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: Tue Feb 01 2022 16:07:42 GM

Applicant Name: Heywood Healthcare, Inc.

Mailing Address: 242 Green Street

City: Gardner State: Massachusetts Zip Code: 01440

Contact Person: Carol Roosa Title: VP of Operations & Chief Information Officer

Mailing Address: 242 Green Street

City: Gardner State: Massachusetts Zip Code: 01440

Phone: 9786306448 Ext: E-mail: carol.roosa@heywood.org

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name: Heywood Hospital

Facility Address: 242 Green Street

City: Gardner State: Massachusetts Zip Code: 01440

Facility type: Hospital CMS Number:

Add additional Facility Delete this Facility

2 Facility Name: Athol Hospital

Facility Address: 2033 Main Street

City: Athol State: Massachusetts Zip Code: 01331

Facility type: Hospital CMS Number:

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? HH

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

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.

Due to its proximity to the construction site for its recently DON-approved surgical pavilion project (and the discovery of ledge near the site), Heywood Hospital is obliged to temporarily discontinue use of an MRI that is located on its campus and that serves Heywood inpatients and outpatients. The existing MRI is operated by Alliance Imaging and Heywood. Heywood's relationship with Alliance Imaging will be terminating, and an MRI operated by Shields PET-CT at Heywood Healthcare, LLC (approved by the Department on November 29, 2021) is expected to take the place of the Alliance Imaging MRI unit this Fall and to serve Heywood Hospital and its patients.

Heywood Hospital plans to temporarily relocate to Heywood's campus a mobile MRI unit that is currently in use two days a week at Heywood's affiliate, Athol Hospital, for outpatient services. The Athol unit is also operated by Alliance Imaging. The Athol unit will be relocated to a part of the Heywood campus that is more removed from the surgical pavilion construction than the current Heywood unit, and it will be utilized to meet the ongoing needs of Heywood patients (and Athol's—see below) during the first phases of the surgical pavilion construction. Heywood has already notified the Department's Plan Review Office of its plans regarding the siting of the Athol unit at Heywood, and Heywood will be submitting a Self-Certification plan and an OP-19 compliance checklist to the Plan Review Office for its approval. Use of the Athol unit will be discontinued when the Shields unit commences operations at Heywood; and Athol patients requiring MRIs while the Athol unit is in use at Heywood will have access to the Athol unit for their scans.

Although the contemplated use of the Athol unit at Heywood is arguably only a temporary "replacement" of the current MRI at Heywood (which would ordinarily not be subject to DON review), Heywood is mindful that the use of the Athol unit could also be viewed as a transfer of Site of "DON-required Equipment" pursuant to 105 CMR 100.745. This application/notice is provided with that prospect in mind, and Heywood asserts that the transfer will not result in either (i) a substantial capital expenditure (since the unit is a "replacement" and the only costs associated with the replacement are a total of approximately $60,000 for dedicated electrical wiring, the construction of a temporary enclosure from the MRI trailer entry door to the Heywood building, and placement of a temporary pad under the trailer), or (ii) a substantial change in service (since the service--the DON-required Equipment--is already provided on the Heywood campus, and will not be duplicated, but will rather be replaced temporarily).

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

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

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:	$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:	$0.00
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.

Factor 1: Applicant Patient Panel Need, Public Health Values and Operational Objectives

F1.a.i **Patient Panel:**
Describe your existing Patient Panel, including incidence or prevalence of disease or behavioral risk factors, acuity mix, noted health disparities, geographic breakdown expressed in zip codes or other appropriate measure, demographics including age, gender and sexual identity, race, ethnicity, socioeconomic status and other priority populations relevant to the Applicant's existing patient panel and payer mix.

F1.a.ii **Need by Patient Panel:**
Provide supporting data to demonstrate the need for the Proposed Project. Such data should demonstrate the disease burden, behavioral risk factors, acuity mix, health disparities, or other objective Patient Panel measures as noted in your response to Question F1.a.i that demonstrates the need that the Proposed Project is attempting to address. If an inequity or disparity is not identified as relating to the Proposed Project, provide information justifying the need. In your description of Need, consider the principles underlying Public Health Value (see instructions) and ensure that Need is addressed in that context as well.

F1.a.iii **Competition:**
Provide evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. When responding to this question, please consider Factor 4, Financial Feasibility and Reasonableness of Costs.

F1.b.i **Public Health Value /Evidence-Based:**
Provide information on the evidence-base for the Proposed Project. That is, how does the Proposed Project address the Need that Applicant has identified.

F1.b.ii **Public Health Value /Outcome-Oriented:**
Describe the impact of the Proposed Project and how the Applicant will assess such impact. Provide projections demonstrating how the Proposed Project will improve health outcomes, quality of life, or health equity. Only measures that can be tracked and reported over time should be utilized.

F1.b.iii **Public Health Value /Health Equity-Focused:**
For Proposed Projects addressing health inequities identified within the Applicant's description of the Proposed Project's need-base, please justify how the Proposed Project will reduce the health inequity, including the operational components (e.g. culturally competent staffing). For Proposed Projects not specifically addressing a health disparity or inequity, please provide information about specific actions the Applicant is and will take to ensure equal access to the health benefits created by the Proposed Project and how these actions will promote health equity.

F1.b.iv Provide additional information to demonstrate that the Proposed Project will result in improved health outcomes and quality of life of the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.

