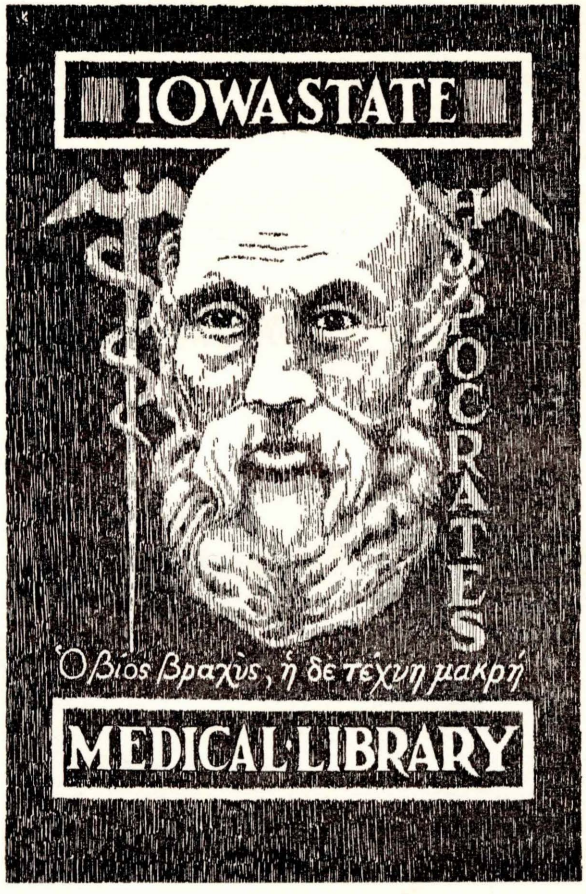
IOWA PLAN

AN INTEGRATED PROGRAM FOR HOSPITALS AND RELATED HEALTH FACILITIES

15TH REVISION
1 JULY 1962

IOWA STATE DEPT. HEALTH
HOSPITAL SERVICES DIV.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W. W. Lane, B.S.	Engineer
H. W. Stricker, B.S.	Chief Engineer

Offices

State Office Building

Des Moines 19, Iowa

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Iowa
1967

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INTRODUCTION

In accordance with the Hospital Survey and Construction Act, Public Laws 725 and 380, 79th Congress, a statewide inventory of existing hospital and public health facilities was completed. This information was presented in the Report of Hospital and Public Health Resources in Iowa, Iowa State Department of Health. The report included statistical data on hospital and public health facilities and services, professional personnel, and related resources.

In 1954, the original Hospital Survey and Construction Act was further amended by Public Law 482, 83rd Congress, known as the Medical Facilities Survey and Construction Program. The scope of the basic program was thereby broadened to meet the needs of the chronically ill and impaired with specific provision for convalescent nursing homes, diagnostic facilities, and rehabilitation centers.

The following is the 15th Revision of the Iowa Hospital Plan for construction of hospitals and other health facilities. Based upon current inventory and survey data, the proposal provides suitable and adequate statewide hospital and related health facilities reasonably and realistically accessible to all residents of Iowa.

The Plan reflects the findings from inventory and survey data of approximately 200 hospitals, 4,200 doctors' offices (M.D., D.O. and D.D.S.), 50 major industries and 1,000 care institutions.

DEFINITIONS

ACUTE GENERAL HOSPITAL A general hospital is "Any hospital for inpatient medical or surgical care of acute illness or injury and for obstetrics, of which not more than 50 per cent of the total patient days during the year are customarily assignable to the following categories of cases: chronic, convalescent and rest, drug and alcoholic, epileptic, mentally deficient, mental, nervous and mental and tuberculosis."

ANCILLARY SERVICES Ancillary services are those adjunct facilities normally associated with the diagnostic/treatment fields of patient care and which are available to outpatient/inpatient demands. The term "patient care" shall include medicine, surgery, laboratory, x-ray and others such as obstetrics and physical medicine.

AREA An area is "A logical hospital service area, taking into account such factors as population distribution, natural geographic boundaries, transportation and trade patterns, all parts of which are reasonably accessible to existing or proposed hospital facilities and which has been designated by the State Department of Health as a base, intermediate or rural area."

BASE AREA A base area is "Any area which is so designated by the State Agency and has the following characteristics: (1) Irrespective of the population of the area, it shall contain a teaching hospital or a medical school; this hospital must be suitable for use as a base hospital in a coordinated hospital system within the state; or (2) The area has a total population of at least 100,000 and contains or will contain, on completion of the hospital construction program under the State Plan, at least one general hospital which has a complement of 200 or more beds for general use. This hospital must furnish internships and residencies in two or more specialties and must be suitable for use as a hospital in a coordinated hospital system within the state."

CHRONIC ILLNESS HOSPITAL A chronic illness hospital is "A hospital, the primary purpose of which is medical treatment of chronic illness, including the degenerative diseases, and which furnishes hospital treatment and care, administered by or under the direction of persons licensed to practice medicine in the state. The term includes such convalescent homes as meet the foregoing qualifications. It excludes tuberculosis and mental hospitals, nursing homes and also institutions the primary purpose of which is domiciliary care."

COMMUNITY SERVICE "A facility renders a community service when (a) the services furnished are available to the general public, or (b) admission is limited only on the bases of age, medical indigency, or medical or mental disability or (c) the facility constitutes a medical or nursing care unit of a home or other institution which is available in accordance with (a) or (b) of this paragraph. Examples of facilities which do not provide a community service are those whose services are limited to the inmates of institutions such as prisons, industrial schools, and orphanages; and members of a fraternal, labor, or denominational, or similar group."

COORDINATED HOSPITAL SYSTEM A coordinated hospital system is "An inter-related network of general hospitals throughout the state in which one or more base hospitals provide district hospitals and the latter in turn provides rural and other small hospitals with such services relative to diagnosis, treatment, medical research and teaching as cannot be provided by the smaller hospitals individually."

CUSTODIAL HOME "Custodial home means any institution, place, building or agency which is devoted primarily to the maintenance and operation of facilities for the housing, for a period exceeding twenty-four (24) hours, and for care in excess of food, shelter, laundry or services incident thereto for, two (2) or more nonrelated individuals who are not in need of nursing care or related medical services but who, by reason of age, illness, disease, injury, convalescence or physical or mental infirmity are unable to care for themselves. Custodial home does not mean hospitals or nursing homes." (Not qualified for grants participation)

DIAGNOSTIC OR TREATMENT CENTER "A facility providing community service for the diagnosis or diagnosis and treatment of ambulatory patients, which is operated in connection with a hospital, or in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State, or, in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State. This includes outpatient departments, clinics of public or nonprofit hospitals, and diagnostic or diagnostic and treatment centers for the mentally handicapped. The applicant must be either (1) a State, political subdivision, or public agency, or (2) a corporation or an association which owns and operates a nonprofit hospital."

DISABLED PERSON "A disabled person is an individual who has a physical or mental condition which, to a material degree, limits, contributes to limiting, or if not corrected, will probably result in limiting, the individual's performance or activities to the extent of constituting a substantial physical, mental or vocational handicap."

DOMICILIARY CARE "Institutions furnishing primarily domiciliary care. The primary purpose of these facilities is to furnish food, shelter, and other nonmedical services and wherein medical treatment or nursing care is incidental to boarding care. A "nursing home" which provides personal services only, or such limited medical attention as the individual would normally receive if he were living in a private home is not eligible for Federal aid."

DOMICILIARY INSTITUTIONS "Domiciliary institutions are institutions which have as their primary purpose the furnishing of food, shelter, and other nonmedical services. This definition includes those institutions in which there might be available temporary, incidental, and limited medical attention such as the individual would normally receive if he were living in a private home."

HOSPITALS Hospitals shall include "public health centers and acute general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities such as laboratories, outpatient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, but not institutions furnishing primarily domiciliary care. The term "hospital," except as applied generally to include public health centers, shall be restricted to institutions providing community service for inpatient medical or surgical care of the sick or injured; this includes obstetrics. It shall exclude Federal hospitals and institutions found to constitute a public hazard." (for special categories, see Acute General, Chronic, Mental, Psychiatric and Tuberculosis)

HOSPITAL BED A bed for an adult or child patient. Bassinets for the newborn in a nursery, beds in labor rooms and in health centers, and other beds used exclusively for emergency purposes are not included in this definition.

INTERMEDIATE AREA An intermediate area is, "Any area so designated by the State Department of Health which: (1) has a total population of at least 25,000 and, (2) contains, or will contain on completion of the hospital construction program under the State Plan, at least one general hospital which has a complement of 100 or more beds and which would be suitable for use as a district hospital in a

coordinated hospital system within the state."

LOCAL HEALTH DEPARTMENT "A single county, city, city-county, multi-county, or local district health department as well as state health district unit, where the primary function of the state district unit is the direct provision of public health services to the population under its jurisdiction."

MENTAL HOSPITAL A mental hospital is "A hospital for the diagnosis and treatment of nervous and mental illness but excluding institutions for the feeble-minded and epileptic."

NONPROFIT HOSPITAL AND OTHER HEALTH FACILITIES "Any hospital or health facility, as the case may be, owned and operated by one or more nonprofit corporations or associations, no part of the net earning of which inures, or may lawfully inure, to the benefit of any private shareholder or individual."

NURSING HOME "A facility which is operated in connection with a hospital, or in which nursing care and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery in the state, for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who do require skilled nursing care and related medical services. The term "nursing home" shall be restricted to those facilities, the purpose of which is to provide skilled nursing care and related medical services for a period of not less than 24 hours per day to individuals admitted because of illness, disease, or physical or mental infirmity and which provide a community service."

POPULATION The civilian population data used in this revision analysis is extracted from the U. S. Department of Commerce, U. S. Census of Population - 1960, Final Report PC(1)-17A.

Civilian Population 2,757,535 (Basis for Plan)

County and area population were ascertained by analyzing the counties and townships as reported.

It should be noted that projected population data was utilized in developing a population increase factor.

The population density for Iowa is $\frac{2,757,535}{56,290} = 48.988$ persons/square mile.

PSYCHIATRIC HOSPITAL A psychiatric hospital is "A type of mental hospital where patients may receive intensive treatment and where only a minimum of continued treatment facilities will be afforded."

PUBLIC HAZARD "A public hazard as it applies to hospitals shall mean hospital beds housed in non-fire resistive buildings. One story buildings shall be constructed of not less than one-hour fire resistive construction throughout, except that the boiler room shall be of three-hour fire resistive construction. Buildings that are more than one story in height shall be constructed of incombustible material with a three to four hour fire resistive rating as established by the National Board of Fire Underwriters."

PUBLIC HEALTH CENTER A public health center is "A publicly owned facility utilized by a local health department for the provision of public health services, including related facilities, such as laboratories, clinics, and administrative offices operated in connection with public health centers."

PUBLIC HEALTH SERVICES Public health services are "Full-time services provided through organized community effort in the endeavor to prevent disease, prolong life and maintain a high degree of physical and mental efficiency. In addition to the services which the community already provides as a matter of practice, the term shall include such additional services as the community from time to time may deem it desirable to provide."

REHABILITATION "An integrated program brings together, as a team, specialized personnel from the medical, psychological, social, and vocational areas for the purpose of pooling information, interpretations and opinions for the development of a rehabilitation plan of services in which the disabled individual is viewed as a whole. When members of the team contribute to the diagnosis and treatment of illness, their contributions must be coordinated under medical responsibility. These integrated services may be provided in a facility to care for many types of disabilities or a single type of disability."

REHABILITATION FACILITY "A facility providing community service which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision. The major portion of such evaluation and services must be furnished within the facility; and the facility must be operated either in connection with a hospital or as a facility in which all medical and related health services are prescribed by, or under the general direction of, persons licensed to practice medicine or surgery in the State."

RURAL AREA A rural area is "Any area so designated by the State Department of Health which constitutes a unit, no part of which has been included in a base or intermediate area."

TUBERCULOSIS HOSPITAL A tuberculosis hospital is "A hospital for the diagnosis and treatment of tuberculosis, excluding preventoria."

STATE PLAN

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
Des Moines, Iowa

1. DESIGNATION OF STATE AGENCY *(See Section .3 of the instruction).*

A. The name of the State Agency designated as the sole agency to administer or supervise the administration of the State Plan is:

IOWA STATE DEPARTMENT OF HEALTH

B. The name of the organizational unit within the State Agency which is authorized to immediately direct the administration of the State Plan is:

DIVISION OF HOSPITAL SERVICES

C. Attached is one (1) copy of an organization chart which shows the relationship of the organizational unit named in "B" above to the State Agency as a whole. This chart is labeled Exhibit A.

2. AUTHORITY OF STATE AGENCY *(See Section .4 of the instructions)*

A Attached is the material described in Section .4B of the instructions. This material is labeled Exhibit B.

3. DESIGNATION OF STATE ADVISORY COUNCIL *(See Section .5 of the instructions)*

Check one

A. [X] The State Advisory Council has been appointed, and a list of the members is attached which shows their present positions and the interest or profession each represents. *(See instructions regarding identification of members of working executive committees, if any).* This list is labeled Exhibit C.

B. [ ] The State Advisory Council has not been appointed. A State Advisory Council will be appointed prior to the submission of individual construction projects, and it will include members representing the groups or interests required by the Act. The Council will be appointed on or before

_____
(FILL IN DATE)

4. DEVELOPMENT OF HOSPITAL CONSTRUCTION PROGRAM *(See Section .6 and Exhibit 1 of the instructions)*

A. Forms PHS-5(HF); PHS-7(HF); PHS-8(HF) or the optional statement; PHS-10(HF); PHS-11 (HF); and PHS-12(HF) and the maps and other material requested in Exhibit 1 of the instructions are attached. These forms and material are labeled Exhibit D.

