1 DEVICE

APPLICATION FOR AN AUTOMATIC AMUSEMENT DEVICE LICENSE

Application Fee $60.00 per device

Date 11/14/2011

FOR CITY CLERK'S OFFICE ONLY
Date Recorded 11-30-11
Amount Paid $60.00 CR5523

__ New Application

__ Renewing Application with Additions or Changes

✓ Renewing Application with NO Additions or Changes

Business (DBA) Name: HOLIDAY INN Phone: 617-628-1000

Business Location (with Zip Code): 30 WASHINGTON ST SOMERVILLE, MA 02184

Applicant's Legal Name: DDH HOTEL SOMERVILLE, LLC

Applicant's Address (with Zip Code): 319 SPEEN ST, NATICK, MA 01760

Applicant's Email Address: DSHAMOIAN@DISTINCTIVEHOSPITALITYGROUP.COM

Applicant's Federal Employer Identification Number: 27-2167407

Mailing Name (where we should send correspondence to): JIM HARVEY

Mailing Address (with Zip Code): 30 WASHINGTON ST, SOMERVILLE, MA 02184

Emergency Contact: JIM HARVEY Phone: 617 628-1000

Type of Business (Check one): __Sole Proprietor __Partnership (inc. LLP) __Trust
✓ Corporation (inc. LLC) __Other

IF A SOLE PROPRIETOR:

Owner's Name:

Address with Zip Code:

IF A PARTNERSHIP, TRUST OR CORPORATION (Attach additional sheets as needed):

Partner's/Member's/President's Name: LOU CARRIER

Address with Zip Code: 319 SPEEN ST, NATICK, MA 01760

Partner's/Member's/Secretary's Name: DAVID SHAMOIAN

Address with Zip Code: 319 SPEEN ST, NATICK MA 01760

Partner's/Member's/Treasurer's Name:

Address with Zip Code:

CITY CLERK'S OFFICE SOMERVILLE, MA 2011 NOV 30 P 1:19

Number of automatic amusement devices to be kept: 1 (ONE)

ACKNOWLEDGEMENT

I hereby state that all information provided on this application is true and accurate, and I understand that any information that is found to be false or misleading may result in the forfeiture of this license. This license will be subject to all of the terms, conditions, and limitations set forth in the Somerville Code of Ordinances, any applicable State and Federal laws, and any conditions prescribed by the City of Somerville.

Signature of Applicant: _____ Date: 11/22/11

Print Name: DAVID V. SHAMOIAN Phone: 508-651-8300

LICENSING COMMISSION RECOMMENDATION:

The Licensing Commission recommends that the application be: ____Approved ____Denied

Signature: _____ Date: _____

FOR NEW APPLICANTS OR APPLICANTS ADDING AMUSEMENT DEVICES:

INSPECTIONAL SERVICES DEPARTMENT RECOMMENDATION:

The Inspectional Svcs. Dept. recommends that the application be: ____Approved ____Denied

Signature: _____ Date: _____

POLICE DEPARTMENT RECOMMENDATION:

The Chief of Police recommends that the application be: ____Approved ____Denied

Signature: _____ Date: _____

MASSACHUSETTS DEPARTMENT OF REVENUE
REVENUE ENFORCEMENT AND PROTECTION (REAP)
ATTESTATION

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all State tax returns and paid all State taxes required under law.

DDH HOTEL SOMERVILLE, LLC

*Signature of Individual or Corporate Name (Mandatory)

By: Corporate Officer (Mandatory, if a corporation)

27-2167407

**Social Security Number (Voluntary) or Federal Identification Number (Mandatory, if a corporation)

* This license will not be issued unless this certification clause is signed by the applicant.

** Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G.L. c. 62C s. 49A.

City of Somerville, Massachusetts
Finance Department, Treasury Division

WARNING: TREASURY NEEDS FIVE BUSINESS DAYS TO PROCESS THIS FORM.

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: DDH HOTEL SOMERVILLE, LLC

Address of taxpayer/applicant's business in Somerville: 30 WASHINGTON ST

Address of taxpayer/applicant's home in Somerville: _____

Taxpayer/applicant's phone: day: 508-651-8300 evening: 617-628-1000

I, (print name) DAVID SHAMOIAN, the undersigned Taxpayer, do hereby certify that all the information contained herein is true and correct and all taxes and fees due the City have been paid or that the Taxpayer has entered into an agreement to pay all taxes and fees and is current on said agreement.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY, this 14 day of NOVEMBER, 20 11.

(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: _____ **INCLUDES RELEVANT POSTINGS THROUGH:** _____

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

☐ Real Estate	☐ Water/Sewer	☐ Personal Property	☐ Other: ___
# 15451	# 66102200 1	# 1301	#

NOTES:

CLERK'S INITIALS: LB **ORIGINAL STAMP:** RECEIVED LBarnes 11-30-11

Print Form

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name: DDH Hotel Somerville, LLC

Address: 30 Washington Street

City/State/Zip: Somerville, MA 02184 Phone #: 617-628-1000

Are you an employer? Check the appropriate box:

1. ☑ I am a employer with 90 employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☑ Other Full Service Hotel

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name: Philadelphia Insurance Company

Insurer's Address: c/o Michael Auricchio Inc., 3800 Seneca Street

City/State/Zip: West Seneca, NY 14224-3478

Policy # or Self-ins. Lic. #: PH-UB-7206X81-0-11 Expiration Date: 4/28/2012

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature: Date: 11/14/2011

Phone #: 508-651-8300

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ **Permit/License #** _____

Issuing Authority (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person: _____ **Phone #:** _____

OP ID: SW

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/20/11

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Michael A. Auricchio, Inc. 3800 Seneca Street West Seneca, NY 14224-3478	716-675-3800 716-675-1522
CONTACT NAME:	
PHONE (A/C, No, Ext):	FAX (A/C, No):
E-MAIL ADDRESS:	
PRODUCER CUSTOMER ID #: DDHHO-1	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Travelers Indemnity	
INSURER B : National Union Fire Ins Co PA	
INSURER C : Philadelphia Insurance Company	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
DDH Hotel Natick/Speen LLC
DDH Hotel Natick/Worcester LLC
DDH Hotel Somerville LLC
DD Hotels I LLC
617 Dingens Street
Buffalo, NY 14206

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR X LIQUOR LIABILITY No Ded or SIR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT X LOC	X		630-9598N883 AGGREGATE APPLIES PER LOCATION	04/28/11	04/28/12	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			BA 1513R171	04/28/11	04/28/12	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Comp Ded Coll Ded	$ 1,000,000 $ $ $ $ 1,000 $ 1,000
B	UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DEDUCTIBLE X RETENTION $ 10,000	X		CMTY064125011	04/28/11	04/28/12	EACH OCCURRENCE AGGREGATE FOLLOW	$ 25,000,000 $ 25,000,000 $ $
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		PH-UB-7206X81-0-11	04/28/11	04/28/12	WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000
D	EPL			PHSD613359	05/20/11	05/20/12	Per Occur Aggregate	1,000,000 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Re:319 Speen St& 1360 Worcester St,Natick &30 Washington St,Somerville, MA *
GL & Umb incl Terrorism *CIBC inc as mort,lenders loss payee & as collateral agent (and ISAOA, ATIMA) for the benefit of the holder or holders of the A note and the Bnote (if any), together with their respective ISAOA, ATIMA.
Cert Holder 30 day notice for canc wxcept non-pay which is 10 days notice.

CERTIFICATE HOLDER

CIBC Inc ISAOA ATIMA
4th Floor
425 Lexington Avenue
New York, NY 10017

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Michael C Auricchio