DEPARTMENT OF HEALTH

Application for a License to Operate a Hospital

According to Minnesota Statute, section 13.41 (https://www.revisor.mn.gov/statutes/cite/13.41), **all data provided on this license renewal application shall be classified as public data once the license is issued.**

Answer all questions completely and accurately to avoid unnecessary delay. Mail the completed application, fee payment, and applicable supporting documents to MDH (see last page for mailing address). Renewal license applications should be submitted 30 days prior to the expiration date of the current license.

Incomplete applications will be communicated to the provider via email.

The undersigned hereby renews an application to operate a hospital provider subject to the provision of Minnesota Statutes, section 144.50 to 144.591 (https://www.revisor.mn.gov/statutes/cite/144.50) and Minnesota Statutes, section 144.651 (https://www.revisor.mn.gov/statutes/cite/144.651), Minnesota Statutes, section 144.1461, and the rules adopted thereunder.

Keep a copy of the application and attachments for your records.

Application Type

Check one option (see Appendix A for documents to attach)

☐ Initial License

☐ Change of Ownership. Proposed effective date: _____

☐ License Renewal

Facility Identification

Hospital Name (doing business as): _____

Address: _____

City/State/Zip: _____

☐ Check here if mailing address is the same as above.

Complete if different: _____

Health Facility Identification (HFID) number: _____

Telephone number: _____

Fax number (if applicable): _____

☐ Check here if new telephone and/or fax number.

Hours of operation: _____

Name of county in which the hospital is located: _____

Agent/Administrator's Name: _____

- Direct Email Address: _____
- Direct Phone Number: _____

Name of person responsible for completing application: _____

Email to receive correspondences from MDH: _____

☐ Check here if email is the same as the Administrator.

Ownership

Fill in the code that corresponds to the type of entity legally responsible for operating the facility.

Ownership Code_____

Governmental Non-Federal	Governmental Non-Profit	Non-Governmental For-Profit	Other
11. State 12. County 13. City 14. City – County 15. Hospital district of Authority	20. Church-related 21. Nonprofit Corporation 22.Other Nonprofit Ownership	23. Individual 24. Partnership 25. Corporation 26. Group 28. Limited Liability Company 29. Business Trust 30. Housing and Redevelopment Employment	27. Tribal

Provide the legal entity name that is responsible for the operation of this facility, as it appears on file with the Office of the Minnesota Secretary of State (https://mblsportal.sos.state.mn.us/Business/Search):

_____

Federal EIN #: _____

State Tax ID #: _____

President/Owner Representative: _____

- Address: _____
- City/State/Zip: _____

Licensed Beds (A bed must be licensed if it is available for use by patients or residents)

A "**Hospital**" means an institution primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

A "**Psychiatric Hospital**" means an entire institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnostic and treatment of mentally ill persons. A psychiatric wing or building of a general hospital would not be considered a psychiatric hospital.

A "**Specialized Hospital (Mental)**" means a state-operated institution for the diagnosis and treatment of mentally ill persons.

Insert the licensed bed and bassinets capacity for the applicable hospital to determine license fee.

Type of Hospital	Beds	Bassinets (If applicable)	Total Beds & Bassinets
Example: Hospital	*100*	*20*	*120*
Hospital			
Psychiatric Hospital			
Specialized Hospital (Mental)			

Personnel

Name and title of person in charge in the absence of the administrator: _____

Provide the names of the person in charge for each category.

- Nursing Service: _____
- Dietary Service: _____
- Medical Records: _____

Accreditation Status

Minnesota Statures, section 144.55, subd. 4, states as follows:

Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance.

If accredited, attach the documents required by subdivision 4 above. Failure to submit the required information with this license application will result in the loss of the presumption of compliance provided in the law.

Is the hospital accredited? If accredited, attach the documents as required by subd. 4 above.

☐ Yes

☐ No

Affiliation and Management Agreement Information

Is the hospital chain affiliated?

☐ Yes

☐ No

If yes, list the name, address of the corporation and employer identification number.

- Name: _____
- Address: _____
- City/State/Zip: _____
- EIN #: _____

Is the hospital operated by a management company, or leased in whole or part by another organization?

☐ Yes

☐ No

If yes, list the name, address of the corporation and employer identification number.

- Name: _____
- Address: _____
- City/State/Zip: _____
- EIN #: _____

Provider-based Locations Under the Hospital's License and CMS Certification Number (CCN)

Complete and provide the names and addresses of all components that are billed under the hospital's CCN and that operates under the hospital's license. Additional sheets may be submitted.