5. RELATIVE NEED DETERMINATIONS *(See Section .7 of the instructions.)*

A. Form PHS-13(HF) and the other material called for in section .7D of the instructions are attached, and are labeled Exhibit E.

6. METHODS OF ADMINISTRATION *(See Section .8 of the instructions)*

A. Statements are attached which cover as a minimum each method of administration described in Section .8C to .8I inclusive of the instructions. Each method of administration is described under the same heading used in the instructions. These statements are identified as Exhibit F.

7. MINIMUM STANDARDS FOR MAINTENANCE AND OPERATION OF HOSPITALS WHICH RECEIVE FEDERAL AID UNDER THE HOSPITAL SURVEY AND CONSTRUCTION ACT *(See Section .9 of the instructions)*

A. One copy of the minimum standards which the State Agency has adopted are attached and are labeled Exhibit C

8. FAIR HEARING *(See Section .10 of the instructions)*

A. One copy of the Rules and Regulations governing the fair hearing procedure which the State Agency has adopted are attached and are labeled Exhibit H.

9. SUBMISSION OF REPORTS AND ACCESSIBILITY OF RECORDS *(See Section .11 of the instructions)*

A. The State Agency hereby agrees to make such reports in such form and containing such information as the Surgeon General may from time to time reasonably require, and to give the Surgeon General or his representatives, upon demand, access to the records upon which such information is based.

10. REVISION OF HOSPITAL CONSTRUCTION *(See Section .12 of the instructions.)*

A. The State Agency hereby agrees that it will from time to time as is necessary, but at least annually, review the over-all hospital construction program. The State Agency further agrees that it will on or before May 15 of each year submit to the Surgeon General a report which contains such revision of the over-all hospital construction program as the State Agency considers necessary.

I hereby certify that the above statements and attached statements, charts, maps, and tables are true and correct to the best of my knowledge and belief, and are an accurate presentation of the State Plan adopted by the State Agency.

Signature	*Typed Name and Title*	*Date*
Walter L. Bierring	Walter L. Bierring, M.D. Commissioner	December 10, 1947

IOWA STATE DEPT. OF HEALTH

DIVISION OF HOSPITAL SERVICES

Des Moines, Iowa

ANNUAL REVISION OF STATE PLAN

A. DESIGNATION OF STATE AGENCY

1. Give the name of the State Agency which is responsible for administering the State Plan.

IOWA STATE DEPARTMENT OF HEALTH

2. Has the organization of the State Agency been changed since the existing State plan was approved?

[Yes] [X No] *(If "yes", attach a chart (identify as Exhibit A) which shows the organization of the State Agency and the relationship of the unit which is immediately responsible for administering the state plan to the other units of the state agency).*

B. AUTHORITY OF THE STATE AGENCY

Has any change been made in the authority of the State Agency to carry out the provisions of the State Plan?

[Yes] [X No] *(If "yes", attach a copy (identify as Exhibit B) of the legislation or Governor's order which accomplished the change.)*

C. DESIGNATION OF STATE ADVISORY COUNCIL

Has any change been made in the membership of the State Advisory Council? [X Yes] [No]
(See Exhibit C)

(If "Yes" attach a statement (identify as Exhibit C) showing the names, present positions, and interests or professions represented by each new member and the names of the members replaced.)

D. DEVELOPMENT OF HOSPITAL CONSTRUCTION PROGRAM

Attach new forms PHS-5 (HF); PHS-7(HF); PHS-10(HF); PHS-11(HF); and PHS-12(HF), (iden. as Fxh. D) to replace the existing forms included in the State Plan. If separate facilities are planned for separate population groups in the State, Form PHS-8(HF) shall be resubmitted, if any changes have occurred which require supplementation or revision. Maps submitted with the current approved plan shall be revised and resubmitted if changes have occurred. As a minimum, consider the factors described in the instructions on the reverse side.

E. RELATIVE NEED DETERMINATIONS

Submit a new Form PHS-13(HF) to replace the form approved in the existing State Plan. (Identify as Exhibit E). As a minimum, take into consideration the factors described in the instructions on the reverse side.

F. METHODS OF ADMINISTRATION

Do the methods of administration included in the approved State Plan reflect accurately the current or projected method of administering the State Plan?

[X Yes] [No]

(If "No", attach revised or additional pages (identify as Exhibit F) to be included in the State Plan.)

I hereby certify that the above statements and attached statements, charts, maps, and tables are true and correct to the best of my knowledge and belief, and are an accurate presentation of the revised State Plan adopted by the State Agency.

SIGNATURE	TYPE NAME AND TITLE	EFFECTIVE DATE OF REVISION
Edmund G. Zimmerer	Edmund G. Zimmerer, M.D. Commissioner	1 JULY 1962

CP-3915

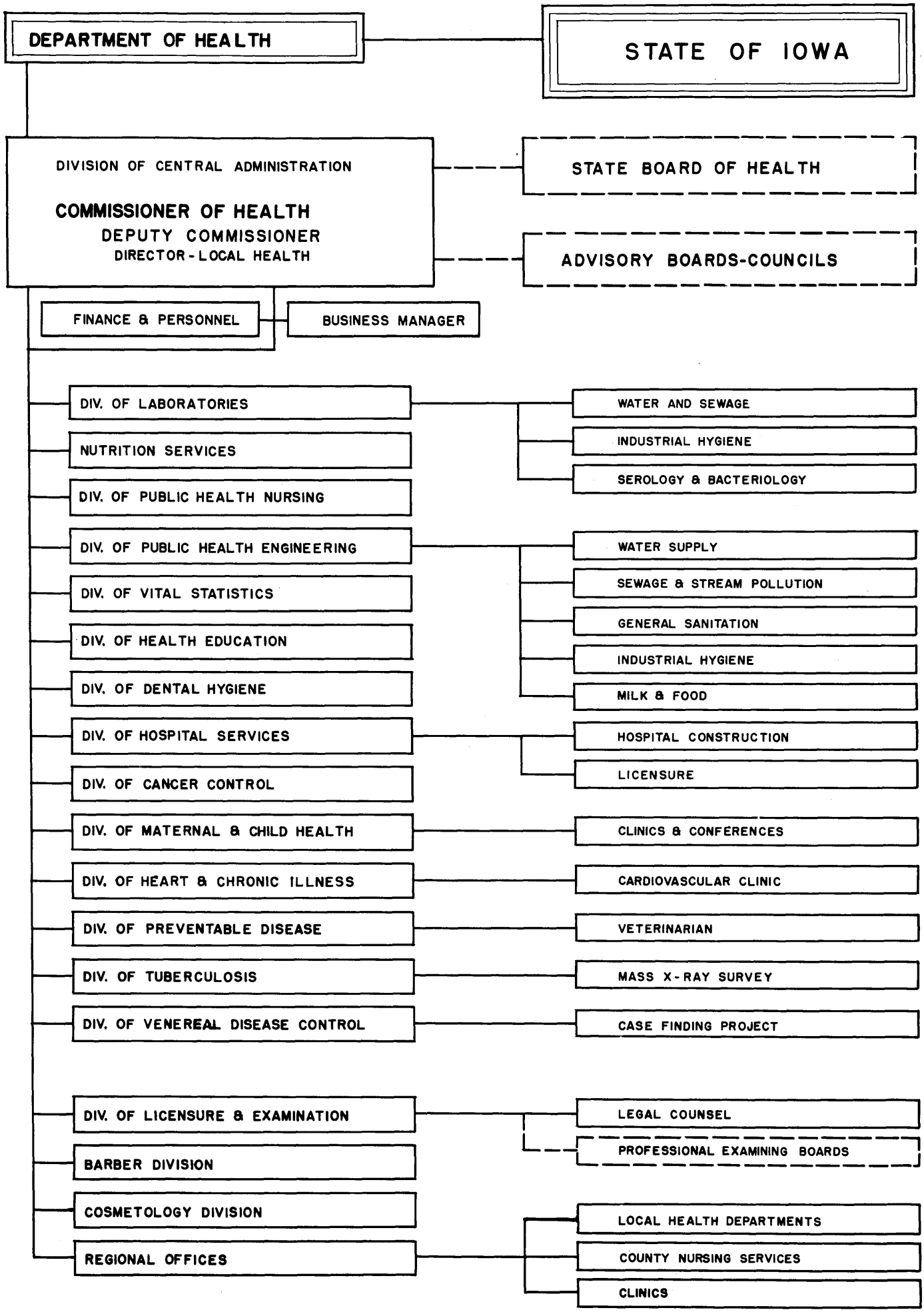

DEPARTMENT OF HEALTH
STATE OF IOWA
DIVISION OF CENTRAL ADMINISTRATION
COMMISSIONER OF HEALTH
DEPUTY COMMISSIONER
DIRECTOR - LOCAL HEALTH
STATE BOARD OF HEALTH
ADVISORY BOARDS-COUNCILS
FINANCE & PERSONNEL
BUSINESS MANAGER
DIV. OF LABORATORIES
WATER AND SEWAGE
INDUSTRIAL HYGIENE
SEROLOGY & BACTERIOLOGY
NUTRITION SERVICES
DIV. OF PUBLIC HEALTH NURSING
DIV. OF PUBLIC HEALTH ENGINEERING
WATER SUPPLY
SEWAGE & STREAM POLLUTION
GENERAL SANITATION
INDUSTRIAL HYGIENE
MILK & FOOD
DIV. OF VITAL STATISTICS
DIV. OF HEALTH EDUCATION
DIV. OF DENTAL HYGIENE
DIV. OF HOSPITAL SERVICES
HOSPITAL CONSTRUCTION
LICENSURE
DIV. OF CANCER CONTROL
DIV. OF MATERNAL & CHILD HEALTH
CLINICS & CONFERENCES
DIV. OF HEART & CHRONIC ILLNESS
CARDIOVASCULAR CLINIC
DIV. OF PREVENTABLE DISEASE
VETERINARIAN
DIV. OF TUBERCULOSIS
MASS X-RAY SURVEY
DIV. OF VENEREAL DISEASE CONTROL
CASE FINDING PROJECT
DIV. OF LICENSURE & EXAMINATION
LEGAL COUNSEL
PROFESSIONAL EXAMINING BOARDS
BARBER DIVISION
COSMETOLOGY DIVISION
REGIONAL OFFICES
LOCAL HEALTH DEPARTMENTS
COUNTY NURSING SERVICES
CLINICS

EXHIBIT B

AUTHORITY

House File 314, 52nd General Assembly, became Chapter 90, Sessions Laws, became Chapter 135 A, Code of Iowa, 1958. The purpose was to designate the State Department of Health as the sole Agency to administer this plan for hospitals.

House File 392, 56th General Assembly, was incorporated in Chapter 135 A, Code of Iowa, 1958 and broadened basic authority enabling the State Agency to survey, plan and administer for medical facilities in conjunction with hospitals.

House File 465, 52nd General Assembly, became Chapter 91 of the Sessions Laws, and was codified as 135 B, Code of Iowa, 1958, which established the hospital licensing statute and designated the Iowa State Department of Health as administering agency.

IOWA ADVISORY COUNCIL
for Hospitals and Related Health Facilities

CHAIRMAN EX OFFICIO....Edmund G. Zimmerer, M.D., Commissioner of Public Health

	Appointment Expires
FIELD OF HOSPITAL ADMINISTRATION	
Iowa Hospital Association:	
Louis B. Blair, Superintendent St. Luke's Methodist Hospital, Cedar Rapids	6-30-63
Leon A. Bondi, Administrator St. Luke's Hospital, Davenport	6-30-66
B. D. Fickess, R.N., Administrator Story County Hospital, Nevada	6-30-64
J. A. Anderson, Administrator Lutheran Hospital, Fort Dodge	6-30-64
Iowa Osteopathic Hospital Association:	
John Schwartz, Sr., D.O. Des Moines General Hospital, Des Moines	6-30-64
FIELD OF HEALTH	
Iowa State Medical Society:	
Robert N. Larimer, M.D., Sioux City	6-30-63
Wendell L. Downing, M.D., LeMars	6-30-66
Samuel Leinbach, M.D., Belmond	6-30-64
C. N. Hyatt, Jr., M.D., Corydon	6-30-64
Iowa Society of Osteopathic Physicians & Surgeons:	
H. B. Willard, D.O., Davenport	6-30-63
Iowa Dental Society:	
F. W. Pillars, D.D.S., Des Moines	6-30-63
Iowa State Nurses Association:	
Marie Tener, Iowa City	6-30-66
FIELD OF REHABILITATION	
Merrill E. Hunt, Director, Vocational Rehabilitation Division, Department of Public Instruction, Des Moines	6-30-64
REPRESENTING CIVIC AND CONSUMER INTERESTS:	
Mrs. James Henderson, Waterloo	6-30-63
Elmer H. Den Herder, Sioux Center	6-30-66
Benjamin F. Carter, Jr., Forest City	6-30-64
Mrs. Jay S. Tone, Jr., Des Moines	6-30-64

EXHIBIT D

DEVELOPMENT OF HOSPITAL AND MEDICAL FACILITIES PROGRAM

The original program created by the Congress of the United States resulted from a thorough study of the nation in terms of hospital needs and the resources available to answer these needs.

These basic surveys concluded that the cumulative effect of a harsh depression period, the attrition of time, and the lack of man power and materials during war years, had created a backlog of unmet needs well beyond the reach of local resources, the normal means for providing health facilities. Because the costs appeared to be out of reach of most communities, it was predicted that such construction as would take place would be forced to compromise and thus be far short of worthy hospital standards.

