State of Illinois
Illinois Department of Public Health

# Project Submission Form for Hospitals

## Facility identifying information

*All sections of this form must be completed. Altered forms will not be accepted*

Facility name _____

Street address _____

City _____ IL ___ ZIP code _____

## Project identifying information

*All sections of this form must be completed. Altered forms will not be accepted* **IDPH Number**_____

Project name _____

Type of project

☐ new/replace facility ☐ renovation/update to existing facility ☐ addition to existing facility
☐ PPS rehab unit ☐ PPS psychiatric unit ☐ Safety Net/Community hospital grant

Type of submission

☐ design development drawings, first stage ☐ construction/working drawings, second stage

Total gross square footage of project area _____

Number of beds

| | | | | | | |
|---|---|---|---|---|---|---|
| acute mental illness beds | present | _____ | proposed | _____ | change | _____ |
| ICU beds | present | _____ | proposed | _____ | change | _____ |
| long term acute care beds | present | _____ | proposed | _____ | change | _____ |
| long term care beds | present | _____ | proposed | _____ | change | _____ |
| medical/surgical beds | present | _____ | proposed | _____ | change | _____ |
| neonatal beds | present | _____ | proposed | _____ | change | _____ |
| obstetric beds | present | _____ | proposed | _____ | change | _____ |
| pediatric beds | present | _____ | proposed | _____ | change | _____ |
| rehabilitation beds | present | _____ | proposed | _____ | change | _____ |
| TOTAL | present | _____ | proposed | _____ | change | _____ |

IF THIS PROJECT CHANGES THE FACILITY'S LICENSED BED COUNT BY ADDING OR REDUCING BEDS, IT WILL BE NECESSARY TO CONTACT THE HEALTH FACILITIES AND SERVICES REVIEW BOARD.

**Certificate of Need**

**Submit a copy of the approved certificate of need (CON). A review by the Department WILL NOT begin until a CON or appropriate documentation is received. Written documentation from the Health Services and Review Board may be requested indicating a CON is not required.**

CON project number _____ Date approved _____

Is this a phased occupancy project? ○ Yes ○ No

If yes, attach an occupancy schedule describing the rooms to be occupied in each phase with a small scale graphic plan

**Mail completed submission to**

**Illinois Department of Public Health**
**Design and Construction Section**
**525 W. Jefferson Street, Fourth Floor**
**Springfield, IL 62761**

**For questions, please call**

**217-785-4264**

**Drawing submission**

Provide **one set** of signed/sealed drawings and outline specifications for review in accordance with Section 250.2430 of the Illinois Hospital Licensing Requirements. This includes design development drawings and outline specifications and working/construction drawings and specifications.

Drawings are not to exceed 30" x 42".

## Estimated project cost

1. Site preparation costs $ _____
2. Demolition costs $ _____
3. Construction contracts (including cost of materials) $ _____
4. Change orders $ _____
5. Subtotal - lines 1 thru 4 $ _____
6. Fixed capital equipment* $ _____
7. Add lines 5 and 6 $ _____

*If the fixed capital equipment is not more than 51 percent of the total cost, then use line 7 for the plan review fee calculation below.*

8. If line 6 is 51 percent more than line 7, then multiply line 6 by .20 $ _____
9. Add lines 5 and 8: this is your adjusted estimated project cost $ _____

*Place the total adjusted estimated project cost in the appropriate estimated project cost category listed below.*

*Fixed capital equipment is any equipment that is not movable from room to room and includes but is not limited to diagnostic equipment (MRI,scanners, X-ray equipment, etc). Equipment which is part of the building such as AHU, boilers, chillers, lights, fire alarm panels and all related components are to be included in the construction costs.

## Plan review fee calculation

The plan review fee is due and payable upon submission of this form along with the drawings and required information. Using the figures in line 7 or line 9, whichever is applicable, calculate the plan review fee.

| ***Estimated project cost*** | ***Fee as listed below*** |
|---|---|
| Less than $500,000 | No fee |
| $500,000 - $999,999 | |
| Project cost _____ x .0096 = _____ | **or $6,000, whichever is greater** |
| $1,000,000 - $4,999,999 | |
| Project cost _____ x .0022 = _____ | **or $9,600, whichever is greater** |
| Greater than $5,000,000 | |
| Project cost _____ x .0011 = _____ | **or $11,000, whichever is greater; maximum fee of $40,000** |

10. Plan review fee to be submitted $ _____
11. Is the facility a disproportionate share hospital? ☐ Yes ☐ No
12. Is the facility a rural hospital with 75 beds or less? ☐ Yes ☐ No
13. If line 11 or line 12 is "yes"; reduce line 10 by 50 percent. $ _____
14. Total from line 10 or line 13 (whichever is applicable) $ _____

Remittance should be made payable to the **IDPH Plan Review Fund** in the form of a check or money order

**Code analysis information for EXISTING BUILDING for a renovation/remodel project**

Building Construction type per NFPA 220 for the existing building in which the renovation/remodel is occurring.

