State of Illinois
Illinois Department of Public Health

Application for Hospital Licensure

CONFIDENTIAL NATURE OF INFORMATION - As required by law, the information given in this application will be considered confidential and will not be disclosed publicly by the Department in such manner as to identify individuals or hospitals, except in a proceeding involving the question of licensure or revocation or in other circumstances as may be approved by the Hospital Licensing Board.

GENERAL INSTRUCTIONS

A. All items of information on the Application for Hospital Licensure form must be filled in when a hospital makes its initial application for license.

B. Prepare the application form in duplicate; send the original to the Illinois Dept. of Public Health, 525 West Jefferson Street, Fourth Floor, Springfield, Illinois 62761-0001; and keep a copy for the hospital files.

C. Please complete using PDF writer or print and complete with typewriter or print legibly with permanent type ink.

D. The applicant should feel free to provide additional information on an attached sheet. This should be done whenever the space on the form is inadequate to give a complete answer.

E. This application *must* be executed and verified by the individual owner or by two officers in the case of a hospital-owned corporation, association, or governmental unit or agency.

F. There is an initial license bed fee of $55 per licensed bed, as well as an annual fee of $55 per licensed bed.

G. This initial application is the only one required of the hospital. Annual re-application is not required, however the annual bed fee of $55 per licensed bed is required annually. Additionally, if the hospital's location, ownership changes, or a change in clinical services results in a change of license category, a re-application is then required. Refer to Section 250.110a.

H. Separate applications are required for hospitals operated on separate premises, even though operated under the same ownership and/or management.

I. Separate applications are required for each individual hospital, even though ownership is the same.

Additional instruction for completing the application for hospital license

Section 250.210 The Governing Board

This section of the hospital licensing requirements states that the hospital governing board be formally organized in accordance with a written constitution and by-laws.

Please include a copy of the hospital's constitution and by-laws as part of this application.

Application for Hospital Licensure

Definitions

1. Definition of Hospital. For the purposes of this application, the term hospital means any institution, place, building or agency, public or private, whether organized for profit or not, devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment and/or care of two or more unrelated persons admitted for overnight stay or longer in order to obtain medical, including obstetric, psychiatric and nursing, care of illness, disease, injury, infirmity or deformity. All places where pregnant females are received, cared for or treated during delivery shall be considered to be a hospital within the meaning of this act irrespective of the number of patients received or the duration of their stay. The term hospital includes general and specialized hospitals, tuberculosis sanitaria, and includes maternity homes, lying-in homes and homes for unwed mothers in which care is given during delivery.

2. Bed complement. Give the present number of beds actually set up for in-patient care, including children's cribs. (Exclude bassinets in maternity department nurseries, but count those in pediatric departments and in premature nurseries if not located in the maternity department. Exclude labor and recovery beds.)

3. Bed capacity. Based only on space designed as patient rooms, whether or not beds are installed; compute the “normal” bed count on the basis of a minimum of 100 square feet of floor area per bed in private rooms, 80 square feet per bed in semi-private and ward rooms, 50 square feet per pediatric crib or bed, 30 square feet per bassinet in pediatric departments. There shall be a minimum of 30 square feet of floor area for each bassinet and three feet between bassinets in a nursery. In Special Care and Observation Nurseries, the floor area per bassinet shall be determined by the program but not be less than 40 square feet. There should be 80 to 100 square feet of space for each infant cared for in the Level III or Intensive Care area.

4. Emergency capacity. Number of beds that can reasonably be added to the bed complement in periods of unusually high occupancy.

STATUTORY PURPOSE AS OUTLINED UNDER I.R.S. Chap. 111 1/2, Secs. 142 to 157. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THIS FORMS HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER

State of Illinois
Illinois Department of Public Health

Application for Hospital Licensure

DEPARTMENT USE ONLY
Hospital ID Number _____

In accordance with requirements of the Hospital Licensing Act (Ill.Rev.Stat. 1961, Chap 111 1/2, Secs. 142-157) and the regulations issued pursuant thereto, application is hereby made for a license to establish, conduct and/or maintain a hospital.

I. Name and Location of Hospital

Exact legal name _____

Assumed / DBA Name _____

Address _____

City _____ Zip Code _____

Township _____ County _____

Is the hospital located outside the corporate limits of the city? ☐ Yes ☐ No

Main phone number for public use _____

Administration phone number for IDPH use _____

Administration fax number for IDPH use _____

II. Ownership and Administration

Type of control (check one only)

GOVERNMENTAL

○ Federal ○ State ○ County ○ Township ○ City ○ Hospital district ○ Sanitarium district

NOT FOR PROFIT CORPORATION

○ Church operated or affiliated ○ Other non-profit

PROPRIETARY

○ Individual ○ Partnership ○ Corporation

Other (explain) _____

Date incorporated under the laws of the State of Illinois _____

Established by * _____ Year Opened _____

Now owned by * _____ Date Ownership Effective _____

Operated by * _____

* Name of the Agency, Organization, Association, Corporation, or Individual

Application for Hospital Licensure

II. Ownership and Administration (continued)

Official name of governing body _____

(i.e. Board of Trustees, Board of Directors, etc.)

