

# **MASSACHUSETTS DETERMINATION OF NEED PROGRAM APPLICATION KIT**

**March 19, 2015 Revision**

**Determination of Need Program  
99 Chauncy Street  
Boston, MA 02111**

## Table of Contents

INTRODUCTION .....	1
GENERAL INSTRUCTIONS .....	2
FACE SHEET.....	4
AFFIDAVIT OF TRUTHFULNESS AND PROPER SUBMISSION.....	6
APPLICANT INFORMATION.....	8
APPLICATION NARRATIVE (PROJECT SUMMARY) .....	9
FACTOR 1: HEALTH PLANNING PROCESS.....	11
FACTOR 2: HEALTH CARE REQUIREMENTS.....	13
FACTOR 3: OPERATIONAL OBJECTIVES.....	17
FACTOR 4: STANDARDS COMPLIANCE .....	18
FACTOR 5: REASONABLENESS OF EXPENDITURES AND COSTS .....	19
Schedule 5.1 Square Footage And Cost Per Square Foot .....	20
Schedule 5.2 Project Implementation.....	22
FACTOR 6: FINANCIAL FEASIBILITY .....	23
Schedule A: Statement of Revenues and Expenses.....	26
Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers .....	27
Schedule C: Staffing Patterns .....	31
Schedule D: Estimated Capital Expenditure.....	32
Schedule E: Depreciation Expense.....	33
Schedule F: Proposed Funds for Estimated Capital Expenditure .....	34
Schedule F1: Features of Permanent Financing of Estimated Capital Expenditure <sup>a</sup> .....	35
Schedule F2: Application of Permanent Financing Proceeds .....	36
Schedule G: Fixed Charges Covered .....	37
Schedule H: Revenue by Payer .....	39
FACTOR 7: RELATIVE MERIT.....	40
FACTOR 8: ENVIRONMENTAL IMPACT.....	41
Factor 8: DoN GREEN GUIDELINES .....	43
FACTOR 9: COMMUNITY HEALTH SERVICE INITIATIVES.....	44



The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
99 Chauncy Street, Boston, MA 02111

CHARLES D. BAKER  
Governor

KARYN E. POLITO  
Lieutenant Governor

MARYLOU SUDDERS  
Secretary

MONICA BHAREL, MD, MPH  
Commissioner

March 19, 2015

Notice to Applicants:

This version of the Determination of Need Application Kit contains revisions to Factor 8, Environmental Impact. Page 41 of the application form contains revised instructions for meeting the requirements of the Massachusetts Environmental Protection Act ("MEPA"). On page 42, the former MEPA checklist has been replaced by a new form, titled Certification of MEPA Compliance. This form must be completed and signed by an individual authorized by the Applicant.

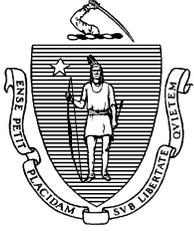
Prospective applicants may obtain guidance and advice in the preparation of an application from a member of the DoN Program staff. Our contact information is as follows:

Telephone: 617-753-7340, Email: [DPH.DoN@massmail.state.ma.us](mailto:DPH.DoN@massmail.state.ma.us)

Sincerely,

A handwritten signature in black ink, appearing to read "Bernard Plovnick".

Bernard Plovnick, Director  
Determination of Need Program



The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
99 Chauncy Street, Boston, MA 02111

**CHARLES D. BAKER**  
Governor

**KARYN E. POLITO**  
Lieutenant Governor

**MARYLOU SUDDERS**  
Secretary

**MONICA BHAREL, MD, MPH**  
Commissioner

February 24, 2015

Dear Prospective Applicant:

Enclosed is the updated version of the Determination of Need (“DoN”) Application Kit to be completed for original DoN applications involving substantial capital expenditure or substantial change in service. The DoN Application Kit is modified from time to time to reflect changes in the DoN review process resulting from changes to Massachusetts statutes (M.G.L. c.111, §§ 25B to 25G, §§ 51 through 53, 51A, and 71) and the DoN regulation (105 CMR 100.000).. The latest revisions to the DoN regulation ([105 CMR 100.000](#)) went into effect on August 1, 2014. Please consult the regulation for detailed filing requirements. Note especially the section of the regulation listed below for DoN actions that do not use this application kit:

- Amendments to Approved DoN Projects – 105 CMR 100.750 et seq.
- Change of Ownership (Hospitals and Ambulatory Care Centers) – 105 CMR 100.600 et seq.
- Conversion of Acute Care Beds to Non-Acute - 105 CMR 100.604 et seq.
- Transfer of Ownership for Approved, Unimplemented Projects – 105 CMR 100.710
- Transfer of Site – 105 CMR 100.720

#### Preparation of Application

An application must be prepared in conformance with the DoN regulation and pertinent guidelines that are in effect at the time of filing as well as DoN policy advisories as may be posted from time to time on the DoN website. Every prospective applicant is strongly encouraged to consult with DoN Program staff during the preparation of an application.

#### DoN Guidelines

The DoN Program utilizes guidelines for analyzing need for the following regulated services:

- Acute Inpatient Rehabilitation Services
- Conversion of Acute Care Beds to Non-Acute Care Services
- Ambulatory Surgery
- Nursing Homes that are part of Continuing Care Retirement Communities
- Level IV Residential Care Facilities
- Long Term Care Facility Replacement and Renovation
- Magnetic Resonance Imaging
- Megavoltage Radiation Therapy
- Neonatal Intensive Care Units
- Positron Emission Tomography (PET)

If a project involves any of the categories listed above, an applicant should request the appropriate guidelines by contacting the DoN Program Office ([DPH.DoN@massmail.state.ma.us](mailto:DPH.DoN@massmail.state.ma.us) or 617-753-7340).

Any project involving new construction or gut renovation is subject to the DoN Guidelines for Environmental and Human Health Impact (“[Green Guidelines](#)”).

Please note that, pursuant to 105 CMR 100.301 of the DoN Regulation, an application shall not be accepted for filing if the applicable DoN guidelines in effect at the time of filing indicate that no need exists for the service.

#### Factor 9: Community Health Initiatives

For information regarding completion of DoN Factor 9, applicants should review the memorandum on Community Health Initiatives posted on the DoN website [www.mass.gov/dph/don](http://www.mass.gov/dph/don).

#### Submission of Application

1. **Filing Dates** for DoN Applications, set forth at 105 CMR 100.302, were not changed in the August 2014 revisions of the regulation and are summarized as follows:
  - **First business days of February and August** - applications for establishment of services and devices from the list of [Innovative Services and New Technology](#).
  - **Any business day** – all other applications
2. **Application Fee.** Pursuant to a change to M.G.L. c. 111, §25C enacted in St. 2012, c. 224, (“Chapter 224”), the application fee for Determination of Need has changed. Effective August 1, 2014, the fee for applications involving substantial capital expenditure or substantial change in service is 0.2% (.002) of the total requested capital expenditure, or a minimum of \$250.00, whichever is greater.
3. **Application Format and Required Copies.** Applicants should note that all required copies of a DoN application may now be submitted to the appropriate state office by email in electronic PDF format. Only one original hard copy of the application is required to be submitted to the DoN Program in addition to one copy in PDF format.

Contact information for each agency, division or office where a copy of the application is required to be submitted may be found at <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/ohp/don/apply/applications.html>.

A copy of an application is only required to be submitted to Department of Mental Health and Executive Office of Elder Affairs if the proposed project involves mental health services or long term care, respectively. Chapter 224 added the requirement that a copy of all DoN applications be submitted to the Health Policy Commission.

Please contact a DoN staff member for guidance and advice in the preparation of an application. Our contact information is as follows: Telephone: 617-753-7340, Email: [DPH.DoN@massmail.state.ma.us](mailto:DPH.DoN@massmail.state.ma.us)

Sincerely,



Bernard Plovnick, Director  
Determination of Need Program

TO: Prospective Applicants for  
Long Term Care Projects

FROM: Determination of Need Program Director

DATE: March 16, 2004  
(Updated August 27, 2013)

SUBJECT: Special Instructions for Completion of the  
Determination of Need Application Kit

Long Term Care applicants should complete the entire application kit, with the following changes or additions:  
(see also May 25, 1993 Determination of Need Guidelines for Nursing Facility Replacement and Renovation).

