



Massachusetts Department of Public Health

Determination of Need

Change in Service

Version: DRAFT
3-15-17

DRAFT

Application Date: 07/06/2017

Application Number: -17070616-RE

Applicant Information

Applicant Name: Shields PET-CT at Berkshire Medical Center, LLC

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Title: Attorney

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Facility: Complete the tables below for each facility listed in the Application Form

Facility Name: Not Applicable

CMS Number: Not Applicable

Facility type: *Select from dropdown list or enter type if not on list*

Change in Service

2.2 Complete the chart below with existing and planned service changes. Add additional services with in each grouping if applicable.

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds +/-		Number of Beds After Project Completion (calculate)		Patient Days (Current/ Actual)	Projected Patient Days	Occupancy rate for Operating Beds (Current/Actual)		Average Length of Stay	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating			Current Beds	Projected		
	Acute												
	Medical/Surgical									0%	0%		
	Obstetrics (Maternity)									0%	0%		
	Pediatrics									0%	0%		
	Neonatal Intensive Care									0%	0%		
	ICU/CCU/SICU									0%	0%		
+	-									0%	0%		
	Total Acute									0%	0%		
	Acute Rehabilitation									0%	0%		
+	-									0%	0%		
	Total Rehabilitation									0%	0%		
	Acute Psychiatric												
	Adult									0%	0%		
	Adolescent									0%	0%		

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds +/-		Number of Beds After Project Completion (calculate)		Patient Days (Current/ Actual)	Projected Patient Days	Occupancy rate for Operating Beds (Current/Actual)		Average Length of Stay	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating			Current Beds	Projected		
	Pediatric									0%	0%		
	Geriatric									0%	0%		
<div>+ -</div>										0%	0%		
	Total Acute Psychiatric									0%	0%		
	Chronic Disease									0%	0%		
<div>+ -</div>										0%	0%		
	Total Chronic Disease									0%	0%		
	Substance Abuse												
	detoxification									0%	0%		
	short-term intensive									0%	0%		
<div>+ -</div>										0%	0%		
	Total Substance Abuse									0%	0%		
	Skilled Nursing Facility												
	Level II									0%	0%		
	Level III									0%	0%		
	Level IV									0%	0%		
<div>+ -</div>										0%	0%		
	Total Skilled Nursing									0%	0%		

2.3 Complete the chart below If there are changes other than those listed in table above.

Add/Del Rows	List other services if Changing e.g. OR, MRI, etc	Existing Number of Units	Change in Number +/-	Proposed Number of Units	Existing Volume	Proposed Volume
<div>+ -</div>						

Add additional Facility

Delete this Facility

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To submit the application electronically, click on the "E-mail submission to Determination of Need" button.

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Date/time Stamp: 07/06/2017 4:40 pm

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