

**APPLICATION FOR DETERMINATION OF NEED**

**EMERGENCY APPLICATION**

**STURDY HEALTH FOUNDATION, INC.**

**DON APPLICATION # -24110416-EA**

**Submitted by**

**STURDY HEALTH FOUNDATION, INC.**

**211 PARK STREET**

**ATTLEBORO, MA 02703**

**NOVEMBER 4, 2024**

**STURDY HEALTH FOUNDATION, INC.**  
**DON APPLICATION # -24110416-EA**

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## **APPENDIX 1**

### **APPLICATION FORM**



# Massachusetts Department of Public Health

## Determination of Need

### Application Form

Version: 11-8-17

Application Type:  Application Date: 11/04/2024 4:35 pm

Applicant Name:

Mailing Address:

City:  State:  Zip Code:

Contact Person:  Title:

Mailing Address:

City:  State:  Zip Code:

Phone:  Ext:  E-mail:

### Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name:

Facility Address:

City:  State:  Zip Code:

Facility type:  CMS Number:

### 1. About the Applicant

1.1 Type of organization (of the Applicant):

1.2 Applicant's Business Type: ☒ Corporation ☐ Limited Partnership ☐ Partnership ☐ Trust ☐ LLC ☐ Other

1.3 What is the acronym used by the Applicant's Organization?

1.4 Is Applicant a registered provider organization as the term is used in the HPC/CHIA RPO program? ☒ Yes ☐ No

1.5 Is Applicant or any affiliated entity an HPC-certified ACO? ☒ Yes ☐ No

1.5.a If yes, what is the legal name of that entity?

1.6 Is Applicant or any affiliate thereof subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00 (filing of Notice of Material Change to the Health Policy Commission)? ☐ Yes ☒ No

1.7 Does the Proposed Project also require the filing of a MCN with the HPC? ☐ Yes ☒ No

1.8 Has the Applicant or any subsidiary thereof been notified pursuant to M.G.L. c. 12C, § 16 that it is exceeding the health care cost growth benchmark established under M.G.L. c. 6D, § 9 and is thus, pursuant to M.G.L. c. 6D, §10 required to file a performance improvement plan with CHIA? ☐ Yes ☐ No

1.9 Complete the Affiliated Parties Form

## 2. Project Description

2.1 Provide a brief description of the scope of the project.

See Attached

2.2 and 2.3 Complete the Change in Service Form

## 3. Delegated Review

3.1 Do you assert that this Application is eligible for Delegated Review? ☒ Yes ☐ No

3.1.a If yes, under what section? Emergency Application

## 4. Conservation Project

4.1 Are you submitting this Application as a Conservation Project? ☐ Yes ☒ No

## 5. DoN-Required Services and DoN-Required Equipment

5.1 Is this an application filed pursuant to 105 CMR 100.725: DoN-Required Equipment and DoN-Required Service? ☐ Yes ☒ No

## 6. Transfer of Ownership

6.1 Is this an application filed pursuant to 105 CMR 100.735? ☐ Yes ☒ No

## 7. Ambulatory Surgery

7.1 Is this an application filed pursuant to 105 CMR 100.740(A) for Ambulatory Surgery? ☐ Yes ☒ No

## 8. Transfer of Site

8.1 Is this an application filed pursuant to 105 CMR 100.745? ☐ Yes ☒ No

## 9. Research Exemption

9.1 Is this an application for a Research Exemption? ☐ Yes ☒ No

## 10. Amendment

10.1 Is this an application for a Amendment? ☐ Yes ☒ No

## 11. Emergency Application

11.1 Is this an application filed pursuant to 105 CMR 100.740(B)? ☒ Yes ☐ No

11.2 Is the emergency situation due to a government declaration? ☐ Yes ☒ No

11.3 If No, Please describe the destruction/substantial damage to the Applicant's Health Care Facility and its impact upon public health.

12. Total Value and Filing Fee

Enter all currency in numbers only. No dollar signs or commas. Grayed fields will auto calculate depending upon answers above.

Your project application is for: Emergency Application

|   |        |
|---|--------|
| 12.1 Total Value of this project:   | \$0.00 |
| 12.2 Total CHI commitment expressed in dollars: (calculated)  | \$0.00 |
| 12.3 Filing Fee: (calculated)   | \$0.00 |
| 12.4 Maximum Incremental Operating Expense resulting from the Proposed Project:   |        |
| 12.5 Total proposed Construction costs, specifically related to the Proposed Project, If any, which will be contracted out to local or minority, women, or veteran-owned businesses expressed in estimated total dollars. |        |

### 13. Factors

Required Information and supporting documentation consistent with 105 CMR 100.210

Some Factors will not appear depending upon the type of license you are applying for.

Text fields will expand to fit your response.

