



Massachusetts Department of Public Health Determination of Need Change in Service

Version: DRAFT
6-14-17

DRAFT

Application Number: ESC-22101909-AS

Original Application Date: 11/17/2022

Applicant Information

Applicant Name: EXCEL SURGERY CENTER, LLC

Contact Person: RAMI R. RUSTUM, MD Title: PRESIDENT

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

1 Facility Name: EXCEL SURGERY CENTER CMS Number: Pending Facility type: Freestanding Ambulatory Surgery capacity

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 (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating			Current Beds	Projected		Actual	Projected
	Acute													
	Medical/Surgical	0	0	0	0	0	0	0		0%	0%	0	0	0
	Obstetrics (Maternity)	0	0	0	0	0	0	0	0	0%	0%	0	0	0
	Pediatrics	0	0	0	0	0	0	0	0	0%	0%	0	0	0
	Neonatal Intensive Care	0	0	0	0	0	0	0		0%	0%	0	0	0
	ICU/CCU/SICU	0	0	0	0	0	0	0		0%	0%	0	0	0
+	-	0	0	0		0	0			0%	0%			
	Total Acute	0	0	0	0	0	0	0	0	0%	0%	0	0	0
	Acute Rehabilitation	0	0		0	0	0	0		0%	0%	0	0	0
+	-									0%	0%			
	Total Rehabilitation	0	0		0	0	0	0		0%	0%	0	0	0
	Acute Psychiatric													

Add/Del Rows		Licensed Beds		Operating Beds		Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days (Current/Actual)	Patient Days Projected	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	
		Existing		Existing		Licensed	Operating	Licensed	Operating			Current Beds	Projected		Actual	Projected
	Adult	0		0				0	0	0	0	0%	0%	0	0	0
	Adolescent	0		0				0	0	0	0	0%	0%	0	0	0
	Pediatric	0		0				0	0	0	0	0%	0%	0	0	0
	Geriatric	0		0				0	0	0	0	0%	0%	0	0	0
<input type="checkbox"/> <input type="checkbox"/>		0		0				0	0	0	0	0%	0%			
	Total Acute Psychiatric	0		0				0	0	0	0	0%	0%	0	0	0
	Chronic Disease	0		0				0	0			0%	0%	0	0	0
<input type="checkbox"/> <input type="checkbox"/>												0%	0%	0	0	0
	Total Chronic Disease	0		0				0	0			0%	0%	0	0	0
	Substance Abuse															
	detoxification	0		0				0	0		0	0%	0%		0	0
	short-term intensive	0		0				0	0		0	0%	0%		0	0
<input type="checkbox"/> <input type="checkbox"/>												0%	0%		0	0
	Total Substance Abuse	0		0				0	0		0	0%	0%		0	0
	Skilled Nursing Facility															
	Level II	0		0				0	0		0	0%	0%		0	0
	Level III	0		0				0	0		0	0%	0%		0	0
	Level IV	0		0				0	0		0	0%	0%		0	0
<input type="checkbox"/> <input type="checkbox"/>												0%	0%		0	0
	Total Skilled Nursing	0		0				0	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
<input type="checkbox"/> <input type="checkbox"/>	OR	0	2	2	0	1,200
<input type="checkbox"/> <input type="checkbox"/>	Pre-OP Beds	0	3	3		
<input type="checkbox"/> <input type="checkbox"/>	Post-OP Beds	0	3	3		

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