DETERMINATION OF NEED FOR DON-REQUIRED EQUIPMENT AT

UMASS MEMORIAL MEDICAL CENTER – NASHOBA REGIONAL SATELLITE EMERGENCY FACILITY

APPLICATION # UMMHC-25080814-RE

Submitted on October 2, 2025

BY

UMASS MEMORIAL HEALTH CARE, INC.
One Biotech Park
365 Plantation Street
Worcester, MA 01605

UMass Memorial Health Care

Determination of Need Application #UMMHC-25080814-RE

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APPENDIX 1 APPLICATION FORM



Massachusetts Department of Public Health Determination of Need Application Form

Version:	11-8-17
version.	11-0-1/

Application Type:	DoN-Required Equipm	nent		Application Date: 10/02	/2025 1:18 pm	
Applicant Name:	UMass Memorial Health Care, Inc.					
Mailing Address:	One Biotech Park					
City: Worcester			State: Massachusetts	Zip Code: 01605		
Contact Person:	Pavid Bierschied		Title: Sr. Director of Strategic Financial Planning			
Mailing Address:	306 Belmont Street					
City: Worcester			State: Massachusetts			
Phone: 50833404	163	Ext:	E-mail: david.biersc	hied@umassmemorial.org		
Facility Infor List each facility a	mation ffected and or include	ed in Proposed Pro	ject			
1 Facility Name:			shoba Regional Satellite	Emergency Facility		
Facility Address:	490 Main Street					
City: Groton			State: Massachusetts	Zip Code: 01450		
Facility type:	Hospital			CMS Number: NA		
		Add additional Fa	cility	Delete this Facility		
2 Facility Name:	UMass Memorial I	Medical Center				
Facility Address:	55 Lake Avenue North					
City: Worcester			State: Massachusetts	Zip Code: 01655		
Facility type:	Hospital			CMS Number: 220613		
		Add additional Fa	cility	Delete this Facility		
1. About the	Applicant					
1.1 Type of organi	zation (of the Applican	t): nonprofit		-		
1.2 Applicant's Bus	siness Type:	rporation C Limi	ted Partnership	rtnership	Other	
1.3 What is the acr	onym used by the App	licant's Organizatio	n?		иммнс	

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? UMass Memorial Accountable Care Organization, Inc.		
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 t health care cost growth benchmark established under M.G.L. c. 6D, § 9 and is thus, pursuant to M.G.L. c. 6D, § required to file a performance improvement plan with CHIA?	~	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 (Appendix 2)		
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	e? • Yes	○ No
5.2 If yes, is Applicant or any affiliated entity thereof a HPC-certified ACO?	Yes	○No
5.2.a If yes, Please provide the date of approval and attach the approval letter:	12/20/2023	
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?	C	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 depo	ending upon answer	rs above	2.
Your project application is for: DoN-Required Equipment			
12.1 Total Value of this project:	\$2,195,943.00		
12.2 Total CHI commitment expressed in dollars: (calculated)	\$109,797.15		
12.3 Filing Fee: (calculated)	\$4,391.89		
12.4 Maximum Incremental Operating Expense resulting from the Proposed Project:			
12.5 Total proposed Construction costs, specifically related to the Proposed Project, If any, which wi be contracted out to local or minority, women, or veteran-owned businesses expressed in estimated total dollars.	\$500,000.00		

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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".

Please see attached Narrative (Appendix 2)

Application Form UMass Memorial Health Care, Inc.

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.

Please see attached Narrative (Appendix 2)

F2.b Public Health Outcomes:

Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.

Please see attached Narrative (Appendix 2)

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.