## Documentation Check List

The Check List below will assist you in keeping track of additional documentation needed for your application. Once you have completed this Application Form the additional documents needed for your application will be on this list. E-mail the documents as an attachment to: [DPH.DON@state.ma.us](mailto:DPH.DON@state.ma.us)

- ☐ Copy of Notice of Intent
- ☐ Certification from an independent Certified Public Accountant
- ☐ Articles of Organization / Trust Agreement

## Document Ready for Filing

When document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form.

To make changes to the document un-check the "document is ready to file" box. 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:**



Date/time Stamp: 11/04/2024 4:35 pm

E-mail submission to  
Determination of Need

**Application Number: -24110416-EA**

**Use this number on all communications regarding this application.**

☐ Community Engagement-Self Assessment form

## **APPENDIX 2**

### **NARRATIVE**

## **1. Identity of the Applicant.**

Sturdy Health Foundation, Inc. (“Applicant”) is filing a Notice of Determination of Need (“DoN”) (“Application”), pursuant to *105 CMR 100.740: Emergency Applications*, with the Massachusetts Department of Public Health (“Department” or “DPH”) for the expansion of Sturdy Memorial Hospital’s (“Sturdy”) CT services through the operation of a CT unit located at 70 Walnut Street in Foxboro. The Applicant is requesting DoN approval for the right to operate the CT unit as a licensed satellite of Sturdy that will also provide other diagnostic imaging services not regulated by DoN (“Proposed Project”).

Sturdy Health is an independent, community-driven, fully integrated health system that offers hospital-based care, emergency and urgent care, primary care, and specialty care at 26 locations across Southeastern Massachusetts. It includes Sturdy Memorial Hospital, which opened its doors in 1913 as a 15-bed hospital. Today, Sturdy is a 128-bed community hospital in Attleboro, Massachusetts that offers the emergency care, labor and delivery services, and a wide range of inpatient and outpatient services.

## **2. Nature of the Emergency.**

The termination of the Norwood Hospital license will result in the closure of outpatient services in Foxborough, including convenient access to diagnostic CT imaging. Norwood Hospital’s hospital license expires on November 5. On September 25th, 2024, Steward Healthcare Inc. filed a Transition and Closure Plan for Norwood Hospital with the Department for the proposed closure of the Steward Norwood Hospital, Inc (“Norwood Hospital”) licensed satellites. On October 7, 2024, Steward filed a notice (“Notice”) with the United States Bankruptcy Court for the Southern District of Texas, stating that it was abandoning Norwood Hospital and its four affiliated clinics, including the satellites. On October 11th, 2024, Steward Healthcare filed a Closure Notice with the Department.

One of the satellites that will close is a radiology service located at 70 Walnut Street in Foxboro (“Radiology Center”). Approximately 4,411 CT scans were provided at the Radiology Center in FY23. Steward plans to abandon the property and all equipment by November 5, 2024. The closure of the Radiology Center will cause disruption to vital patient care for patients in the Foxborough service area for patients who depend on regular access to diagnostic imaging services close to home. Accordingly, closure of the Radiology Center would mean that patients will need to travel farther and wait longer to access lifesaving care and thus failure to prevent the closure of these Radiology Center would substantially impact public health.

## **Nature, scope, location, and projected costs of the Proposed Project.**

To address the Emergency Situation, the Applicant proposes a Substantial Change in Service in which:

- (a) Sturdy assumes control of operations of the Radiology center;
- (b) the Radiology Center is added to the Sturdy Memorial Hospital license as a satellite; and,
- (c) Sturdy will operate the DoN-Required Equipment, i.e. the CT unit in the Radiology Center.

To provide this service in the same location, the Applicant will lease facility, staff the service and assume operation of the CT. The Total Value of the Proposed Project is \$0. The Proposed Project involves no Capital Expenditure and does not involve a Transfer of Ownership.

The Proposed Project will ensure access for patients in the region to diagnostic CT services. The ability to obtain CT services in a timely manner impacts both patient outcomes and cost of care as the longer wait for diagnostic imaging care result in delays in care. This can add to the cost of care for both insurers, including the Commonwealth, and patients. Through the Proposed Project, these potential adverse impacts will be avoided, providing patients with access to diagnostic imaging in a setting close to home, thereby improving patient outcomes.

**3. Demonstrate that the Proposed Project will address the Emergency Situation, and without issuance of a Notice of Determination of Need, that the public health will be measurably harmed.**

The closure of the Radiology Center will reduce access for individuals residing in the Foxborough area to needed diagnostic imaging services, including CT. Through the Proposed Project, the community will maintain access to convenient high-quality CT services in Foxborough without further disruption for a community that has already faced uncertainty and meaningful disruption in accessing health care services in recent years.

