Rhode Island Department of Health
Center for Health Systems Policy and Planning
Three Capitol Hill, Room 410
Providence, RI 02908

Phone: (401) 222-2788
Website:
Office of Health Systems Development

Initial Licensure Application Instructions

Please submit a paper copy and an electronic copy (as a single pdf file) [to: Paula.Pullano@health.ri.gov with a copy (Cc) [to: jim.suah@health.ri.gov] of the completed application to the address listed above. Upon submission, the application will be reviewed for acceptability, and the applicant will be notified of any deficiencies if the application has been found not acceptable in form. All questions concerning this application should be directed to the Center for Health Systems Policy and Planning at (401) 222-2788.

Regulatory Requirements: Completion and submission of this application is a prerequisite to licensure of a new health care facility. This application should be completed after a thorough review of Title 23, Chapter 17 of the General Laws of Rhode Island, as amended, and the Rules and Regulations for the specific license being sought (see below):

- ❑ Rules and Regulation for Licensing of Kidney Disease Treatment Center (216-RICR-40-10-12):
- ❑ Rules and Regulation for Licensing of Organized Ambulatory Care Facility (216-RICR-40-10-3):
- ❑ Rules and Regulation for Licensing of Birth Center (216-RICR-40-10-8):

Format: Full responses to each question must be submitted and references to other responses shall not be accepted as a complete response. Paper copy attachments must be listed under an individual tab at the end of the application form and the electronic copy must provide electronic links ("hyperlinks") to the applicable tab when responding to questions where attachments have been provided as a response within the application. Applications should not include the instruction pages nor appendices not applicable to the proposal. The applications should be completed in a typewritten format and should be submitted in a soft bound (e.g. prong fastener) format. A table of contents must be included to identify the specific location of responses to questions.

Timeframe: Regulations permit a ninety-day review time frame once an application is accepted for review.

Application Fee: The application must be accompanied by an appropriate fee, in the form of a check made out to the "General Treasurer of Rhode Island" in the amount of (0.002 times the Total Revenue projected for the first full fiscal year (Appendix A # 4)), $1,500 minimum to $50,000 maximum. The fee is non-refundable. Applications without fees will not be reviewed for acceptability.

Legal Fees: In addition to the application fee, please be advised that you may be charged for Department's costs for legal services performed with regards to the review of the application [pursuant to RIGL 23-1-53].

INITIAL LICENSURE APPLICATION

Version 6.2024

Name of Applicant:
Name of Facility (Legal name of proposed facility);
Date Application Submitted (MM/DD/YYYY):
Date Application Resubmitted (MM/DD/YYYY):
Amount of Fee:

All questions concerning this application should be directed to the Center for Health Systems Policy and Planning at (401) 222-2788

Please have the appropriate individual attest to the following:

"I hereby certify under penalty of perjury that the information contained in this application is complete, accurate, and true."

_____

signed and dated by the President or Chief Executive Officer

_____

signed and dated by Notary Public

Table of Contents:

1. Requested Facility License (select only 1 per application):

	Kidney Disease Treatment Centers (216-RICR-40-10-12)
	Organized Ambulatory Care Facility (216-RICR-40-10-3)
	(Outpatient) Birth Center (216-RICR-40-10-8)

2. Please provide an executive summary describing the nature and scope of the proposal which should at least include the following: (1) identification of all parties and their track record and experience, (2) the types of services to be offered, (3) operational information about the proposed facility (hours of operation, whether the site if leased or owned, geographic area to be served, estimated date of when service will start being offered, if approved), (4) whether the applicant will seek professional accreditation from a nationally recognized accrediting agency (eg. CHAP, TJC, etc.).

