

**SOUTHCOAST HEALTH SYSTEM, INC.
DETERMINATION OF NEED APPLICATION # SHS-24050109-TO**

TRANSFER OF OWNERSHIP

SAME DAY SURGICARE OF NEW ENGLAND, INC.

**272 STANLEY STREET
FALL RIVER, MASSACHUSETTS 02720-6009**

May 1, 2024

**BY
SOUTHCOAST HEALTH SYSTEM, INC.
101 PAGE STREET
NEW BEDFORD, MASSACHUSETTS 02740**



Massachusetts Department of Public Health Determination of Need Application Form

Version: 11-8-17

Application Type: Application Date: 05/01/2024 9:16 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

1.5.a If yes, what is the legal name of that entity?

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

1.7.a If Yes, has Material Change Notice been filed? Yes No

1.7.b If yes, provide the date of filing.

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.

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

6.2 If Yes, Is Applicant's Proposed Project subject to 958 CMR 7.00 (Notices of Material Changes and Cost and Market Impact Reviews)? Yes No

6.3 Does the Proposed Project constitute the transfer of the Health Care Facility's license in its entirety to a single transferee? Yes No

6.4 Which of the following most closely characterizes the Proposed Project;

- A transfer of a majority interest in the ownership of a Hospital or Clinic;
- A transfer of a majority of any class of the stock of a privately-held for-profit corporation;
- A transfer of a majority of the partnership interest of a partnership;
- A change of the trustee or a majority of trustees of a partnership;
- Changes in the corporate membership and/or trustees of a non-profit corporation constituting a shift in control of the Hospital or Clinic;
- Foreclosure proceedings have been instituted by a mortgagee in possession of a Hospital or Clinic;
- A change in the ownership interest or structure of a Hospital or Clinic, or of the Hospital or Clinic's organization or parent organization(s), such that the change results in a shift in control of the operation of the Hospital or Clinic.

6.5 Explain why you believe this most closely characterizes the Proposed Project.

The Applicant, Southcoast Health System, Inc. ("SHS"), is the ultimate parent of Southcoast Hospitals Group, Inc. Southcoast Hospitals Group, Inc. is the sole corporate member of Southcoast Health Surgical Holdings, LLC ("SHSH"). SHSH owns 49% of Same Day Surgicare of New England, Inc. ("SDS") and individual physicians own 51% of SDS. The Project is a Transfer of Ownership which will result in SHSH becoming the sole stockholder of SDS located at 272 Stanley Street, Fall River, Massachusetts 02720-6009. At the conclusion of the Project, SDS will still be the entity that holds the clinic license.

6.6 In context of responding to each of the Required Factors 1, 3, and 4, consider how the proposed transaction will affect the manner in which Applicant serves its existing Patient Panel in the context of value (that is cost and quality), and describe the impact to the Patient Panel in the context of Access, Value (price, cost, outcomes), and Health Disparities.

The attached Narrative describes how the Project will affect the Applicant's Patient Panel with respect to access, value and public health disparities.

6.7 See section on Transfer of Ownership in the Application Instructions

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

7.2.a If yes, Please provide the date of approval and attach the approval letter:

04/12/2022

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

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 Ownership

12.1 Total Value of this project:	\$5,300,000.00
12.2 Total CHI commitment expressed in dollars: (calculated)	\$0.00
12.3 Transfer of ownership Filing Fee: (calculated)	\$10,600.00
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.

See attached.

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.

See attached.

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.

See attached.

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.

See attached.

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.

See attached.

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.

See attached.

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.

See attached.

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.

See attached.

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.

See attached.

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.

See attached.

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".

See attached.

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
<input type="checkbox"/> + <input type="checkbox"/> -				

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.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)			
<input type="checkbox"/> + <input type="checkbox"/> -				
	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)			
<input type="checkbox"/> + <input type="checkbox"/> -				
	Total Financing Costs			
	Estimated Total Capital Expenditure			

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
- 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

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: 05/01/2024 9:16 am

E-mail submission to
Determination of Need

Application Number: SHS-24050109-TO

Use this number on all communications regarding this application.

Community Engagement-Self Assessment form