**APPENDIX 3**

**CHANGE IN SERVICE**



# Massachusetts Department of Public Health

## Determination of Need

### Change in Service

Version: DRAFT  
6-14-17

**DRAFT**

Application Number: -24110416-EA

Original Application Date: 11/04/2024

#### Applicant Information

Applicant Name: Sturdy Health Foundation, Inc.

Contact Person: Aimee Brewer Title: President

Phone: 5082368000 Ext: E-mail: ABrewer@sturdyhealth.org

#### Facility: Complete the tables below for each facility listed in the Application Form

1 Facility Name: Sturdy Memorial Hospital CMS Number: 220008 Facility type: Hospital

#### Change in Service

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

| Add/Del<br>Rows |                             | Licensed Beds | Operating<br>Beds | Change in Number of Beds<br>( +/- ) |           | Number of Beds After Project<br>Completion (calculated) |           | Patient Days         | Patient Days | Occupancy rate for Operating<br>Beds |           | Average<br>Length of<br>Stay<br>(Days) | Number of<br>Discharges | Number of<br>Discharges |
|-----------------|-----------------------------|---------------|-------------------|-------------------------------------|-----------|---|-----------|----------------------|--------------|--------------------------------------|-----------|--|-------------------------|-------------------------|
|                 |                             | Existing      | Existing          | Licensed                            | Operating | Licensed  | Operating | (Current/<br>Actual) | Projected    | Current Beds                         | Projected | (Days)                                 | Actual                  | Projected               |
|                 | <b>Acute</b>                |               |                   |                                     |           |   |           |                      |              |                                      |           |  |                         |                         |
|                 | Medical/Surgical            |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
|                 | Obstetrics (Maternity)      |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
|                 | Pediatrics                  |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
|                 | Neonatal Intensive Care     |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
|                 | ICU/CCU/SICU                |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
| <b>+</b>        | <b>-</b>                    |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
|                 | Total Acute                 |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
|                 | <b>Acute Rehabilitation</b> |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
| <b>+</b>        | <b>-</b>                    |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
|                 | Total Rehabilitation        |               |                   |                                     |           |   |           |                      |              | 0%                                   | 0%        |  |                         |                         |
|                 | <b>Acute Psychiatric</b>    |               |                   |                                     |           |   |           |                      |              |                                      |           |  |                         |                         |

| Add/Del<br>Rows |                          | Licensed Beds | Operating<br>Beds | Change in Number of Beds<br>( +/- ) |           | Number of Beds After Project<br>Completion (calculated) |           | Patient Days<br>(Current/<br>Actual) | Patient Days<br>Projected | Occupancy rate for Operating<br>Beds |           | Average<br>Length of<br>Stay<br>(Days) | Number of<br>Discharges | Number of<br>Discharges |
|-----------------|--------------------------|---------------|-------------------|-------------------------------------|-----------|---|-----------|--------------------------------------|---------------------------|--------------------------------------|-----------|--|-------------------------|-------------------------|
|                 |                          | Existing      | Existing          | Licensed                            | Operating | Licensed  | Operating |                                      |                           | Current Beds                         | Projected |  | Actual                  | Projected               |
|                 | Adult                    |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Adolescent               |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Pediatric                |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Geriatric                |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
| <div>+ -</div>  |                          |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Total Acute Psychiatric  |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Chronic Disease          |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
| <div>+ -</div>  |                          |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Total Chronic Disease    |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Substance Abuse          |               |                   |                                     |           |   |           |                                      |                           |                                      |           |  |                         |                         |
|                 | detoxification           |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | short-term intensive     |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
| <div>+ -</div>  |                          |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Total Substance Abuse    |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Skilled Nursing Facility |               |                   |                                     |           |   |           |                                      |                           |                                      |           |  |                         |                         |
|                 | Level II                 |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Level III                |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Level IV                 |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
| <div>+ -</div>  |                          |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |
|                 | Total Skilled Nursing    |               |                   |                                     |           |   |           |                                      |                           | 0%                                   | 0%        |  |                         |                         |

|   |   |  |  |  |  |                          |                      |                          |                 |                 |
|---|---|--|--|--|--|--------------------------|----------------------|--------------------------|-----------------|-----------------|
| 2.3 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 |
| <div><div>+</div><div>-</div></div>   | CT  |  |  |  |  | 0                        | 1                    | 1                        |                 | 4,400           |
|   |   |  |  |  |  |                          |                      |                          |                 |                 |

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## **APPENDIX 4**

### **AFFILIATED PARTIES**



Massachusetts Department of Public Health  
Determination of Need  
Affiliated Parties

Version: DRAFT  
3-15-17

DRAFT

Application Date: 11/04/2024      Application Number: -24110416-EA

Applicant Information

Applicant Name: Sturdy Health Foundation, Inc.

