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 January 2026)

All applicants must file a Letter of Intent (LOI) electronically (as a single PDF file) on this form 45 days prior to filing a Certificate of Need (CON) application. In order to be eligible to file a CON application in the **June 10, 2026**, batch, an LOI must be filed with the Office of Health Systems Development by 4:30 PM **April 27, 2026**. 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 **June 10, 2026**, CON electronic deadline submission. CON application fees are to be mailed.

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

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)

Name:
Address:

3. Facility (if different from applicant):

Name:
Address:

4. Chief Executive Officer:

Name:	Telephone:
Address:	
E-mail:	Fax number:

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 **July 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 (including in- home infusion therapy)
- ☐ 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. Please check each and every category that describes this proposal.

A. _____construction, development, or establishment of a new 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 10;

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; and
   4. _____ an 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 the licensed bed capacity of a hospital or a rehabilitation hospital center;

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 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 or a surgi-center premises of a healthcare facility; and

H. ____tertiary or specialty care services:
   1. ___new full body MRI, full body CT, cardiac catheterization, positron emission tomography, linear accelerators, open heart surgery, organ transplantation, and neonatal intensive care services; or
   2. ___expansion of an existing tertiary or specialty care service involving capital and/or operating expenses for additional equipment or facilities.

13. For each single piece of new health care equipment with a capital expenditure in excess of $3,247,713, or tertiary or specialty care equipment regardless of capital expense or operating expenses, please provide the following: (If there are none, please so state)

Type:	Manufacturer's Name:	Model Name & Number:	Cost:

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%**		

* 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 Determination of Need for New Health Care Equipment and New Institutional Health Services (216-RICR-40-10-22).

** If debt and/or lease financing is indicated, please complete **Appendix B.**

15. Will zoning approval be required as part of this proposal? Yes_____No_____

16. Will this proposal involve new construction or expansion of patient occupancy, that will require an approved plan for water supply and sewage disposal from the state and/or 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; or
_____c. 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.

Name of Applicant: _____

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.) prepayment penalties or call features: _____
   h.) front-end costs
   (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.