**FACTOR 3 (Operational Objectives – see also May 25, 1993 Nursing Facility Replacement and Renovation Guidelines)**

3.4 - Nursing Home DoN applicants should state: (1) their plans for referring applicants for admission who may be appropriate for acute care services or home care services, and (2) their plans for coordination of services with the appropriate home care corporation, including planning for residents who are appropriate candidates for discharge into the community.

NOTE: Home Care Corporations are independent corporations charged with the responsibility of carrying out the Home Care Program of the Executive Office of Elder Affairs. Each Home Care Corporation provides or arranges home care for residents in the service area of the corporation. Home care services are designed to assist elders in maintaining independent living within their home environment.

If in doubt, an applicant for DoN should contact the Executive Office of Elder Affairs to determine which Home Care Corporation serving the geographic region of the service area of the proposed facility. The general information number at the Executive Office of Elder Affairs is 1-617-727-7750.

**FACTOR 4 (Standards Compliance):**

Applicants should review the general standards of construction for a long-term care facility (105 CMR 150.000) which is available at <http://www.mass.gov/eohhs/docs/dph/regs/105cmr150.pdf> or at the State House Bookstore (617-727-2834).

**FACTOR 5 (Reasonableness of Expenditures and Costs):**

Complete schedules A, C, D, E, F, F1, F2, G, and H. Schedule H should be completed by level of care. Substitute “Level of Care” for “Service” wherever the term appears.

**FACTOR 6. (Financial Feasibility and Capability)**

- Applicants are advised to review the Center for Health Information and Analysis regulations at 114.2 CMR 6.00 to determine the actual payment to providers for MassHealth (Medicaid) residents.
- Applicants should consult the DoN staff for the latest standards on cost per gross square footage, major movable equipment, and pre- and post- planning costs.
- Applications involving Life Safety Code renovations should include copies of survey reports.

**FACTOR 8 (Environmental Impact)**

Applications involving new construction or gut renovation should consult the Determination of Need Guidelines for Environmental and Human Health Impact.

## INTRODUCTION

---

The purpose of the Massachusetts Determination of Need Application Kit is twofold. First, it is to provide applicants with a clear indication of the nature, scope and depth of preparations expected of them. Second, it is to provide DoN Program staff, as well as the Public Health Council, with the information necessary for fair and thorough evaluations. The kit should contribute to the speed, consistency, and predictability of reviews while increasing public involvement.

It should be noted that many of the questions presented in this kit are organized according to the factors found in 105 CMR 100.533. The questions listed under individual factors in the kit are intended to assist applicants and reviewers by gathering relevant information in a structured and convenient manner. Although questions are grouped by factors, the completed application will be viewed and evaluated in its entirety. Questions have been categorized in order to avoid unnecessary repetition of data requests rather than to limit the use of specific information to the evaluation of any particular factor or factors.

Since no general kit can be exhaustive in its data requests, it will remain the responsibility of applicants to provide all necessary information. Currently, it is often necessary for reviewers to request information not supplied in an applicant's original submission. Use of this kit is expected to substantially reduce, although not eliminate, the need for additional data requests. Statutory and regulatory changes may take place from time to time and may not be reflected in this kit. It is the duty of the applicant to be cognizant of such changes and to file an application consonant with such changes.

## GENERAL INSTRUCTIONS

---

Enclosed is an application form for Determination of Need. In order to complete this form, it is necessary to read and comply with the Massachusetts Determination of Need Regulation 105 CMR 100.000. An unofficial version of the regulation may be found online at the DoN website ([www.mass.gov/dph/don](http://www.mass.gov/dph/don)) or the official version may be obtained from the State House Bookstore, Boston, MA 02133, Telephone: (617) 727-2834 (<http://www.sec.state.ma.us/spr/sprcat/catidx.htm>).

Assistance in preparing applications is available from the Determination of Need Staff (617-624-5690).

### CONTENTS OF APPLICATION

Please refer to 105 CMR 100.300-100.303 and 105 CMR 100.320-100.326 regarding the required contents of the application.

Please note that 105 CMR 100.350-100.354 substantially limits the right of applicants to alter applications or to provide additional information after an application has been submitted. Therefore, applicants should not file an application unless and until all important information is included.

Please note that if a filing fee is required (See 105 CMR 100.323) it must be submitted with the application, by check, payable to the "**Commonwealth of Massachusetts.**"

Please see 105 CMR 100.306 which requires documentation as to ownership and zoning. Such documentation need only be submitted with the original copy and referenced in succeeding copies.

Newspaper Notice: Every applicant for Determination of Need is required to publish a notice of application, as prescribed in 105 CMR 100.330-100.332, in the legal notice section of the appropriate newspaper and an identical notice at least once in some other section as well. Refer to the regulation for details of publication. Please note that the final day to request a public hearing or to register as a ten taxpayer group (following the publication) must be on a business day. Please attach a true copy of the notices of publication with date of publication, as required under the above-referenced section, immediately after page 3 of general instructions.

No application will be accepted if the requirements of 105 CMR 100.306 and 100.320-100.326 are not met, and no application will be accepted if all relevant parts of the application kit are not complete.

PLEASE NOTE: The Determination of Need application kit asks applicants, in some cases, to supply answers on additional sheets. Where additional sheets are used, they should be clearly labeled with the factor name, question number (and page number) to which they pertain.

# GENERAL INSTRUCTIONS

---

## DISTRIBUTION OF COPIES

(105 CMR 100.300) Applicants must submit one complete original hard copy and one electronic copy in PDF format (or one original and two additional hard copies) to:

Department of Public Health  
Determination of Need Program  
99 Chauncy Street  
Boston, MA 02111  
[Dph.don@massmail.state.ma.us](mailto:Dph.don@massmail.state.ma.us)

Applicants must also submit one hard copy (or electronic copy in PDF format) to the offices listed below. An updated list of contact persons with phone numbers and email addresses is available at the DoN website ([www.mass.gov/dph/don](http://www.mass.gov/dph/don)) in the "Applications" section.

Department of Public Health  
Regional Health Office  
(See 100.300 for appropriate office)

*If relevant under Section 100.152:*

Executive Office of Elder Affairs  
One Ashburton Place, 5th Floor  
Boston, MA 02108

Center for Health Information and  
Analysis  
501 Boylston Street  
Boston, MA 02116

*If relevant under Section 100.153:*

Department of Mental Health  
Division of Clinical & Professional Services/  
Office of Policy Development  
25 Staniford Street  
Boston, MA 02114

Division of Medical Assistance  
Office of Acute and Ambulatory Care  
100 Hancock Street  
Quincy, MA 02171

Health Policy Commission  
50 Milk Street, 8th Floor  
Boston, MA 02109

MassHealth  
1 Ashburton Place  
Boston, MA 02108

## FILING FEE AND COMPUTATION SHEET

Every applicant, other than a government agency, filing under M.G.L. c. 111, §25C is required to accompany the application with a filing fee as indicated below:

MAXIMUM CAPITAL EXPENDITURE: \$ \_\_\_\_\_ x .0020  
= \$ \_\_\_\_\_ Filing Fee

Minimum Filing Fee is \$250.00, regardless of maximum capital expenditure.

Applicant must attach a check or money order made payable to the "**Commonwealth of Massachusetts**" in the amount indicated above. If applicant claims an exemption from the filing fee, state here why the applicant is exempt, citing the applicable section of the regulation.

## FACE SHEET

1a. FILING DATE: \_\_\_\_\_ 1b. FILING FEE: \$ \_\_\_\_\_

2. HSA: \_\_\_\_\_ 3.  REGULAR or  UNIQUE APPLICATION (Check one)

4. APPLICANT NAME: \_\_\_\_\_

5. ADDRESS: \_\_\_\_\_

6. CONTACT PERSON: (Name) \_\_\_\_\_ (Title) \_\_\_\_\_

(Mailing Address): \_\_\_\_\_ (Telephone) \_\_\_\_\_

Email: \_\_\_\_\_

7a. FACILITY NAME: \_\_\_\_\_

7b. LOCATION: \_\_\_\_\_

8. FACILITY TYPE (circle one):

1) Acute Care Hospital      2) Nursing Facility      3) Ambulatory Surgery Center

4) Chronic Disease/Rehabilitation Hospital      5) Other \_\_\_\_\_

9. TYPE OF OWNERSHIP (circle as appropriate):

1) Private non-profit

3) Public

2) Private for-profit

4) Other \_\_\_\_\_

10. BRIEF PROJECT DESCRIPTION (consistent with newspaper notice):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. PROJECT TYPE (check one or more as appropriate):

- Substantial Change in Service** – The addition or expansion of or conversion to a new technology, innovative service, or ambulatory surgery by acute care or non-acute care facilities regardless of whether the expenditure minimum is exceeded; non-acute care services provided by acute care hospitals; and any increase in bed capacity by a non-acute care facility totaling more than 12 beds to the licensed bed capacity of the entire facility.
- Substantial Capital Expenditure** – Any capital expenditure that is at or exceeds the DoN expenditure minimums for acute care, non-acute care (including nursing homes) facilities and clinics.
- Original Licensure** – Original licensure of hospitals or clinics providing ambulatory surgery. This includes an original license to be issued following a transfer of ownership.