- Services provided (i.e., physical therapy, speech therapy, occupational therapy, ambulatory surgery, outpatient medical services)
- The CCN (this number should be the same as the hospital's CCN)
- Established Date (date facility began billing for provider-based services under hospital's CCN)
- Sprinkler Status options:
  - Totally sprinklered: All required areas are sprinklered
  - Partially sprinklered: Some but not all required areas sprinklered
  - Sprinklers: None
  - Sprinklers are not required, but the location is sprinklered

Hospital Name: _____

Hospital Provider Number: _____

Name	Address, City and Zip	Phone Number	Services Provided	# of Beds	CCN #	Established Date	Sprinkler Status

Evidence of Compliance with Worker's Compensation

State law requires that the Commissioner of Health shall withhold the license for the operation of a health care provider until the applicant presents acceptable evidence of compliance with workers' compensation coverage provisions.

One of the following documents must accompany this application. Please check which document is attached.

- ☐ **Certificate of Insurance** supplied by an authorized Workers' Compensation carrier pursuant to Minn. Statute 60A.06, Subd. 1(5b) (https://www.revisor.mn.gov/statutes/cite/60A.06). The Certificate should include the name of the licensee, the name of the corporation legally responsible for the licensee, or the name that the licensee is doing business as. The Certificate of Insurance must be in effect prior to the issuance of an initial license or have an effective date on or after the effective date of renewal license.
- ☐ **Self-insured workers' compensation (including its Attachment "A")**. This type of coverage is generally held by large organizations. The certificate is issued from the commissioner of commerce permitting an organization to self-insure pursuant to Minn. Stat. 79A (https://www.revisor.mn.gov/statutes/cite/79A) and Minn. Rules 2780 (https://www.revisor.mn.gov/rules/2780/). Questions regarding self-insurance should be directed to the Minnesota Department of Commerce.
- ☐ Written confirmation from your Third-Party Administrator or evidence of coverage from the Workers' Compensation Reinsurance Association (WCRA) allowing you to **self-insure as a Government Entity/Political Subdivision** pursuant to Minn. Statute 176.181, Subd. 2 (https://www.revisor.mn.gov/statutes/cite/176.181). The Reinsurance Certificate must be renewed annually on a calendar year basis.

You cannot be issued a license and may not operate as a health care provider unless acceptable evidence of compliance with workers' compensation coverage provisions is provided.

Fees

Type	Fees
Accredited Hospital	$9,524.00
Non-Accredited Hospital	$6,318.00 base fee plus $317.00 per bed including bassinets
All Hospitals	$600.00 base fee plus $16.00 per bed including bassinets for Adverse Health Care Events Reporting, and $1,826 base fee plus $23.00 per bed including bassinets for Statewide Trauma System

Affirmation and License Fee

☐ I certify that the information provided on this form is accurate and complete.

☐ I have enclosed the appropriate evidence of compliance with Workers' Compensation Coverage Provisions.

☐ Enclosed is the renewal licensee fee made payable to the **Minnesota Department of Health**.

In accordance with MN Statutes, section 144.52 Application (https://www.revisor.mn.gov/statutes/cite/144.52), the law requires that an application on behalf of a corporation, association or governmental unit shall be made by any two officers thereof or by its managing agents. **This requires two (2) signatures**. All other applications require one (1) signature.

Signature of Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____

Signature of Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____

If you have questions concerning this license application, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.

Mailing Address
Minnesota Department of Health
Health Regulation Division
Federal Licensing, Certification and Registration section
P.O. Box 64900
St. Paul, Minnesota 55164-0900

07/08/2025

To obtain this information in a different format, call: 651-201-4200.

Appendix A: Application Type

Submit the following documents based on the application type.

Initial License

Required documents for an initial license include:

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.
- Organizational chart demonstrating relationship of owners to licensee.

Renewal

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.
- Approval of License condition for Swing Beds – Addendum (if applicable)

Change of Ownership

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.
- Organizational charts demonstrating relationship of owners to licensee, both pre-sale and post-sale.
- Bill of Sale

Addendum: Approval of License Condition for Swing Beds

The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of Minnesota Statute 144.562, Subdivision 3.

The _____ agrees:

(Name of Hospital)

- To report to the Commissioner of Health annually, the number of patients readmitted to a swing bed within 60 days of patients discharge from the facility, the hospital's charges for care in a swing bed during the reporting period with description of the care provided for the rate charged, and the number of beds used by the hospital for transitioned care and similar sub-acute inpatient care.
- To report to the Commissioner statistical data on the utilization of the swing beds.

The below items do not apply to Critical Access Hospitals that have an attached nursing home or that own a nursing home in the same municipality per Minnesota Statute, Section 144.562, Subd. 2 (b).

- The hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the duration of Medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation.
- The hospital must agree, in writing, to limit admission to a swing bed only to (1) patients who have been hospitalized and not yet discharged from the facility, or (2) patients who are transferred directly from an acute care hospital.

Affirmation and Signature

☐ I agree to comply with items above.

Signature of Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____