



Massachusetts Department of Public Health Determination of Need Application Form

Version: 11-8-17

Application Type: Application Date: 09/12/2023 10:03 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

1.8 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.

Please see attached narrative.

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

4.2 Within the Proposed Project, is there any element that has the result of modernization, addition or expansion? Yes No

4.3 Does the Proposed Project add or accommodate new or increased functionality beyond sustainment or restoration Yes No

4.4 As part of the Proposed Project, is the Applicant:

<input type="checkbox"/> Adding a new service?	<input type="checkbox"/> Expanding a service?
<input type="checkbox"/> Modernizing the provision of a service?	<input type="checkbox"/> Substituting a service?
<input type="checkbox"/> Otherwise altering a serves's usage or designation, including patients served?	
<input type="checkbox"/> Adding a new piece(s) of equipment	<input type="checkbox"/> Modernizing a piece(s) of equipment?
<input type="checkbox"/> Expanding bed capacity?	<input type="checkbox"/> Adding bed capacity?
<input type="checkbox"/> Otherwise altering bed capacity, usage, or designation?	<input type="checkbox"/> Adding additional square footage?

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: Conservation Hospital/Clinic Project

12.1 Total Value of this project:

\$26,498,000.00

12.2 Total CHI commitment expressed in dollars: (calculated)

\$662,450.00

12.3 Filing Fee: (calculated)

\$52,996.00

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 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"/> -	4-3C47	10/27/2016	Hospital/Clinic Substantial Change in Service	Boston Children's Hospital
<input type="checkbox"/> + <input type="checkbox"/> -	DoN 20040309-CL	02/13/2021	Conservation Hospital/Clinic Project	Boston Children's Hospital
<input type="checkbox"/> + <input type="checkbox"/> -	Emergency DoN	01/15/2021	Emergency Application	Boston Children's Hospital
<input type="checkbox"/> + <input type="checkbox"/> -	BCH-21072306-CH	02/04/2022	Conservation Hospital/Clinic Project	Boston Children's Hospital
<input type="checkbox"/> + <input type="checkbox"/> -	BCH-20171411-HE	12/19/2022	Hospital/Clinic Substantial Change in Service	Boston Children's Hospital
<input type="checkbox"/> + <input type="checkbox"/> -	BCH-22031810-TO	08/10/2022	Transfer of Ownership	Franciscan Hospital for Children
<input type="checkbox"/> + <input type="checkbox"/> -	BCH-230825140-HE		Hospital/Clinic Substantial Change in Service	Franciscan Hospital for Children

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.

Add/Del Rows	Functional Areas	Present Square Footage		Square Footage Involved in Project				Resulting Square Footage		Total Cost		Cost/Square Footage	
		Net	Gross	New Construction		Renovation		Net	Gross	New Construction	Renovation	New Construction	Renovation
<input type="checkbox"/> + <input type="checkbox"/> -	Infrastructure - Boston Campus		2,076,015				2,076,015		2,076,015		\$9,060,000.00		\$4.36
<input type="checkbox"/> + <input type="checkbox"/> -	Infrastructure-Waltham Campus		375,000				375,000		375,000		\$500,000.00		\$1.33
<input type="checkbox"/> + <input type="checkbox"/> -	Radiology Department		26,310				26,310		26,310		\$6,235,000.00		
<input type="checkbox"/> + <input type="checkbox"/> -	Design fees for Various Outpatient Services		24,862				24,862		24,862		\$747,000.00		\$30.04
<input type="checkbox"/> + <input type="checkbox"/> -	Sterile Processing - Waltham Campus		2,556				2,556		2,556		\$9,956,000.00		\$3,895.15
<input type="checkbox"/> + <input type="checkbox"/> -													
<input type="checkbox"/> + <input type="checkbox"/> -													
<input type="checkbox"/> + <input type="checkbox"/> -													
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<input type="checkbox"/> + <input type="checkbox"/> -													
<input type="checkbox"/> + <input type="checkbox"/> -													
	Total: (calculated)		2,504,743				2,504,743		2,504,743		\$26,498,000.00		\$3,930.88

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)		\$11459000.	\$11459000.
	Fixed Equipment Not in Contract		\$6467000.	\$6467000.
	Architectural Cost (Including fee, Printing, supervision etc.) and Engineering Cost		\$8572000.	\$8572000.
	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		\$26498000.	\$26498000.
	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		\$26498000.	\$26498000.

Factor 6: Community Based Health Initiatives

F6 Does your existing CHNA/CHIP meet the minimum standards outlined in the Community Engagement Standards for Community health Planning Guideline?

Yes No

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
- Current IRS Form, 990 Schedule H CHNA/CHIP and/or Current CHNA/CHIP submitted to Massachusetts AGO's Office
- Community Engagement Stakeholder Assessment form
- Community Engagement-Self Assessment 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: 09/12/2023 10:03 am

E-mail submission to
Determination of Need

Application Number: BCH-23082615-CH

Use this number on all communications regarding this application.

Community Engagement-Self Assessment form