## FACE SHEET

12. BEDS INVOLVED IN THE PROJECT (select all that apply):

	Existing Number of Licensed Beds	Number of Additional Beds Requested	Number of Beds Replaced/Renovated
<b>Acute</b>			
Medical/Surgical			
Obstetrics (Maternity)			
Pediatrics			
Neonatal Intensive Care			
ICU/CCU/SICU			
<b>Acute Rehabilitation</b>			
<b>Acute Psychiatric</b>			
adult			
adolescent			
pediatric			
<b>Chronic Disease</b>			
<b>Substance Abuse</b>			
detoxification			
short-term intensive rehabilitation			
<b>Skilled Nursing Facility</b>			
Level II			
Level III			
Level IV			
<b>Other (specify)</b>			

13. MAXIMUM CAPITAL EXPENDITURE: \$ \_\_\_\_\_

14. ANNUAL INCREMENTAL OPERATING COST: \$ \_\_\_\_\_

15. COMMUNITY HEALTH SERVICES INITIATIVES EXPENDITURE (see Factor 9)  
\$ \_\_\_\_\_



**AFFIDAVIT OF TRUTHFULNESS AND PROPER SUBMISSION** continued

I, the undersigned, certify that:

1. I have read 105 CMR 100.000, the Massachusetts Determination of Need Regulation.
2. I have read this application for Determination of Need including all exhibits and attachments, and the information contained therein is accurate and true.
3. I have submitted the required copies of this application to the Determination of Need Program and to all relevant agencies (see below<sup>1</sup>) as required.
4. I have caused notices to be published as required by 105 CMR 100.330-100.332. The notices, true copies of which are enclosed, were published in the

\_\_\_\_\_ on \_\_\_\_\_  
(Name of Newspaper) (Date of Publication)

\_\_\_\_\_ on \_\_\_\_\_  
(Name of Newspaper) (Date of Publication)

5. The applicant is, or will be, the eventual licensee of the facility.

Signed on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, under the pains and penalties of perjury.

For Corporation: \_\_\_\_\_ and \_\_\_\_\_  
Chief Executive Officer Chairman of the Board

Partnership: \_\_\_\_\_  
All Partners

Limited Partnership: \_\_\_\_\_  
General Partner

Trust: \_\_\_\_\_  
All Trustees

FORM MUST BE NOTARIZED IN THE SPACE PROVIDED BELOW:

\_\_\_\_\_  
Notary Signature

**<sup>1</sup>Copies of the application have been submitted as follows:**

- |  |   |
|--|---|
| <input type="checkbox"/> Department of Public Health                 | <input type="checkbox"/> Center for Health Information and Analysis |
| <input type="checkbox"/> Regional Health Office                      | <input type="checkbox"/> Executive Office of Elder Affairs*         |
| <input type="checkbox"/> Division of Medical Assistance (MassHealth) | <input type="checkbox"/> Department of Mental Health**              |
| <input type="checkbox"/> Health Policy Commission                    |   |

\*Only if the project relates to long term care

\*\*Only if project relates to mental health

## APPLICANT INFORMATION

---

1. List all officers, members of the board of directors, trustees, stockholders, partners, and any other individuals who have an equity or otherwise controlling interest in the application. With respect to each of these persons, please give his or her address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of, partnership or other equity interest. (Answer on additional sheet).
2. Have any of the individuals listed ever been convicted of any felony or ever been found in violation of any local, state or federal statute, regulation, ordinance, or other law which arises from or otherwise relates to that individual's relationship to a health care facility?
3. For all individuals listed, list all other health care facilities, within or without the Commonwealth in which they are officers, directors, trustees, stockholders, partners, or in which they hold an equity interest.
4. State whether any of these individuals presently have, or intend to have, any business relationship, including but not limited to: supply company, mortgage company, etc., with the applicant.
5. If the applicant is a corporation, please attach a copy of your articles of incorporation to this section of your application.
6. Indicate here the applicant's representative in regard to this application:

\_\_\_\_\_

Name

\_\_\_\_\_

Telephone

\_\_\_\_\_

Title

\_\_\_\_\_

Email

\_\_\_\_\_

Facility/ Organization

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Address (Street, Town/City, and Zip Code)

All written and oral communications will be directed accordingly.

## **APPLICATION NARRATIVE (PROJECT SUMMARY)**

---

Please describe *briefly* the proposed project in the space indicated below. Detailed information is requested elsewhere in the application under “Factors Applied in Determination of Need.” All applicants are required to provide an application narrative.

# **FACTORS APPLIED IN DETERMINATIONS OF NEED**

## FACTOR 1: HEALTH PLANNING PROCESS

---

1.1 Please provide a brief description of the annual planning process used by your institution, including the decision to undertake the proposed project. (Answer on a separate sheet)

1.2 Did you consult with other providers in the primary service area of this project about the relationship of this project to existing or planned operations at their institutions?

YES \_\_\_\_\_ NO \_\_\_\_\_

1.2a If your answer to question 1.2 was "NO", please explain below why you did not consult with other providers.

---

---

---

---

---

---

---

---

---

---

1.2b. If your answer to question 1.2 was "YES", please supply the name and titles of persons with whom you consulted and results of the consultation. (use separate sheet if necessary)

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

1.3 Since a broad range of inputs is valuable in the planning of a project, applicants are encouraged to undertake a diverse consultative process. Please indicate which, if any, of the following agencies or groups you consulted in the development of this application.

Determination of Need Program (DPH) YES \_\_\_\_\_ NO \_\_\_\_\_

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Department of Mental Health (for mental health projects) YES \_\_\_\_\_ NO \_\_\_\_\_ N.A. \_\_\_\_\_

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Executive Office of Elder Affairs (for projects with special significance for elders) YES \_\_\_\_\_ NO \_\_\_\_\_ N.A. \_\_\_\_\_

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

EOHHS Office of Acute and Ambulatory Care YES \_\_\_\_\_ NO \_\_\_\_\_ N.A. \_\_\_\_\_

Date (s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Other Relevant Agencies or Parties YES \_\_\_\_\_ NO \_\_\_\_\_ N.A. \_\_\_\_\_

Name (s) \_\_\_\_\_

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

Name (s) \_\_\_\_\_

Date(s) \_\_\_\_\_

Contact Person(s) \_\_\_\_\_

## FACTOR 2: HEALTH CARE REQUIREMENTS

---

- 2.1 How will this project affect accessibility of services for the prospective patients who are poor, medically indigent and/or Medicaid eligible?

---

---

---

---

---

- 2.2 Describe below and on additional sheet(s) your need analysis for this project including any special conditions for consideration. If your analysis is inconsistent with the relevant need methodology or criteria of Determination of Need Guidelines, please explain on the additional sheet(s) why you believe your methodology is more appropriate. Long-term care applications should show how they meet the criteria for bed replacement and/or substantial renovation of beds or the facility, consistent with the *May 25, 1993 Determination of Need Guidelines for Nursing Facility Replacement and Renovation*.

**Factor 2: HEALTH CARE REQUIREMENTS, continued**

2.3: Statistical Data--Routine Inpatient Services

Complete only for those routine inpatient cost centers, as specified by the *Hospital Uniform Reporting Manual\*\**, in which you are requesting a change.

	(1)	(2)	(3)	(4)	(5)	(6)
	Cost Center	Licensed Weighted Average Bed Capacity	Occupancy Rate	Average Length of Stay	Number of Discharges	Number of Patient Days
1						
2	20 Actual (A)					
3	20 (A)					
4	20 (A)					
5						
6	20 (P <sub>1</sub> )*					
7	20 (P <sub>1</sub> )					
8	20 (P <sub>1</sub> )					
9	20 (P <sub>1</sub> )					
10						
11	20 (P <sub>2</sub> )*					
12	20 (P <sub>2</sub> )					
13	20 (P <sub>2</sub> )					
14	20 (P <sub>2</sub> )					
15						
16						
17	20 Actual (A)					
18	20 (A)					
19	20 (A)					
20						
21	20 (P <sub>1</sub> )*					
22	20 (P <sub>1</sub> )					
23	20 (P <sub>1</sub> )					
24	20 (P <sub>1</sub> )					
25						
26	20 (P <sub>2</sub> )*					
27	20 (P <sub>2</sub> )					
28	20 (P <sub>2</sub> )					
29	20 (P <sub>2</sub> )					
30						
31						
32	20 Actual (A)					
33	20 (A)					
34	20 (A)					
35						
36	20 (P <sub>1</sub> )*					
37	20 (P <sub>1</sub> )					
38	20 (P <sub>1</sub> )					
39	20 (P <sub>1</sub> )					
40						
41	20 (P <sub>2</sub> )*					
42	20 (P <sub>2</sub> )					
43	20 (P <sub>2</sub> )					
44	20 (P <sub>2</sub> )					

\*Note: P<sub>1</sub> assumes project is approved and P<sub>2</sub> assumes project is denied.

\*\*Hospital Uniform Reporting Manual is available at <http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>.

**Factor 2: HEALTH CARE REQUIREMENTS, continued**

2.4: Statistical Data--Routine Inpatient Services

Complete only for those routine inpatient cost centers, as specified by the Division of Health Care Finance and Policy Uniform Reporting Manual\*\*, in which you are requesting a change.

	(1)	(2)	(3)	(4)	(5)	(6)
	Cost Center	Licensed Weighted Average Bed Capacity	Occupancy Rate	Average Length of Stay	Number of Discharges	Number of Patient Days
1						
2	20 Actual (A)					
3	20 (A)					
4	20 (A)					
5						
6	20 (P <sub>1</sub> )*					
7	20 (P <sub>1</sub> )					
8	20 (P <sub>1</sub> )					
9	20 (P <sub>1</sub> )					
10						
11	20 (P <sub>2</sub> )*					
12	20 (P <sub>2</sub> )					
13	20 (P <sub>2</sub> )					
14	20 (P <sub>2</sub> )					
15						
16						
17	20 Actual (A)					
18	20 (A)					
19	20 (A)					
20						
21	20 (P <sub>1</sub> )*					
22	20 (P <sub>1</sub> )					
23	20 (P <sub>1</sub> )					
24	20 (P <sub>1</sub> )					
25						
26	20 (P <sub>2</sub> )*					
27	20 (P <sub>2</sub> )					
28	20 (P <sub>2</sub> )					
29	20 (P <sub>2</sub> )					
30						
31						
32	20 Actual (A)					
33	20 (A)					
34	20 (A)					
35						
36	20 (P <sub>1</sub> )*					
37	20 (P <sub>1</sub> )					
38	20 (P <sub>1</sub> )					
39	20 (P <sub>1</sub> )					
40						
41	20 (P <sub>2</sub> )*					
42	20 (P <sub>2</sub> )					
43	20 (P <sub>2</sub> )					
44	20 (P <sub>2</sub> )					

\*Note: P1 assumes project is approved and P2 assumes project is denied.

\*\*Hospital Uniform Reporting Manual is available at <http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>.

**Factor 2: HEALTH CARE REQUIREMENTS, continued**

2.5: Statistical Data--Major Ancillary Services

Complete only for those routine inpatient cost centers, as specified by the *Hospital Uniform Reporting Manual\*\**, in which you are requesting a change.

	(1) Service	(2) Standard Units of Measure	
1	<b>Surgical Services</b>	*	
2	20 Actual (A)		
3	20 (A)		
4	20 (A)		
5			
6	20 (P <sub>1</sub> )*		
7	20 (P <sub>1</sub> )		
8	20 (P <sub>1</sub> )		
9	20 (P <sub>1</sub> )		
10			
11	20 (P <sub>2</sub> )*		
12	20 (P <sub>2</sub> )		
13	20 (P <sub>2</sub> )		
14	20 (P <sub>2</sub> )		
15			
16	<b>Radiology Diagnostic</b>	*	
17	20 Actual (A)		
18	20 (A)		
19	20 (A)		
20			
21	20 (P <sub>1</sub> )*		
22	20 (P <sub>1</sub> )		
23	20 (P <sub>1</sub> )		
24	20 (P <sub>1</sub> )		
25			
26	20 (P <sub>2</sub> )*		
27	20 (P <sub>2</sub> )		
28	20 (P <sub>2</sub> )		
29	20 (P <sub>2</sub> )		
30			
31	<b>Laboratory</b>		
32	20 Actual (A)		
33	20 (A)	*	
34	20 (A)		
35			
36	20 (P <sub>1</sub> )*		
37	20 (P <sub>1</sub> )		
38	20 (P <sub>1</sub> )		
39	20 (P <sub>1</sub> )		
40			
41	20 (P <sub>2</sub> )*		
42	20 (P <sub>2</sub> )		
43	20 (P <sub>2</sub> )		
44	20 (P <sub>2</sub> )		

\* On this line, column 2, state the standard unit of measure as specified by the *Hospital Uniform Reporting Manual*. Note: Use copies of this sheet as needed.

\*\*Hospital Uniform Reporting Manual is available at <http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>.

### FACTOR 3: OPERATIONAL OBJECTIVES

---

3.1 If this application proposes establishment of a new health service at your institution, do you have evidence of the clinical effectiveness of this new service? Please provide relevant documentation.

3.2 Briefly describe quality assurance mechanisms that will be used to assess the appropriateness of the health service proposed in this project.

---

---

---

---

---

---

3.3 Does your institution have written referral arrangements pertaining to services covered in this application with other health care providers in the primary service area of this project? (Nursing and rest homes' applicants should have an agreement with at least one acute care hospital and one home health organization).

YES \_\_\_\_\_(Please give brief descriptions of these referral arrangements)

---

---

---

---

---

---

NO \_\_\_\_\_(Please explain why you do not have referral arrangements)

---

---

---

---

---

---

Note: In addition to the above measures, all projects must meet the operational objectives of relevant service-specific guidelines.

## **FACTOR 4: STANDARDS COMPLIANCE**

---

If this project involves renovation or new construction, please submit schematic line drawings for that construction.

Please consult the Determination of Need Program staff if you require guidance in completion of this section.

See "Square Footage" under DEFINITIONS, FACTOR 5.

## FACTOR 5: REASONABLENESS OF EXPENDITURES AND COSTS

---

### Definitions

1. Capital Expenditure

Cost of the project expressed in a dollar amount as of the filing date (i.e., assuming the project were to commence on the filing date). (See discussion in Factor 6, Schedule D.)

2. Functional Areas

Unit of space directly related to a particular service (e.g., nursing unit, laboratory, radiology, dietary and admissions) or a space common to the operation of the entire facility (e.g., lobby, mechanical, major circulation, exterior wall).

3. Square Footage

Net Square Feet (NSF): The space associated with a particular department. It includes all functional space within a department; e.g., the interior of exam rooms, closets, utility rooms and waiting areas. Also, toilet rooms, walk-in refrigerators, and storage areas should be included if they are specifically for that department. It does not include allowances for internal partitions, departmental circulation, major circulation, shafts, ductways, general mechanical space and exterior walls.

Gross Square Feet (GSF): Includes the NSF of a Department plus circulation within the department, partitions within the department, and dedicated mechanical space (e.g., pump room for a surgical suite). The GSF for a specific functional department excludes major general mechanical space, ductwork, elevator shafts, and stairwells located within the department's boundaries; these components should instead be assigned to the GSF of a non-departmental- functional area such as "Elevators and Shafts," if they are significant.

If a department's perimeter is an interior wall, half of the thickness of the wall is allocated to the department. If the perimeter is an exterior wall, only 3 inches (i.e., half of a standard partition) of that wall's thickness is assigned to the department; the remainder belongs to the functional area "Exterior Wall."

Using these definitions, a facility's overall GSF is the sum total of the GSF of each functional area; that is, the total of the departmental GSF figures plus the area allocated to Major Circulation and Exterior Walls (i.e., the non-departmental areas.)