Circle all that apply: I(443) I(332) II(222) II(111) II(000) III(211) III(200) V(111) V(000)

Year built _____ Number of stories _____ Height in feet _____

☐ The information provided on the existing building relates to a new addition code analysis on the next page.

Provide the following information to describe how the existing building meets the above noted construction type:

| Existing structural component | Existing assembly rating or new assembly rating due to alterations | UL assembly number |
|---|---|---|
| Roof | | |
| Floor | | |
| Beams | | |
| Columns | | |
| Girders | | |
| Interior walls | | |
| Exterior walls | | |

**Sprinkler system**

☐ Full ☐ Partial ☐ Dry ☐ Wet ☐ None Fire pump capacity _____ Water main size _____

**Emergency power**

Type _____

Generating set _____ UPS _____ Other _____ Fuel storage in gallons _____

**Fire alarm**

☐ Direct F.D. connection ☐ Remote station ☐ Proprietary protective ☐ Coded ☐ Supervisory

| Fire walls | | Through wall/floor penetrations | | |
|---|---|---|---|---|
| Rating | UL assembly number | Penetration type | Rating | UL assembly number |
| 1-hr fire | | wall | | |
| 1-hr fire/smoke | | curtain wall/slab | | |
| 2-hr fire | | floor | | |

**Code analysis information for NEW CONSTRUCTION of a new building or addition to the existing building.**

Construction type per NFPA 220 for the new construction. **Complete the code analysis information on the existing building that the new construction is connected to or adjacent to on the previous page under EXISTING BUILDING.**

Circle all that apply: I(443) I(332) II(222) II(111) II(000) III(211) III(200) V(111) V(000)

Number of stories _____ Height in feet _____

Provide the following information for the new building construction and/or addition(s):

| New structural component | New assembly rating | UL assembly number |
|---|---|---|
| Roof | | |
| Floor | | |
| Beams | | |
| Columns | | |
| Girders | | |
| Interior walls | | |
| Exterior walls | | |

**Sprinkler system**

☐ Full ☐ Partial ☐ Dry ☐ Wet ☐ None Fire pump capacity _____ Water main size _____

**Emergency power**

Type _____

Generating set _____ UPS _____ Other _____ Fuel storage capacity _____

**Fire alarm**

☐ Direct F.D. connection ☐ Remote station ☐ Proprietary protective ☐ Coded ☐ Supervisory

| Fire walls | | Through wall/floor penetrations | | |
|---|---|---|---|---|
| Rating | UL assembly number | Penetration type | Rating | UL assembly number |
| 1-hr fire | | wall | | |
| 1-hr fire/smoke | | curtain wall/slab | | |
| 2-hr fire | | floor | | |

## Contact Information

**Name of facility representative** _____ Title _____

Facility/Organization _____

Address _____

City _____ State _____ ZIP code _____

Phone number _____

E-mail address _____

**Architectural firm** _____

Address _____

City _____ State _____ ZIP code _____

Phone number _____

Name of architect of record for the project licensed in State of Illinois _____

E-mail address for architect of record _____ Illinois license number _____

**Sprinkler contractor** _____ Illinois State Fire Marshall license number _____

Address _____

City _____ State _____ ZIP code _____

Contact name _____ Phone number _____

E-mail address _____

**HVAC design firm** _____

Address _____

City _____ State _____ ZIP code _____

Contact name _____ Phone number _____

E-mail address _____

**Electrical system designer** _____

Address _____

City _____ State _____ ZIP code _____

Contact name _____ Phone number _____

E-mail address _____

**Fire alarm company** _____

Address _____

City _____ State _____ ZIP code _____

Contact name _____ Phone number _____

E-mail address _____

**Functional program narrative**

Provide a functional program narrative for the project that describes the purpose of the project, departmental relationships, space requirements and other basic information relating to fulfillment of the facility's objectives. The functional program shall include a description of those services necessary for the complete operation of the facility.

*Attach additional sheets if needed.*

**Systems program narrative**

Provide a systems program narrative describing all special systems including, but not limited to, fire alarm, nurses call, special locking devices, security packages, electrical, plumbing, HVAC, medical gas and fire protection.

*Attach additional sheets if needed.*

**Important notice** The state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 90-0327. Disclosure of this information is mandatory.