



Project Submission Form for Ambulatory Surgical Treatment Center

Project identifying information

For IDPH Use only

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

IDPH number _____

Facility name _____

Street address _____

City _____ IL ZIP code _____

Project name (as it appears on the drawings) _____

Licensure category Multi-specialty
 Single specialty GI Laser Pregnancy termination center

Type of project New/replace facility Renovation/update to existing facility Addition to existing facility

Is this a phased project? Yes No

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

Submission type

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. Drawing size may not exceed 30" X 42".

- Design development drawings - 30-day review time after deemed complete
- Working/construction drawings - 60-day review time after deemed complete
- Revised drawings - 45-day review time after deemed acceptable
- Additional/addendum drawings - 45-day review time after deemed acceptable

Certificate of need

Provide a copy of a valid certificate of need (CON) or written documentation from the Health Facilities Services and Review Board that the project does not require a CON. A review by the Department **WILL NOT** begin until a CON or appropriate documentation is received.

CON project number _____ Date approved _____

Mail completed submission to:

**Design and Construction Section, Illinois Department of Public Health
525 W. Jefferson St., Fourth Floor, Springfield, IL 62761
217-785-4264, 217-785-4247 or TTY 800-547-0466**

For questions, call:

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.



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Estimated project cost

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

If line 5 is not 51 percent or more of line 6, then use line 6 for the plan review fee calculation below.

- 7. If line 5 is 51 percent or more than line 6, then multiply line 5 by .20 \$ _____
- 8. Add lines 4 and 7: 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 5, calculate the plan review fee.

Estimated project cost

Fee as listed below

Less than \$100,000

No fee

\$100,000 - \$499,999

Project cost _____ x .012 = _____ **or \$2,400, whichever is greater**

\$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**

Plan review fee to be submitted \$ _____

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



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

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 _____

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

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 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 _____

Structural component	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 in gallons _____

Fire alarm Direct F.D. connection Remote station Proprietary protective Coded Supervisory



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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 narrative shall include a description of those services necessary for the complete operation of the facility. The functional program narrative must be available for use in the development of project design and construction documents.

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.



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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 _____