Contact Person: Aimee Brewer      Title: President

Phone: 5082368000      Ext:      E-mail: ABrewer@sturdyhealth.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/<br>Del<br>Rows                               | Name<br>(Last)      | Name<br>(First) | Mailing Address | City      | State | Affiliation                    | Position with affiliated<br>entity<br>(or with Applicant) | Stock,<br>shares, or<br>partnership | Percent<br>Equity<br>(numbers<br>only) | Convictions<br>or<br>violations | List other health care<br>facilities affiliated with | Business<br>relationship<br>with<br>Applicant |
|---|---------------------|-----------------|-----------------|-----------|-------|--------------------------------|---|-------------------------------------|--|---------------------------------|--|---|
| <input type="checkbox"/> <input type="checkbox"/> | Brewer              | Aimee           | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | President   |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | Pfeffer             | Amy             | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Treasurer   |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | Larson              | Rose            | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Clerk   |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | DeSimone            | Cathleen        | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | DiGiacomo           | Richard         | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | Cryan               | Kevin           | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  | Yes   |
| <input type="checkbox"/> <input type="checkbox"/> | Van Ness-<br>Otunnu | Ronald          | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | Thursby             | Michael         | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | Kimmel              | Donna           | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Chair   |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | DiLisio             | James           | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | Burlone             | Stephen         | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | Forman              | Roger           | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  | Yes   |
| <input type="checkbox"/> <input type="checkbox"/> | Noel                | Thomas          | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <input type="checkbox"/> <input type="checkbox"/> | Schlenker           | Ralph           | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |

| Add/<br>Del<br>Rows                 | Name<br>(Last) | Name<br>(First)     | Mailing Address | City      | State | Affiliation                    | Position with affiliated<br>entity<br>(or with Applicant) | Stock,<br>shares, or<br>partnership | Percent<br>Equity<br>(numbers<br>only) | Convictions<br>or<br>violations | List other health care<br>facilities affiliated with | Business<br>relationship<br>with<br>Applicant |
|-------------------------------------|----------------|---------------------|-----------------|-----------|-------|--------------------------------|---|-------------------------------------|--|---------------------------------|--|---|
| <div><div>+</div><div>-</div></div> | Cook           | Frank               | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <div><div>+</div><div>-</div></div> | Leahy          | Dennis              | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  | Yes   |
| <div><div>+</div><div>-</div></div> | Karanth        | Nithin              | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <div><div>+</div><div>-</div></div> | Gignac         | Laura               | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <div><div>+</div><div>-</div></div> | Patel          | Brian               | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <div><div>+</div><div>-</div></div> | Korona         | John                | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <div><div>+</div><div>-</div></div> | Beise          | Frederick<br>Andrew | 211 Park Street | Attleboro | MA    | Sturdy Memorial Hospital, Inc. | Director  |                                     |  | No                              |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |
| <div><div>+</div><div>-</div></div> |                |                     |                 |           | MA    |                                |   |                                     |  |                                 |  |   |

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# **APPENDIX 5**

## **ARTICLES OF ORGANIZATION**

[https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP\\_DRIVE1/2011/0404/000339424/0024/020500208391\\_1.pdf](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2011/0404/000339424/0024/020500208391_1.pdf)

[https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP\\_DRIVE1/2002/1106/000037689/0001/200225106910\\_1.pdf](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2002/1106/000037689/0001/200225106910_1.pdf)

[https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP\\_DRIVE1/2009/0529/000293946/0001/200968252480\\_1.pdf](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2009/0529/000293946/0001/200968252480_1.pdf)

[https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP\\_DRIVE1/2023/0928/002658466/0001/202319410190\\_1.pdf](https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2023/0928/002658466/0001/202319410190_1.pdf)

## **APPENDIX 6**

### **AFFIDAVIT**



# 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:  Original Application Date:

Applicant Name:

Application Type:

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~~<sup>\*</sup> 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~~<sup>\*</sup> this application for Determination of Need including all exhibits and attachments, and ~~certify that~~<sup>\*\*</sup> 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~~<sup>\*\*</sup> 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~~<sup>\*\*\*</sup> Notices of Determination of Need ~~and the terms and Conditions attached therein;~~
11. I have ~~read~~<sup>\*</sup> 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

Type name here  
Aimee Brewer

Signed by:

11/4/2024

CEO for Corporation Name:

Signature:  
6219130445436...

Date

Type name here  
Donna Kimmel

Signed by:

11/4/2024

Board Chair for Corporation Name:

Signature:  
6219130445436...

Date

\*been informed of the contents of

\*\*have been informed that

\*\*\*issued in compliance with 105 CMR 100.00, the Massachusetts Determination of Need Regulation effective January 27, 2017 and amended December 28, 2018

**This document is ready to print:** ☐

Date/time Stamp: