

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

## **Letter of Intent Form**

(Version September 2025)

All applicants must file a Letter of Intent (LOI) on this form <u>45 days prior</u> filing a Certificate of Need (CON) application. In order to be eligible to file a CON application in the **January 9**, **2026**, batch, an LOI must be filed with the Office of Health Systems Development by 4:30 PM **November 25**, **2025**. Please note, the LOI will be reviewed, and the applicant may be contacted with a request for additional information. If you do not hear from a staff member, please proceed with completing the CON application to meet the January 9, 2026, CON hard copy and electronic deadline submission along with the accompanying CON application fee.

Please submit one electronic copy ONLY of the LOI to: <u>Paula.Pullano@health.ri.gov</u> with a copy (Cc) to <u>jim.suah@health.ri.gov</u>

Please direct any questions to the Office of Health Systems Development via email or at: 401-222-2788.

1.	Brief Descriptive Title of Proposal:  (Legal Name of Facility and application type for licensure that describes facility)		
2.	. Applicant:		
	(Legal Name of Facility)		
Nar	Name:		
Ado	Address:		
3.	. Facility (if different from applicant):		
Nar	lame:		
Ado	Address:		
4.	Chief Executive Officer:		
Nar	Tame: Telepl	hone:	
Ado	ddress:		
E-n	-mail: Fax n	umber:	

5. Person to contact regarding this proposal: Name: Telephone: Address: E-mail: Fax number: 6. Brief Summary Description of Proposal: Include: Ownership information, Operational information about the proposed facility, (e.g., description of services to be provided, hours of operation, whether the site is leased or owned, and geographic area to be served). 7. a. Capital Cost of Proposal: \$\_\_\_\_\_ b. First Full Year Operating Cost of Proposal: \$ 8. Month and year the proposal would be implemented: (taking into consideration the 120-day Certificate of Need review period from the February 20, 2026, initiation of review date) 9. Will you be requesting: Expeditious review? Yes\_\_\_\_No\_\_\_If Yes, please complete Appendix A 10. Please select the licensure category that best describes the facility: ☐ Freestanding Ambulatory Surgical Center ☐ Home Nursing Care Provider ☐ Hospice Provider ☐ Rehabilitation Hospital Center ☐ Multi-practice Physician Ambulatory Surgery Center ☐ Multi-practice Podiatry Ambulatory Surgery Center ☐ Nursing Facility ☐ Home Care Provider ☐ Hospital Other (specify):

11. Please identify the tax status of the facility: \_\_\_\_non-profit\_\_\_\_for-profit\_\_\_other

12. Ple	ease checl	k each and every categor	y that describes this proposal.		
A.	home ca		t, or establishment of a new heal hospice, ambulatory surgery cent in Ouestion 10;		
Ba capital expenditure for: 1health care equipment in excess of \$3,247,713;			,		
			in excess of \$3.247.713:		
	2.		tion of a health care facility in exc	ess of \$7,577,998;	
	3.		or on behalf of a healthcare facil		
		donation; and			
	4.		f an existing health care facility, if will be changed;	f the services or the bed	
C.			e which results in an increase in th	e licensed bed capacity	
	of a	hospital or a rehabilitati		1 3	
D.		*	e which results in an increase in be	ed capacity of a nursing	
	faci	lity in excess of 10 beds	s or 10% of facility's licensed bed	d capacity, whichever is	
	grea	ater, and for which the re	lated capital expenditures exceed	\$2,000,000;	
E.					
F.	pre	development activities no	ot part of a proposal, but which co	ost in excess of	
		577,998;			
G.					
	health care facility or a surgi-center premises of a healthcare facility; and				
Htertiary or specialty care services:					
	1.	new full body MRI,	full body CT, cardiac catheterizati	ion, positron emission	
		tomography, linear acce	elerators, open heart surgery, organ	n transplantation, and	
		neonatal intensive care	services; or		
	2.	expansion of an exis	ting tertiary or specialty care serv	ice involving	
		capital and/or operating	expenses for additional equipment	nt or facilities.	
13. Fo	or each sir	ngle piece of new health	care equipment with a capital expe	enditure in excess of	
\$3,247	7,713, or t	ertiary or specialty care	equipment regardless of capital ex	pense or operating	
expens	ses, pleaso	e provide the following:	(If there are none, please so state)		
7	Гуре:	Manufacturer's	Model Name & Number:	Cost:	
	<u> </u>	Name:			

14. Please indicate the financing mix for the capital cost of this proposal.

**NOTE:** The Health Services Council's policy requires a minimum 20% equity investment in CON projects (33% equity minimum for equipment-related proposals).

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

<sup>\*</sup> 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. Rules and regulations for the <a href="Determination of Need for New Health Care Equipment and New Institutional Health Services">Determination of Need for New Health Care Equipment and New Institutional Health Services</a> (216-RICR-40-10-22).

** If	debt and/or lease financing is indicated, please complete <b>Appendix B.</b>		
15.	Will zoning approval be required as part of this proposal? YesNo		
16. Will this proposal involve new construction or expansion of patient occupancy, that require an approved plan for water supply and sewage disposal from the state a municipal authority? Yes No			
	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

## **Appendix A - 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 documented emergency needs;b. for the purpose of eliminating or preventing fire and/or safety hazards affecting the lives and health of patients or staff; orc. for compliance with accreditation standards required for receipt of federal or state reimbursement.

- 3.) For each response with an 'X' beside it in Question 2 above, please provide a detailed explanation for this request and <u>furnish documentation</u> as indicated:
  - 2.a: a written communication from the State Fire Marshal or other authority, recognized by the state agency, 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 authority, recognized by the state agency, stating 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 eliminate these hazards; or
  - 2.c: a written communication from the accrediting agency citing specific deficiencies and required remedies for situations of failure of compliance which will jeopardize receipt of federal or state reimbursement.

## **Appendix B - Debt 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.

Na	me of Applicant:		
	Describe the proposed debt by completing the form 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.) prepayment penalties or call features: h.) front-end costs	following:	
	(e.g., feasibility study and legal expense): i.) 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. If lease financing for this proposal is contemplated, please compare the advantages and disadvantages of a lease versus the option of purchase. Please make the comparison using the following criteria: term of lease, annual lease payments, salvage value of equipment at lease termination, purchase options, value of insurance and purchase options contained in the lease, discounted cash flows under both lease and purchase arrangements, and the discount rate.
- 4. 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.