Rhode Island Department of Health
Center for Health Systems Policy and Planning
Three Capitol Hill, Room 410
Providence, RI 02908-5097

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

Certificate of Need Application Submission Instructions

Please submit 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 by 4:30 PM **10 June 2026** (for non-expeditious applications) to the Center for Health Systems Policy and Planning, Rhode Island Department of Health, Three Capitol Hill, Room 410, Providence, Rhode Island 02908. No application shall be accepted for review without a Letter of Intent submitted at least 45 days in advance by **27 April 2026** (for non-expeditious applications).

This application should be completed only after a thorough review of Chapter 23-15, of the General Laws of Rhode Island, as amended, and the rules and regulations, *Determination of Need for New Health Care Equipment and New Institutional Health Services* (216-RICR-40-10-22).

Upon submission, the application will be reviewed for acceptability, and within fifteen (15) working days the applicant will be notified of any deficiencies if the application has been found not acceptable in form. Applications found substantially deficient may not be reviewed in the current cycle.

Additional Questions: Please note that RIDOH reserves its right to request additional information and pose additional questions as part of the application.

Format: Full responses to each question must be provided and references to other responses shall not be accepted as a complete response. **The electronic submission must include electronic links ("hyperlinks")** to the applicable tab when responding to questions where attachments have been included as a response within the application. Applications should not include the instruction pages, nor appendices not applicable to the application proposal. The application should be completed in a typewritten format. A table of contents must be included to identify the specific location of responses to questions.

Consultants, Legal and Application Fee Instructions

Consultants: The state agency may in effectuating the purposes of Chapter 23-15 of the Rhode Island General Laws, as amended, engage experts or consultants including, but not limited to, actuaries, investment bankers, accountants, attorneys, or industry analysts. Except for privileged or confidential communications between the state agency and engaged attorneys, all copies of final reports prepared by experts and consultants, and all costs and expenses associated with the reports, shall be public. All costs and expenses incurred under this provision shall be the responsibility of the applicant in an amount to be determined by RIDOH, the amount is not to exceed $31,079. An application shall not be considered

complete unless an agreement has been executed and submitted to RIDOH for the payment of all costs and expenses, if determined by the state agency that such an agreement shall be required.

Legal: The state agency may engage legal services for the review of the application. All costs and expenses incurred shall be the responsibility of the applicant [pursuant to Rhode Island General Laws §23-1-53].

Application: Pursuant to Rhode Island General Laws §23-15-10 and §23-15-11, the application fee requirements are as follows:

- Health care facilities owned and operated by the State of Rhode Island are exempt

- Application fees shall be paid by check and made payable to: **General Treasurer, State of Rhode Island**

- **All checks are to be mailed to**: Rhode Island Department of Health, Three Capitol Hill, Suite 410, Office of Health Systems Development, Providence, Rhode Island, 02908, with a follow up confirmation email to: Paula.Pullano@health.ri.gov

- Application fees for applications accepted for review shall be non-refundable. Should your application be deemed unacceptable for review, the check for the application fee will be returned.

- The application fee formula is: base rate + (0.25%*capital cost from Appendix A Question 1)

Application Type	Base Rate
Regular Review*	$ 500
Expeditious Review*	$ 750
Tertiary or Specialty Care Review**	$ 10,000

*for non-tertiary or specialty care review projects
**this rate applies to any application that checks off "5 H "
from Question 5, category H

Certificate of Need Application Form
Version: December 2025

Name of Applicant (Name of proposed facility)	
Title of Application (Legal name of proposed facility)	
Date(s) of Submission and Resubmission (MM/DD/YYYY)	___/___/___; ___/___/___
Application Type	_____ Regular Review _____ Expeditious Review (complete Appendix E) _____ Tertiary or Specialty Care Review
Tax Status of Applicant	_____ Non-Profit _____ For-Profit

Pursuant to Chapter 23-15 of The General Laws of Rhode Island, rules and regulations, *Determination of Need for New Health Care Equipment and New Institutional Health Services* (216-RICR-40-10-22).