3. Legal name and address of the applicant (i.e the proposed licensee):

Name:	Telephone:
Address:	Zip Code:

4. Information of the President or Chief Executive Officer of the applicant:

Name:	Telephone:
Address:	Zip Code:
E-Mail:	Fax:

5. Information for the person to contact regarding this proposal (only if different from the President/CEO in Question 4):

Name:	Telephone:
Address:	Zip Code:
E-Mail:	Fax:

6. Applicant's legal status: ___ Sole Proprietorship ___ Partnership

___ Corporation ___ Limited Liability Corporation

Applicant's tax status: ___ For-Profit ___ Not-For-Profit

7. Name of the proposed facility administrator, please also attach a job description for the position and a resume (with professional references & phone numbers) for this individual:

8. Will the facility be operated under management agreement? Yes___ No ___

   ❑ If the response to Question 8 is "Yes", please provide copies of that agreement.

9. Will the facility offer healthcare services provided under contract with an outside party? Yes___ No ___

   ❑ If response to Question 9 is "Yes", please identify and describe those services to be contracted out.

10. For all plans for new construction or the renovation, alteration, extension, modification or conversion of an existing facility, the plans must be reviewed by a licensed architect acceptable to the Director. Please provide a copy of the architect's signed certification stating that the plans comply with the construction requirements outlined in the applicable rules and regulations.

    ❑ In the event of non-conformance with any construction requirements for which the facility seeks variance(s), please include details of the non-conformance for which the variance(s) is sought and alternate provisions made, as well as detailing the basis upon which the request is made.

11. Please demonstrate that the facility, as proposed, will be in full compliance with all applicable rules and regulations and not require any variances (apart from any variance(s) requested for the physical facility as outlined in Question 10).

    ❑ If the facility finds that a literal enforcement of the provisions of any rule and regulation will result in unnecessary hardship to the applicant and that such variance(s) will not be contrary to the public interest, public health and/or health and safety of patients, please include details of the non-conformance for which the variance(s) is sought and alternate provisions made, as well as detailing the basis upon which the request is made.

12. Please provide an organizational chart identifying all "parent" legal entities with direct or indirect ownership in or control of the applicant, all "sister" legal entities also owned or controlled by the parent(s), and all "subsidiary" legal entities owned or controlled by the applicant. Please provide a brief narrative clearly explaining the relationship of these entities, the percent ownership the principals have in each (if applicable), and the role of each and every legal entity that will have control over the applicant.

13. For all entities identified in response to Question 12, please provide a brief narrative clearly explaining the relationship of these entities to each other and to the applicant, including ownership.

14. Does the entity seeking licensure plan to participate in Medicare or Medicaid (Titles XVIII or XIX of the Social Security Act)?

    MEDICARE: Yes___ No___ MEDICAID: Yes___ No___

    ❑ If the response to Question 14, for either Medicare and/or Medicaid is 'No', please explain.

15. If the proposed owner, operator or director of the proposed health care facility owned, operated or

directed a healthcare facility (both within and outside Rhode Island) within the past three years, please demonstrate the record of that person(s) with respect to access of traditionally underserved populations to its health care facilities.

16. Please provide a copy of proposed charity care policies and procedures and charity care application form.

17. Please identify the proposed immediate and long-term plans of the applicant to ensure adequate and appropriate access to the program and health care services to be provided by the proposed health care facility to traditionally underserved populations.

18. Will the facility provide healthcare services (for which it is seeking licensure) to patients without discrimination, including the patients' ability to pay for services? Yes___ No___

    - If the response to Question 18 is "No", please explain.

19. Please identify and describe all instances **involving the applicant and/or its affiliates** and the status or disposition of each of the following within the past 3 years:

    A. Citations, enforcement actions, violations, charges, investigations, or similar types of actions involving the applicant and/or its affiliates (including but not limited to actions brought forward by any governmental agency, accrediting agency, or similar type of an agency.);

    B. Civil proceedings (whether pending or which have resulted in a disposition or settlement) in any court of law, in which the applicant and/or its affiliates and/or any officers, directors, trustees, members, managing or general partners, or other senior management of the applicant and/or its affiliates has been a party to;

    C. Convictions and/or placement on probation for any criminal offenses by any state, local or federal government of any officers, directors, trustees, members, managing or general partners, or other senior management of the applicant and/or its affiliates;

20. Please provide a copy of the Quality Assurance Policies (for the proposed services) and a detailed explanation of how quality assurance for patient services will be implemented at the proposed facility.