Officers of the governing body (Governmental and non-profit hospitals list officers of governing body. Proprietary hospitals list names and address of individual owner, partners or officers of corporation.)

President _____ Address _____

Vice President _____ Address _____

Secretary _____ Address _____

Treasurer _____ Address _____

Person in Charge of the Hospital:

Name _____ Title _____

Date appointed to this position _____ ☐ Full time ☐ Part time

If part time, what other position or employment

Applicants (who are not individuals or sole proprietorships) provide the name and address of registered agent or person designated to receive service of process in Illinois.

Name _____

Address _____

City _____ State _____ Zip Code _____

Application for Hospital Licensure

II. Ownership and Administration (continued)

Number of Beds for Patients (exclude beds in emergency departments, labor and delivery, recovery rooms, etc.)

	Number of Beds
Total Bed Complements	
Bed Capacity	
Emergency Capacity	
Total Adult Certified Beds	
Extended Care Facilities Certified Beds (hospital licensed)	
Extended Care Facilities Certified Beds (nursing home licensed)	

Bed complement (breakdown of total bed complement) by clinical service

	Number of Beds
Internal Medicine	
General Surgical	
Gynecological and Obstetrics	
Intensive Care	
Acute Mental Illness	
Neonatal Intensive Care Level II	
Neonatal Intensive Care Level III	
Pediatrics	
Long Term Care	
Restorative / Rehabilitation	
Other	
Total	

Number of bassinets in maternity department nurseries _____

Are any patient beds located in rooms below ground level? ☐ Yes ☐ No How many beds? _____

Number of patient care days (exclusive of newborn) rendered in last calendar or fiscal year _____

Number of patients discharged and those who died (exclusive of newborn) in same period _____

Application for Hospital Licensure

III. Medical Staff

Is the medical staff organized with written by-laws, officers, regular meetings, and written minutes? ☐ Yes ☐ No

Is the medical staff "closed" (i.e. restricted to active staff only) or open? _____ (i.e. both active and courtesy groups?)

To what staff group do dentists belong? _____

Chief of Staff _____ Illinois license no. _____

IV. Departments and Services

A. Nursing Department

Name of person in charge _____ Title _____

Current Illinois registration number _____

B. Dietary Department

Name of person in charge _____ ☐ Full Time ☐ Part Time

Has the hospital arranged for the service of a consultant dietician if no full time or part time dietician is employed?

☐ Yes ☐ No

C. Radiological Department

Are radiological services provided in the hospital? ☐ Yes ☐ No

If not, name hospital, clinic or other facility providing this service _____

Types of services provided:

Diagnostic

Radiographic ☐ Yes ☐ No

Regular	No. of radiographic units	_____	MA rating of each radiographic unit	_____
Portable	No. of radiographic units	_____	MA rating of each radiographic unit	_____
Dental	No. of radiographic units	_____	MA rating of each radiographic unit	_____
Other	No. of radiographic units	_____	MA rating of each radiographic unit	_____

Fluoroscopic	☐ Yes	☐ No
Radioactive Isotopes	☐ Yes	☐ No
Interventional	☐ Yes	☐ No

Is it hospital policy to make an x-ray film of the chest as a routine admission procedure? ☐ Yes ☐ No

Application for Hospital Licensure

IV. Departments and Services (continued)

C. Radiological Department (continued)

Therapeutic

Deep Therapy	☐ Yes	☐ No	KVP rating of unit _____
Intermediate	☐ Yes	☐ No	KVP rating of unit _____
Superficial	☐ Yes	☐ No	KVP rating of unit _____
Radium (radon) Therapy	☐ Yes	☐ No	
Radioactive Isotopes	☐ Yes	☐ No	

Name of physician in charge of service _____

Are they Board certified? ☐ Yes ☐ No Current Illinois registration number _____

Are they (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

If hospital is not served by a full time radiologist, or regularly visited by a part time radiologist, is the radiological service supervised by a member of the medical staff?

☐ Yes ☐ No

Name _____ Illinois license number _____

D. Clinical Laboratory Department

Is laboratory service provided in the hospital? ☐ Yes ☐ No CLIA # _____

If not, name hospital, clinic or other facility providing this service

_____

Check the type(s) of services provided

☐ Tissue Pathology	☐ Histocompatibility	☐ Photography	☐ Hematology
☐ Clinical Pathology	☐ Blood bank	☐ Autopsy	☐ Chemistry
☐ Radiobioassay	☐ Diagnostic Immunology	☐ Microbiology	
☐ Immunohematology	☐ Clinical Cytogenetics	☐ Basal metabolism	
☐ Other (specify) _____			

Name of physician in charge of service _____

Are they Board Certified? ☐ Yes ☐ No Illinois license number _____

Are they (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

If the hospital is not served by a fill time pathologist, or is regularly visited by a pathologist, is the clinical laboratory service supervised by a member of the medical staff?