In the light of these considerations, the grants-in-aid feature was conceived, whereby Federal funds could become available to qualified communities to help themselves in providing structures which would meet a good standard in lieu of stringent compromises which otherwise might be exercised in attempting to meet their needs. In other words, the program's intent was to assist communities to help themselves by providing matching funds sufficient to upgrade the end product and thus better meet local needs for a longer period while conforming to sound national standards.

At this point considerable persuasion (by older hospitals of the nation's population centers) is directed toward a Federal grants program for renovating and remodeling outmoded facilities in blighted urban areas. These renovating needs are the by-product of having ignored the transition in the environs surrounding such facilities. Generally speaking, Iowa's larger hospitals have circumvented such adverse development with appropriate foresight and protective corrective action during the past ten years.

We have also witnessed the effectiveness of corrective means available for such hospitals through the urban renewal programs in effect, which do give appropriate consideration to hospitals that are involved. The programs are guided by a thorough evaluation of the merits of all possibilities available before guiding the corrective action which will be taken as opposed to a new broadside grants program which may or may not be guided by a combination of merit and/or emotion.

Bitter experience by this State Agency in limited remodel and renovation occuring within the existing program has amply demonstrated the fallacy of renovation as opposed to new construction, where programs leaned heavily on the false value of existing structures and overlooked the true amount of expenditure involved to upgrade existing structures. Iowa's future programming is placing greater emphasis on constructing new areas with only nominal expenditure for connecting to existing structures in a manner that will permit acceptable and economical operation of the completed composite plant. The State Plan emphatically gives only limited value to existing structures and reduces the valuation of such areas to be in keeping with the realistic value of their services expressed in terms of the common denominator of "suitable, replaceable, and/or unsuitable beds."

SCOPE OF HEALTH FACILITY NEEDS

The forerunner of this hospital program goes back to a national study of hospitals and health facilities. An element of this national study was a

survey of Iowa's hospitals and public health resources conducted prior to the original Iowa Hospital Plan. The basic study was in terms of hospital needs and the usage patterns of hospital service areas.

In 1957 the basic Federal Act was expanded to incorporate medical facilities within the scope of the program.

In developing a target for the study of hospital and health facility requirements of the state, the entire range of care facilities are surveyed and studied to determine, in terms of current national standards what each trade area's resources are and to what extent existing facilities must be supplemented to meet their over-all needs. The total field of hospitals has been segmented to several categories of hospitals and studied separately. These are identified as Acute General (green section), Tuberculosis (white section), Nervous and Mental (pink section), and Chronic Illness (blue section). Specific definition of these several terms can be found in an earlier section titled "Definitions." In addition to hospitals categories are needs for other means and services providing a complete medical care program. Included will be gradations of facilities offering less intensive nursing care than hospitals, but nevertheless imperative to meet needs beyond short term acute treatment and nursing care.

It is realized that hospital construction costs are considerable and that local resources are not unlimited. The obvious consideration in establishing the target is that every economic advantage must be exercised to the fullest if we are to realize maximum economy in terms of professional personnel and consumer's resources.

It follows then that the ultimate goal of this plan, as set forth by State Statutes, is a pattern proposing construction of adequate hospitals and other health facilities distributed throughout the state in such a manner as to make all types of hospital and health facilities reasonably accessible to all residents of the state. The plan shall recognize economic limitations of local resources in terms of both construction costs and the eventual cost of operation. These considerations include factors affecting operation, such as the availability of professional personnel, all staff requirements, and the hazard of unnecessary duplication of facilities by overlapping facility service areas.

In reviewing the total plan in the following pages, we are confident you will find that the pattern set forth does provide acute care facilities for each population segment's normal needs, and is correlated by channels of reference to intermediate and base hospitals of the acute general category. Referral to facilities providing specialized services other than medical, surgical, and/or obstetrical can also be accomplished reasonably.

There are a number of orbital facilities existing within the acute general hospital, which, if appropriately available, will make for economies. Included would be outpatient services (which can forestall excessive demand for inpatient facilities) and nursing homes contiguously located for appropriate correlation with hospital operation, thus providing long-term recuperation and care with reduced expenditure of professional personnel and individual resource. Still another phase would be rehabilitation activities which may be represented by a tremendous range of service capabilities from highly refined centers (as the Younker Rehabilitation Center in Des Moines) down to a partial unit with only a single physical therapist.

This revision of the Iowa Hospital Plan proposes a total pattern which will, if executed, locate optimum facilities for meeting all the needs of all residents of Iowa, provided the public demands are realistic (not beyond their actual requirements). We believe such a total program can be realized within the limitations of the composite resources available to Iowa communities.

SUITABILITY OF FACILITIES

The annual inventory of hospital facilities in the state is presented in tabular form in the several suitability reports. Military and prison hospitals, as well as institutions furnishing primarily domiciliary care (not providing a community service) are excluded from these inventories.

It will be noted that the several categories of facilities have their bed count reported in terms of suitability, replaceableness and/or unsuitability. A hospital bed is determined to be unsuitable if it constitutes a public hazard, as defined in this Plan. Data on whether the building is considered fire resistive was secured from surveys by Division personnel and further verified by the records of the Iowa Insurance Service. This information has been further substantiated by conferences with designing architects, hospital administrators, the State Fire Marshal, as well as by physical surveys at the site of the installation.

Bed capacities reported in these inventories indicate the normal designed capacity of the facility. The criteria used in these determinations are applied to the architectural plans, where available. Otherwise, the designed capacity of the building is ascertained by physical check of the building. The space requirements, which are the rule of thumb in determining capacity, are on the basis of 100 sq. ft. for single beds, 80 sq. ft. per bed in multiple bed rooms, 40 sq. ft. per bed for pediatric departments, whether they be beds or cribs, and 25 sq. ft. per bassinet in newborn nurseries. The above criteria are established by Iowa Statutes.

It should be pointed out that designed capacity as outlined above, may vary from the bed complement report in other sources. Usually this discrepancy is attributable to the excessive demands placed upon hospitals, forcing them to set up additional beds beyond the designed capacity to meet the needs of the public in that community. However, the occupancy rates reflected in the several reports of the following sections are based upon designed capacity to more accurately reflect the crowded circumstances for such facilities.

The classification "replaceable" has become necessary to give recognition to normal attrition and obsolescence while recognizing that the facilities do continue to render a degree of service. We concede that while they do not embody flagrant fire hazards or structural instability, their years of expectancy are definitely less than a new structure. Deterioration of fenestration, the increased cost of maintaining mechanical facilities, and the cost of replacing same have become exhorbitant. The electrical system has been underdesigned for current loads, and insulation will have deteriorated.

In recognizing these failures, the classification "unacceptable" was broadened to encompass this "gray zone" with the classification "replaceable" facilities, and is interpolated for expression in terms of "equivalent" beds. In an attempt to be reasonable, 50% of this unacceptable gross bed inventory within the "replaceable" category has been arbitrarily added to the existing suitable beds to permit a degree of gradation of need, while recognizing the service these marginal facilities do currently render in the role of hospital facilities. Specific points for classifying certain facilities as "replaceable" are as follows:

(1) The facility is not reasonably accessible in terms of performing appropriate community service.

(2) The structure, because of obsolescence, original design or general arrangement, cannot economically or reasonably be modified or corrected in terms of present day care standards.

(3) A structure of 35 years of age or more which has not been appropriately renovated and upgraded to comply with current standards for the implied type of facility.

(4) By virtue of admission policies, the care rendered and/or the inadequacies of the facilities indicate that the institution cannot reasonably provide the services implied by their classification.

Another approach in ascertaining the true applicability of these replaceable units in terms of well-equipped hospital beds was an evaluation of space assignment to the hospital services supporting existing beds. It has been obvious that many institutions attempt a volume of patient care with services that are inadequate for the patient load placed upon them. A broad sample study has been made whereby square feet of space assigned to specific services was evaluated. From these initial findings it became apparent that no more than 15 or 20% value actually exists in the marginal facilities which heretofore were accepted at full value. This facet is covered in a separate report and analysis. The point to be borne in mind is that the 50% discounting of these replaceable beds in arriving at a net "equivalent" bed value is very conservative and is not unduly distorting the ultimate inventory.

Because of the stimulation from the Federal Agency and the current executive administration, the program is accelerated by applying the above expedient formula to permit prompt presentation of this Revision. This State Agency is executing a statewide re-evaluation on the basis of square feet per bed per service in ascertaining accurately the net bed capacity available in the state in terms of equivalent hospital beds.

Applications for fiscal funds responding to this Revision of the Iowa Hospital Plan shall be supported by a thorough analysis of existing replaceable elements in terms of optimum square feet per bed per service, and the evaluation will be an element of consideration in ascertaining the merits of the total presentation.

In addition to the previously indicated criteria for classifying facilities as "unsuitable," recognition is given to evidence that an installation, by virtue of its admission policies or other restrictive considerations, fails to provide a community service in terms of the intent of the basic Federal program. Such a determination may be made without regard for the features of the physical structure.

Legislative Intent

In keeping with expanded Federal legislation, Iowa's 56th General Assembly provided enabling legislation permitting Iowa to participate in the broadened program. In modifying the term "hospital" to "hospitals and related health facilities," the intent of the Act is induced into this construction program and all of its elements.

SUMMARY OF TOTAL HILL-BURTON PROGRAM IN IOWA

1 JULY 1962

LINE ITEM	CATEGORIES OF PATIENT BEDS				
	GENERAL	T. B.	NERV./MENTAL	CHRON. ILL.	NRSG. HOME
Annual Hospital Bed Construction during 1948	253	---	---	---	---
1949	444	---	26	---	---
1950	794	---	---	---	---
1951	204	---	138	---	---
1952	201	---	33	86	---
1953	158	---	---	---	---
1954	141	---	---	57	---
1955	267	---	25	46	---
1956	152	---	48	163	31
1957	127	---	---	26	0
1958	392	---	32	---	156
1959	198	---	45	---	200
1960	141	---	---	137	164
1961	75	---	---	220	109
Total Beds Built W/Grants-in-Aid	3,547	---	347	735	660
Beds Available in 1947	6,663	672	3,113	0	0
Deletions/Reclassification/Closing	(-620)	(-260)	1,639	(-198)	324
Beds Built Without Aid	2,134	0	884	76	2,182
Total Suitable Plus Replaceable Beds	11,724	412	4,259	613	3,166
Less "Replaceable" Factor	(-1,858)	---	(-1,832)	---	(-1,103)
Number of Beds to be Added	3,600	---	9,637	3,751	6,382
Total Beds Proposed	13,466	412	13,788	4,364	8,445
Per Cent of Need Met	73.27	100	17.57	14.05	23.89

HOSPITAL ADVISORY COUNCIL RESOLUTIONS

Since the inauguration of the Hill-Burton Program in Iowa, the Iowa Hospital Advisory Council has presented to this Agency the following resolutions as guidance in administering its duties:

1. Fire Safety Resolution, adopted May 23, 1949

"Resolved that we recommend to the State Department of Health that no hospital, construction of which is now proposed or which may be proposed in the future, be approved for licensure unless fireproof in construction, and further, that in case of fireproof additions to existing non-fireproof hospital buildings, the Department require the elimination of fire hazards in the existing buildings to the fullest reasonable extent."

2. Bed Need Resolution, adopted July 10, 1952

"Resolved that the total bed need for each of the hospital categories and the total beds programmed by this Plan for each of the hospital areas or individual hospitals constitute the maximum number of beds which may be built with Federal Grants-in-Aid and do not necessarily represent the accurate and exact hospital bed need for the respective hospital or area."

3. Budget Increase Resolution, adopted September 30, 1960

"Resolved that:

(a) Henceforth assignment of Grants-in-Aid funds will be established on the basis of firm and logical shematic/preliminary drawings, acceptably realistic architectural cost estimates of construction and such other pertinent budget items as are a part of Application Part I.

(b) Said assignment of funds stated in Application Part I will be the maximum amount assignable to the particular project, and

(c) In the event actual costs exceed budget proposals previously filed, the sponsors will proceed directly toward construction, and provide all necessary additional funds to meet the total budget increase, or drop the project."