21. Please provide a detailed description about the amount and source of the equity and debt commitment for this transaction. (**NOTE**: If debt is contemplated as part of the financing, please complete Appendix C). Additionally, please demonstrate the following:

    A. The immediate and long-term financial feasibility of the proposed financing plan;

    B. The relative availability of funds for capital and operating needs; and

C. The applicant's financial capability;

22. Please provide legally binding evidence of site control (e.g., deed, lease, option, etc.) sufficient to enable the applicant to have use and possession of the subject property.

23. Please identify any zoning approvals that may be required in order to implement this proposal and the applicant's actions taken to date to obtain such approvals.

24. Please provide pictures and schematics of the proposed facility in sufficient detail to show use and dimensions of the space.

25. Please provide each of the following documents applicable to the applicant's legal status:

- ❑ Certificate and Articles of Incorporation and By-Laws (for corporations)
- ❑ Certificate of Partnership and Partnership Agreement (for partnerships)
- ❑ Certificate of Organization and Operating Agreement (for limited liability corporations)

26. If the applicant or one of its parent companies (or ultimate parent) is not a publicly traded corporation, please provide the audited financial statements for the most recent three years, if applicable.

27. If the applicant or one of its parent companies (or ultimate parent) is a publicly traded corporation, please provide copies of its most recent SEC 10K filing.

28. All applicants please complete Appendixes A, D, and E.

Appendix A

1. Please indicate the financing mix for the capital cost of this proposal, if applicable. **NOTE:** the Health Services Council's policy requires a minimum 20 percent equity investment.

Source	Amount	Percent	Interest Rate	Terms (Yrs.)
Equity*	$	%		
Debt**	$	%	%	
Lease	$	%	%	
TOTAL	**$**	**100%**		

* Equity means non-debt funds contributed towards the capital cost related to a change in owner or change in operator of a healthcare facility which funds are free and clear of any repayment or liens against the assets of the proposed owner and/or licensee and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged.

** If debt financing is indicated, please complete Appendix C.

2. Please identify the total number of FTEs (full time equivalents) and the associated payroll expense (with fringe benefits) required to staff this proposal.

	RAMP UP YEAR 20____		**FIRST FULL FISCAL YEAR 20**	
Personnel	**Number of FTEs**	**Payroll W/Fringes**	**Number of FTEs**	**Payroll W/Fringes**
Medical Director	#	$	#	$
Physicians	#	$	#	$
Administrator	#	$	#	$
Director of Nursing	#	$	#	$
RNs	#	$	#	$
LPNs	#	$	#	$
Nursing Aides	#	$	#	$
PTs	#	$	#	$
OTs	#	$	#	$
Speech Therapists	#	$	#	$
Clerical	#	$	#	$
Housekeeping	#	$	#	$
Other: (_____)	#	$	#	$
Other: (_____)	#	$	#	$
TOTAL:	**#**	**$**	**#**	**$**

Appendix A (cont.)

3. All applicants must complete Table A. Please include the data for the ramp up year and first full year after implementation. Please provide both the amounts and percentages for each category.

