



# APPLICATION FOR LICENSE TO OPERATE A HOSPITAL

State Form 44885 (R5/6-04)  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-21-2 and 410 IAC 15-1.3-1)  
Form Approved By State Board of Accounts, 2004

## Division of Acute Care Use Only

Date Received \_\_\_\_\_ Date Approved \_\_\_\_\_ Date Rejected \_\_\_\_\_

Please Type or Print Legibly

### SECTION I - TYPE OF APPLICATION

Application (check appropriate item)

New Facility

Renewal

Change of Ownership: Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

### SECTION II - IDENTIFYING INFORMATION

#### A. Hospital Location (facility location)

Name of Hospital

Street Address

P.O. Box

City

County

Zip Code +4

Telephone Number

Fax Number

( )

( )

#### B. Mailing Address (if different from hospital location)

Street Address

P.O. Box

City

County

Zip Code +4

#### C. Ownership Information

The applicant entity as registered with the secretary of state

Street Address

P.O. Box

City

State

Zip Code+4

Telephone Number

Fax Number

EIN Number

Fiscal Year End Date (mm/dd)

( )

( )

#### D. Provider Numbers

Medicare Provider Number:

Medicaid Provider Number:

**E. Additional Services and/or Off-site Practice Locations Operated Under Hospital License:**

If not applicable, leave blank. Do not list on-site skilled or distinct part units unless located off-site. *(use additional sheet if necessary)*

<i>Type of Service</i>	<i>Name</i>	<i>Address</i>	Provider Number if different from Hospital
Blood Center			
Hospice			
Home Health			
Other Off-Site Locations List below:			

**F. Long Term Care Unit:**

Does the hospital have a long term care unit? \_\_\_\_Yes \_\_\_\_No If yes: Number of Beds \_\_\_\_\_

Are the beds Medicare certified? \_\_\_\_Yes \_\_\_\_No

If yes, Medicare certification number: \_\_\_\_\_

Is the long term care unit also licensed by the Indiana State Department of Health Division of Long Term Care? \_\_\_\_Yes \_\_\_\_No

**G. Beds:**

Total Number of setup and staffed beds for inpatients in the hospital (exclude pediatric visitors, newborn nursery cribs, maternity labor and delivery beds) as of the date of this application: \_\_\_\_\_

Does this facility have swing beds? \_\_\_\_Yes \_\_\_\_No

**H. Hospital within a Hospital Status:**

Is this a host hospital? \_\_\_\_Yes \_\_\_\_No

Is this a tenant hospital? \_\_\_\_Yes \_\_\_\_No

**I. Type of Control:** (Check all that apply)**For Profit**

- Sole Proprietorship  
 Partnership  
 Corporation  
 Limited Liability Company  
 Other: (specify below)

**Non-Profit**

- Church Related  
 Sole Proprietorship  
 Partnership  
 Corporation  
 Limited Liability Company  
 Other (specify below):

**Government**

- State  
 County  
 City  
 City/County  
 Federal  
 Other (specify below):

**J. Corporate Officers** (complete if the business entity is incorporated)

Position	Name	Address/City/State/Zip
President/Chairperson/CEO		
Vice-President/Vice-Chairperson/COO		
Treasurer/CFO		
Secretary		

**K. Change in Ownership**

If this application is for a change in ownership (required if the change in ownership is fifty percent (50%) or greater), complete the following. Otherwise, leave blank. (The mere sale of shares of an owning corporation [or for corporations controlled by a 'member' or 'members' which can be individuals, partnerships, or other corporations] does not constitute a change of ownership)

- Asset Purchase Agreement  
 Merger  
 Termination of Lease  
 Assignment of Interest  
 New Partnership  
 Transfer of Asset Agreement  
 Lease  
 Sale  
 Other \_\_\_\_\_

**Change of Ownership Continued**

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address/City/State/Zip	EIN Number

**CERTIFICATION OF APPLICATION**

The undersigned hereby make application for a license to operate a hospital in the State of Indiana pursuant to hospital statute, IC 16-21, and the rules promulgated there under at 410 IAC 15.

I certify that the operational policies of the hospital will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are true and accurate and in compliance with regulations, laws, and rules governing the licensing of hospitals in Indiana.

**Signature of Chief Executive Officer or designee:**

Printed Name and Title:

Date of Signature:

**Signature of Governing Board Chairperson/President or designee:**

Printed Name and Title:

Date of Signature:

**Signature of Chief of Medical Staff or designee:**

Printed Name and Title:

Date of Signature:

**License Fee**

**Select the appropriate license fee below and return the application, any attachments, and license fee made payable to:**

INDIANA STATE DEPARTMENT OF HEALTH  
ATTENTION: CASHIER 2<sup>ND</sup> FLOOR  
P. O. Box 7236  
INDIANAPOLIS, INDIANA 46207-7236

**Total Operating Expenses are found on the most recently filed Hospital Fiscal Report, State Form 49520 as required by IC 16-21-6-3.**

Check One	Total Operating Expenses	Fee
	Zero to \$49,999,999.00	\$1,000.00
	\$50,000,000.00 to \$99,999,999.00	\$2,000.00
	\$100,000,000.00 to \$199,999,999.00	\$3,000.00
	\$200,000,000.00 to \$299,999,999.00	\$4,000.00
	\$300,000,000.00 and above	\$5,000.00

*Indiana Hospital Council; 414 IAC 1-1*