All questions concerning this application should be directed to the Office of Health Systems Development 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:

PROJECT DESCRIPTION AND CONTACT INFORMATION

1.) Please provide below an Executive Summary of the proposal. Include ownership information and a detailed description of services to be provided. Please include: Operational information about the proposed facility, (e.g., hours of operation, whether the site is leased or owned, geographic area to be served (e.g., primary cities/towns and or secondary cities/towns), population niche, if any, and estimated date of when service will start being offered, taking into consideration the 120-day Certificate of Need review period from the **February 20, 2026**, initiation of review date, if approved).

2.)

Capital Cost	$	Match with responses from Questions Appendix A Question 1 and 2
Operating Cost	$	For the first full year after implementation, match with response from Appendix A Question 7
Date of Proposal Implementation	_____/_____ (e.g., MM/YYYY)	Month and year (taking into consideration the 120-day Certificate of Need review period from the **July 20, 2026**, initiation of review date)

3.) Please provide the following information:

Information of the applicant:

Name:		Telephone #:	
Address:		Zip Code:	

Information of the facility (if different from applicant):

Name:		Telephone #:	
Address:		Zip Code:	

Information of the Chief Executive Officer:

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

Information for the person to contact regarding this proposal:

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

4.) Select **one** category that best describes the healthcare facility named in Question 3.

☐ Freestanding ambulatory surgical center

☐ Home Care Provider

☐ Home Nursing Care Provider (including in-home infusion therapy)

☐ Hospital

☐ Hospice Provider

☐ Rehabilitation Hospital Center

☐ Multi-practice physician ambulatory surgery center

☐ Multi-practice podiatry ambulatory surgery center

☐ Nursing facility ☐ Other (specify): _____

5.) Please select each and every category that describes this proposal.

A. ___ construction, development, and establishment of a healthcare facility (e.g., **New** home care, home nursing care, hospice, ambulatory surgery center, etc.), or **new services** for a healthcare facility selected in Question 4;
B. ___ a capital expenditure for:
1. ___ health care equipment in excess of $3,247,713;
2. ___ construction or renovation of a health care facility in excess of $7,577,998;
3. ___ an acquisition by or on behalf of a healthcare facility or HMO by lease or donation;
4. ___ acquisition of an existing health care facility, if the services or the bed capacity of the facility will be changed;
C. ___ any capital expenditure which results in an increase in bed capacity of a hospital and inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers);
D. ___ any capital expenditure which results in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of facility's licensed bed capacity, whichever is greater, and for which the related capital expenditures do not exceed $2,000,000;
E. ___ the offering of a new health service with annualized costs in excess of $2,165,142;
F. ___ predevelopment activities not part of a proposal, but which cost in excess of $7,577,998;
G. ___ establishment of an additional inpatient premise of an existing inpatient health care facility;
H. ___ tertiary or specialty care services: full body MRI, full body CT, cardiac catheterization, positron emission tomography, linear accelerators, open heart surgery, organ transplantation, and neonatal intensive care services. Or expansion of an existing tertiary or specialty care service involving capital and/or operating expenses for additional equipment or facilities;

HEALTH PLANNING AND PUBLIC NEED

6.) Please discuss the relationship of this proposal to any state health plans that may have been formulated by the state agency and any state plans for categorically defined programs. In your response, please identify all such priorities and how the proposal supports these priorities.

7.) Please discuss the proposal and present the demonstration of the public need for this proposal.

- Provide a brief description of public need for this proposal:

A. Please identify the documented availability and accessibility problems, if any, of **all** existing facilities, equipment, and services available **in the state** similar to the one proposed herein:

*Please provide electronic links ("hyperlinks") to facilities/service provider

Name of *Facility/Service Provider	List similar type of Service/Equipment	Documented Availability Problems (Y/N)	Documented Accessibility Problems (Y/N)	Distance from Applicant (in miles)

B. Please discuss the extent to which the proposed service or equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment, including those identified in (A) above. In addition, identify what portion of the need for the services proposed in this project is not currently being satisfied, and what portion of that unmet need would be satisfied by approval and implementation of this proposal.

C. Please identify the cities and towns that comprise the primary and secondary service area of the facility. Identify the size of the population to be served by this proposal and (if applicable) the projected changes in the size of this population.

D. Please indicate the population that the applicant is proposing to serve. Please state why the proposed service population is underserved with regard to Home Health services and how the applicant plans to specifically address this underserved population.

