

INSTRUCTIONS

Close Instructions

Print Instructions

Filling in Form: This form should be completed and submitted on line using Adobe Acrobat Reader Version 9 or higher. Go to Adobe.com if you do not have the latest version.

Save completed form for your reference (Use the "Save" option only, "Save as" will remove your ability to enter data.)
Reset button will clear all data from the form. **Print button** will print a hard copy of the form.

General Rules for Filling in Forms

☐ Radio Button

☐ Check Box

+

-

Button

Radio Button: Select only one answer from the group.

Check Box: Select all the answers that apply from the group.

Button: Clicking on a button will perform the task listed on the label. Plus and minus buttons will add or delete a row in a table.

Date Field: Click on calendar for arrow to appear, select date. If you type in the date be sure to use this format: MM/DD/YYYY.

Drop Down List: Click on the arrow and select a response from the items supplied. Some drop down lists will allow you to type in custom information.

Text Field: Type response in the area provided. Answers that require large amounts of text will grow as you type. You can cut and paste text from MS Products or another PDF form.

Numeric Field: Enter numbers only. No \$ signs, % signs or commas. If you enter anything other than a number the field will appear blank.

Required Entry: Fields with red boxes are required to have a response before form is submitted.

Signature Fields: Click on field to sign and date stamp the form with your electronic signature. Signing the form usually locks data entered on the form to prevent change. To change the data on the form delete the signature.

Date/Time Field

Drop-down List

Text Field

Numeric Field

Required

Signature Field

Application Instructions

1. Be sure that you are using the most current version of this Application. www.mass.gov/dph/don Additional forms for Affidavit of Truthfulness, Affiliated Parties, Change in Service and Factor 6 can also be found on this site.
2. You can only select a single Application Type. The Application Type selected will determine what documents are needed to complete. Choose the type that best describes the Proposed Project.
3. If you have questions please contact the Determination of Need program at 617- 624- 5690 or via e-mail at dph.don@state.ma.us



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:	03/02/2022 11:27 AM		
Applicant Name:	Boston Eye Surgery and Laser Center Trust						
Mailing Address:	50 Staniford Street, Lobby Level						
City:	Boston	State:	Massachusetts	Zip Code:	02114		
Contact Person:	Jonathan Herlihy		Title:	Administrator			
Mailing Address:	50 Staniford Street						
City:	Boston	State:	Massachusetts	Zip Code:	02114		
Phone:	6177232015	Ext:		E-mail:	JHERLIHY@eyeboston.com		

Facility Information

List each facility affected and or included in Proposed Project

1	Facility Name:	Boston Eye Surgery and Laser Center - West				
	Facility Address:	52 Second Avenue, Suite 2500				
	City:	Waltham	State:	Massachusetts	Zip Code:	02451
	Facility type:	Freestanding Ambulatory Surgery Facility		CMS Number:	NPI 1639215502	
		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:	<input type="radio"/> Corporation <input type="radio"/> Limited Partnership <input type="radio"/> Partnership <input checked="" type="radio"/> Trust <input type="radio"/> LLC <input type="radio"/> Other	
1.3 What is the acronym used by the Applicant's Organization?	BESLC	
1.4 Is Applicant a registered provider organization as the term is used in the HPC/CHIA RPO program?	<input type="radio"/> Yes <input checked="" type="radio"/> No	
1.5 Is Applicant or any affiliated entity an HPC-certified ACO?	<input type="radio"/> Yes <input checked="" type="radio"/> 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)?	<input type="radio"/> Yes <input checked="" type="radio"/> No	
1.7 Does the Proposed Project also require the filing of a MCN with the HPC?	<input type="radio"/> Yes <input checked="" type="radio"/> 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.

BESLC-West currently is located at 52 Second Avenue, Suite 2200, Waltham, MA 02451. The landlord of the current space notified BESLC-West that the space no longer will be available, the lease cannot be renewed, and the lease will terminate on 10.31.2022. BESLC-West identified new space in Waltham, approximately 1-mile from the existing space. The new space is located at 195 West Street, 2nd Floor, Waltham, MA 02451. BESLC-West anticipates relocating to the new space, effective as of 5.1.22.

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?

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

- 7.2 If yes, is Applicant or any affiliate thereof a HPC-certified ACO OR in the process of becoming a Certified ACO? ☐ Yes ☒ No

- 7.3 Does the Proposed Project constitute: (Check all that apply)

- ☐ Ambulatory Surgery capacity located on the main campus of an existing Hospital **105 CMR 100.740(A)(1)(a)(i);**
- ☐ An Expansion, Conversion, Transfer of Ownership, transfer of Site, or change of designated Location for Ambulatory Surgery capacity located on a satellite campus of an existing Hospital **105 CMR 100.740(A)(1)(a)(ii);**
- ☐ A Freestanding Ambulatory Surgery Center within the Primary Service Area of an independent community hospital (Refer to a list that we update regularly with support from HPC) **105 CMR 100.740(A)(1)(a)(iii);** or
- ☒ An Expansion, Conversion, Transfer of Ownership, transfer of Site, or change of designated Location for a Freestanding Ambulatory Surgery Center that received an Original License as a Clinic on or before January 1, 2017 **105 CMR 100.740(A)(1)(a)(iv).**

- 7.4 See section on Ambulatory Surgery in the Application Instructions

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: Boston Eye Surgery and Laser Center - West

Physical Address: 52 Second Avenue, Suite 2500

City: Waltham

State: Massachusetts

Zip Code: 02451

Facility type: Freestanding Ambulatory Surgery capacity

8.3 Location of Proposed Site

Facility Name: Boston Eye Surgery and Laser Center - West

Physical Address: 195 West Street, 2nd Floor



























City: Waltham

State: Massachusetts

Zip Code: 02451

Facility type: Freestanding Ambulatory Surgery capacity

8.4 Compare the scope of the project for each element below:		
	Current Site	Proposed Site
Gross Square Feet	4,700	7,389
Primary Service Area Towns served	See Attachment 1 - Narrative	See Attachment 1 - Narrative
Patient Population (Demographics)	See Attachment 1 - Narrative	See Attachment 1 - Narrative
Patient Access	See Attachment 1 - Narrative	See Attachment 1 - Narrative
Impact on Price	See Attachment 1 - Narrative	See Attachment 1 - Narrative
Total Medical Expenditure	See Attachment 1 - Narrative	See Attachment 1 - Narrative
Provider Costs	See Attachment 1 - Narrative	See Attachment 1 - Narrative
Description	See Attachment 1 - Narrative	See Attachment 1 - 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
 	See Attachment 1 - Narrative	
 		
 		
 		
 		
 		
 		
 		
 		
 		
 		
 		
 		
	Total Cost	

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:

\$1,940,191.80

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:

\$129,071.00

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.

\$0.00

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

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: 03/02/2022 11:27 AM

E-mail submission to
Determination of Need

Application Number: BESLC-20032516-TS

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form