## Attachment 2: Change in Service Form



## Massachusetts Department of Public Health Determination of Need Change in Service

DRAFT
6-14-17



Application Number: BMIC-25012212-AM			Original Application Date:			02/05/2002									
Appli	icant Information			7 1 100		1000		10000			No. of the last				
Applica	nt Name: Baystate MRI	and Imaging Cente	r, LLC												
Contac	t Person: Kerry Whelan	Kerry Whelan Title: Vice President of Government Affairs													
Phone:	6173767421		Ex	t:	E-mail:	kerry@:	shields.com		Water Annual Anderson Marian San						
Facili	ty: Complete the tab	les below for each	facility listed	in the Appli	cation Fo	rm	TAY OF			- W. T. A. S.	- 12 EX.51 W	St. Marine		STORY S	Too St In
1 Facility Name: Baystate MRI and Imaging Center									CMS Number: 0018589		Facility type: cli	nic			
Chan	ge in Service												No. of St.		
2.2 Con	nplete the chart below wi	th existing and plar	nned service ch	anges. Add	additional	services	with in each gro	ouping if applica	able.						
Add/Del Rows		Licensed Beds  Existing	Operating Beds  Existing	Change in Number of Beds (+/-) Licensed Operating				ds After Project n (calculated) Operating	Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate Bed Current Beds	ds	Average Length of Stay (Days)	Number of Discharges Actual	Number of Discharges Projected
	Acute	Existing	Existing	Licensed	Орс	rating	Election	operating	rictally	110,000	current beas	rrojected	(54)5/	rictaar	
	Medical/Surgical										0%	0%			
	Obstetrics (Maternity)						V ANSARIOS (1)				0%	0%			
	Pediatrics										0%	0%			
	Neonatal Intensive Care	9									0%	0%			
	ICU/CCU/SICU										0%	0%			
+ -							FILE				0%	0%			
	Total Acute		THE PARTY OF			Year					0%	0%			
	Acute Rehabilitation										0%	0%			
1-1-											0%	0%			
Hammel Immend	Total Rehabilitation	OT A SALES				JET DY				Minusey	0%	0%			
	Acute Psychiatric														

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Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days (Current/	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay	Number of Discharges	Number of Discharges
Rows		Existing	Existing	Licensed	Operating	Licensed	Operating	Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	Adult					A PURPLE				0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric					NAME OF STREET				0%	0%			
+										0%	0%			
	Total Acute Psychiatric	Mare Wille			No. of the latest	HOTOLEVES HOTO				0%	0%		Presidents	
	Chronic Disease									0%	0%			
-  -										0%	0%			
	Total Chronic Disease	Derrie C.				101/102	MARKET AND THE	TO NO.		0%	0%	The state of	SECTION .	
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive					N historia	BEAT STORY			0%	0%			
[+][-]	And the control of th									0%	0%			
	Total Substance Abuse	1 10 10 10 10 10 10 10 10 10 10 10 10 10							a had a soft	0%	0%			
	Skilled Nursing Facility													
	Level II				Ť	THE PARTY OF	State No.			0%	0%			
	Level III									0%	0%			
	Level IV					Suran S				0%	0%			
+ -	2010.11									0%	0%			
	Total Skilled Nursing		7 000 1100					NO SECTION		0%	0%		TO THE WATER	
	plete the chart below If th	ere are changes o	ther than those	e listed in table	above.									
Add/Del									Existing Num	ber Change in	Propos	ed e	Nes of	Proposed
Rows	List other services if Ch	t other services if Changing e.g. OR, MRI, etc							of Units	Number +/	- Number of	Units	ng Volume	Volume
+ -	Addition of four days of	Addition of four days of PETCT service for a total of seven days								3	4	7		

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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:

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Date/time Stamp: 04/22/2025 10:03 am

E-mail submission to Determination of Need

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