Please see attached Narrative (Appendix 2)

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
+ -	2-3C06	02/06/2012	Transfer of Site/Change in Designated Location	UMass Memorial Medical Center (26 Queen Street Campus)
+ -	2-3X01	08/16/2012	Transfer of Site/Change in Designated Location	UMass Memorial Medical Center Cancer Center at Marlborough Hospital
+ -	1-3C40	08/14/2014	Transfer of Ownership	Wing Memorial Hospital
+ -	2-4952	08/12/2015	Ambulatory Surgery	Healthcare Enterprises, LLC - The Surgery Center (Shrewsbury)
+ -	1-3C59	02/08/2017	Hospital/Clinic Substantial Change in Service	HealthAlliance - Clinton Hospital Emergency Department (Leominster Campus)
+ -	2-3C60	06/22/2017	Hospital/Clinic Substantial Change in Service	UMass Memorial Medical Center (University Campus)
+ -	20121712-TO	05/12/2021	Transfer of Site/Change in Designated Location	UMass Memorial Health - Harrington Hospital, Inc.
+ -	UMMHC-21120 810-RE	05/06/2022	DoN-Required Equipment	UMass Memorial Medical Center (University Campus)
+ -	UMMHC-22042 514-HE	11/18/2022	Hospital/Clinic Substantial Change in Service	UMass Memorial Health Care
+ -	UMMHC-24021 420	07/17/2024	Transfer of Ownership	Milford Regional Medical Center
+ -	UMMHC-25012 116-TO	07/10/2025	Transfer of Ownership	Marlborough Hospital
+ -				

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.

	each Functional Alea document the square lootage and c	Present Foot	Square		re Footage Ir	nvolved in P	roject	Resulting Foot		Total	Cost	Cost/Squar	e Footage
				New Con	struction	Reno	vation						
Add/Del Rows	Functional Areas	Net	Gross	Net	Gross	Net	Gross	Net	Gross	New Construction	Renovation	New Construction	Renovation
ا الله الشا	Nashoba Satellite Emergency Facility CT Scan			732	833			732	833	\$2,195,943.00		\$2,636.19	
+ -													
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+ -													
+ -													
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+ -													
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+ -													
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+ -													
	Total: (calculated)			732	833			732	833	\$2,195,943.00		\$2,636.19	

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	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)	\$809343.		\$80934
	Fixed Equipment Not in Contract	\$1220000.		\$122000
	Architectural Cost (Including fee, Printing, supervision etc.) and Engineering Cost	\$124950.		\$1249
	Pre-filing Planning and Development Costs			
	Post-filing Planning and Development Costs	\$16660.		\$1666
dd/Del Rows	Other (specify)			
+ -				
	Net Interest Expensed During Construction			
	Major Movable Equipment			
	Total Construction Costs	\$2170953.		\$217095
	Financing Costs:			
	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc	\$24990.		\$2499
	Bond Discount			
KOWS	Other (specify			
+ -				
	Total Financing Costs	\$24990.		\$2499
	Estimated Total Capital Expenditure	\$2195943.		\$2195

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:		<u> </u>			
Please see the attache	Please see the attached Narrative (Appendix 2)				
Quality:					
Please see the attached Narrative (Appendix 2)					
Efficiency:					
Please see the attache	d Narrative (Appendix 2)				
Capital Expense:					
Please see the attache	d Narrative (Appendix 2)				
Operating Costs:					
Please see the attache	d Narrative (Appendix 2)				
List alternative options for the Proposed Project:					
Alternative Proposal	:				
Please see the attached Narrative (Appendix 2)					
Alternative Quality:					
Please see the attached Narrative (Appendix 2)					
Alternative Efficiency:					
Please see the attache	Please see the attached Narrative (Appendix 2)				
Alternative Capital Expense:					
Please see the attached Narrative (Appendix 2)					
Alternative Operating Costs:					
Please see the attache	d Narrative (Appendix 2)				
	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.

Please see the attached Narrative (Appendix 2)

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
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
🔀 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:

 \boxtimes

Date/time Stamp: 10/02/2025 1:18 pm

E-mail submission to **Determination of Need**

Application Number: UMMHC-25080814-RE

Use this number on all communications regarding this application.

Community Engagement-Self Assessment form