E. Please identify the health needs of the population in (C) relative to this proposal.

F. Please identify utilization data for the past three years (if existing service) and as projected through the next three years, after implementation, for each separate area of service affected by this proposal. Please identify the units of service (e.g., by hours, number of procedures, and number of treatments, etc.) used. Please complete the table(s) below for Actual (last 3 years), if there are none, please so state and Projected (3 years).

Actual (last 3 years)	FY____	FY ____	FY ____
Hours of Operation			
Utilization (#)			
Throughput Possible (#)			
Utilization Rate (%)			

Projected	FY ____	FY ____	FY ____
Hours of Operation			
Utilization (#)			
Throughput Possible (#)			
Utilization Rate (%)			

Health Disparities and Charity Care

8.) The RI Department of Health defines health disparities as inefficiencies in health status, disease incidence, disease prevalence, morbidity, or mortality rates between populations as impacted by access to services, quality of services, and environmental triggers. Disparately affected populations may be described by race & ethnicity, age, disability status, level of education, gender, geographic location, income, or sexual orientation.

A) Discuss the impact of the proposal on reducing and/or eliminating health disparities in the applicant's service area.

9.) Please provide a copy of the applicant’s charity care policies and procedures and charity care application form.

10.) Please discuss the impact of approval or denial of the proposal on the future viability of the (1) applicant and (2) providers of health services to a significant proportion of the population served or proposed to be served by the applicant.

Quality, Track Record, Continuity of Care, and Relationship to the Health Care System

11.) Please address the following:

A) How the applicant will ensure full and open communication with their patients' primary care providers for the purposes of coordination of care;

12.) 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;

Provision of Health Services to Inpatients

13.) Are there similar programmatic alternatives to the provision of institutional health services as proposed herein which are superior in terms of cost, efficiency, and/or appropriateness.

14.) In the absence of proposed institutional health services proposed herein, will patients encounter serious problems in obtaining care of the type proposed in terms of availability, accessibility, and/or cost

Select and complete the Appendices applicable to this application:

Appendix	Check off:	Required for:
A		Financial Analysis – All applications
B		Debt or Lease Financing – All applications
C		Ownership Information – All applications
D		Change in Space Form - All applications
E		Request for Expeditious Review

Appendix A – Financial Analysis

1. A) Please itemize the capital costs of this proposal. Present all amounts in thousands (e.g., $112,527=$113). If the proposal is going to be implemented in phases, identify capital costs by each phase.

CAPITAL EXPENDITURES		
	Amount	**Percent of Total**
Soft Construction Costs		
Survey/Studies	$	%
Fees/Permits	$	%
Architect	$	%
Subtotal "Soft" Construction Costs	**$**	**%**
Hard Construction Costs		
Site Preparation	$	%
Demolition	$	%
Renovation	$	%
New Construction	$	%
Contingency	$	%
Subtotal "Hard" Construction Costs	**$**	**%**
Equipment Costs		
Furnishings	$	%
Movable Equipment	$	%
Fixed Equipment	$	%
Subtotal "Equipment" Costs	**$**	**%**
Financing Costs		
Capitalized Interest	$	%
Bond Costs/Insurance	$	%
Debt Services Reserve[1]	$	%
Accounting/Legal	$	%
Financing Fees	$	%
Subtotal "Financing" Costs	**$**	**%**
Other Costs		
Land	$	%
Other (specify _____)	$	%
Subtotal "Other" Costs	**$**	**%**
TOTAL CAPITAL COSTS	**$**	**100%**

[1]Should not exceed the first full year's annual debt payment.

B) Please provide audited financial statements for the applicant, for the most recent year, if available.

C) Please provide the following for the applicant:

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

II. The relative availability of funds for capital and operating needs.

2. 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.)	List sources(s) of funds (and amount if multiple sources)
Equity*	$	%	%		
Debt**	$	%	%		
Lease	$	%	%		
TOTAL	**$**	**100%**			

* Equity means non-debt funds contributed towards the capital cost of an acquisition or project which are free and clear of any repayment obligation or liens against assets, and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged (216-RICR-40-10-22.2A(11)).
** If debt and/or lease financing is indicated, please complete Appendix B.

