred Twenty Three Dollars and 11 Cents

DATE _____

AMOUNT

\$12,223.11

PAY
TO THE
ORDER
OF

COMMONWEALTH OF MASSACHUSETTS
POST OFFICE BOX 3538
BOSTON, MA 02241-3538

09/21/2021

Nicholas Russo

