ATTACHMENT 10

Change in Service Form

Massachusetts Department of Public Health
Determination of Need
Change in Service

Version: DRAFT 6-14-17

DRAFT

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 Ext: E-mail: khealy@rc.com

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 with in 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 (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected		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 Psychiatric													

Add/Del Rows		Licensed Beds Existing	Operating Beds Existing	Change in Number of Beds (+/-) Licensed	Operating	Number of Beds After Project Completion (calculated) Licensed	Operating	Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds Current Beds	Projected	Average Length of Stay (Days)	Number of Discharges Actual	Number of Discharges Projected
	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%			
+ -										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													
	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													
	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%			

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
+ -	Not applicable					

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: [x]

Date/time Stamp: 02/15/2024 1:45 pm

E-mail submission to Determination of Need