TEACHING FACILITIES

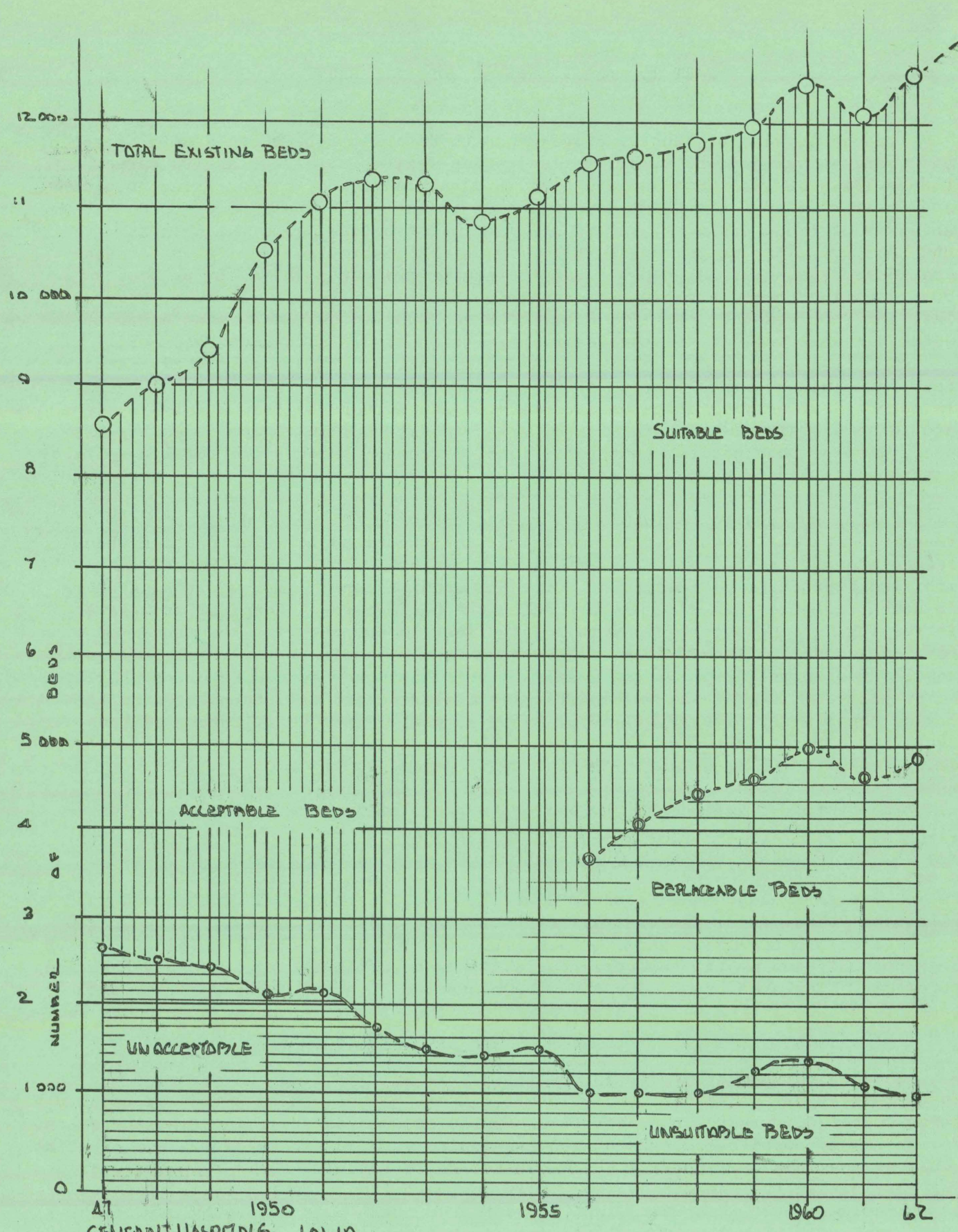
Because of the need for specialized personnel, communities of Iowa have indicated reluctance to construct specialized categories of hospital units. Therefore, to enhance the possibility of a pool of qualified doctor personnel, a compensation is induced by allowing an additional five beds per authorized post graduate training year.

To indicate the relative position of this state in professional training, one category, the medical doctor, was reviewed. It was interesting to note that while Iowa's population is 1.66 per cent of the nation's total, and Iowa's single medical college provides 1.65 per cent of the medical graduates, this state has only 38 per cent of its equivalent proportion of authorized residencies and fellowships. This unfavorable circumstance is further emphasized when we note that only 78 per cent of the authorized internships were utilized in 1956.

The authorized post graduate years were utilized in developing the "teaching" factor for application to the appropriate regions. The results are tabulated below:

Region		Postgraduate Years Authorized	Pool Beds Allocated
Symbol	Center		
T-1	Sioux City	2	10
T-7	Cedar Rapids	18	90
T-8	Iowa City	179	895
T-9	Davenport	2	10
T-12	Des Moines	116	580
T-13	Council Bluffs	4	20
Statewide Total --		321	1,605

These results are applied to the specialized categories of psychiatric and chronic illness beds in subsequent sections and are identified as "teaching" beds.



GENERAL HOSPITALS - IOWA

BED CLASSIFICATION (QUALITY) AND NO OF BEDS - SUITABLE / REPLACEABLE / UNSUITABLE

EXHIBIT D

PART I. ACUTE GENERAL HOSPITAL BEDS

The basis for this entire program was to determine the acute general hospital bed need, as well as the number of facilities available. An extensive survey of the entire state was made and did include an evaluation of the existing hospitals and their related facilities, population distribution, evaluation of road systems, analysis of trade patterns, relative financial resources, geographic factors, unnormal community patterns, degree of industrialization and equivalent considerations. These several factors were carefully evaluated while giving proper consideration to the location of present hospital facilities. In turn, needs were interpolated into specific facilities and applied on a statewide basis to ascertain what would best serve every population group in the most economical manner with a minimum of overlapping and duplication. This involved dividing the state into hospital service areas as shown on the Hospital Service Area Map. In turn, these service areas were correlated and integrated into a total pattern providing a desirable coordination of all hospital facilities complementing the ready flow of both patient and professional personnel between the rural hospitals, intermediate and/or base hospitals.

During successive revisions and re-evaluation of findings of subsequent re-surveying, one factor has become increasingly noticeable. The pattern which recognized and interpolated the effect of trade areas is being minimized and modified toward the perimeters of political subdivisions. Improved road systems, no doubt, enhance this end. As a result, the perimeters of hospital areas are increasingly being superimposed on county lines in keeping with the manner of financing construction programs. Throughout the periodic surveys, information was gleaned to reflect existing hospital facilities and the use to which they are being placed. Their relative condition is evaluated and is interpolated to the common denominator of suitability of beds, as well as the total number of beds available. Usage is reflected in terms of percentage of occupancy and the average daily census which is shown in the following pages.

The state average bed-birth, bed-death ratio of 3.4 beds per thousand population as developed in the Report on Hospital & Public Health Resources in Iowa, was the basis for determining the occupied bed need of the several hospital service areas. When the occupied bed need, based on the population and bed-birth, bed-death ratio, indicated a bed need between 0 and 74 occupied beds, 0.5 of the need was allocated to the area. Similarly, between 75 and 149 occupied, 0.6; between 150 and 224, 0.7; between 225 and 300, 0.8; all over 300, 1.0. The remaining occupied beds not allotted by this criterion were allotted to the intermediate and base area hospitals. The area occupied needs were converted to a total bed need for each facility by the following formulae: 4 ADC + ADC (low level occupancy--under 100 beds) and 3 ADC + ADC (high level occupancy--over 100 beds.)

The bed birth-death ratio is not applicable in computing the occupied bed need in certain areas, particularly the larger cities, because these areas now receive a large number of hospital patients from population outside their intermediate areas. In fact, many hospital centers now have occupied beds in excess of the number which would be indicated by applying the bed birth-death ratio to their respective areas. In these areas, the present average daily census of the existing facilities was used as an indication of their need, and converted to total beds needed by use of the above mentioned high level/low level occupancy formulae. This recognizes the crowded conditions in the present hospitals and expands them to permit a normal occupancy.

The needs are further adjusted to meet local conditions such as financial resources, industrialization, location of hospitals with respect to state lines or the proximity of other hospitals, and population trends. (See Population Factor Discussion)

The University Hospital, State University of Iowa, Iowa City, provides statewide comprehensive hospital and medical care of indigent, clinical pay and private patients, in cooperation with the Colleges of Medicine, Dentistry, Pharmacy, School of Nursing, and Hospital Administration. The University Hospital admits patients from all sections of the state. As provided by law, the county quota of patients is based on population and eliminates the possibility of an inequitable distribution of hospital services to the indigent. The quotas are based on the latest official census. Recognizing this statewide service to the entire state population, the total bed need of each area was reduced by its proportionate share of the University Hospital's service as beds. This proportionate share was determined on the basis of the pattern of admission of indigent patients during the period July 1, 1946 to June 30, 1947. This pattern of the use of the University Hospitals over the entire state is believed to be quite representative of the total admission to this hospital.

The occupied beds remaining after allocating 0.5, 0.6, 0.7, and 0.8 to each area were practically balanced by the needs in the largest areas.

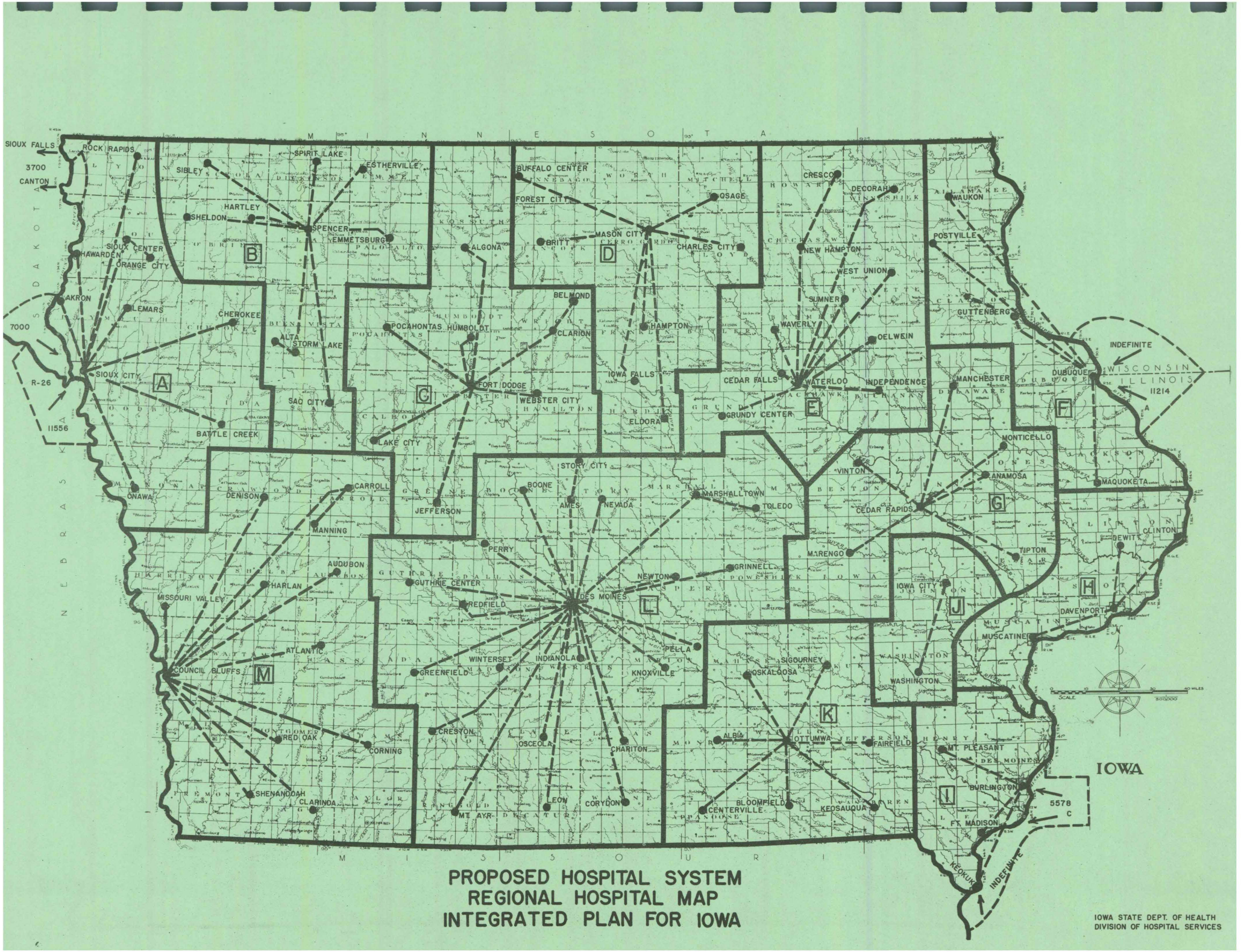
During recent revisions, the Iowa State Plan was based on population estimates as published by the appropriate Federal Agency and adjusted to conform with the needs for this presentation. Such estimates, based on 1950 census data, were inaccurate which in turn induced an automatic error into bed planning for specific communities throughout the state and especially in a number of the rural areas. This in turn leaves us with an irrevocable error that must be compensated from pool beds in this Plan. It should also be pointed out that the error is mechanical and that the actual usage of these beds would indicate that their number is reasonable and appropriate. However, the regulations do require that we conform to certain limitations set forth in the basic ground rules for the grants program and therefore induce a hardship in the category of acute general hospital beds.

The Division of Hospital Services of the Iowa State Department of Health made a study of out-of-state hospital demand together with the state agencies of the several surrounding states. The State of Iowa is unique in that in excess of 50% of its larger cities are located on the border of the state with a normal trade area extending into the border states. The state agencies of our border were generally willing to concede that a portion of their state population patronized Iowa hospitals. However, except in a few rare instances, the adjacent states were unwilling to assign definite population groups to Iowa's total population. Existing regulations provide that a maximum number of general hospital beds which may be constructed must be based upon the state population, and if a state gains population in one area it must lose a corresponding population in another area to compensate. In view of the fact that Iowa gains population in a large number of areas and loses population in a relatively small number of areas, it is reasonable to assume that the hospitals of Iowa are normally serving a population in excess of the population shown by the State census.

The excess existing general hospital beds in certain areas are due to out-of-state population. A pool bed adjustment is necessary to eliminate this excess and prevent the over-building of general hospital beds for the state. In effect, this pool bed adjustment is the number of beds needed in Iowa to serve the out-of-state population seeking hospital service in Iowa.

