Massachusetts Department of Public Health
Determination of Need
Application Form

Version: 11-8-17

Application Type: Amendment

Application Date: 01/13/2025 10:59 am

Applicant Name: Shields Healthcare of Dartmouth, Inc. d/b/a Fall River-New Bedford Regional MRI Center

Mailing Address: 700 Congress Street, Suite 204

City: Quincy State: Massachusetts Zip Code: 02169

Contact Person: Kathleen Healy Title: Attorney

Mailing Address: One Boston Place, 25th Floor

City: Boston State: Massachusetts Zip Code: 02108

Phone: 6175575995 Ext: E-mail: khealy@rc.com

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name: Fall River-New Bedford Regional MRI Center

Facility Address: 361 Allen Street

City: New Bedford State: Massachusetts Zip Code: 02740

Facility type: Clinic CMS Number: 1902855489

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? FRNB

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.

See attached.

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? Certified ACO/DoN-Required Service or Equipment

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

5.2 If yes, is Applicant or any affiliated entity thereof a HPC-certified ACO? ○ Yes ◉ No

5.3 **See section on DoN-Required Services and DoN-Required Equipment in the Application Instructions**

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

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

10.3 Original Application number: 5-4887

10.3.a Original Application Type: DoN-Required Equipment

10.3.b Original Application filing date: 04/20/2001

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.

See attached narrative.

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

See attached narrative.

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

See attached narrative.

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

See attached narrative.

☒ **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:	$2,600,000.00
12.2 Total increase in CHI commitment expressed in dollars: (calculated)	$130,000.00
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.	

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

- [x] Copy of Notice of Intent
- [x] Affidavit of Truthfulness Form
- [X] Electronic copy of Staff Summary for Approved DoN
- [x] Electronic copy of Original Decision Letter for Approved DoN
- [x] Change in Service Tables Questions 2.2 and 2.3
- [ ] Certification from an independent Certified Public Accountant
- [ ] Notification of Material Change
- [x] Articles of Organization / Trust Agreement

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: 01/13/2025 10:59 am

E-mail submission to Determination of Need

Application Number: FRNB-25011310-AM

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form