PROJECT SUBMISSION FORM
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF LONG TERM CARE QUALITY ASSURANCE

	FOR INTERNAL	USE ONLY
	Facility No.	
	License .No.	
	C.O.N. No.	
	Medicare No.	
	I.D.P.H. No.	

PROJECT IDENTIFYING INFORMATION

Facility Name_____

Street Address_____

City_____ **ZIP Code**_____**County**_____

Project Description_____

CON Project Number_____**Date Approved**_____

Type of Project: ____New_____Addition___Alteration____ Modernization____ Renovation

Is This a Phased Project? _____Yes _____No **If Yes, attach an occupancy schedule that describes the rooms to be occupied in each phase.**

Does this project include a designated Alzheimer Special Care Unit? ____ Yes ___ No

	Number of Beds			Square Footage	
Licensure Category	Present	Proposed	Change	Increase	Decrease
Skilled Nursing	_____	_____	_____	_____	_____
Skilled Under Age 22	_____	_____	_____	_____	_____
Intermediate Nursing Care	_____	_____	_____	_____	_____
Intermediate Care for Developmentally Disabled	_____	_____	_____	_____	_____
Sheltered Care	_____	_____	_____	_____	_____
Veterans Facility	_____	_____	_____	_____	_____

CERTIFICATE OF NEED

Provide a copy of a valid Certificate of Need (CON) for the specific project from the Illinois Health Facilities Planning Board, if required. A review by the Department **will not** be made if a Certificate of Need is required but has not been issued.

PROJECT COST

Item	Estimated Project Cost
Pre-Planning Cost	$_____
Site Survey and Soil Investigation Fees	$_____
Site Preparation Cost (Including Demolition)	$_____
Off-Site Work	$_____
New Construction Contracts	$_____
Modernization Contracts	$_____
Contingencies	$_____
Architectural/Engineering Fees	$_____
Consulting and Other Fees	$_____
Fixed Equipment Not in Construction Contracts (kitchen, laundry, therapy tubs, etc.)	$_____
Bond Issuance Expenses (Project Related)	$_____
Net Interest Expense during Construction (Project Related)	$_____
Other Costs that are to be Capitalized	$_____
Acquisition of Building or Other Property (Excluding Land)	$_____
TOTAL	$_____

FEE

A plan review fee is payable upon submission of this form with the plans and additional information. Submit the fee in the form of a check or money order made payable to the "Illinois Department of Public Health Plan Review Fund." Using the project cost above, submit the fee listed below:

Proposed Project Cost	Fee
Less than $ 100,000	No Fee
$ 100,000 - $ 200,000	$ 2,400
$ 200,000 - $ 500,000: Project Cost $ _____ x .012 =	$_____
$ 500,000 - $ 625,000	$ 6,000
$ 625,000 - $ 1,000,000: Project Cost $_____ x .0096 =	$_____
$1,000,000 - $ 4,363,636.37	$ 9,600
$ 4,363,636.37 - $5,000.000: Project Cost $_____ x .0022 =	$_____
$ 5,000,000 - $ 10,000,000	$ 11,000
$ 10,000,000 - $ 36,363,636.37: Project Cost $ _____ x .0011 =	$_____
Greater than $ 36,363,636.37	$40,000

FUNCTIONAL PROGRAM NARRATIVE

Provide a functional program for the facility that describes the purpose of the project, the projected demand and utilization, staffing patterns for each unit, departmental relationships, space requirements, and other basic information relating to fulfillment of the facility's objectives. The program shall include a description of each function or service, the operational space required for each functions, the quantity of staff or other occupants of the various spaces, the numbers, type and areas (in net square feet) of all spaces, the special design features, the systems of operation and the interrelationships of various functions and spaces.

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, etc.

THE FOLLOWING INFORMATION IS NOT MANDATORY BUT WOULD HELP EXPEDITE THE PLAN REVIEW PROCESS

CONTACT INFORMATION

(Complete entries for any applicable services or representatives.)

