State of Illinois
Illinois Department of Public Health

Application for Rural Emergency 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 Illinois Department of Public Health 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 Rural Emergency Hospital Licensure form must be filled in when a rural emergency hospital makes its initial application for license.

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

C. Complete using PDF writer or print and complete with a typewriter or print legibly with permanent ink.

D. The applicant may provide additional information on an attached sheet if the space provided 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. Submission of a copy of the transfer agreement with Medicare-certified hospital that is a level I or level II trauma center is required.

G. Annual re-application is not required. However, a new application is required if the hospital's location or ownership changes or if there is a change in clinical services which results in a change of license category. Refer to Section 250.110(a) of the Hospital Licensing Requirements (77 Ill. Admin. 250).

H. Separate applications are required for hospitals operated on separate premises, even if 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.

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

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Definitions

1. Rural emergency hospital (REH) - an entity that operates for the purpose of providing emergency department services, observation care, and other outpatient medical and health services in which the annual per patient average length of stay does not exceed 24 hours. The entity must not provide inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish post-REH or post-hospital extended care services pursuant to 42 CFR 485.502.

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DEPARTMENT USE ONLY
Hospital ID Number ______________

In accordance with the requirements of the Hospital Licensing Act (210 ILCS 85) 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

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II. Ownership and Administration (continued)

Official name of governing body ______________________________

(e.g. 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 owners, 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 ____________

Number of Observation Beds ____________

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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 number ____________

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

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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
- ☐ Clinical pathology
- ☐ Radiobioassay
- ☐ Immunohematology
- ☐ Other (specify) ______
- ☐ Histocompatibility
- ☐ Blood bank
- ☐ Diagnostic immunology
- ☐ clinical Cytogenetics
- ☐ photography
- ☐ Autopsy
- ☐ Microbiology
- ☐ Basal Metabolism
- ☐ Hematology
- ☐ Chemistry

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 full-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 ______

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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 (e.g. 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 ☐ Therapy services

G. 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

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IV. Departments and Services (continued)

H. 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

I. 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) ______________________

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J. 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

K. 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

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Personnel by Departments

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				

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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, list and designate the department or the employee's job title.

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Physical Plant

Physical Plant	Original Building	Additions			
		1.	2.	3.	4.
A. Year built		Text	Text	Text	Text
B. Number of stories (exclude basement)		Text	Text	Text	Text
C. Sprinkler system	☐ Full ☐ Partial ☐ None	☐ Full ☐ Partial ☐ None	☐ Full ☐ Partial ☐ None	☐ Full ☐ Partial ☐ None	☐ Full ☐ Partial ☐ None
D. Number of observation beds on each floor	Text				

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, describe:

____

____

2. How will this affect bed complement? ________________________________

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Accreditation

A. Is the hospital fully approved by the Joint Commission on 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 ______________

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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 ______

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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), requires individual licensees to certify whether they are delinquent in payment of child support. 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)).

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 ______________