Table A (All Applicants)

	RAMP UP YEAR 20___				FIRST FULL FISCAL YEAR 20___			
PAYOR SOURCE	**Units of Service (specify_____)**		**NET PATIENT REVENUE**		**Units of Service (specify_____)**		**NET PATIENT REVENUE**	
	#	**%**	**$**	**%**	**#**	**%**	**$**	**%**
Medicare	#	%	$	%	#	%	$	%
Medicaid	#	%	$	%	#	%	$	%
Blue Cross	#	%	$	%	#	%	$	%
Commercial	#	%	$	%	#	%	$	%
HMOs	#	%	$	%	#	%	$	%
Workers' Comp.	#	%	$	%	#	%	$	%
Self-Pay	#	%	$	%	#	%	$	%
Other: (_____)	#	%	$	%	#	%	$	%
TOTAL:	**#**	**%**	**$**	**100%**	**#**	**%**	**$**	**100%**
Charity Care*	#	%	**$0**	**0%**	#	%	**$0**	**0%**

***** Charity care does not include bad debt and is based on costs (not charges).

Appendix A (cont.)

4. Please complete the following projected income statements for the first three years after implementation. Round all amounts to the nearest dollar.

PRO-FORMA FOR PROPOSED FACILITY			
	Ramp up Year 20___	**First Full Fiscal Year 20___**	**Second Full Fiscal Year 20___**
REVENUES:			
Net Patient Revenue	$	$	$
Other: (_____)	$	$	$
Total Revenue	$	$	$
EXPENSES:	$	$	$
Payroll w/Fringes	$	$	$
Bad Debt	$	$	$
Supplies	$	$	$
Office Expenses	$	$	$
Utilities	$	$	$
Insurance	$	$	$
Interest	$	$	$
Depreciation/Amortization	$	$	$
Leasehold Expenses	$	$	$
Other: (_____)	$	$	$
Other: (_____)	$	$	$
Total Expenses	$	$	$
OPERATING PROFIT:	**$**	**$**	**$**

Number of Patients:			
Number of Visits:			

(TO BE COMPLETED BY THE APROPRIATE STATE AGENCY)

Appendix B

Rhode Island Department of Health
Center for Health Systems Policy and Planning

Compliance Report

*(Name of Applicant)*_____ has applied for licensure as a healthcare facility in Rhode Island. As part of the regulatory requirements to determine the character, competence and other quality related information of the applicant, the Center for Health Systems Policy and Planning is requesting the following information regarding the health care facilities operated by or affiliated with the applicant, as listed on the attached sheet.

Please answer the following questions.

1. Are the agencies/facilities currently licensed and in substantial compliance with all applicable codes, rules and regulations? Yes__ No__

If the answer to #1 is "NO", please identify the facility(ies) and briefly explain the licensure status.

2. Has there been any enforcement actions against these agencies/facilities in the past three years? Yes__ No__

If the answer to #2 is "YES", please identify the facility(ies) and include any information relevant to those enforcement actions (reason for action, stipulation, fine, etc.). In addition, please furnish a brief description of the outcome of the most recent survey, including any deficiencies cited. Additional pages may be attached, if needed.

Reviewer's Name: _____ Title: _____
Department: _____ State: _____
Telephone_____ E-mail _____
Reviewer's Signature: _____ Date: _____

If you have any questions, please contact Paula Pullano at (401) 222-2788 or e-mail, Paula.Pullano@health.ri.gov. Please return the completed form within 15 days to Paula.Pullano@health.ri.gov or to the address below:

Rhode Island Department of Health
Center for Health Systems Policy and Planning
3 Capitol Hill, Room 410
Providence, Rhode Island 02908

Appendix B (cont.)

Applicant, please provide the following information identifying each facility to the appropriate state agency as an attachment to the letter in the table below, use additional pages if necessary. Please make sure to identify yourself in the cover letter by filling in the blank for 'Name of Applicant'.

State	Facility Name, Address and Contact Information	License Number

Appendix C

Debt Financing

All applicants proposing debt financing must complete this Appendix.

Applicants contemplating the incurrence of a financial obligation for full or partial funding of the proposal must complete and submit this appendix.

