STURDY MEMORIAL HOSPITAL, INC.

DETERMINATION OF NEED FILING FOR A TRANSFER OF SITE
ON BEHALF OF
STURDY MEMORIAL HOSPITAL

APPLICATION # SMH-24031214-TS

SUBMITTED ON APRIL 10, 2024

BY

STURDY MEMORIAL HOSPITAL, INC.
211 PARK STREET
ATTLEBORO, MA 02703

STURDY MEMORIAL HOSPITAL, INC.
DoN APPLICATION # SMH-24031214-TS

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APPENDIX 1

APPLICATION FORM

Massachusetts Department of Public Health
Determination of Need
Application Form

Version: 11-8-17

Application Type: Transfer of Site/Change in Designated Location

Application Date: 04/10/2024 12:50 pm

Applicant Name: Sturdy Memorial Hospital, Inc.

Mailing Address: 211 Park Street

City: Attleboro State: Massachusetts Zip Code: 02703

Contact Person: Crystal Bloom Title: Attorney

Mailing Address: One Beacon Street Suite 1320

City: Boston State: Massachusetts Zip Code: 02118

Phone: 6175486700 Ext: E-mail: Crystal.Bloom@huschblackwell.com

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name: Sturdy Memorial Hospital

Facility Address: 211 Park Street

City: Attleboro State: Massachusetts Zip Code: 02703

Facility type: Hospital CMS Number: 220008

Add additional Facility Delete this Facility

1. About the Applicant

1.1 Type of organization (of the Applicant): nonprofit

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? SMH

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? Boston Accountable Care Organization, Inc.

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 narrative

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? Transfer of Site or change of a designated Location

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

8.2 Current location of Site

Facility Name: Mansfield Health Center

Physical Address: 200 Copeland Drive

City: Mansfield State: Massachusetts Zip Code: 02048

Facility type: Hospital

8.3 Location of Proposed Site

Facility Name:	Sturdy Memorial Hospital
Physical Address:	211 Park Street
City:	Attleboro
State:	Massachusetts
Zip Code:	02703
Facility type:	Hospital

8.4 Compare the scope of the project for each element below:

	Current Site	Proposed Site
Gross Square Feet	See attached narrative	See attached narrative
Primary Service Area Towns served	See attached narrative	See attached narrative
Patient Population (Demographics)	See attached narrative	See attached narrative
Patient Access	See attached narrative	See attached narrative
Impact on Price	See attached narrative	See attached narrative
Total Medical Expenditure	See attached narrative	See attached narrative
Provider Costs	See attached narrative	See attached narrative
Description	See attached narrative	See attached narrative

8.5 Detail all Anticipated Capital Expenditures to be incurred as a result of the proposed Transfer of Site.

Add Del Row	Anticipated Capital Expenditure	Cost
+ -	Pain Management Suite, including the transferred procedure room	$3,460,000.00
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
	Total Cost	$3,460,000.00

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

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: Transfer of Site/Change in Designated Location

12.1 Total Value of this project:	$3,460,000.00
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:	$20,000.00
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

☒ Affidavit of Truthfulness Form

☒ 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: 04/10/2024 12:50 pm

E-mail submission to Determination of Need

Application Number: SMH-24031214-TS

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form

APPENDIX 3

AFFILIATED PARTIES FORM

TO BE PROVIDED

APPENDIX 4

ARTICLES OF INCORPORATION

https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2011/0401/000339421/0005/000042768252_1.pdf

APPENDIX 5

AFFIDAVIT OF TRUTHFULNESS AND COMPLIANCE

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: SMH-24031214-TS

Original Application Date: 4/10/2024

Applicant Name: Sturdy Memorial Hospital, Inc.

Application Type: Transfer of Site/Change in Designated Location

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

Aimee Brewer	Aimee Brewer	4/4/2024
CEO for Corporation Name:	Signature:	Date
Donna Kimmel	DocuSigned by: Donna Kimmel	4/4/2024
Board Chair for Corporation Name:	Signature: [illegible]B539452...	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: [ ]