3. Please calculate the yearly amount of depreciation and amortization to be expensed.

Depreciation/Amortization Schedule - Straight Line Method					
	Improvements	**Equipment**		**Amortization**	**Total**
		Fixed	**Movable**		
Total Cost	$	$	$	$	$ *1*
(-) Salvage Value	$	$	$	$	$
(=) Amount Expensed	$	$	$	$	$
(/) Average Life (Yrs.)					
(=) Annual Depreciation	**$**	**$**	**$**	**$**	**$ *2***

1 Must equal the total capital cost (Appendix A Question 1 above) less the cost of land and less the cost of any assets to be acquired through lease financing
2 Must equal the incremental "depreciation/amortization" expense, column -5-, in **Pro-Forma P&L Statement for the whole facility.**

4. For the first full operating year of the proposal (identified in Pro-Forma P&L Statement for the whole facility), please identify the total number of FTEs (full time equivalents) and the associated payroll expense (including fringe benefits) required to staff this proposal. Please follow all instructions and present the payroll in thousands (e.g., $42,575=$43).

Personnel	**Existing**		**Additions/(Reductions)**		**New Totals**	
	# of FTEs	**Payroll W/Fringes**	**# of FTEs**	**Payroll W/Fringes**	**# of FTEs**	**Payroll W/Fringes**
Medical Director		$		$		$
Physicians		$		$		$
Administrator		$		$		$
RNs		$		$		$
LPNs		$		$		$
Nursing Aides		$		$		$
PTs		$		$		$
OTs		$		$		$
Speech Therapists		$		$		$
Clerical		$		$		$
Housekeeping		$		$		$
Other: (specify)		$		$		$
TOTAL		**$**		**$ *1***		**$**

1 Must equal the incremental "payroll w/fringes" expense in column -5-, Pro-Forma P&L Statement for the whole facility.

"FTEs": full time equivalents, are the equivalent of one employee working full time (i.e., 2,080 hours per year)
"Additions": are NEW hires
"Reductions": are staffing economies achieved through attrition, layoffs, *etc.* It does NOT report the reallocation of personnel to other departments.
"Administrator": Please note if the facility administrator will be a non-nurse, pursuant to Section 17.5.3(M)(2) of the HNCP and HCP Rules and Regulations, the nursing services will be under the direction of a registered nurse licensed in Rhode Island. Please provide

5. Please describe the plan for the recruitment and training of personnel.

6. Pursuant to Section 17.3(A)(2) of the rules and regulations, *Licensing Home Nursing Care Providers and Home Care Providers* ("HNCP and HCP Rules and Regulations") (216-RICR-40-10-17), please note that the administrator must either (1) be a licensed physician; or (2) have training and experience in health service administration and at least one year of supervisory or administrative experience in home nursing care or home care or related health programs; or (3) be a registered nurse who meets qualifications of as set forth in 42 CFR Part 484.

    A. Please provide a job description for the position, demonstrating compliance with Section 17.5.3(B) of the HNCP and HCP Rules and Regulations.

7. Please complete the following pro-forma income statement for each unit of service. Present all dollar amounts in thousands (e.g., $112,527=$113). Be certain that the information is accurate and supported by other tables in this worksheet (i.e., "depreciation" from Question 3 above, "payroll" from Question 4 above). If this proposal involved more than two separate "units of service" (e.g., pt. days, CT scans, outpatient visits, etc.), insert additional units as required.

PRO-FORMA P & L STATEMENT FOR WHOLE FACILITY					
	Actual Previous Year 20__ (1)	**Budgeted Current Year 20__ (2)**	**<-- FIRST FULL OPERATING YEAR 20__ -->**		
			CON Denied (3)	**CON Approved (4)**	***1* Incremental Difference (5)**
REVENUES:					
2 Net Patient Revenue	$	$	$	$	$
Other:	$	$	$	$	$
Total Revenue	$	$	$	$	$
OPERATING EXPENSES:					
3 Payroll w/Fringes	$	$	$	$	$
4 Bad Debt	$	$	$	$	$
Supplies	$	$	$	$	$
Office Expenses	$	$	$	$	$
Utilities	$	$	$	$	$
Insurance	$	$	$	$	$
5 Interest	$	$	$	$	$
6 Depreciation/Amortization	$	$	$	$	$
Leasehold Expenses	$	$	$	$	$
Rent Expense	$	$	$	$	$
Other: (specify)	$	$	$	$	$
***7* Total Operating Expenses**	$	$	$	$	$
OPERATING PROFIT:	$	$	$	$	$

INSTRUCTIONS: pertaining to Pro-Forma P&L Statement for whole facility: Present all dollar amounts (except unit revenue and expense) in thousands

1 The Incremental Difference (column -5-) represents the actual revenue and expenses associated with this CON. It does not include any already incurred allocated or overhead expenses. It is column -4- less column –3-.

