 Version: 11-8-17

Massachusetts Department of Public Health  
Determination of Need  
Application Form

Application Type: Transfer of Site/Change in Designated Location

Application Date: 04/02/2025 11:27 am

Applicant Name: VHS Acquisition Subsidiary Number 9, Inc., d/b/a MetroWest Medical Center

Mailing Address: 115 Lincoln Street

City: Framingham State: Massachusetts Zip Code: 01702

Contact Person: Neil Wallis

Title: MetroWest Medical Center Associate Administrator

Mailing Address: 115 Lincoln Street

City: Framingham State: Massachusetts Zip Code: 01702

Phone: 5182609999 Ext: none

Email: [Neil1.Wallis@mwmc.com](mailto:Neil1.Wallis@mwmc.com)

**Facility Information**

**List each facility affected and or included in Proposed Project**

1. Facility Name: MetroWest Health & Wellness Center

Facility Address: 761 Worcester Rd #2

City: Framingham State: Massachusetts Zip Code: 01701

Facility type: Hospital CMS Number: 220175

2. Facility Name: MetroWest Medical Center Outpatient Primary Care

Facility Address: 61 Lincoln Street

City: Framingham State: Massachusetts Zip Code: 01702

Facility type: Hospital CMS Number: 220175

3. Facility Name: Framingham Union Hospital

Facility Address: 115 Lincoln Street

City: Framingham State: Massachusetts Zip Code: 01702

Facility type: Hospital CMS Number: 220175

**1. About the Applicant**

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

1.2 Applicant’s Business Type: Corporation

1.3 What is the acronym used by the Applicant’s Organization: MWMC

1.4 Is Applicant a registered provider organization as the term is used in the HPC/CHIA RPO program? Yes

1.5 Is Applicant or any affiliated entity an HPC-certified ACO? Yes

1.5.a If yes, what is the legal name of that entity? Boston Medical Center Health Plan, Inc., d/b/a WellSense Health Plan

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? No

1.7 Does the Proposed Project also require the filing of a MCN with the HPC? 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? 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 attached.

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

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? 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? No

**6. Transfer of Ownership**

6.1 Is this an application filed pursuant to 105 CMR 100.735? No

**7. Ambulatory Surgery**

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

**8. Transfer of Site**

8.1 Is this an application filed pursuant to 105 CMR 100.745? Yes

8.2 Current Location of Site

Facility Name: MetroWest Health & Wellness Center

Physical Address: 761 Worcester Rd #2

City: Framingham

State: Massachusetts

Zip Code: 01701

Facility Type: Hospital

8.3 Location of Proposed Site

Facility Name: Please see attached.

Physical Address: [blank]

City: [blank]

State: [blank]

Zip Code: [blank]

Facility Type: [blank]

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

|  | Current Site | Proposed Site |
| --- | --- | --- |
| Gross Square Feet | Please see attached. | Please see attached. |
| Primary Service Area Towns served | Please see attached. | Please see attached. |
| Patient Population (Demographics) | Please see attached. | Please see attached. |
| Patient Access | Please see attached. | Please see attached. |
| Impact on Price | Please see attached. | Please see attached. |
| Total Medical Expenditure | Please see attached. | Please see attached. |
| Provider Costs | Please see attached. | Please see attached. |
| Description | Please see attached. | Please see attached. |

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 |
| --- | --- | --- |
| +/- | Please see attached. | [blank] |
| +/- |  |  |
| +/- |  |  |
| +/- |  |  |
|  | Total Cost | [blank] |

**9. Research Exemption**

9.1 Is this an application for a Research Exemption? No

**10. Amendment**

10.1 Is this an application for a Amendment? No

**11. Emergency Application**

11.1 Is this an application filed pursuant to 105 CMR 100.740(B)? 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 a**: Transfer of Site/Change in Designated Location

12.1 Total Value of this project: $0.00

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: $137,600.00

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. $0.00

**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](mailto:DPH.DON@state.ma.us)

Affidavit of Truthfulness Form: check

Articles of Organization/Trust Agreement: check

**Documentation 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? Yes Date/time Stamp: 04/02/2025 11:27 am

E-mail submission to Determination of Need

**Application Number: MWMC-25040109-TS**

**Use this number on all communications regarding this application**