State of Illinois
Illinois Department of Public Health

# Project Submission Form for Long Term Care Facilities

## Project identifying information

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

*For IDPH Use only*

**IDPH number**_____

Facility name _____

Street address _____

City _____ IL ZIP code _____

Project name (as it appears on the drawings) _____

Licensure category
- ☐ Skilled nursing
- ☐ Skilled nursing under 22
- ☐ Intermediate nursing care
- ☐ Intermediate care for the Developmentally Disabled
- ☐ Sheltered care
- ☐ Veterans facility

Number of beds

Present _____

Propose _____

Change _____

Square footage

Present _____

Propose _____

Change _____

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 300.2830 of the Skilled Nursing and Intermediate Care Facilities Codes. 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, submission of working drawing required
- ☐ Working/construction drawings - 60-day review time after deemed complete

### 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 _____

**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

| ***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.

**Mail completed submission to:** **Design and Construction Section, Illinois Department of Public Health**
**525 W. Jefferson St., Fourth Floor, Springfield, IL 62761**

**For questions, call:** **217-785-4264, 217-785-4247 or TTY 800-547-0466**

# Project Submission Form for Long Term Care Facilities

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

Construction type per NFPA 220 construction type 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 _____

**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 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 _____

| 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

# Project Submission Form for Long Term Care Facilities

## 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 _____

Project architect licensed in State of Illinois _____

E-mail address _____ Illinois license number _____

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

Address _____

City _____ State _____ ZIP code _____

Contact name _____ Phone number _____

E-mail address _____

**HVAC designer** _____

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 _____