**ATTACHMENT 10**

**CHANGE IN SERVICE FORM**

 Version 6-14-17

**Massachusetts Department of Public Health**

**Determination of Need Change in Service**

Application Number: UMMHC 24021420-TO

Original Application Date: 02/15/2024

**Applicant Information:**

Applicant Name: UMass Memorial Health Care, Inc.

Contact Person: Kathleen G. Healy

Title: Legal Counsel

Phone: 6175575995

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**Facility:**

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

1 Facility Name: Milford Regional Medical Center, Inc.

CMS Number: 22090

Facility Type: Hospital

**Change in Service:**

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

| **Add/ Del Rows** |  | **Licensed Beds** | **Operating Beds** | **Change in Number of Beds (+/-)** | **Number of Beds After Project Completion (calculated)** | **Patient Days** | **Patient Days** | **Occupancy Rate for Operating Beds** | **Average Length of Stay**  | **Number of Discharges** | **Number of Discharges** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Existing | Existing | Licensed | Operating | Licensed | Operating | (Current/ Actual) | Projected | Current Beds | Projected | (Days) | Actual | Projected |
|  | **Acute** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Medical/ Surgical | 124 | 124 |  |  | 124 | 124 |  |  | 0% | 0% |  |  |  |
|  | Obstetrics (Maternity) | 14 | 14 |  |  | 14 | 14 |  |  | 0% | 0% |  |  |  |
|  | Pediatrics | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | Neonatal Intensive Care | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | ICU/CCU/SICU | 10 | 10 |  |  | 10 | 10 |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Acute | 148 | 148 |  |  | 148 | 148 |  |  | 0% | 0% |  |  |  |
|  | **Acute Rehabilitation** | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Rehabilitation | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | **Acute Psychatric** | 0 | 0 |  |  | 0 | 0 |  |  |  |  |  |  |  |
|  | Adult | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | Adolescent | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | Pediatric | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | Geriatric | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Total Acute Psychiatric | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | **Chronic Disease** | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Chronic Disease | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | **Substance Abuse** | 0 | 0 |  |  | 0 | 0 |  |  |  |  |  |  |  |
|  | Detoxification | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | Short-term intensive | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Substance Abuse | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | **Skilled Nursing Facility** | 0 | 0 |  |  | 0 | 0 |  |  |  |  |  |  |  |
|  | Level II | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | Level III | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
|  | Level IV | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |
| +/- |  |  |  |  |  |  |  |  |  | 0% | 0% |  |  |  |
|  | Total Skilled Nursing | 0 | 0 |  |  | 0 | 0 |  |  | 0% | 0% |  |  |  |

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** |
| +/- |  |  |  |  |  |  |

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