F1.c Provide evidence that the Proposed Project will operate efficiently and effectively by furthering and improving continuity and coordination of care for the Applicant's Patient Panel, including, how the Proposed Project will create or ensure appropriate linkages to patients' primary care services.

F1.d Provide evidence of consultation, both prior to and after the Filing Date, with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project.

F1.e.i Process for Determining Need/Evidence of Community Engagement: For assistance in responding to this portion of the Application, Applicant is encouraged to review *Community Engagement Standards for Community Health Planning Guideline.* With respect to the existing Patient Panel, please describe the process through which Applicant determined the need for the Proposed Project.

F1.e.ii Please provide evidence of sound Community Engagement and consultation throughout the development of the Proposed Project. A successful Applicant will, at a minimum, describe the process whereby the "Public Health Value" of the Proposed Project was considered, and will describe the Community Engagement process as it occurred and is occurring currently in, at least, the following contexts: Identification of Patient Panel Need; Design/selection of DoN Project in response to "Patient Panel" need; and Linking the Proposed Project to "Public Health Value".

Factor 2: Health Priorities

Addresses the impact of the Proposed Project on health more broadly (that is, beyond the Patient Panel) requiring that the Applicant demonstrate that the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.

F2.a **Cost Containment:**
Using objective data, please describe, for each new or expanded service, how the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment.

F2.b **Public Health Outcomes:**
Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.

F2.c **Delivery System Transformation:**
Because the integration of social services and community-based expertise is central to goal of delivery system transformation, discuss how the needs of their patient panel have been assessed and linkages to social services organizations have been created and how the social determinants of health have been incorporated into care planning.

Factor 3: Compliance

Applicant certifies, by virtue of submitting this Application that it is in compliance and good standing with federal, state, and local laws and regulations, including, but not limited to M.G.L. c. 30, §§ 61 through 62H and the applicable regulations thereunder, and in compliance with all previously issued notices of Determination of Need and the terms and conditions attached therein .

F3.a Please list all previously issued Notices of Determination of Need

Add/Del Rows	Project Number	Date Approved	Type of Notification	Facility Name
+ -				

Factor 4: Financial Feasibility and Reasonableness of Expenditures and Costs

Applicant has provided (as an attachment) a certification, by an independent certified public accountant (CPA) as to the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's existing Patient Panel.

F4.a.i **Capital Costs Chart:**
For each Functional Area document the square footage and costs for New Construction and/or Renovations.

		Present Square Footage		Square Footage Involved in Project				Resulting Square Footage		Total Cost		Cost/Square Footage	
				New Construction		Renovation							
Add/Del Rows	Functional Areas	Net	Gross	Net	Gross	Net	Gross	Net	Gross	New Construction	Renovation	New Construction	Renovation
+ -													
+ -													
+ -													
+ -													
+ -													
+ -													
+ -													
+ -													
+ -													
	Total: (calculated)												

F4.a.ii For each Category of Expenditure document New Construction and/or Renovation Costs.

	Category of Expenditure	New Construction	Renovation	Total (calculated)
	Land Costs			
	Land Acquisition Cost			
	Site Survey and Soil Investigation			
	Other Non-Depreciable Land Development			
	Total Land Costs			
	Construction Contract (including bonding cost)			
	Depreciable Land Development Cost			
	Building Acquisition Cost			
	Construction Contract (including bonding cost)			
	Fixed Equipment Not in Contract			
	Architectural Cost (Including fee, Printing, supervision etc.) and Engineering Cost			
	Pre-filing Planning and Development Costs			
	Post-filing Planning and Development Costs			
Add/Del Rows	Other (specify)			
+ -				
	Net Interest Expensed During Construction			
	Major Movable Equipment			
	Total Construction Costs			
	Financing Costs:			
	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc			
	Bond Discount			
Add/Del Rows	Other (specify			
+ -				
	Total Financing Costs			
	Estimated Total Capital Expenditure			

Factor 5: Relative Merit

F5.a.i Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

Proposal:

Quality:

Efficiency:

Capital Expense:

Operating Costs:

List alternative options for the Proposed Project:

Alternative Proposal:

Alternative Quality:

Alternative Efficiency:

Alternative Capital Expense:

Alternative Operating Costs:

Add additional Alternative Project | Delete this Alternative Project

F5.a.ii Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

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

- ☐ Copy of Notice of Intent
- ☒ Affidavit of Truthfulness Form
- ☐ Scanned copy of Application Fee Check
- ☐ Electronic copy of Staff Summary for Approved DoN
- ☐ Electronic copy of Original Decision Letter for Approved DoN
- ☐ Electronic Copy of any prior Amendments to the Approved DoN
- ☐ Affiliated Parties Table Question 1.9
- ☐ Change in Service Tables Questions 2.2 and 2.3
- ☐ Certification from an independent Certified Public Accountant
- ☐ Notification of Material Change
- ☐ Articles of Organization / Trust Agreement
- ☐ Limited Liability Company agreement
- ☐ Partnership agreement
- ☐ Trust agreement
- ☐ Current IRS Form, 990 Schedule H CHNA/CHIP and/or Current CHNA/CHIP submitted to Massachusetts AGO's Office

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: Tue Feb 01 2022 16:07

E-mail submission to Determination of Need

Application Number: HH-22031615-TS

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form