

Massachusetts Department of Public Health Determination of Need Change in Service

Version: DRAFT 6-14-17

DRAFT

Application Numbe	er: -17122113-TO	Original Application Date:	12/22/2017		
Applicant Inf	ormation				
Applicant Name:	Reliant Medical Group, Inc.				
Contact Person:	M. Daria Niewenhous, Esq.		Title: Attorney		
Phone:	6173484865 Ext:	E-mail: dniewenhous@mintz.cor	n		
Facility: Com	plete the tables below for each facility listed in the App	lication Form			
1 Facility Name:	Reliant Medical Group The Endoscopy Center, LLC d/b/a T	he Endoscopy Center	CMS Number: 221067	Facility type: Freestanding <i>P</i>	Ambulatory Surgery Facility

Change in Service

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

	•	5 1		5		5	1 9 11	,							
		Licensed Beds	Operating	Change in Nu	Imber of Beds	Number of Beds After Project		Patient Days	Patient Days	Occupancy rate for Operating			Number of	Number of	
Add/Del			Beds	(+	-/-)	Completion (calculated)					ls	Length of	Discharges	Discharges	
Rows		- • •	- • •		o		o <i>i</i> :	(Current/	Due is stord			Stay		Dustantad	
		Existing	Existing	Licensed	Operating	Licensed	Operating	Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected	
	Acute														
	Medical/Surgical									0%	0%				
	Obstetrics (Maternity)									0%	0%				
	Pediatrics									0%	0%				
	Neonatal Intensive Care									0%	0%				
	ICU/CCU/SICU									0%	0%				
+ -										0%	0%				
	Total Acute									0%	0%				
	Acute Rehabilitation									0%	0%				
+ -										0%	0%				
	Total Rehabilitation									0%	0%				
	Acute Psychiatric			•		·		•							

Change in Service Reliant Medical Group, Inc.

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	n of Discharges	
nows		Existing	Existing	Licensed	Operating	Licensed	Operating	Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	Adult									0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	Total Acute Psychiatric									0%	0%			
	Chronic Disease									0%	0%			
+ -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility									l.				I
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	Total Skilled Nursing									0%	0%			
ļ	plete the chart below If the	ere are changes o	ther than those	e listed in table a	above.									
Add/De Rows	List other services if Cha	anging e.g. OR, M	RI, etc						Existing Numb of Units	oer Change in Number +/		ed Units Existin	ng Volume	Proposed Volume
+ -	None													
										I				

Facili	ty: Complete the table	s below for each	facility listed	in the Applicat	ion Form									
2 Fa	cility Name: Surgical Eye Ex	perts, LLC					CMS Number:	221072		Facility type: Fre	eestanding Am	bulatory Surge	ery Facility	
							-							
Chan	ge in Service													
2.2 Cor	nplete the chart below with	existing and plai	nned service ch	anges. Add add	ditional services	with in each gro	ouping if applica	able.						
Add/De Rows		Licensed Beds Operating Change Beds		(-	(+/-) Completion			(Current/		Occupancy rate for Operating Beds		Length of Stay	Number of Discharges	Number of Discharges
	A	Existing	Existing	Licensed	Operating	Licensed	Operating	Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	Acute			1	1			1		201	00/			
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity) Pediatrics									0%	0% 0%		ļ]	
	Neonatal Intensive Care									0%	0%			
	ICU/CCU/SICU									0%	0%			
+ -										0%	0%			
	Total Acute									0%	0%			
	Acute Rehabilitation									0%	0%		ļ/	
+ -										0%	0%			
	Total Rehabilitation Acute Psychiatric									0%	0%			
	Adult									0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	Total Acute Psychiatric									0%	0%			
	Chronic Disease									0%	0%			
+ -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			

Change in Service Reliant Medical Group, Inc.

Add/Del Rows		Licensed Beds Operating Change in Number of Bed Beds (+/-)			Completion (calculated)		Patient Days (Current/	Patient Days	Occupancy rate Bed		Average Length of Stay			
nows		Existing	Existing	Licensed	Operating	Licensed	Operating	Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility													
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	Total Skilled Nursing									0%	0%			
2.3 Complete the chart below If there are changes other than those listed in table above.														
Add/De Rows	el List other services if Changing e.g. OR, MRI, etc								Existing Numb of Units	oer Change in Number +/			ing Volume	Proposed Volume
+ - None														
													1	

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