2 Net Patient Revenue (column -5-) equals the different units of service times their respective unit reimbursement.

3 Payroll with fringe benefits (column -5-) equals that identified in the Personnel table above.

4 Bad Debt is the same as that identified in column -4-.

5 Interest Expense equals the first full year's interest paid on debt.

6 Depreciation equals a full year's depreciation (in depreciation/amortization schedule above), not the half year booked in the year of purchase.

7 Total Expense (column -5-) equals the operating expense of this proposal and is defined as the sum of the different units of service.

8. Please provide Projected First Three Operating Years after implementation, by payor source of the facility.

	Projected First Three Operating Years (if approved)					
	FY: _____		FY: _____		FY: _____	
PAYOR SOURCE:	$	%	$	%	$	%
Medicare	$	%	$	%	$	%
Medicaid	$	%	$	%	$	%
Blue Cross	$	%	$	%	$	%
Commercial	$	%	$	%	$	%
HMO's	$	%	$	%	$	%
Self-Pay	$	%	$	%	$	%
Other:	$	%	$	%	$	%
TOTAL Net Patient Revenue	$	%	$	%	$	%
Charity Care*	$	%	$	%	$	%

*The applicant shall meet the requirements of Section 17.4.4 of the HNCP and HCP Rules and Regulations with regard to the statewide community standard for uncompensated care shall be one percent (1%) of net patient revenue earned on an annual basis. Uncompensated care shall be cost adjusted by applying a ratio of costs to charges from the licensee's Medicare Cost Report. Licensees not filing Medicare Cost Reports shall submit an audited financial report or such other report as deemed acceptable to the Director

Appendix B – Debt or Lease Financing

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

1. 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. likely security:_____

    g. disposition of property (if a lease is revoked) : _____

    h. prepayment penalties or call features:_____

    i. front-end costs (e.g., underwriting spread, feasibility study, legal and printing expense, points etc.): _____

    j. 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. 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 C – Ownership Information

All applications must be accompanied by responses to the questions posed herein.
Full responses to each question must be submitted and references to other responses shall not be accepted as a complete response. 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.

1. List all officers, members of the board of directors, stockholders, and trustees of the licensee, applicant, and/or ultimate parent entity. For each individual, provide their principal occupation, position with respect to the licensee, 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 #, and F) any professional accreditation (e.g., TJC, CHAP, etc.).

3. If any individual listed in response to Question 1 above, has any business relationship with the licensee, applicant, and/or ultimate parent entity, 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 the response is 'Yes,' please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

5. Please provide an organization chart for the applicant, identifying all "parent" 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 entities owned 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.

6. 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 5 above (applicant and/or its principals). 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 #, and F) any professional accreditation (e.g., TJC, CHAP, etc.).

7. Have any of the facilities identified in Question 5 or 6 above had: A) federal conditions of participation out of compliance, B) decertification actions, or C) any actions towards revocation of any state license? Yes ___ No ___

    - If the response is 'Yes,' please identify the facility involved, the nature of each incident, and the resolution of each incident.

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

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

9. Please provide the following documents for the applicant and any of its controlling entities/persons:

    - 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

Appendix D – Change in Space

All applications must be accompanied by responses to the questions posed herein.
Full responses to each question must be submitted and references to other responses shall not be accepted as a complete response. 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.

1. Provide a description and schematic drawing of the contemplated construction or renovation or new use of an existing structure and complete the Change in Space Form.

2. Please provide a letter stating that a preliminary review by a Licensed architect indicates that the proposal is in full compliance with the current edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" and identify the sections of the guidelines used for review. Please include the name of the consulting architect, and their RI Registration (license) number and RI Certification of Authorization number.

3. Provide assurance and/or evidence of compliance with all applicable federal, state, and municipal fire, safety, use, occupancy, or other health facility licensure requirements.

