Massachusetts Department of Public Health
Determination of Need
Application Form

Version: 8-15-17

Application Type: Transfer of Site/Change in Designated Location

Application Date: 04/10/2018 2:07 pm

Applicant Name: Reliant Medical Group, Inc.

Mailing Address: 100 Front Street

City: Worcester State: Massachusetts Zip Code: 01608

Contact Person: Matthew Fisher, Esq. Title: Attorney

Mailing Address: Mirick O'Connell, 100 Front Street

City: Worcester State: Massachusetts Zip Code: 01608

Phone: 5089291648 Ext: E-mail: mfisher@mirickoconnell.com

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name: Reliant Medical Group Department of Radiology

Facility Address: 300 Grove Street

City: Worcester State: Massachusetts Zip Code: 01605

Facility type: Diagnostic Imaging Service Facility CMS Number:

Add additional Facility Delete this Facility

2 Facility Name: Reliant Medical Group Department of Radiology

Facility Address: 5 Neponset Street

City: Worcester State: Massachusetts Zip Code: 01606

Facility type: Diagnostic Imaging Service Facility CMS Number:

Add additional Facility Delete this Facility

1. About the Applicant

1.1 Type of organization (of the Applicant): for profit

1.2 Applicant's Business Type: (•) Corporation ( ) Limited Partnership ( ) Partnership ( ) Trust ( ) LLC ( ) Other

1.3 What is the acronym used by the Applicant's Organization?

1.4 Is Applicant a registered provider organization as the term is used in the HPC/CHIA RPO program? (●) Yes ( ) No

1.5 Is Applicant or any affiliated entity an HPC-certified ACO? (●) Yes ( ) No

1.5.a If yes, what is the legal name of that entity? Reliant Medical Group, Inc.

1.6 Is Applicant or any affiliate thereof subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00 (filing of Notice of Material Change to the Health Policy Commission)? ( ) Yes (●) No

1.7 Does the Proposed Project also require the filing of a MCN with the HPC? ( ) Yes (●) No

1.8 Has the Applicant or any subsidiary thereof been notified pursuant to M.G.L. c. 12C, § 16 that it is exceeding the health care cost growth benchmark established under M.G.L. c. 6D, § 9 and is thus, pursuant to M.G.L. c. 6D, §10 required to file a performance improvement plan with CHIA? ( ) Yes (●) No

1.9 Complete the Affiliated Parties Form

2. Project Description

2.1 Provide a brief description of the scope of the project.

Please see description contained in attachment.

2.2 and 2.3 Complete the Change in Service Form

3. Delegated Review

3.1 Do you assert that this Application is eligible for Delegated Review? (●) Yes ( ) No

3.1.a If yes, under what section? Transfer of Site or change of a designated Location

4. Conservation Project

4.1 Are you submitting this Application as a Conservation Project? ( ) Yes (●) No

5. DoN-Required Services and DoN-Required Equipment

5.1 Is this an application filed pursuant to 105 CMR 100.725: DoN-Required Equipment and DoN-Required Service? ( ) Yes (●) No

6. Transfer of Ownership

6.1 Is this an application filed pursuant to 105 CMR 100.735? ( ) Yes (●) No

7. Ambulatory Surgery

7.1 Is this an application filed pursuant to 105 CMR 100.740(A) for Ambulatory Surgery? ( ) Yes (●) No

8. Transfer of Site

8.1 Is this an application filed pursuant to 105 CMR 100.745? (●) Yes ( ) No

8.2 Current location of Site

Facility Name: Reliant Medical Group Department of Radiology

Physical Address: 300 Grove Street

City:	Worcester	State:	Massachusetts	Zip Code:	01605

Facility type: Diagnostic Imaging Service Facility

8.3 Location of Proposed Site

Facility Name: Reliant Medical Group Department of Radiology

Physical Address: 5 Neponset Street

City:	Worcester	State:	Massachusetts	Zip Code:	01606

Facility type: Diagnostic Imaging Service Facility

8.4 Compare the scope of the project for each element below:

	Current Site	Proposed Site
Gross Square Feet	3,325	2,786
Primary Service Area Towns served	See Attached Explanation	See Attached Explanation
Patient Population (Demographics)	See Attached Explanation	See Attached Explanation
Patient Access	See Attached Explanation	See Attached Explanation
Impact on Price	See Attached Explanation	See Attached Explanation
Total Medical Expenditure	See Attached Explanation	See Attached Explanation
Provider Costs	See Attached Explanation	See Attached Explanation
Description	See Attached Explanation	See Attached Explanation

8.5 Detail all Anticipated Capital Expenditures to be incurred as a result of the proposed Transfer of Site.

Add Del Row	Anticipated Capital Expenditure	Cost
+ -	Build out of new location	$1,071,892.00
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
	Total Cost	$1,071,892.00

9. Research Exemption

9.1 Is this an application for a Research Exemption? ○ Yes ◉ No

10. Amendment

10.1 Is this an application for a Amendment? ◯ Yes ◉ No

11. Emergency Application

11.1 Is this an application filed pursuant to 105 CMR 100.740(B)? ◯ Yes ◉ No

12. Total Value and Filing Fee

Enter all currency in numbers only. No dollar signs or commas. Grayed fields will auto calculate depending upon answers above.

Your project application is for: Transfer of Site/Change in Designated Location

12.1 Total Value of this project:	$1,071,892.00
12.2 Total CHI commitment expressed in dollars: (calculated)	$0.00
12.3 Filing Fee: (calculated)	$0.00
12.4 Maximum Incremental Operating Expense resulting from the Proposed Project:	
12.5 Total proposed Construction costs, specifically related to the Proposed Project, If any, which will be contracted out to local or minority, women, or veteran-owned businesses expressed in estimated total dollars.	

13. Factors

Required Information and supporting documentation consistent with 105 CMR 100.210

Some Factors will not appear depending upon the type of license you are applying for.

Text fields will expand to fit your response.

Documentation Check List

The Check List below will assist you in keeping track of additional documentation needed for your application.

Once you have completed this Application Form the additional documents needed for your application will be on this list. E-mail the documents as an attachment to: DPH.DON@state.ma.us

☒ Affidavit of Truthfulness Form

☒ Articles of Organization / Trust Agreement

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: ☒ Date/time Stamp: 04/10/2018 2:07 pm

E-mail submission to Determination of Need

Application Number: -17111409-TS

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form