Facility Representative
Name_____**Position**_____
Street Address_____
City_____ **State**_____ **ZIP Code**_____
Telephone Number (_____)_____-_____ **Fax Number (_____) _____-_____**

Health Planner
Name_____**Position**_____
Firm_____
Street Address_____
City_____ **State**_____ **ZIP Code**_____
Telephone Number (_____)_____-_____ **Fax Number (_____)_____-_____**

Architectural Firm Information
Project Architect_____
Contact Person_____
Architectural Firm_____
Street Address_____
City_____ **State**_____ **ZIP Code**_____
Telephone Number (____)____-_____ **Fax Number (____) ____-_____**

Building or Structural Designer Information
Designer_____
Contact Person_____
Designer Firm_____
Street Address_____
City_____ **State**_____ **ZIP Code**_____
Telephone Number (___)____-_____ **Fax Number (___) ____-_____**

General Contractor Information

Contractor_____

Contact Person_____

Contractor Firm_____

Street Address_____

City_____ **State**_____ **ZIP Code**_____

Telephone Number (____)____-_____ Fax Number (____) ____-_____

HVAC Designer Information

Designer_____

Contact Person_____

Design Firm_____

Street Address_____

City_____ **State**_____ **ZIP Code**_____

Telephone Number (____)____-_____ Fax Number (____) ____-_____

Electrical System Designer Information

Designer_____

Contact Person_____

Design Firm_____

Street Address_____

City_____ **State**_____ **ZIP Code**_____

Telephone Number (____)____-_____ Fax Number (____) ____-_____

Local Code Official Information

Municipality_____ **Code Manager**_____

Reviewer Name_____ **Discipline**_____

Street Address_____

City_____ **State**_____ **ZIP Code**_____

Telephone Number (____)____-_____ Fax Number (____)____-_____

CODE ANALYSIS INFORMATION

Local Code Information

Construction Type_____**Code Name/Year**_____/_____

NFPA Information

Construction Type_____**Code No./Year**_____/_____

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. This form has been approved by the Forms Management Center.

IL482-0950

STRUCTURAL INFORMATION

Number of Stories_____ **GSF/Floor**_____ **Height in Feet**_____
Local Building Code Structural Classification_____
NFPA 220 Structural Classification_____

Structural Component	Assembly Rating	Assembly Number and Testing Agency *
Roof		
Floor		
Beams		
Columns		
Girders		
Interior Walls		
Exterior Walls		

_____

SPRINKLER SYSTEM

Sprinkler System: Full-_____ **Partial-**_____ **None-**_____
Dry_____ **Wet**_____

Size of Water
PSI End of Line_____ **Fire Pump Capacity**_____ **Main**_____
_____

EMERGENCY POWER

Type_____
Generating Set-_____ **UPS-**_____ **Alternative-**_____
Fuel Storage Capacity-_____
Hours of Operation-_____
_____

FIRE ALARM SYSTEM

Direct F.D. Connection-_____ Remote Coded-_____ Proprietary Supervisory-_____ Station-_____Protective-_____

*** Assembly Number shall reflect an assembly tested and listed by a recognized independent testing agency such as Underwriters Laboratories, Inc., Factory Mutual, etc.**

FIRE WALLS		THROUGH WALL/FLOOR PENETRATIONS		
Rating	Assembly Number and Testing Agency *	Penetration Type	Rating	Assembly Number and Testing Agency *
1 Hour Fire		Wall Penetrations		
1 Hour Fire/Smoke		Curtain/Wall Slab		
2 Hour Fire		Floor Penetrations		

Completed forms and documentation should be sent to:

IDPH
Donna Haines
LTC-QA, 5th Floor
525 West Jefferson Street
Springfield, Illinois 62761

Our office considers a complete submittal to consist of the following:

If preliminary drawings:	1 set of drawings and 1 set of specifications
If final drawings:	2 complete sets of sealed drawings and 1 set of sealed specifications
For Fire Alarm Systems only:	1 set of sealed drawings and specifications along with the catalog cut sheets
For Sprinkler Systems only:	1 set of sealed drawings, sealed hydraulic calculations and manufacturer's catalog cut sheets