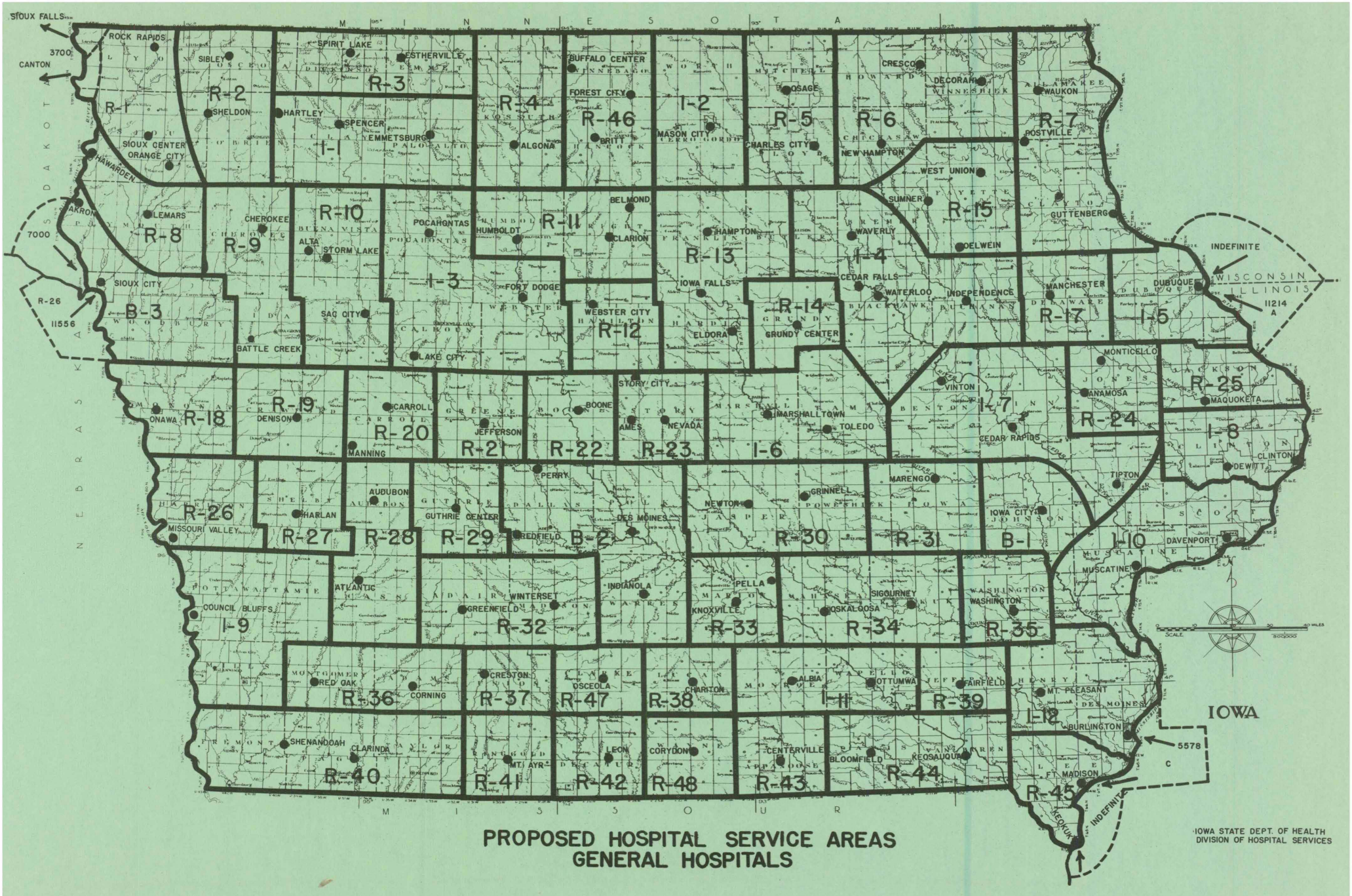
Special problems are constantly developing because of normal obsolescence, unique developments in a particular community, transition in population characteristics, and/or the overloading of ancillary facilities when evaluated in terms of beds they are attempting to serve. It has become necessary to properly recognize the degree of obsolescence in the classification of our beds. Representative sampling on a number of institutions indicates that when applying the rules of thumb on specific services within general hospitals there are many instances where the number of beds being served by available services is completely unrealistic. These findings have been applied to a former evaluation of the suitability of beds inventoried. It is consistently found that the services available are adequate to serve no more than 50% of the replaceable beds they presently are attempting to serve. On this basis it is very reasonable to use the rule of thumb that all beds classified as "replaceable" cannot be interpreted as being suitable, but that more properly they qualify only as "unacceptable" beds. To preclude massive overbuilding, 50% of the unacceptable beds falling within the sphere of "replaceable" are being induced into our tabulations as acceptable to accurately reflect the relative degree of urgency into the relative priority of each community.

Still another question which may exist in these marginal facilities is where ancillary services are demanded but existing facilities are inadequate to meet immediate local needs and/or referral load resulting from integration of medical services. A special consideration is available to prospective sponsors, even though it may be beyond the needs implied by the relative priority table which is based on beds. The Advisory Council will recognize a sponsor's presentation of such a special problem, provided a complete and factual narrative statement and program are submitted with their application and the owner will present himself upon request before a formal meeting of the Advisory Council. The sponsor should be prepared to provide detailed and specific information and a record of studies to support his viewpoint. If requested, he will provide such special studies as may be called for by the Advisory Council to clarify certain details of the proposed program for specific consideration by the council and the State Agency when evaluating the application. In the light of the facts which will have been presented, oral and/or written, the merits of the specific program will be evaluated to determine the relative priority which will be assigned to the proposal.



PROPOSED HOSPITAL SYSTEM
REGIONAL HOSPITAL MAP
INTEGRATED PLAN FOR IOWA

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES



PROPOSED HOSPITAL SERVICE AREAS
GENERAL HOSPITALS

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA
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SUITABILITY REPORT General, HOSPITAL BEDS AND/OR FACILITIES

Summary REGION Statewide

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	o/o OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REGIST.	UNSUIT			PATIENT-DAYS	ADMISSIONS
A	Sioux City				671	421	40	171		324,137	37,741
B	Spencer				378	54	86	111		105,011	20,738
C	Fort Dodge				540	233	14	112		170,566	22,434
D	Mason City				358	318	60	109		147,899	22,178
E	Waterloo				553	355	79	162		266,743	38,794
F	Dubuque				525	178	90	102		147,052	22,469
G	Cedar Rapids				700	150	113	147		226,214	32,265
H	Davenport				555	194	27	134		200,257	31,285
I	Burlington				397	268	18	78		181,593	23,980
J	Iowa City				431	713	0	99		345,043	36,179
K	Ottumwa				576	60	21	98		182,729	23,775
L	Des Moines				1,822	606	179	386		675,345	97,641
M	Council Bluffs				501	167	333	157		233,318	37,308
	STATEWIDE - IOWA - GRAND TOTALS				8,007	3,717	1,060	1,866		3,205,907	446,787

R - REPORT DELINQUENT - DATA ESTIMATED
NA - NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA
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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "A" REGION Sioux City

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPAIR-	UNSUIT			PATIENT-DAYS	ADMISSIONS
R-1	Orange City Municipal	Sioux	Orange City	CITY	27	8	0	6	48.2	6,153	763
R-1	Sioux Center Community	Sioux	Sioux Center	NPA	26	0	0	8	78.0	7,403	793
R-1	Merrill Pioneer Community	Lyon	Rock Rapids	NPA	32	0	0	8	39.2	4,580	908
R-8	Sacred Heart	Plymouth	LeMars	CH	52	0	0	12	69.6	13,217	2,419
R-8	Hawarden Community	Sioux	Hawarden	CITY	14	0	0	6	76.4	3,905	545
R-9	Hartley Memorial	Ida	Battle Creek	CITY	0	15	0	3	56.0	3,067	336
R-9	Ida Grove	Ida	Ida Grove	CITY	0	0	18	6	55.1	3,617	424
R-9	Sioux Valley Memorial	Cherokee	Cherokee	NPA	42	35	0	12	66.7	18,770	2,767
R-18	Onawa Hospital, Inc.	Monona	Onawa	IND	0	0	22	5	137.3	11,027	1,884
R-18	Burgess Memorial Hospital	Monona	Onawa	NPA	40	0	0	8	Project Iowa-113		
B-3	Akron	Plymouth	Akron	NPA	21	0	0	7	28.4	2,177	395
B-3	Lutheran	Woodbury	Sioux City	CH	72	66	0	14	81.0	40,781	4,737
B-3	Methodist	Woodbury	Sioux City	CH	146	0	0	15	80.6	42,968	5,542
B-3	St. Joseph Mercy	Woodbury	Sioux City	CH	156	145	0	40	113.4	124,585	10,464
B-3	St. Vincent's	Woodbury	Sioux City	CH	43	127	0	16	58.6	36,354	5,167
B-3	Gordon Memorial	Woodbury	Sioux City	NPA	0	25	0	5	60.6	5,533	597
	Subtotals Region "A" Sioux City				671	421	40	171	xxxx	324,137	37,741

- REPORT DELINQUENT - DATA ESTIMATED
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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "B" REGION Spencer

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	LICENSE DATA	
		COUNTY	TOWN		SUITABLE	REPLACE-	UNSUIT			PATIENT-DAYS	ADMISSIONS
R-2	Community Memorial	O'Brien	Sheldon	NPA	32	0	0	10	58.6	6,845	1,041
R-2	Ward Memorial	O'Brien	Primghar	CITY	0	0	9	3	39.5	969	268
R-2	Osceola Hospital, Inc.	Osceola	Sibley	IND	0	0	35	12	27.2	3,469	601
R-2	Osceola Community Hospital	Osceola	Sibley	IND	38	0	0	8	Project Iowa-119		
R-3	Holy Family	Emmet	Estherville	CH	85	0	0	14	64.3	19,939	3,401
R-3	Dickinson Co. Memorial	Dickinson	Spirit Lake	CO	48	0	0	8	56.4	9,867	7,568
R-10	Loring	Sac	Sac City	CITY	32	0	0	8	64.1	7,487	810
R-10	Alta Memorial	B. Vista	Alta	NPA	19	0	0	7	NR	(3,900)	(210)
R-10	Sioux Rapids	B. Vista	Sioux Rapids	IND	0	12	18	3	77.5	8,487	131
R-10	Buena Vista County	B. Vista	Storm Lake	CO	49	0	0	10	63.9	14,344	1,940
I-1	Palo Alto Memorial	Palo Alto	Emmetsburg	NPA	0	18	24	8	69.1	10,586	1,474
I-1	Community Memorial	O'Brien	Hartley	NPA	27	0	0	8	39.3	3,872	608
I-1	Spencer Municipal	Clay	Spencer	CITY	48	24	0	12	58.0	15,246	2,686
	Subtotals Region "B" Spencer				378	54	86	111		105,011	20,738

- REPORT DELINQUENT - DATA ESTIMATED
- NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "C" REGION Fort Dodge

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLACEMENT	UNSUITABLE			PATIENT-DAYS	ADMISSIONS
R-4	St. Ann	Kossuth	Algona	CH	61	0	0	10	34.0	7,715	1,190
R-11	Community Memorial	Wright	Clarion	CITY	54	0	0	8	75.0	7,666	1,244
R-11	Belmond Community	Wright	Belmond	CITY	30	0	0	8	58.0	5,076	828
R-12	Hamilton County Public	Hamilton	Webster City	CO	46	32	0	8	63.77	18,156	2,183
R-21	Greene County	Greene	Jefferson	CO	57	0	0	8	68.9	13,287	1,837
I-3	St. Joseph Mercy	Webster	Fort Dodge	CH	61	90	0	24	91.3	50,344	5,631
I-3	Lutheran of Fort Dodge	Webster	Fort Dodge	CH	189	111	0	32	53.4	58,493	7,988
I-3	McCrary-Rost	Calhoun	Lake City	IND	Closed 1 March 1962					5,710	1,211
I-3	McVay Memorial	Calhoun	Lake City	PART	0	0	14	6	80.6	4,119	322
I-3	Stewart Memorial Community	Calhoun	Lake City	NPA	42	0	0	8	Project Iowa-98		
	Subtotals Region "C" Fort Dodge				540	233	14	112	xxxx	170,566	22,434

D - REPORT DELINQUENT - DATA ESTIMATED
A - NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA

DATE 1 July 1962

SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "D" REGION Mason City

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REGIST.	UNSUIT			PATIENT-DAYS	ADMISSIONS
R-5	Riceville	Mitchell	Riceville	CITY	0	0	12	4	13.9	608	131
R-5	Mitchell County Memorial	Mitchell	Osage	CO	63	0	0	9	57.8	13,295	2,364
R-5	Cedar Valley	Floyd	Charles City	CITY	0	72	0	16	69.1	18,155	3,066
R-13	Eldora Memorial	Hardin	Eldora	CITY	0	36	0	8	47.0	6,171	844
R-13	Ellsworth Municipal	Hardin	Iowa Falls	CITY	41	0	0	8	54.5	6,966	1,281 (1
R-13	Lutheran	Franklin	Hampton	CH	0	48	0	8	47.0	8,235	1,341
R-46	Hancock County Memorial	Hancock	Britt	CO	32	0	0	8	48.8	5,702	1,097
R-46	Forest City Municipal	Winnebago	Forest City	CITY	25	0	0	8	42.1	3,844	528
R-46	Buffalo Center Hosp/Clinic	Winnebago	Buffalo Ctr.	IND	17	0	0	5	81.4	5,052	792
I-2	Park Hospital	C. Gordo	Mason City	NPA	0	56	0	10	83.0	16,960	2,190
I-2	St. Joseph Mercy	C. Gordo	Mason City	CH	180	106	48	25	51.6	62,911	8,544
(1)	Project Iowa-115. Occupancy based on 35 beds existing.										
	Subtotals Region "D" Mason City				358	318	60	109	xxxx	147,899	22,178