4. Cost per Gross Square Footage

In calculating the cost/GSF, the DoN Program adds construction contract, fixed equipment not in contract, site survey and soil investigation, and architectural and engineering costs and divide by the proposed gross square footage. However, the specific costs for these components should be included separately in Schedule D.

## Schedule 5.1 Square Footage And Cost Per Square Foot

	(1)	(2)		(3)	(4)	(5)		(6)	(7)
		Present Square Footage				Square Footage Involved in Project			
	Functional Areas	Net <sup>a</sup>	Gross <sup>a</sup>		New Construction Net	Gross		Renovation Net	Gross
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									
37									
38									
39									
40	Total								

<sup>a</sup> See the definitions on page 23.

**Schedule 5.1 Square Footage And Cost Per Square Foot, continued**

		(8)	(9)	(10)	(11)	(12)	(13)
		Resulting Square Footage <sup>a</sup>		Total Cost		Cost/Square Footage	
	Functional Areas	Net	Gross	New Construction	Renovation	New Construction	Renovation
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40	Total			\$	\$		

<sup>a</sup> Column 8 does not necessarily equal Columns 4 plus 6 or Columns 2 plus 4 plus 6; Column 9 does not necessarily equal Columns 5 plus 7 or Columns 3 plus 5 plus 7. This is because, for example, a) there may be demolition and b) department A may be reassigned to department B.

<sup>b</sup> If this does not equal the sum of Lines 3,9,10 and 11 of Schedule D, please reconcile the difference (for example, do the costs include site survey and soil investigation, fixed equipment not in contract, and architectural and engineering costs which are not figured into Line 9 of Schedule D)

## Schedule 5.2 Project Implementation

---

### 6.2 Anticipated Project Schedule

Construction/ Renovation or Installation	Start Date	Completion Date
• Phase One	_____	_____
• Phase Two	_____	_____
• Phase Three	_____	_____
• Phase Four	_____	_____
Etc.		

Operations	Start Date	Reach Normal Volume
• Phase One	_____	_____
• Phase Two	_____	_____
• Phase Three	_____	_____
• Phase Four	_____	_____

Please *briefly* describe the phrases cited above:

Phase One \_\_\_\_\_

Phase Two \_\_\_\_\_

Phase Three \_\_\_\_\_

Phase Four \_\_\_\_\_

### 6.3 If you have not already provided a listing and description of the equipment requirements (if any) of this project please do so in the space below or on an additional sheet.

---



---



---



---



---

### 6.4 Do you have any additional information, which you would like to supply concerning the reasonableness of the expenditures and costs associated with this project?

YES \_\_\_\_\_ NO \_\_\_\_\_

If "YES", please supply this information on an additional sheet or sheets.

## FACTOR 6: FINANCIAL FEASIBILITY

---

### LIST OF SCHEDULES FOR FACTOR SIX

SCHEDULE A:	Statement of Revenues and Expenses
*SCHEDULE B:	Statistical/Financial Data - Revenue Producing Cost Centers
SCHEDULE C:	Staffing Patterns
SCHEDULE D:	Estimated Capital Expenditure
SCHEDULE E:	Depreciation Expense
SCHEDULE F:	Proposed Funds for Estimated Capital Expenditure
SCHEDULE F1:	Features of Permanent Financing of Estimated Capital Expenditure
SCHEDULE F2:	Application of Permanent Financing Proceeds
SCHEDULE G:	Fixed Charges Covered
SCHEDULE H:	Revenue by Payer

The purpose of “Factor Six - Financial Feasibility” of the DoN Application is to: (1) collect evidence regarding the ability of the applicant to finance and support the operation of the proposed project; and (2) highlight the probable effects of the project, in cost and statistical terms.

It may be useful as a conceptual aid to think of the schedules that comprise “Factor Six- Financial Feasibility” as sorting into these categories:

- 1) Schedules A-C - information about the likely impact of the proposed project on operations of the applicant (institution).
- 2) Schedules D-G - information about the capital cost and the method of financing for the proposed project; and
- 3) Schedule H - information about the applicant's recent payer mix.

The schedules request the most recent annual historical data plus two sets of three-year projections for single service projects and the most recent three years historical data plus two sets of four-year projections for capital expenditure projects. “P1” is the projection of the likely future course of operations, assuming the project under consideration is approved by the Department. “P2” is the projection of the likely future course of operations, assuming the project under consideration is not approved by the Department.

The first projection year should be the first year following the last actual. The second, third, or fourth year projection should be the point in time when the project reaches normal volume.

The applicant must clearly explain its assumptions about costs (both operating and capital) on separate sheets to be attached to Schedule A.

## Factor 6 FINANCIAL FEASIBILITY

---

Consistency is a key to the fairness and usability of “Factor Six- Financial Feasibility.” If assumptions about unit costs, occupancies, or similar items differ between P1 and P2, explain the reasons for these differences on separate sheets. Since it is obvious that the approval or denial of this application will not alter demographic or economic trends in the applicant’s area, it is expected that assumptions for P1 and P2 will be uniform for these items. This section uses Schedule A, the operating statement, to link the various other schedules together. This interlocking system will ensure that all comparisons of P1 and P2 will be made using consistent data, which fit smoothly into the broader financial situation of the applicant.

In order to obtain forecasts or financial and statistical impacts, it is necessary to consider the interrelationship of determination of need projects filed by an individual applicant. Therefore, if the applicant’s institution has more than one DoN application pending, or expects to file additional applications within one year of the date of this application, please note the application numbers and dates of the pending applications and the nature and scope of expected applications on the “assumptions” sheet attached to Schedule A. “P1” and “P2” projections must assume approval of all pending (rather than anticipated or expected) DoN applications. For example, an institution that has one application pending consideration, by the Department, and which is now filing another application, should:

- note the first application in the assumption section of Schedule A of the new application; and
- assume approval of the first application in both the “P1” and “P2” projections of the new application.

The new application should, in effect, show the combined projections if the first application were, in fact, to be implemented on the applicant’s proposed schedule.

On some schedules, hospitals are required to report financial and statistical data according to the specifications of the *Hospital Uniform Reporting Manual*.\*\* Of course, this requirement does not apply to non-hospital applicants.

These schedules will provide necessary information about the probable impacts of determination of need actions on individual applicants. Schedules A, G, and H should be completed for the whole facility and not only for the project’s revenue producing cost center(s).

\*\*Hospital Uniform Reporting Manual is available at <http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>.

## Factor 6 FINANCIAL FEASIBILITY

---

### Notes:

1. The financial and statistical information requested in Factor Six must be submitted on the schedules provided or on copies thereof.
2. Copies of audited financial statements for the most recent year must be filed with this application.
3. Assumptions used in projecting capital and operating costs, revenues, and demographic factors must be clearly explained on a separate sheet attached to the beginning of Factor 6.
4. Statistical data and projections provided in Factor Two are important for the Factor Six data and projections. Please review both Factor Two and Factor Six carefully to ensure overall consistency between them.
5. It is permissible to round dollar amounts to the nearest thousand, as long as such rounding does not materially affect the results. If you do so, please clearly indicate this on each page on which such rounding is done.
- 6(a) Use constant dollars for the projection years (that is, do not include inflation). Do not restate actual dollars.
- 6(b) In general, use the last complete fiscal year as the basis for constant dollars (e.g., an applicant filing May 2014 with a fiscal year ending September 2014 would state project costs in 2014 dollars).

## Schedule A: Statement of Revenues and Expenses

The data presented here must tie to later schedules and **should be for the entire institution and not only for the project's cost center**. Explain all variances. Should your institution have another application pending (i.e. accepted and under review by the Determination of Need Program), the projections made in these schedules must assume *approval* of all pending applications.

	(1)	(2)	(3)	(4)
		Actual <u>20</u>	Actual <u>20</u>	Actual <u>20</u>
1	Gross Patient Service Revenue*			
2	Less: Contractuals			
3	Provision for Doubtful Accounts			
4	Free Care			
5	Other (Specify)			
6	Net Patient Service Revenue			
7				
8	Other Operating Revenue*			
9				
10	Net Operating Revenue			
11				
12	Operating Expenses			
13a	Salaries, Wages* and Fringe Benefits (Exclude Pension)*			
13b	Purchased Services			
14	Supplies and Other Expenses			
15	Depreciation			
16	Interest			
17	Pension			
18				
19	Total Operating Expenses*			
20				
21	Gain (Loss) from Operations			
22				
23	Total Non-operating Revenue			
24				
25	Excess of Revenues Over Expenses			
26				
27				
28				
29				
30				

Note: For a single service project, complete the most recent year actual data and for a capital expenditure project by a hospital complete the most recent three years actual data.

## Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers

	(5)	(6)	(7)	(8)	(9)	(10)	(11)
		Assuming Project Approval			Assuming Project Denial		
		Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P1)	Projection 20____(P2)	Projection 20____(P2)	Projection 20____(P2)
1	Gross Patient Service Revenue*						
2	Less: Contractuals						
3	Provision for Doubtful Accounts						
4	Free Care						
5	Other (Specify)						
6	Net Patient Service Revenue						
7							
8	Other Operating Revenue*						
9							
10	Net Operating Revenue						
11							
12	Operating Expenses						
13 a	Salaries, Wages* and Fringe Benefits (Exclude Pension)*						
13 b	Purchased Services						
14	Supplies and Other Expenses						
15	Depreciation						
16	Interest						
17	Pension						
18							
19	Total Operating Expenses*						
20							
21	Gain (Loss) from Operations						
22							
23	Total Non-operating Revenue						
24							
25	Excess of Revenues Over Expenses						
26							
27							
28							
29							
30							

\*For each of these items state on a separate and attached sheet the assumptions you made in arriving at P1 (assuming project approval, columns 5-8) and P2 (assuming project denial, columns 9-12) figures.

**Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers, continued**

Complete in detail for each revenue producing cost center affected by the project. Data for revenue-producing cost centers not affected by the project should be presented in aggregate under "Other Revenue-Producing Cost Centers". Under Other it is expected that P1 and P2 will be identical. The cost centers and standard units of measure must be those required by *Hospital Uniform Reporting Manual*.

<http://www.mass.gov/chia/docs/p/hospital-reports/hospital-uniform-reporting-manual.pdf>

	(1)	(2)	(3)	(4)
	Cost Center	Standard Unit of Measure	Gross Patient Service Revenue	Major Movable Equipment Depreciation
	a	b		
1	20 Actual (A)			
2	20 (A)			
3	20 (A)			
4	20 (P1)			
5	20 (P1)			
6	20 (P1)			
7	20 (P1)			
8	20 (P2)			
9	20 (P2)			
10	20 (P2)			
11	20 (P2)			
12				
13				
14	20 Actual (A)			
15	20 (A)			
16	20 (A)			
17	20 (P1)			
18	20 (P1)			
19	20 (P1)			
20	20 (P1)			
21	20 (P2)			
22	20 (P2)			
23	20 (P2)			
24	20 (P2)			
25				
26				
27	20 Actual (A)			
28	20 (A)			
29	20 (A)			
30	20 (P1)			
31	20 (P1)			
32	20 (P1)			
33	20 (P1)			
34	20 (P2)			
35	20 (P2)			
36	20 (P2)			
37	20 (P2)			
38				

<sup>a</sup> On this line state the name of the cost center (Column 1)

<sup>b</sup> On this line indicate the standard unit of measure (column 2) and number of units for Actual, P<sub>1</sub> and P<sub>2</sub>

Note: Use copies of this sheet for additional cost centers

**Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers, continued**

	(5)	(6)	(7)	(8)	(9)	
	Cost Center	Physician Compensation & Benefits*	Direct Expenses Excluding Physician Compensation & Benefits & MME Depreciation	Total Direct Expenses (Cols. 4+5+6)	Allocated Expenses	Total Expenses (Cols. 7+8)
	a					
1	20 Actual (A)					
2	20 (A)					
3	20 (A)					
4	20 (P1)					
5	20 (P1)					
6	20 (P1)					
7	20 (P1)					
8	20 (P2)					
9	20 (P2)					
10	20 (P2)					
11	20 (P2)					
12						
13						
14	20 Actual (A)					
15	20 (A)					
16	20 (A)					
17	20 (P1)					
18	20 (P1)					
19	20 (P1)					
20	20 (P1)					
21	20 (P2)					
22	20 (P2)					
23	20 (P2)					
24	20 (P2)					
25						
26						
27	20 Actual (A)					
28	20 (A)					
29	20 (A)					
30	20 (P1)					
31	20 (P1)					
32	20 (P1)					
33	20 (P1)					
34	20 (P2)					
35	20 (P2)					
36	20 (P2)					
37	20 (P2)					
38						

\* Include in this column fringe benefits.

Note: The difference between P<sub>1</sub> and P<sub>2</sub> Schedule A, Line 19 "Total Operating Expenses" must tie to the difference between P<sub>1</sub> and P<sub>2</sub> "Schedule B, Column 9, "Total Expenses"

**Schedule B: Statistical/Financial Data - Revenue Producing Cost Centers, continued**

	(10)	(11)	(12)	(13)
	Cost Center	Standard Unit of Measure	Gross Patient Service Revenue	Major Movable Equipment Depreciation
	a	b		
1	20 Actual (A)			
2	20 (A)			
3	20 (A)			
4	20 (P1)			
5	20 (P1)			
6	20 (P1)			
7	20 (P1)			
8	20 (P2)			
9	20 (P2)			
10	20 (P2)			
11	20 (P2)			
12				
13	Other Revenue Producing Cost Centers			
14	20 Actual (A)			
15	20 (A)			
16	20 (A)			
17	20 (P1)			
18	20 (P1)			
19	20 (P1)			
20	20 (P1)			
21	20 (P2)			
22	20 (P2)			
23	20 (P2)			
24	20 (P2)			
25				
26	Total Revenue Producing Cost Centers			
27	20 Actual (A)			
28	20 (A)			
29	20 (A)			
30	20 (P1)			
31	20 (P1)			
32	20 (P1)			
33	20 (P1)			
34	20 (P2)			
35	20 (P2)			
36	20 (P2)			
37	20 (P2)			
38				
39				
40				

<sup>a</sup> On this line state the name of the cost center, Column 10.

<sup>b</sup> On this line indicate the standard unit of measure, Column 11, and number of units for Actual, P<sub>1</sub> and P<sub>2</sub>

## Schedule C: Staffing Patterns

Complete in detail the staffing level of the service(s) that will be affected by the proposed project.

	(1)	(2)			(3)	(4)
		Number of FTEs*				
		20 <sup>a</sup> Actual Year	20 <sup>b</sup> P1 Year	20 <sup>b</sup> P2 Year		
1	Service (specify):					
2	Personnel category					
3						
4						
5						
6						
7						
8	Service (specify):					
9	Personnel category					
10						
11						
12						
13						
14						
15	Service (specify):					
16	Personnel category					
17						
18						
19						
20						
21						
22	Service (specify):					
23	Personnel category					
24						
25						
26						
27						
28						
29	Service (specify):					
30	Personnel category					
31						
32						
33						
34						
35						
36	Service (specify):					
37	Personnel category					
38						
39						
40						
41						
42						
43	All Personnel					

\*A FTE is a full-time equivalent employee. See the *Hospital Uniform Reporting Manual* for the computation of full-time equivalent.

<sup>a</sup> For the fiscal year most recently completed.

<sup>b</sup> The year when normal operating volume is achieved.

## Schedule D: Estimated Capital Expenditure

Outlined below is a comprehensive list of all components of Estimated Capital Expenditures. Capital Expenditure as defined in the Regulations includes the site acquisition cost of land and buildings or **fair market value of land and buildings if leased (capital or operating) or donated**, the total cost of construction including all site improvements, the cost of all capital equipment or **fair market value if leased (capital or operating) or donated**, the cost of all professional fees associated with the development of the project, including fees for architectural, engineering, legal, accounting, feasibility, planning and financing services, any fee associated with financing including any bond discount, and the interest cost to be incurred on funds borrowed during construction (but not including the on-going interest expense of permanent financing).

The estimate to be computed below must be based on costs and interest rates, which assume commencement and/or implementation of the project as of the date of application; therefore, the estimate should *not* include inflation up to the *anticipated actual* commencement and/or implementation date. (Where appropriate, an inflationary allowance is applied later during the DoN Staff's monitoring of the approved project.)

Because the inflation allowance is an important factor in large, costly construction projects, prospective applicants for such projects should consult the DoN Office for technical advice regarding completion of Schedule D. Do not include a special provision for contingency.

