



**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.

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*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.

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*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.