4. Will the construction, renovation or use of space described herein correct any fire and life safety, The Joint Commission (TJC), U.S. Department of Health and Human Services (DHHS) or other code compliance issues: Yes____ No_____

    - If yes, include specific reference to the code(s). For each code deficiency, provide a complete description of the deficiency and the corrective action being proposed, including considerations of alternatives such as seeking waivers, variances, or equivalencies.

5. Attach evidence of site control (e.g., deed, lease, rental agreement, etc.), a fee simple, or such other estate or interest in the site.

6. If zoning approval is required, attach evidence of application for zoning approval.

7. Provide an estimated date of contract award for this construction project, assuming approval within a 120-day cycle.

8. Assuming approval within a 120-day cycle, please provide the estimated date of contract award for this construction project, as well as the estimated date (month/year) when the service will begin or the change in service will be implemented. If the service will be phased in, please describe the activities planned for each phase.

Change in Space Form Instructions

The purpose of this form is to identify the major effects of your proposal on the amount, configuration, and use of space in your facility.

Column 1
Column 1 is used to identify discrete units of space within your facility, which will be affected by this proposal. Enter in Column 1 each discrete service (or type of bed) or department, which as a result of this proposal is:

a.) to utilize newly constructed space
b.) to utilize renovated or modernized space
c.) to vacate space scheduled for demolition

In each of the Columns 3, 4, and 5, you are requested to disaggregate the construction, renovation, and demolition components of this proposal by service or department. In each instance, it is essential that the total amount of space involved in new construction, renovation or demolition be totally allocated to these discrete services or departments listed in Column 1.

Column 2
For each service or department listed in Column 1, enter in this column the total amount of space assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 3
For each service or department, please fill in the amount of space which that service or department is to occupy in proposed new construction. The figures in Column 3 should sum to the total amount of space of new construction in this proposal.

Column 4
For each service or department, please fill in the amount of space, which that service or department is to occupy in space to be modernized or renovated. The figures in column 4 should sum to the total amount of space of renovation and modernization in this proposal.

Column 5
For each service or department fill in the amount of currently occupied space which is proposed to be demolished. The figures in Column 5 should sum to the total amount of space of demolition specified in this proposal.

Column 6
For each service or department entered in Column 1, enter in this column the total amount of space which will, upon completion of this project, be assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 7
Subtract from the amount of space shown in Column 6 the amount shown in Column 2. Show an increase or decrease in the amount of space.

Change in Space Form

Please identify and provide a definition for the method used for measuring the space (i.e., gross square footage, net square footage, etc.):

_____
_____
_____
_____

1. Service or Department Name	2. Current Space Amount	3. New Construction Space Amount	4. Renovation Space Amount	5. Amount of Space Currently Occupied to be Demolished	6. Proposed Space Amount	7. Change [(6)-(2)]
TOTAL:						

Appendix E - Request for Expeditious Review

1.) Name of applicant: _____

2.) Indicate why an expeditious review of this application is being requested by marking at least one of the following with an 'X.'

_____a. for emergency needs documented in writing by the state fire marshal or other lawful authority with similar jurisdiction over the relevant subject matter;
_____b. for the purpose of eliminating or preventing fire and/or safety hazards certified by the state fire marshal or other lawful authority with similar jurisdiction of the relevant subject matter as adversely affecting the lives and health of patients or staff;
_____c. for compliance with accreditation standards failure to comply with which will jeopardize receipt of federal or state reimbursement;
_____d. for such an immediate and documented public health urgency as may be determined to exist by the Director of Health with the advice of the Health Services Council.

3.) For each response with an 'X' beside it in Question 2 above, furnish documentation as indicated:

2.a: a written communication from the State Fire Marshal or other lawful authority with similar jurisdiction over the relevant subject matter setting forth the particular emergency needs cited, and the measures required to meet the emergency;

2.b: documentation from the State Fire Marshal or other lawful authority with similar jurisdiction of the relevant subject matter certifying that particular fire and/or safety hazards currently exist which adversely affect the life and health of patients or staff and outlining the measures which must be taken in order to alleviate these hazards;

2.c: a written communication from the accrediting agency naming specific deficiencies and required remedies for situations failure of compliance with which will jeopardize receipt of federal or state reimbursement;

2.d: a complete description and documentation of the immediate and documented public health urgency, which, in the applicant's opinion, necessitates an expeditious review.