Massachusetts Department of Public Health
Determination of Need
Application Form

Version: 11-8-17

Instructions

Application Type: Amendment

Application Date: 05/14/2021 11:42 am

Applicant Name: Advocate Healthcare of East Boston

Mailing Address: 111 Orient Avenue

City: East Boston State: Massachusetts Zip Code: 02128

Contact Person: Nina Edwards Title: Attorney

Mailing Address: 4 Bayberry Lane

City: Framingham State: Massachusetts Zip Code: 01701

Phone: 6175849030 Ext: E-mail: nina@bayberrylaw.com

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name: Advocate Healthcare of East Boston

Facility Address: 111 Orient Avenue

City: East Boston State: Massachusetts Zip Code: 02128

Facility type: Long Term Care Facility CMS Number: 225413

Add additional Facility Delete this Facility

1. About the Applicant

1.1 Type of organization (of the Applicant): for profit

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

1.6 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

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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.

The proposed amendment Is primarily focused on securing approval for the increases in the capital cost. It does not seek to materially change the scope of the approved Project, however, certain additional building repairs and/or replacements are requested as required for HUD insured financing. The approved Project was for the restoration of two nursing units and related infrastructure of this aging, long term care facility. This request does not change that scope. The Project as approved and as continues to be planned includes replacement and or repair of critical systems and fixed equipment, asbestos removal, and renovations addressing improved compliance with health care construction requirements for resident rooms and related service areas. It will result in a reduction of beds from the current licensed capacity of 190 to 165. It will also result in the elimination of all rooms with three or four beds on the affected or renovated units. The Project will create an additional 7 single bed rooms.

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? Conservation Projects

4. Conservation Project

4.1 Are you submitting this Application as a Conservation Project? ◉ Yes ○ No

4.2 Within the Proposed Project, is there any element that has the result of modernization, addition or expansion? ○ Yes ◉ No

4.3 Does the Proposed Project add or accommodate new or increased functionality beyond sustainment or restoration ○ Yes ◉ No

4.4 As part of the Proposed Project, is the Applicant:

- ☐ Adding a new service?
- ☐ Expanding a service?
- ☐ Modernizing the provision of a service?
- ☐ Substituting a service?
- ☐ Otherwise altering a serves's usage or designation, including patients served?
- ☐ Adding a new piece(s) of equipment
- ☐ Modernizing a piece(s) of equipment?
- ☐ Expanding bed capacity?
- ☐ Adding bed capacity?
- ☒ Otherwise altering bed capacity, usage, or designation?
- ☐ Adding additional square footage?

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

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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

10.2 This Amendment is: ◯ Immaterial Change ◯ Minor Change ◉ Significant Change

10.3 Original Application number: -19120215-CL

10.3.a Original Application Type: Conservation Long Term Care Project

10.3.b Original Application filing date: 12/04/2019

10.3.c Have there been any approved Amendments to the original Application? ◯ Yes ◉ No

For Significant Amendment Changes:

10.5.a Describe the proposed change.

This amendment is filed for the purpose of requesting an increase in the approved capital expenditure. The significant majority of the increase in capital expenditure relates to the increase in Project cost from the time the DoN was developed. The project scope remains the renovations and improvements to two nursing units and the Facility's aging infrastructure; however, due to the requirements of HUD insured financing, certain additional critical and noncritical repairs are required that were not included in the original DoN's Project scope. These items include overhaul of the two elevators, replacement of boilers, removal of underground storage tan, facade repairs, replacement of an electrical panel and other similar items as discussed in 10.5.d.

10.5.b Describe the associated cost implications to the Holder.

This amendment requests an increase in the approved maximum capital expenditure associated with the approved Project. The Applicant is is seeking an approval for a total capital expenditure of $17,496,500.00. This is a 73.4% increase from the currently approved $10,087,722. Due to the increased borrowing required, the Applicant will have additional interest expense. There are no other material changes projected in operating expenses upon the completion of the project and there continues to exist the potential for savings from the variety of energy-related improvements in the Project.

10.5.c Describe the associated cost implications to the Holder's existing Patient Panel.

There should be minimal or no cost impact implications for the Applicant's existing Patient Panel. Any patient paid amounts are preset amounts not impacted by the Applicant's costs. Private pay rates may experience limited increases; however the Applicant averages only about two percent (2%) of its residents who pay privately.

10.5.d Provide a detailed narrative, comparing the approved project to the proposed Significant Change, and the rationale for such change.

Please see the attached narrative response

☒ **The Holder hereby swears or affirms that the above statements with respect to the proposed Significant Change are True.**

11. Emergency Application

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

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12. Total Value for Significant Amendments

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 a: Significant Amendment

Filing Fee: $0

12.1 Proposed increase in total value of this project:	$7,408,778.00
12.2 Total increase in CHI commitment expressed in dollars: (calculated)	$370,438.90
12.3 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.	

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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.

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Documentation CheckList

The CheckList 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

- [x] Electronic copy of Staff Summary for Approved DoN
- [x] Electronic copy of Original Decision Letter for Approved DoN
- [ ] Electronic Copy of any prior Amendments to the Approved DoN

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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: 05/14/2021 11:42 am

E-mail submission to Determination of Need

Application Number: -21051411-AM

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form

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