☐ Yes ☐ No

Name _____

Application for Hospital Licensure

IV.Departments and Services (continued)

E. Anesthesiology Department

Name of physician in charge of service _____

Are they Board certified? ☐ Yes ☐ No Illinois license number _____

Are they (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

If the hospital is not organized under Anesthesia Service, is the anesthesia department supervised by a member of medical staff?

☐ Yes ☐ No

Name _____ Illinois License number _____

Who usually gives the anesthetic? ☐ M.D. ☐ Nurse Anesthetist ☐ Other, specify _____

Is the person who usually gives the anesthetic a hospital employee? ☐ Yes ☐ No

F. Outpatient Department

If the hospital has an organized outpatient department, please list the organized clinics conducted (i.e. STD, Cancer, Prenatal, Orthopedic, etc.)

_____ _____ _____

_____ _____ _____

If the hospital has no organized outpatient department, check the type(s) of service(s) provided for outpatients:

☐ Laboratory services ☐ Emergency services
☐ X-ray examinations ☐ Outpatient surgical services ☐ Other _____
☐ X-ray or radium therapy

G. Medical Department

If there an organized medical department? ☐ Yes ☐ No

Name of physician in charge of service _____ Illinois license number _____

Are they Board certified? ☐ Yes ☐ No

Are they (check one)? ☐ Full time ☐ Part time days per week _____ days per month _____ ☐ On call

H. Surgical Department

Is there an organized surgical department? ☐ Yes ☐ No

Name of chief surgeon _____

Are they Board certified? ☐ Yes ☐ No Illinois license number _____

Does this person devote full time to surgery? ☐ Yes ☐ No

If No, indicate: ☐ Part time ☐ Full time days per week _____ days per month _____ ☐ On call

Application for Hospital Licensure

IV. Departments and Services (continued)

I. Restorative and Rehabilitation Department

Is there a restoration and rehabilitation department? ☐ Yes ☐ No

Check the type(s) of service(s) provided:

☐ Physical Therapy ☐ Vocational Counseling ☐ Dietary
☐ Occupational Therapy ☐ Therapeutic Recreation ☐ Psychology
☐ Speech Pathology ☐ Social Services ☐ Other (specify) _____

Name of Person in charge of services _____

Professional Specialty _____ Illinois License Number _____

Are they (check one)? ☐ Full time ☐ Part time Days per Week _____ Days per Month _____ ☐ On Call

J. Pathology Department

Is there an organized pathology department?	☐ Yes	☐ No
Is there a tissue committee of the medical staff?	☐ Yes	☐ No
Are anatomical, pathological, services provided in the hospital?	☐ Yes	☐ No

If not, name the hospital, clinic, or other facility providing this service

_____

Name of the pathologist in charge of services _____

Are they Board certified? ☐ Yes ☐ No Illinois License Number _____

Indicate basis of employment:

☐ Full time ☐ Part time ☐ Regular Consultative (consultative visits at least semi - monthly)

☐ Other (specify) _____

K. Intensive Care Department

Is there an organized intensive care department? ☐ Yes ☐ No

Name of Person in charge _____

Illinois License Number _____

Are they (check one)? ☐ Full time ☐ Part time Days per Week _____ Days per Month _____ ☐ On Call

Application for Hospital Licensure

L. Dental Department

Is there an organized dental department? ☐ Yes ☐ No

Name of Dentist in charge of services _____

Illinois License Number _____

Are they (check one) ☐ Full time ☐ Part time Days per Week _____ Days per Month _____ ☐ On Call

M. Social Services Department

Is there an organized social services department? ☐ Yes ☐ No

Name of Person in charge _____

Are they (check one) ☐ Full time ☐ Part time Days per Week _____ Days per Month _____ ☐ On Call

N. Medical Records

Is there an organized medical records department? ☐ Yes ☐ No

Name of Person in charge _____

Are they (check one) ☐ Full time ☐ Part time Days per Week _____ Days per Month _____ ☐ On Call

Is there a medical records committee, as per section 250.310 b) 4 under organization of medical staff?

☐ Yes ☐ No

Application for Hospital Licensure

Personnel by Departments

Please indicate the anticipated total number of full time employees (FTE) to be employed at the hospital per Department. Place an X in the appropriate category (employed or contractual) for the Department. If this application is for an existing licensed hospital then identify the total FTE on the last day of the most recent pay period. Include only paid employees. If one employee serves in more than one position, include them in both departments.