	(1) Category of Expenditure	(2) New Construction	(3) Renovation
1	Land Costs:	\$	\$
2	Land Acquisition Cost		
3	Site Survey and Soil Investigation		
4	Other Non-Depreciable Land Development <sup>a</sup>		
5	Total Land Costs (Lines 2 through 4)		
6	Construction Costs:		
7	Depreciable Land Development Cost <sup>b</sup>		
8	Building Acquisition Cost		
9	Construction Contract (including bonding cost)		
10	Fixed Equipment Not in Contract		
11	Architectural Cost (including fee, printing, supervision etc.) and Engineering Cost		
12	Pre-filing Planning and Development Costs		
13	Post-filing Planning and Development Costs		
14	Other (specify):		
15	Other (specify):		
16	Net Interest Expense During Construction <sup>c</sup>		
17	Major Movable Equipment <sup>d</sup>		
18	Total Construction Costs (Lines 7 through 17)		
19	Financing Costs:		
20	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc.)		
21	Bond Discount		
22	Other (specify):		
23	Total Financing Costs (Lines 20 through 22)		
24	Estimated Total Capital Expenditure (Line 5 + Line 18 + Line 23)		

**Footnotes:**

- a. *Examples of Other Non-Depreciable Land Development Costs:* commissions to agents for purchase of land, attorney fees related to land, demolition of old buildings, clearing and grading, streets, removal of ledge, off-site sewer and water lines, public utility charges necessary to service the land, zoning requirements, and toxic waste removal.
- b. *Examples of Depreciable Land Development Costs:* construction of parking lots, walkways and walls; on-site septic systems; on-site water and sewer lines; and reasonable and necessary landscaping.
- c. *Describe assumptions used in calculating interest rates and costs.*
- d. *Acute care hospitals need not include equipment expenditure unless for DoN regulated device (see 105 CMR 100.022, definition of Expenditure Minimum).*

## Schedule E: Depreciation Expense

Complete for project's estimated capital expenditure (including the fair market value for capital lease), which will be depreciated. For a given category and cost center show in aggregate the data for assets with the same useful lives. Include in the basis the asset's appropriate share of construction interest and professional fees. Use the estimates from Schedule D.

	(1)	(2)	(3)	(4)
	Description of Asset	Basis for Depreciation	Useful Life	Annual Depreciation Expense
1	Building:			
2				
3				
4				
5				
6				
7	Land Improvements:			
8				
9				
10				
11				
12				
13	Building Improvements:			
14				
15				
16				
17				
18				
19	Parking Facilities:			
20				
21				
22				
23				
24				
25	Fixed Equipment:			
26				
27				
28				
29				
30				
31	Major Movable Equipment:			
32				
33				
34				
35				
36				
37	Total			

Note: For simplicity assume first year of depreciation is a full year depreciation not one half year of depreciation. Also, if project is to be gradually phased in do not adjust for such phasing unless it significantly affects this Schedule. Explain such adjustments.

## Schedule F: Proposed Funds for Estimated Capital Expenditure

Show only those funds, which are intended to finance the estimated capital expenditure.

	(1)	(2)
	<b>Funds Available as of Application Filing Date:</b>	
1	Plant Replacement and Expansion Fund	\$
2	Unrestricted Fund	
3	Endowment Fund	
4	Specific Purpose Fund	
5	Other (specify):	
6	Subtotal	
	<b>Funds to be Generated/Raised:</b>	
	Internal Sources:	
7	Accumulated Gain from Operations	
8	Accumulated Non-operating Revenue <sup>a</sup>	
	External Sources:	
9	Long Term Debt Proceeds <sup>b</sup> (available _____ / _____) <sup>c</sup> month year	
10	Grants (available _____ / _____) month year	
11	Unrestricted Gifts/ Bequests (available _____ / _____) month year	
12	Plant Fund Drive (available _____ / _____) month year	
13	Capital Lease (terms) _____ / _____ rate years	
14	Subtotal	
15	<b>Total Funds</b> (Line 6 - Line 13)	\$

<sup>a</sup> Exclude unrestricted gifts and bequests. Show these on Line 11.

<sup>b</sup> Complete Schedule F1.

<sup>c</sup> Provide date when total amount will be available.

## Schedule F1: Features of Permanent Financing of Estimated Capital Expenditure <sup>a</sup>

1. a) Loan principal\_\_\_\_\_ b) Interest rate\_\_\_\_\_ c) Term\_\_\_\_\_yrs.
  
2. Does the proposed debt service require even periodic payments, which include interest and principal?  
 Yes     No  
  
 If No, attach a separate sheet outlining the required schedule of payments of interest and principal over the term of the loan.
  
3. Check anticipated source of permanent financing.<sup>b</sup>  
 Lending Institution (specify)\_\_\_\_\_
   
 Massachusetts Health and Educational Facilities Authority
   
 Federal Housing and Urban Development Administration Insured Mortgage
   
 Public or Private Sale Bonds
   
 Other (specify) \_\_\_\_\_
  
4. Check anticipated debt instrument.  
 Mortgage
   
 Mortgage Bonds
   
 Notes
   
 Taxable Bonds
   
 Tax-exempt Bonds
   
 Bond Anticipation Note
   
 Other (specify) \_\_\_\_\_
  
5. Specify the loan covenants (such as required sinking fund payments, and compensating balances) associated with the proposed financing.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
6. Indicate specific extent of mortgagee's proposed collateral interest in real property, gross receipts, etc.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
7. Will the proposed long term loan refinance a construction loan?                       Yes  No
  
8. If Yes, complete the following:  
 a) Source of construction loan\_\_\_\_\_
   
 b) Maximum principal outstanding\_\_\_\_\_
   
 c) Terms of interest rate\_\_\_\_\_
  
9. Anticipated date for the delivery of the long-term loan proceeds\_\_\_\_\_

<sup>a</sup> If appropriate complete for internal as well as external loans.  
<sup>b</sup> If uncertain, use "1", "2", etc. to indicate order of likelihood. Explain effect on cost in going from source number 1 to source number 2, etc.  
 Complete question 8 only if the project includes refinancing of existing debt

## Schedule F2: Application of Permanent Financing Proceeds

Complete only for the estimated capital expenditures of projects requiring debt financing.

	(1)	(2)
1	Total Estimated Land and Construction Costs (from Schedule D, Columns 2 and 3, Line 5 + Line 18)	\$
2	Debt Service Fund Requirement	
3	Total Financing Costs (from Schedule D, Columns 2 and 3, Line 23)	
4	Refinancing of Existing Debt	
5	Other (specify):	
6	Other (specify):	
7	Subtotal	
8	Less:	
9	Project Costs met by Internal Sources (from Schedule F, Column 2, Lines 6 + 7 + 8)	
10	Interest Income Earned During Construction	
11	Premium on Sale of Bonds	
12	Project Costs Met by External Sources Other than Debt (from Schedule F, Column 2, Lines 10 + 11 + 12)	
13	Total Deductions (Lines 9+10 + 11 + 12)	
14	Loan Principal Required (Line 7 - Line 13)	\$

## Schedule G: Fixed Charges Covered

Complete for the entire institution if the estimated capital expenditure for the project requires debt financing, including capital lease.

	(1)	(2)	(3)	(4)
		Actual 20	Actual 20	Actual 20
1	Gain (Loss) from Operations <sup>a</sup>			
2	Add: Interest Expense <sup>a</sup>			
3	Depreciation Expense <sup>a</sup>			
4	Lease Payments			
5	Cash from Operations Available for Debt Service (Lines 1 + 2 + 3 + 4)			
6	Debt Service Required:			
7	Interest on Long Term Debt (LTD)			
8	Interest on Certain Short Term Debt <sup>b</sup>			
9	Principal Payments – LTD			
10	Reduction in Short Term Debt <sup>b</sup>			
11	Lease Payments			
12	Net Sinking Fund Payment <sup>c</sup>			
13	Total Debt Service Required (Lines 7 + 8 + 9 + 10 + 11 + 12)			
14	Ratio: Fixed Charges Covered (Line 5 ÷ Line 13)			

<sup>a</sup> Must tie to Schedule A data. Explain any variances.

<sup>b</sup> Include only short-term debt that will be rolled over or refinanced with long-term debt and any interest expense on inter-fund loans.

<sup>c</sup> Required payment to sinking fund less payment from sinking fund.

**Schedule G: Fixed Charges Covered, continued**

Complete for the entire institution if the estimated capital expenditures for the project requires debt financing, including capital lease.