- REPORT DELINQUENT - DATA ESTIMATED
- NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT General, HOSPITAL BEDS AND/OR FACILITIES "E" REGION Waterloo

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	A&A	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REGUL-	UNSUIT		OCCUPANCY	PATIENT-DAYS	ADMISSIONS
R-6	St. Joseph Mercy (New)	Howard	Cresco	CH	42	0	0	8	NR	(6,200)	(1,010)
R-6	St. Joseph Mercy (Old)	Howard	Cresco	CH	Closed 26 beds on 10/9/61						
R-6	Smith Memorial	Winneshiek	Decorah	CH	0	20	18	8	64.7	8,500	1,238
R-6	St. Joseph's	Chickasaw	New Hampton	CH	0	45	0	8	78.1	12,841	1,767
R-14	Grundy County Memorial	Grundy	Grundy Center	CO	40	0	0	8	60.3	8,805	1,230
R-15	Palmer Memorial	Fayette	West Union	CITY	22	0	0	8	73.1	5,872	1,327
R-15	Mercy	Fayette	Oelwein	CH	55	0	0	10	85.9	17,245	2,851
R-15	Community Memorial	Bremer	Sumner	NPA	37	0	0	8	71.7	9,678	935
I-4	People's Hospital	Buchanan	Independence	CITY	38	0	15	10	71.2	13,778	1,908
I-4	St. Joseph's Mercy	Bremer	Waverly	CH	0	0	46	10	50.3	8,438	1,069
I-4	Allen Memorial	B. Hawk	Waterloo	NPA	83	130	0	24	76.5	59,476	8,991
I-4	Schoitz Memorial	B. Hawk	Waterloo	NPA	212	0	0	28	82.9	64,150	8,715
I-4	St. Francis	B. Hawk	Waterloo	CH	0	124	0	22	74.5	33,744	5,172
I-4	Sartori Memorial	B. Hawk	Cedar Falls	CITY	24	36	0	10	82.3	18,016	2,581
	Subtotals Region "E" Waterloo				553	355	79	162	xxxx	266,743	38,794

- SURVEY DELINQUENT - DATA ESTIMATED
- N.A. APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "F" REGION Dubuque

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPAIR	UNSUIT			PATIENT-DAYS	ADMISSIONS
-7	Veterans Memorial	Allamakee	Waukon	CITY	46	0	0	8	49.6	8,332	1,251
-7	Community Memorial	Allamakee	Postville	CITY	32	0	0	8	43.4	5,071	708
-7	McGregor Community	Clayton	McGregor	NPA	0	0	15	3	53.4	2,926	229
-7	Elkader Community	Clayton	Elkader	NPA	20	0	0	5	50.5	2,020	264 (1)
-7	Guttenberg Municipal	Clayton	Guttenberg	CITY	38	0	0	6	45.2	6,265	1,089
-25	Jackson County Public	Jackson	Maquoketa	CO	60	0	0	8	NR	(17,000)	(2,900)
-5	Finley	Dubuque	Dubuque	NPA	29	28	56	18	73.2	30,171	4,179
-5	St. Joseph Mercy	Dubuque	Dubuque	CH	200	150	0	24	35.1	44,877	7,166
-5	Xavier	Dubuque	Dubuque	CH	100	0	0	16	69.8	25,488	3,955
-5	Bellevue	Jackson	Bellevue	NPA	0	0	19	6	70.7	4,902	728
	Subtotals Region "F" Dubuque				525	178	90	102	xxxx	147,052	22,469

(1) Occupancy based on 200 days operation

REPORT DISCUSSED - DATA ESTIMATED
NOT APPROVED FOR DESIGNATION

SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "G" REGION Cedar Rapids

AREA	NAME OF FACILITY	LOCATION		CONTROL	BED CAPACITY			No. of Bassinets	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		CERTIFIED	REGULAR	EMERGENCY			PATIENT-DAYS	ADMISSIONS
R-17	Delaware County Memorial	Delaware	Manchester	CO	66	0	0	8	64.2	15,476	2,609
R-24	John McDonald	Jones	Monticello	NPA	53	0	0	8	NR	(9,100)	(1,380)
R-24	Mercy	Jones	Anamosa	CH	0	0	23	9	76.2	6,402	1,027
	Irregular Facility								NA	5,060	433
R-31	Marengo Memorial	Iowa	Marengo	CITY	28	4	0	6	62.3	7,274	1,274
I-7	Virginia Gay	Benton	Vinton	CITY	36	0	0	8	61.9	8,137	862
I-7	Mercy	Linn	Cedar Rapids	CH	103	146	90	48	54.6	67,553	9,799
I-7	St. Luke's Methodist	Linn	Cedar Rapids	CH	414	0	0	60	70.9	107,212	14,881
	Subtotals Region "G" Cedar Rapids				700	150	113	147	xxxx	226,214	32,265

2 - REPORT DELINQUENT - DATA ESTIMATED
4 - NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "H" REGION Davenport

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLACE-	UNSUIT			PATIENT-DAYS	ADMISSIONS
I-8	Jane Lamb Memorial	Clinton	Clinton	NPA	40	49	0	16	81.6	29,461	4,697
I-8	St. Joseph Mercy	Clinton	Clinton	CH	0	55	27	20	74.5	22,304	3,789
I-8	DeWitt Community	Clinton	DeWitt	NPA	32	0	0	8	70.2	8,211	973
I-10	Muscatine General	Muscatine	Muscatine	CO	139	0	0	16	53.2	27,034	4,458
I-10	Mercy	Scott	Davenport	CH	224	0	0	42	61.1	49,912	8,513
I-10	St. Luke's	Scott	Davenport	CH	52	90	0	22	95.2	49,335	6,655
I-10	Davenport Osteopathic	Scott	Davenport	NPA	68	0	0	10	NR	(14,000)	(2,200)
	Subtotals Region "H" Davenport				555	194	27	134	xxxx	200,257	31,285

- REPORT DELINQUENT - DATA ESTIMATED
- NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
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SUITABILITY REPORT General, HOSPITAL BEDS AND/OR FACILITIES "I" REGION Burlington

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REGIST.	UNSUIT			PATIENT-DAYS	ADMISSIONS
R-45	Irregular Facility									8,000	600
R-45	Sacred Heart	Lee	Ft. Madison	CH	61	60	0	24	79.5	35,128	4,748
R-45	Graham	Lee	Keokuk	NPA	0	76	18	5	80.3	27,548	3,949
R-45	St. Joseph's	Lee	Keokuk	CH	55	26	0	10	62.5	18,481	2,516
I-12	Henry County Memorial	Henry	Mt. Pleasant	CO	56	0	0	8	57.5	11,748	1,690
I-12	Burlington	D. Moines	Burlington	CH	206	0	0	16	84.6	46,713	6,393
I-12	Mercy	D. Moines	Burlington	CH	19	106	0	15	74.4	33,975	4,084
	Subtotals Region "I" Burlington				397	268	18	78	xxxx	181,593	23,980

NR - REPORT DELINQUENT - DATA ESTIMATED
NA - NOT APPLICABLE OR REALISTIC

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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "J" REGION Iowa City

Area	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	o/o OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REHAB.	UNSUIT			PATIENT-DAYS	ADMISSIONS
R-35	Washington County	Washington	Washington	CO	0	45	0	8	57.7	9,480	1,425
B-1	Mercy	Johnson	Iowa City	CH	190	0	0	36	86.2	59,759	8,132
B-1	University Hospitals	Johnson	Iowa City	STATE	241	668	0	55	80.1	272,267	25,554
B-1	Irregular Facilities	- - - -	- - - -	- - - -	- - -	- - -	- - -	- - -	- - -	3,537	1,068
	Subtotals Region"J" Iowa City				431	713	0	99	xxxx	345,043	36,179

- REPORT DELINQUENT - DATA ESTIMATED
- NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "K" REGION Ottumwa

Area	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% Occupancy	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REGULAR	UNSUIT			PATIENT-DAYS	ADMISSIONS
-34	Mahaska County	Mahaska	Oskaloosa	CO	0	60	0	10	83.0	18,166	3,170
-34	Keokuk County	Keokuk	Sigourney	CO	34	0	0	8	47.7	5,913	942
-39	Jefferson County	Jefferson	Fairfield	CO	58	0	21	10	98.9	16,599	2,336
-43	St. Joseph Mercy	Appanoose	Centerville	CH	82	0	0	10	50.1	14,996	2,771
-44	Davis County	Davis	Bloomfield	CO	71	0	0	10	78.6	20,386	2,448
-44	Van Buren County Memorial	Van Buren	Keosauqua	CO	16	0	0	5	85.2	7,153	774 (1
-11	Ottumwa	Wapello	Ottumwa	NPA	139	0	0	20	80.2	51,799	5,984
-11	St. Joseph	Wapello	Ottumwa	CH	139	0	0	17	76.9	39,028	3,900 (2
-11	Monroe County	Monroe	Albia	CO	37	0	0	8	64.3	8,689	1,450
	Subtotals Region "K" Ottumwa				576	60	21	98	xxxx	182,729	23,775

(1) Project Iowa-116. Occupancy based on 23 beds

(2) Project Iowa-78. Irregular number of beds during remodel.

REPORT DELINQUENT - DATA ESTIMATED
NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "L" REGION Des Moines

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	LICENSE DATA	
		COUNTY	TOWN		SUITABLE	REGIST.	UNSUIT			PATIENT-DAYS	ADMISSIONS
-22	Boone County	Boone	Boone	CO	100	0	0	16	68.0	24,834	3,732
-22	Irregular Facility									(12,000)	(623)
-23	Story County	Story	Nevada	CO	50	0	0	10	73.9	13,482	1,281
-23	Story City Memorial	Story	Story City	CITY	16	0	0	6	99.2	5,794	1,075
-23	Mary Greeley Memorial	Story	Ames	CITY	81	96	0	17	98.1	24,337	4,323
-23	Irregular Facility									2,148	725
-29	Guthrie County	Guthrie	Guthrie Ctr.	CO	38	0	0	8	59.4	8,233	934
-30	Mary Frances Skiff Memorial	Jasper	Newton	CITY	94	0	0	10	60.5	20,774	3,744
-30	Grinnell Community	Poweshiek	Grinnell	NPA	0	41	0	8	65.8	9,851	1,420
-30	St. Francis	Poweshiek	Grinnell	CH	0	20	0	8	77.9	5,689	1,083
-32	Adair County Memorial	Adair	Greenfield	CO	29	0	0	8	58.9	6,238	897
-32	Madison County Memorial	Madison	Winterset	CO	39	0	0	8	58.1	8,274	926
-33	Collins Memorial	Marion	Knoxville	IND	30	0	0	6	87.4	9,573	2,124
-33	Pella Community	Marion	Pella	NPA	34	0	0	10	52.9	6,563	864
-37	Greater Community	Union	Creston	CO	0	0	50	10	84.9	15,494	2,670
-38	Yocom	Lucas	Chariton	IND	0	0	21	7	94.6	7,253	647
-38	Lucas County Memorial	Lucas	Chariton	CO	35	0	0	12	47.4	3,574	558 (1)
-41	Ringgold County	Ringgold	Mt. Ayr	CO	30	0	0	8	61.4	6,728	1,071

(1) Project Iowa-82. Occupancy based on 215 days operation.

(Continued on page 13 of 14)

REPORT DELINQUENT - DATA ESTIMATED
NOT APPLICABLE OR REALISTIC

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SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "L" REGION Des Moines (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REQUIRED	UNSUIT			PATIENT-DAYS	ADMISSIONS
-42	Decatur County	Decatur	Leon	CO	0	30	0	5	64.5	7,063	1,426
-47	Clarke County Public	Clarke	Osceola	CO	32	0	0	8	76.1	8,891	1,658
-48	Wayne County	Wayne	Corydon	CO	34	0	0	8	54.5	6,767	620
-6	Mercy	Marshall	Marshalltown	CH	29	62	0	10	NR	(17,000)	(2,102) (3
-6	Evangelical	Marshall	Marshalltown	CH	134	0	0	16	71.5	34,987	4,955 (2
-2	Dallas County	Dallas	Perry	CO	38	0	0	10	78.1	10,827	1,298
-2	Clinic	Dallas	Dexter	PART	14	0	0	4	154.2	7,884	735
-2	Broadlawns Polk County	Polk	Des Moines	CO	0	147	14	14	63.7	37,484	4,922
-2	Iowa Lutheran	Polk	Des Moines	CH	90	135	0	22	89.9	73,793	10,245
-2	Iowa Methodist & Blank Mem.	Polk	Des Moines	CH	343	0	0	45	107.1	134,053	19,351
-2	Mercy	Polk	Des Moines	CH	310	0	50	50	70.8	92,979	13,357
-2	Wilden Osteopathic	Polk	Des Moines	CORP	35	0	11	8	59.2	9,933	2,108
-2	Still Osteopathic	Polk	Des Moines	CORP	0	75	0	6	50.2	13,756	1,670
-2	Des Moines General	Polk	Des Moines	CORP	70	0	33	10	69.7	26,208	4,083
-2	Redfield Hospital & Clinic	Dallas	Redfield	IND	14	0	0	2	56.3	2,881	354
-2	Doctors' Hospital	Polk	Des Moines	CORP	103	0	0	16	Under	Construction	
	Subtotals Region "L" Des Moines				1,822	606	179	386	xxxx	675,345	97,641

(2) Project Iowa-114. Occupancy based on 132 existing beds.

(3) Project Iowa-95. Reporting delinquent....estimated.