Department		Employed Staff	Contractual	Total FTE
A. Administration				
B. Business Office and Records				
C. Medical Records and Library				
D. Anesthesiology	Anesthesiologist			
	Nurse Anesthetist			
E. Nursing	R.N.			
	L.P.N.			
	Others			
F. Nursing Education	Administrative			
	Instructors			
G. X-ray and Radiology	Radiologists			
	Technicians			
	Others			
H. Clinical Laboratory	Pathologists			
	Technicians			
	Others			
I. Dietary	Supervisory			
	Cooks and Bakers			
	Others			
J. Medical Social Service				

Application for Hospital Licensure

Personnel By Departments (continued)

Department		Employed Staff	Contractual	Total FTE
K. Pharmacy	Pharmacist			
	Technicians			
	Others			
L. Restoration and Rehabilitation	P.T.			
	O.T.			
	P.T.A.			
	O.T.A.			
	S.P.			
	Other			
M. Housekeeping				
N. Plant Operations Maintenance and Repair				
O. Laundry				
P. Professional Services	Physicians			
	Surgeons			
	Residents			
	Interns			
Q. Dental				
R. Other Departments*				
	Total			

* If the hospital has other organized departments or other employees, please list and designate the department or the employee's job title.

Application for Hospital Licensure

Physical Plant

Physical Plant	Original Building	Additions			
		1.	2.	3.	4.
A. Year Built					
B. Number of Stories (exclude Basement)					
C. Sprinkler System	☐ Full ☐ Partial ☐ None	☐ Full ☐ Partial ☐ None	☐ Full ☐ Partial ☐ None	☐ Full ☐ Partial ☐ None	☐ Full ☐ Partial ☐ None
D. Number of Beds on Each Floor					

Floor Name		# of Beds		Floor Name		# of Beds	
Floor Name		# of Beds		Floor Name		# of Beds	
Floor Name		# of Beds		Floor Name		# of Beds	
Floor Name		# of Beds		Floor Name		# of Beds	
Floor Name		# of Beds		Floor Name		# of Beds	
Floor Name		# of Beds		Floor Name		# of Beds	
Floor Name		# of Beds		Floor Name		# of Beds	
Floor Name		# of Beds		Floor Name		# of Beds	
Floor Name		# of Beds		Floor Name		# of Beds	

E. Name of Person in charge of physical plant: _____

F. New additions and remodeling

1. Is the hospital building a new addition or making remodeling changes at the present time? ☐ Yes ☐ No

If so, please describe

2. How will this affect bed complement? _____

Application for Hospital Licensure

Accreditation

A. Is the hospital fully approved by the Joint Commission of Accreditation of Hospitals (J.C.), the Accreditation Commission for Health Care (ACHC), the Center for Improvement in Healthcare Quality (CIHQ), or Det Norske Veritas Healthcare Inc (DNV)? ☐ Yes ☐ No

B. If no, has the hospital requested appraisal by the JC / ACHC / CIHQ / DNV? ☐ Yes ☐ No

Information Supplied By:

Name and Title _____

Date _____

CONFIDENTIAL INFORMATION - This information will be considered confidential and will not be disclosed publicly by the Department in such a manner as to identify individuals or hospitals.

VERIFICATOIN

State of _____

County of _____ } S. S.

_____ And _____

being by me duly sworn on _____ oath, deposes, and says that _____

have / has read the foregoing application and know(s) the contents thereof; that the statements concerning the above named hospital, therein contained, are correct and true of _____ own knowledge, and further gives reasonable assurance of the ability and intention of said hospital to comply with the regulations promulgated under the Hospital Licensing Act.

(An application on behalf of a corporation, association, or a governmental unit or agency shall be made and verified by any two officers thereof.)

Signature _____

Title _____

Signature _____

Title _____

Signed and sworn (or attested) to before me this _____ day of _____ 20 _____

_____
Notary Public

My Commission Expires _____ 20 _____

Application for Hospital Licensure

Application Addendum

This addendum must be completed as part of the following program / facility applications:

- Ambulatory Surgical Treatment Center
- Home Health Agency
- Hospice Program
- Hospital

Section 10 - 65 (c) of the Illinois Administrative Procedure Act, 5ILCS 100 / 10 - 65 (c), was amended by P.A / 87 - 823 and required individual licensees to certify whether they are delinquent in payment of child support.

Applicant is an individual (Sole Proprietor) ☐ Yes ☐ No

The following question must be answered only if the applicant is an individual (sole proprietor):

I hereby certify, under penalty of perjury, that ☐ I am ☐ I am not (check one)

more than 30 days delinquent in complying with a child support order.

Signed _____

Date _____

Failure to so certify may result in a denial of the license. Making a false statement may subject the licensee to contempt of court. (5ILCS 100 / 10 - 65 (c)).