	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
	Assuming Project Approval				Assuming Project Denial			
	Projection 20__(P1)	Projection 20__(P1)	Projection 20__(P1)	Projection 20__(P1)	Projection 20__(P2)	Projection 20__(P2)	Projection 20__(P2)	Projection 20__(P2)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								

## Schedule H: Revenue by Payer

Complete for the entire institution: Actual for the two fiscal years most recently completed and Projected (P1 and P2) for first full year of proposed project operation.

	(1)	Payer	(2)	(3)	(4)
			Total Patient Days	Routine Inpatient Gross Patient Service Revenue	Net Patient Service Revenue
1	<b>20</b>	<b>Actual (A)</b>			
2		Medicare			
3		MA Medicaid			
4		Other Government			
5		Private Insurers			
6		Self Pay			
7		Other			
8		TOTAL			
9					
10					
11	<b>20</b>	<b>Actual (A)</b>			
12		Medicare			
13		MA Medicaid			
14		Other Government			
15		Private Insurers			
16		Self Pay			
17		Other			
18		TOTAL			
19					
20					
21	<b>20</b>	<b>Projected (P1)</b>			
22		Medicare			
23		MA Medicaid			
24		Other Government			
25		Private Insurers			
26		Self Pay			
27		Other			
28		TOTAL			
29					
30					
31	<b>20</b>	<b>Projected (P2)</b>			
32		Medicare			
33		MA Medicaid			
34		Other Government			
35		Private Insurers			
36		Self Pay			
37		Other			
38		TOTAL			
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					

## **FACTOR 7: RELATIVE MERIT**

---

- 7.1 Please describe below and on additional sheet (if necessary) any alternatives that you have considered in the development of this project. Please also give your reasons for rejecting these alternatives.

## FACTOR 8: ENVIRONMENTAL IMPACT

---

### I. Compliance with Massachusetts Environmental Protection Act (“MEPA”)

The Massachusetts Environmental Protection Act or “MEPA” (M.G.L. c. 30 §§ 61, 62-62H) requires that state agencies take into account the environmental consequences of their actions. The issuance of a Determination of Need by the Department of Public Health is a state action subject to MEPA. MEPA regulations (301 CMR 11.00 et seq.) require environmental review of all DoN applications for projects exceeding the review thresholds set forth at 301 CMR 11.03.

DoN Applicants should familiarize themselves with the MEPA review thresholds to determine whether MEPA review will be required. MEPA regulations may be viewed online at <http://www.env.state.ma.us/mepa/regs/11-03.aspx> and may be obtained through the State House Bookstore (<http://www.sec.state.ma.us/spr/sprcat/catidx.htm>). Review thresholds are divided into the following categories:

- |   |   |
|---|---|
| (1) Land.                                     | (7) Energy.                                   |
| (2) State-listed Species under M.G.L. c. 131A | (8) Air.                                      |
| (3) Wetlands, Waterways and Tidelands.        | (9) Solid and Hazardous Waste.                |
| (4) Water.                                    | (10) Historical and Archaeological Resources. |
| (5) Wastewater.                               | (11) Areas of Critical Environmental Concern. |
| (6) Transportation.                           | (12) Regulations.                             |

Projects that are subject to MEPA review must circulate and file an Environmental Notification Form (ENF). A 20-day comment period ensues from publication of the ENF in the MEPA Monitor (appears bi-weekly). The proposal and site plans are reviewed, and within a total of 30 days from publication, a decision will be made on whether an environmental impact report (EIR) is required.

If an EIR is required, a “scope” will be issued, identifying items which the EIR must address. Draft and Final EIR’s each go through a 37-day review and comment period.

Certain projects that exceed specified size thresholds (301 CMR 11.03) require a mandatory EIR. The MEPA regulations allow the Secretary of Environmental Affairs to waive a mandatory EIR, or to allow a single EIR, following review of an expanded ENF. See 301 CMR 11.05(7), 11.06(8) and 11.11, and consult with the MEPA Office to discuss whether this approach would be appropriate.

Applicants are advised to consult with the MEPA Office to determine if an Environmental Notification Form must be filed for a DoN project. Address all inquiries to:

MEPA Office  
Executive Office of Energy and Environmental Affairs  
100 Cambridge Street, Suite 900, 9th Floor  
Boston, MA 02114  
Tel: (617) 626-9031

Please note that final approval of a DoN as well as architectural plans and specifications for a project is contingent upon compliance with MEPA regulations.

Every Applicant for Determination of Need is required to certify compliance with MEPA regulations by completing section the form provided in Section 8.1 of this Application Kit.

**Factor 8 ENVIRONMENTAL IMPACT, continued**

**8.1 Certification of MEPA Compliance**

After careful review of the MEPA regulations (301 CMR 11.00 et seq.) in effect at the time of filing this application for Determination of Need, the status of the project as proposed relative to MEPA requirements is as follows:

[Please check one of the following boxes]

- The proposed project neither meets nor exceeds any of the thresholds for MEPA review.
- The proposed project meets one or more of the MEPA review thresholds and an Environmental Notification Form (ENF) was filed on \_\_\_/\_\_\_/\_\_\_\_\_. A copy of the ENF is attached to the DoN application.  
(mm dd yyyy)
- The proposed project meets one or more of the MEPA review thresholds requiring both an Environmental Notification Form (ENF) and a mandatory Environmental Impact Report (EIR). A completed EIR was submitted to MEPA on \_\_\_/\_\_\_/\_\_\_\_\_. and a copy of the EIR is submitted with this DoN application.  
(mm dd yyyy)

Name of DoN Applicant: \_\_\_\_\_

Brief Description of DoN Project: \_\_\_\_\_

\_\_\_\_\_

Signature and Printed Name of Authorized Official: \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Printed Name)

Title: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_\_\_.  
(mm dd yyyy)

## Factor 8 ENVIRONMENTAL IMPACT, continued

### Factor 8: DoN GREEN GUIDELINES

#### II. Compliance with Determination of Need Guidelines for Environmental and Human Health Impact

Effective January 1, 2009 for hospitals and clinics and July 1, 2009 for long term care facilities, all Determination of Need applications involving new construction and/or gut renovation projects are required to demonstrate compliance with the Determination of Need Guidelines for Environmental and Human Health Impact (“DoN Green Guidelines”). Gut renovation is defined as construction within an existing building that requires complete demolition of all non-structural building components (After demolition, only the floor, deck above, outside walls, and structural columns would remain).

Compliance requires achievement of all of the prerequisites and at least 50% of all the possible points for the Leadership in Energy and Environmental Design – Health Care (“LEED-HC”) or, with the Department’s approval, its current equivalent nationally-accepted best practice standard.

Documentation of compliance with DoN Green Guidelines must be included in the submission of DoN Factor 8.

**8.2** In this section, provide complete documentation of how the project, upon its implementation, will achieve compliance with the Determination of Need Guidelines for Environmental and Human Health Impact (“DoN Green Guidelines”). A completed project scorecard based upon the most current version of LEED-HC or its equivalent, as approved by the DoN Program prior to application submission, should accompany a description of the plans for compliance.

## FACTOR 9: COMMUNITY HEALTH SERVICE INITIATIVES

---

For detailed information regarding completion of DoN Factor 9, applicants should consult the Community Health Initiatives Policies and Procedures (Revised August 19, 2014) at [www.mass.gov/dph/don](http://www.mass.gov/dph/don).

The Determination of Need primary and preventive health care services and community contributions review factor is required under 105 CMR 100.533(B)(9) and described under 105 CMR 100.551(J) as follows:

- (1) the holder [of an approved DoN] shall expend, over a five-year period (or other period approved by the Department) an amount reasonably related to the cost of the project, for the provision of primary and preventive health care services necessary for underserved populations in the project's service area (or other area approved by the Department) and reasonably related to the project, in accordance with a plan submitted as part of the application process (see 105 CMR 100.533(B)(9)) and approved by the Department; and
  - (2) the holder shall file reports with the Department detailing compliance with its approved plan, and to the extent practicable, an evaluation of the health effects thereof. The frequency, content and format of such reports shall be established by the Department.
- 1.1 The plan for provision of primary and preventive health services shall be developed in consultation with the Community Health Network Areas (CHNAs) and Department of Public Health's Office of Community Health Planning to identify health issues in the service areas and the community initiatives that should be directed toward them. To identify the CHNAs in your service areas please contact the [Office of Community Health Planning](#).