REPORT DELINQUENT - DATA ESTIMATED
NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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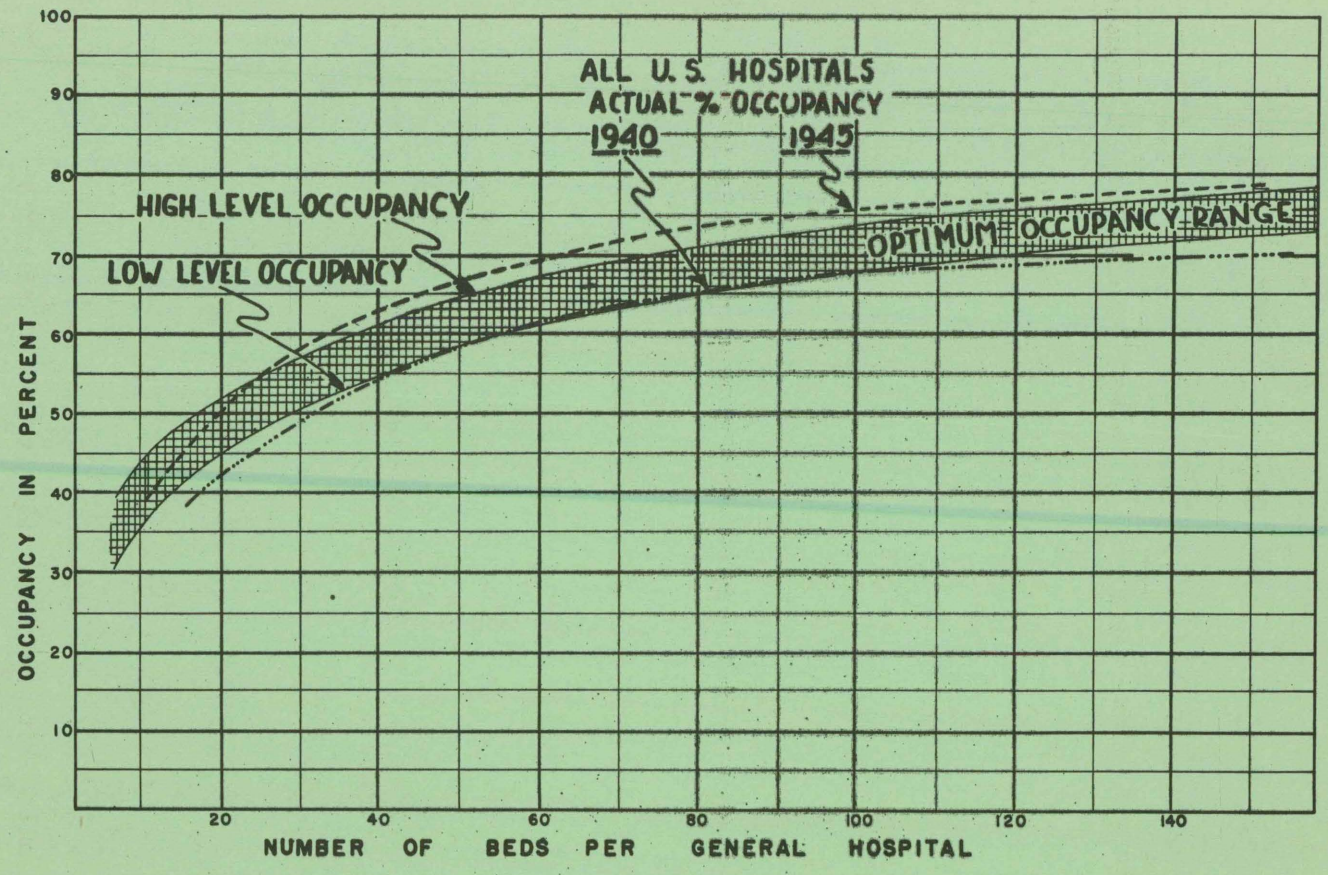
SUITABILITY REPORT General HOSPITAL BEDS AND/OR FACILITIES "M" REGION Council Bluffs

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinets	AHA EXCLUSION	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REMAR.	UNSUIT			PATIENT-DAYS	ADMISSIONS
R-19	Crawford County Memorial	Crawford	Denison	CO	50	0	0	10	57.5	10,486	1,854
R-20	St. Anthony	Carroll	Carroll	CH	0	14	102	20	66.9	28,324	4,059
R-20	Manning General	Carroll	Manning	IND	0	15	0	5	66.6	3,644	475
R-26	Community Memorial	Harrison	Mo. Valley	NPA	30	0	0	8	87.7	8,509	1,190
R-27	Myrtue Memorial	Shelby	Harlan	CO	50	0	0	16	76.9	14,028	2,233
R-28	Atlantic Memorial	Cass	Atlantic	NPA	36	32	0	10	74.6	18,512	5,354
R-28	Audubon County Memorial	Audubon	Audubon	CO	30	0	0	8	42.6	4,666	766
R-36	Rosary	Adams	Corning	NPA	41	0	0	8	53.1	7,943	1,321
R-36	Murphy Memorial	Montgom'y	Red Oak	CITY	43	0	0	10	62.9	9,878	1,333
R-40	Community Hospital, Inc.	Fremont	Hamburg	CITY	0	0	25	6	72.0	6,567	1,028
R-40	Clarinda Municipal	Page	Clarinda	CITY	0	46	0	8	55.9	9,356	1,563
R-40	Hand Community	Page	Shenandoah	NPA	53	0	0	8	53.8	10,403	1,503
I-9	Jennie Edmundson Memorial	Pottawat.	Council Blfs.	NPA	154	60	0	16	80.0	46,135	6,656
I-9	Mercy	Pottawat.	Council Blfs.	CH	14	0	206	24	60.5	48,738	6,983
	Irregular Facility									6,129	990
	Subtotals Region "M" Council Bluffs				501	167	333	157	xxxx	233,318	37,308
REPORT DELINQUENT - DATA ESTIMATED NOT AVAILABLE OR RELIABLE	GRAND TOTALS -- STATEWIDE				8,007	3,717	1,060	1,866	xxxx	3,205,907	446,787



DEFINITION AND INTERPRETATION OF GRAPH

PERCENT OCCUPANCY = $\frac{\text{TOTAL PATIENT DAYS WITHIN PERIOD}}{\text{(TOTAL BEDS) X (TOTAL DAYS WITHIN PERIOD)}}$
= PERCENT OF THEORETICAL CAPACITY ACTUALLY UTILIZED

OPTIMUM OCCUPANCY IS THAT RANGE OF OCCUPANCY WHERE THE GREATEST NUMBER OF PATIENT DAYS OF COMPLETE HOSPITAL SERVICES ARE ADMINISTERED MOST ECONOMICALLY

HIGH LEVEL OCCUPANCY WITHIN OPTIMUM RANGE INDICATES (AND/OR)
1. THE CORRECT STAFF OF PERSONNEL - COMPETELY QUALIFIED
2. FAVORABLE AND CONSISTENT DEMAND FOR HOSPITAL BEDS
3. EFFICIENT LAYOUT AND ORGANIZATION IN PHYSICAL PLANT
4. HIGHER THAN AVERAGE LENGTH OF STAY PER PATIENT
5. HIGH MORALE WITHIN ORGANIZATION

LOW LEVEL OCCUPANCY WITHIN OPTIMUM RANGE INDICATES
1. ERRATIC DEMAND FOR HOSPITAL BEDS
2. INEFFICIENT LAYOUT/ORGANIZATION IN PHYSICAL PLANT
3. INEFFICIENT STAFFING AND/OR UTILIZATION OF SAME
4. RAPID TURNOVER OF PATIENTS
5. LOW MORALE WITHIN ORGANIZATION

OCCUPANCY RATE BELOW OPTIMUM MAY INDICATE OVER-SUPPLY OF BEDS, LOW EFFICIENCY, LACK OF STAFF, OR SEASONAL VARIATIONS ATTRIBUTABLE TO UNUSUAL LOCAL CONDITIONS

OCCUPANCY RATE ABOVE OPTIMUM INDICATES SUB-MARGINAL OPERATION OF LESS PATIENT DAY SERVICE PER DOLLAR OF COST IN THAT STAFF AND OPERATIONAL/MAINTENANCE DEMANDS ARE EXCESSIVE PER UNIT OF SERVICE, OR IT MAY INDICATE EXCESSIVE LONG-TERM PATIENTS ACTUALLY OUT OF PLACE IN AN ACUTE GENERAL HOSPITAL. UNLESS FUTURE PERSPECTIVE CONTRADICTS, EXPANSION AND REORGANIZATION IS NEEDED.

DIVISION OF HOSPITAL SERVICES
IOWA STATE DEPT. OF HEALTH

BED INCREASE DUE TO POPULATION INCREASE FACTOR

For a number of years this State Agency has attempted to compensate for the unique circumstances causing present-day trends in our population. Up to this point we could only surmise what was occurring. Certain known factors were felt in general terms. These were the result of certain conditions existing over many years such as:

(a) The fact that most of the population centers are located on state borders of the early influences of the Missouri and Mississippi rivers. These areas continue to experience hospital demand beyond normal population expectancy because of the out-of-state demand.

(b) Rapid mechanization of the farming industry has reduced population density in most of the agricultural areas. (It should be noted that the accident rate in these reduced population groups is accelerating greatly, and is a matter of concern.)

(c) The transition in occupations resulting from an aggressive program to attract industries into Iowa. This is appreciably accelerating population increase in many of our population centers.

Up to the present, only intra-decade estimates were available for guidance. However, the 1960 census confirmed our general suppositions and refined the degree to which these circumstances were applicable. Up to this point there had been no firm background from which to project future needs because of the erratic decade 1940 to 1950 and the violent transition taking place in this state's economy. At this point, however, with 1960 census figures available, it is very reasonable to project through 1980 in ascertaining needs of specific areas in the state and to compensate the rigidness of the mathematical ratio set forth by the Federal Regulations regarding State Plans. The past decade was projected through 1980. Areas whose population increased at a rate greater than the average rate of increase for the state were given additional consideration for their guidance in planning future needs and to give recognition, priority-wise, to these critical areas.

POPULATION TRENDS IN IOWA - BY COUNTY 1950 THRU 1960

POPULATION INCREASE FACTOR PROJECTED THRU 1980

COUNTY	POPULATION		POPULATION CHANGE	POPULATION INCREASE BEYOND STATE AVERAGE			
				PROJECTED THRU 1980		NET BEDS	APPLICABLE REGION
	1960	1950	IN %	%	NUMBER		
Adair	10,893	12,292	- 11.4				
Adams	7,468	8,753	- 14.7				
Allamakee	15,982	16,351	- 2.3				
Appanoose	16,015	19,683	- 18.6				
Audubon	10,919	11,579	- 5.7				
Benton	23,422	22,656	3.4				
Black Hawk	122,482	100,448	21.9	+43.8	53,647	215	1-4
Boone	28,037	28,139	- 0.4				
Bremer	21,108	18,884	11.8	+23.6	4,981	20	1-4
Buchanan	22,293	21,927	1.7				
Buena Vista	21,189	21,113	0.4				
Butler	17,467	17,394	0.4				
Calhoun	15,923	16,925	- 5.9				
Carroll	23,431	23,065	1.6				
Cass	17,919	18,532	- 3.3				
Cedar	17,791	16,910	5.2				
Cerro Gordo	49,894	46,053	8.3	+16.6	8,282	33	1-2
Cherokee	18,598	19,052	- 2.4				
Chickasaw	15,034	15,228	- 1.3				
Clarke	8,222	9,369	- 12.2				
Clay	18,504	18,103	2.2				
Clayton	21,962	22,522	- 2.5				
Clinton	55,060	49,664	10.9	+21.8	12,003	48	1-8
Crawford	18,569	19,741	- 5.9				
Dallas	24,123	23,661	2.0				
Davis	9,199	9,959	- 7.6				
Decatur	10,539	12,601	- 16.4				
Delaware	18,483	17,734	4.2				
Des Moines	44,605	42,056	6.1	+12.2	5,442	22	1-12
Dickinson	12,574	12,756	- 1.4				
Dubuque	80,048	71,337	12.2	+24.4	19,532	78	1-5
Emmet	14,871	14,102	5.5	+11.0	1,636	4	R-3
Fayette	28,581	28,294	1.0				
Floyd	21,102	21,505	- 1.9				
Franklin	15,472	16,268	- 4.9				
Fremont	10,282	12,323	- 16.6				
Greene	14,379	15,544	- 7.5				
Grundy	14,132	13,722	3.0				
Guthrie	13,607	15,197	- 10.5				
Hamilton	20,032	19,660	1.9				
Hancock	14,604	15,077	- 3.1				
Hardin	22,533	22,218	1.4				
Harrison	17,600	19,560	- 10.0				
Henry	18,187	18,708	- 2.8				
Howard	12,734	13,105	- 2.8				
Humboldt	13,156	13,117	0.3				
Ida	10,269	10,697	- 4.0				
Iowa	16,396	15,835	3.5				
Jackson	20,754	18,622	11.4	+22.8	4,732	12	R-25
Jasper	35,282	32,305	9.2	+18.4	6,491	16	R-30
Jefferson	15,818	15,696	0.8				