1. Please describe the proposed debt by completing the following:
   a.) type of debt contemplated _____
   b.) term (months or years) _____
   c.) principal amount borrowed _____
   d.) probable interest rate _____
   e.) points, discounts, origination fees _____
   f.) compensating balance or reserved fund _____
   g.) likely security _____
   h.) disposition of property (if a lease is revoked) _____
   i.) prepayment penalties or call features _____
   j.) front end costs (e.g. underwriting spread, feasibility study, legal and printing expense, points etc.) _____
   k.) debt service reserve fund _____

2. If this proposal involves refinancing of existing debt, please indicate the original principal, the current balance, the interest rate, the years remaining on the debt and a justification for the refinancing contemplated.

3. Please present a debt service schedule for the chosen method of financing, which clearly indicates the total amount borrowed and the total amount repaid per year. Of the amount repaid per year, the total dollars applied to principal and total dollars applied to interest must be shown.

Appendix D

Disclosure of Ownership and Control Interest

All applicants must complete this Appendix

Please answer the following questions by checking either 'Yes' or 'No'. If any of the questions are answered 'Yes', please list the names and addresses of individuals or corporations.

1. Will there be any individuals (or organizations) having a direct (or indirect) ownership or control interest of 5 percent or more in the applicant, that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX of the Social Security Act? Yes___ No___

2. Will there be any directors, officers, agents, or managers of the applicant (or facility) who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX of the Social Security Act? Yes___ No___

3. Are there (or will there be) any individuals employed by the applicant (or facility) in a managerial, accounting, auditing, or similar capacity who were employed by the applicant's fiscal intermediary within the past 12 months (Title XVIII providers only)? Yes___ No___

4. Will there be any individuals (or organizations) having direct (or indirect) ownership interests, separately (or in combination), of 5 percent or more in the applicant (or facility)? (Indirect ownership interest is ownership in any entity higher in a pyramid than the applicant) Yes___ No___ (Note, if the applicant is a subsidiary of a "parent" corporation, the response is 'Yes')

5. Will there be any individuals (or organizations) having ownership interest (equal to at least 5 percent of the facility's assets) in a mortgage or other obligation secured by the facility? Yes___ No___

6. Will there be any individuals (or organizations) that have an ownership or control interest of 5 percent or more in a subcontractor in which the applicant (or facility) has a direct or indirect ownership interest of 5 percent or more. (Also, please identify those subcontractors.) Yes___ No___

7. Will there be any individuals (or organizations) having a direct (or indirect) ownership or control interest of 5 percent or more in the applicant (or facility), who have been direct (or indirect) owners or employees of a health care facility against which sanctions (of any kind) were imposed by any governmental agency? Yes___ No___

8. Will there be any directors, officers, agents, or managing employees of the applicant (or facility) who have been direct (or indirect) owners or employees of a health care facility against which any sanctions were imposed by any governmental agency? Yes___ No___

Appendix E

Ownership Information

All applicants must complete this Appendix

1. List all officers, members of the board of directors, and trustees of the applicant and/or ultimate parent entity. For each individual, provide their business address, principal occupation, position with respect to the applicant and/or ultimate parent entity, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

2. For each individual listed in response to Question 1 above, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, F) any professional accreditation (e.g. TJC, CHAP, etc.), and G) complete Appendix B 'Compliance Report' and submit it to the appropriate state agency (not applicable for Rhode Island facilities).

3. If any individual listed in response to Question 1 above, has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.

4. Have any individuals listed in response to Question 1 above been convicted of any state or federal criminal violation within the past 20 years? Yes___ No___.

    - ❑ If response to Question 4 is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

5. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 12 of the application. For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, F) any professional accreditation (e.g. TJC, CHAP, etc.), and G) complete Appendix B 'Compliance Report' and submit it to the appropriate state agency (not applicable for Rhode Island facilities).

6. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 above during the last 5-years had bankruptcies and/or were placed in receiverships? Yes___ No___

    - ❑ If response to Question 6 is 'Yes', please identify the facility and its current status.