



# Massachusetts Department of Public Health

## Determination of Need

### Application Form

Version: 11-8-17

Application Type:  Application Date: 06/22/2022 9:40 am

Applicant Name:

Mailing Address:

City:  State:  Zip Code:

Contact Person:  Title:

Mailing Address:

City:  State:  Zip Code:

Phone:  Ext:  E-mail:

### Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name:

Facility Address:

City:  State:  Zip Code:

Facility type:  CMS Number:

### 1. About the Applicant

1.1 Type of organization (of the Applicant):

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

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.

New England Surgery Center, LLC ("Applicant"), a multi-specialty freestanding ambulatory surgery center located at 900 Cummings Center, Suite 122U, Beverly, MA 01915 submits this request for amendment to previously issued Determination of Need ("DoN") Project #20072809-AS. The previously issued DoN approved renovation at 126R Cummings Center and 128V Cummings Center, space adjacent to the current location, for the addition of one (1) outpatient operating room as well as patient support and administrative areas. The proposed amendment is focused on securing approval for the increase in the capital cost. It does not seek to materially change the scope of the approved project, however additional replacements and repairs to HVAC and electric supply are required. The request does not change that scope and additional items/costs do not change any operational or design components of the project that were outlined in the original DoN submission.

## 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

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

## 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:

20072809-AS

10.3.a Original Application Type:

Ambulatory Surgery

10.3.b Original Application filing date:

08/14/2020

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.

Please see the attached narrative response.

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

Please see the attached narrative response.

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

Please see the attached narrative response.

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

## 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:

\$1,358,935.00

12.2 Total increase in CHI commitment expressed in dollars: (calculated)

\$67,946.75

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.

\$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](mailto:DPH.DON@state.ma.us)

- Copy of Notice of Intent
- Affidavit of Truthfulness Form
- Electronic copy of Staff Summary for Approved DoN
- Electronic copy of Original Decision Letter for Approved DoN
- Change in Service Tables Questions 2.2 and 2.3
- Certification from an independent Certified Public Accountant

## 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: 06/22/2022 9:40 am

E-mail submission to  
Determination of Need

**Application Number: NESC-22060213-AM**

**Use this number on all communications regarding this application.**

Community Engagement-Self Assessment form