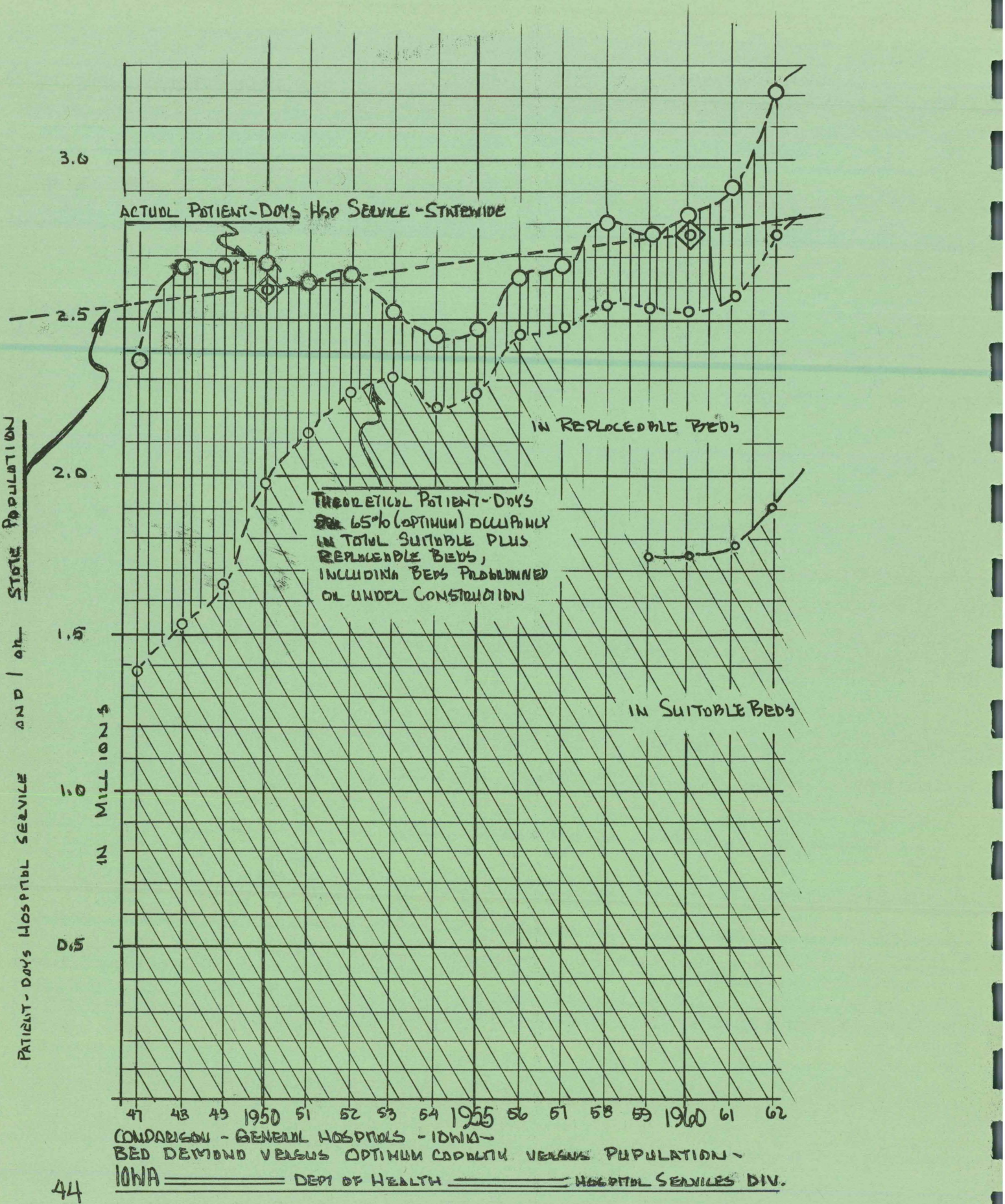
-2

POPULATION TRENDS IN IOWA - BY COUNTY 1950 THRU 1960

POPULATION INCREASE FACTOR PROJECTED THRU 1980 -

COUNTY	POPULATION		POPULATION CHANGE IN %	POPULATION INCREASE BEYOND STATE AVERAGE			
				PROJECTED THRU 1980		NET BEDS	APPLICABLE REGION
	1960	1950		%	NUMBER		
Johnson	53,663	45,756	17.3	+34.6	18,567	84	B-1
Jones	20,693	19,401	6.7	+13.4	2,773	7	R-24
Keokuk	15,492	16,797	- 7.8				
Kossuth	25,314	26,241	- 3.5				
Lee	44,207	43,102	2.6				
Linn	136,899	104,274	31.3	+62.6	85,699	340	1-7
Louisa	10,290	11,101	- 7.3				
Lucas	10,923	12,069	- 9.5				
Lyon	14,468	14,697	- 1.6				
Madison	12,295	13,131	- 6.4				
Mahaska	23,602	24,672	- 4.3				
Marion	25,886	25,930	- 0.2				
Marshall	37,984	35,611	6.7	+13.4	5,090	20	1-6
Mills	13,050	14,064	- 7.2				
Mitchell	14,043	13,945	0.7				
Monona	13,916	16,303	- 14.6				
Monroe	10,463	11,814	- 11.4				
Montgomery	14,467	15,685	- 7.8				
Muscatine	33,840	32,148	5.3	+10.6	3,587	14	1-10
O'Brien	18,840	18,970	- 0.7				
Osceola	10,064	10,181	- 1.1				
Page	21,023	23,921	- 12.1				
Palo Alto	14,736	15,891	- 7.3				
Plymouth	23,906	23,252	2.8				
Pocahontas	14,234	15,496	- 8.1				
Polk	266,315	226,010	17.8	+35.6	94,898	427	B-2
Pottawattamie	83,102	69,682	19.3	+38.6	32,077	128	1-9
Poweshiek	19,300	19,344	- 0.2				
Ringgold	7,910	9,528	- 17.0				
Sac	17,007	17,518	- 2.9				
Scott	119,067	100,698	18.2	+36.4	43,340	173	1-10
Shelby	15,825	15,942	- 0.7				
Sioux	26,375	26,381	---				
Story	49,327	44,294	11.4	+22.8	11,247	28	R-23
Tama	21,413	21,688	- 1.3				
Taylor	10,288	12,420	- 17.2				
Union	13,712	15,651	- 12.4				
Van Buren	9,778	11,007	- 11.2				
Wapello	46,126	47,397	- 2.7				
Warren	20,829	17,758	17.3	+34.6	7,207	32	B-2
Washington	19,406	19,557	- 0.8				
Wayne	9,800	11,737	- 16.5				
Webster	47,810	44,241	8.1	+16.2	7,745	31	1-3
Winnebago	13,099	13,450	- 2.6				
Winneshiek	21,651	21,639	0.1				
Woodbury	107,849	103,917	3.8				
Worth	10,259	11,068	- 7.3				
Wright	19,447	19,652	- 1.0				
IOWA --	2,757,537	2,621,073	+ 5.2			1,732	

Census Data as Published by U. S. Bureau of Census for 1950 and 1960.



COMPARISON - GENERAL HOSPITALS - IOWA -
BED DEMAND VERSUS OPTIMUM CAPACITY VERSUS POPULATION -
IOWA — DEPT OF HEALTH — HOSPITAL SERVICES DIV.

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA

DATE 1 JULY 1962
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ACUTE GENERAL HOSPITAL SUMMARY

Summary REGION Statewide

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
A	Sioux City	207,548	- 745	671-421 882	887	5	
B	Spencer	135,588	(4) 394	378-54 405	466	61	
C	Fort Dodge	170,295	(31) 542	540-233 656	658	2	
D	Mason City	169,809	(33) 515	358-318 517	564	47	
E	Waterloo	269,715	(235) 931	553-335 731	1,193	462	
F	Dubuque	138,746	(90) 469	525-178 614	614	0	
G	Cedar Rapids	227,996	(347) 825	700-150 775	1,192	417	
H	Davenport	218,845	(235) 875	555-194 652	1,110	458	
I	Burlington	109,957	(22) 373	397-268 531	531	0	
J	Iowa City	76,782	(84) 307	431-713 787	814	27	
K	Ottumwa	146,493	- 451	576-60 606	640	34	
L	Des Moines	621,788	(523) 2,269	1822-606 2,125	2,920	795	
M	Council Bluffs	263,943	(128) 805	501-167 585	986	401	
			(1732)				
STATEWIDE -- GRAND TOTALS		2,757,535	9,501	8007-3717 9,866	12,575	2,709	
Pool Beds Held in Reserve					891	891	
Adjusted Totals					13,466	3,600	

13. State Ratio (4.5)(2,757,535)= 12,409
14. Excess Beds--Orig. State Pool= +1,057
15. Total Beds Allowed 13,466

Replaceable Beds
Suitable Beds
Beds From Population Increase Factor

45

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA

DATE 1 JULY 1962

ACUTE GENERAL HOSPITAL SUMMARY

"A" REGION Sioux City

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-1	Orange City Sioux Center Rock Rapids	28,562	71	85+8/2 = 89 27-8 26-0 32-0	86	0	100
R-8	LeMars Hawarden	22,997	57	66+0 = 66 52-0 14-0	66	0	100
R-9	Battle Creek Cherokee	28,867	72	42+50/2 = 67 0-15 42-35	72	5	93.01
R-18	Onawa	13,916	36	40-0 = 40	40	0	100
B-3	Akron Sioux City - Lutheran Methodist St. Jos. Mercy St. Vincent's Gordon Mem.	113,206	509	438+363/2 = 620 21-0 72-66 146-0 156-145 43-127 0-25	620	0	100
Subtotals	Region "A" Sioux City	207,548	745	671+421/2 = 882 671-421	887	5	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA
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ACUTE GENERAL HOSPITAL SUMMARY

"B" REGION Spencer

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-2		30,846	77	70+0 = 70 32-0 38-0	77	7	90.91
	Sheldon Sibley						
R-3		28,984	(4) 72	133+0 = 133 85-0 48-0	133	0	100
	Estherville Spirit Lake						
R-10		38,196	95	100+12/2 = 106 32-0 19-0 49-0 0-12	106	0	100
	Sac City Alta Storm Lake Sioux Rapids						
I-1		37,562	150	75+42/2 = 96 0-18 27-0 48-24	150	54	100
	Emmetsburg Hartley Spencer						
Subtotals	Region "B" Spencer	135,588	(4) 394	378+54/2 378-54 = 405	466	61	

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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ACUTE GENERAL HOSPITAL SUMMARY

"C" REGION Fort Dodge

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-4	Algona	25,314	63	61-0 61	63	2	96.82
R-11	Clarion Belmond	32,603	81	84+0 84 54-0 30-0	84	0	100
R-12	Webster City	20,032	50	46+32/2 46-32 62	62	0	100
R-21	Jefferson	14,379	36	57-0 57	57	0	100
I-3	Lake City Fort Dodge - St. Jos. Mercy Lutheran	77,967	(31) 312	292+201/2 392 42-0 61-90 189-111	392	0	100
Subtotals	Region "C" Fort Dodge	170,295	(31) 542	540+233/2 540-233 656	658	2	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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ACUTE GENERAL HOSPITAL SUMMARY

"D" REGION Mason City

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-5	Osage Charles City	35,145	88	63+72/2 = 99 63-0 0-72	99	0	100
R-13	Eldora Iowa Falls Hampton	46,808	117	41+84/2 = 83 0-36 41-0 0-48	117	34	70.94
R-46	Britt Forest City Buffalo Center	27,703	69	74+0 = 74 32-0 25-0 17-0	74	0	100
I-2	Mason City Park St. Joseph Mercy	60,153	(33) 241	180+162/2 = 261 0-56 180-106	274	13	95.26
				358+318/2			
Subtotals Region "D" Mason City		169,809	(33) 515	358-318 517	564	47	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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ACUTE GENERAL HOSPITAL SUMMARY

"E" REGION Waterloo

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-6		47,225	118	42+65/2 75	118	43	63.56
	Cresco			42-0			
	Decorah			0-20			
	New Hampton			0-45			
R-14	Grundy Center	14,132	35	40-0 40	40	0	100
R-15		36,827	92	114+0 114	114	0	100
	West Union			22-0			
	Oelwein			55-0			
	Sumner			37-0			
I-4		171,531	(235) 686	357+290/2 502	921	419	54.51
	Independence			38-0			
	Waverly			0-0			
	Cedar Falls			24-36			
	Waterloo - Allen Memorial			83-130			
	Schoitz Mem.			212-0			
	St. Francis			0-124			
				553+355/2			
Subtotals Region "E" Waterloo		269,715	(235) 931	553-355 731	1,193	462	

IOWA STATE DEPARTMENT OF HEALTH
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ACUTE GENERAL HOSPITAL SUMMARY

"F" REGION Dubuque

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-7		37,944	95	136+0 = 136	136	0	100
	Waukon			46-0			
	Postville			32-0			
	Elkader			20-0			
	Guttenberg			38-0			
R-25	Maquoketa	19,248	(12) 48	60-0 = 60	60	0	100
I-5		81,554	(78) 326				
	Dubuque			329+178/2 = 418	418	0	100
	Finley			29-28			
	St. Joseph Mercy			200-150			
	Xavier			100-0			
Subtotals Region "F" Dubuque		138,746	(90) 469	525-178 = 614	614	0	

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ACUTE GENERAL HOSPITAL SUMMARY

"G" REGION Cedar Rapids

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-17	Manchester	18,483	46	66-0 66	66	0	100
R-24	Monticello Anamosa	20,693	(7) 52	53+0 53 53-0 0-0	59	6	89.83
R-31	Marengo	18,894	47	28-4 30	47	17	63.83
I-7	Vinton Cedar Rapids ; Mercy St. Luke's Meth.	169,926	(340) 680	553+146/2 626 36-0 103-146 414-0	1,020	394	61.37
Subtotals Region "G" Cedar Rapids		227,996	(347) 825	700-150 775	1,192	417	

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IOWA STATE DEPARTMENT OF HEALTH
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ACUTE GENERAL HOSPITAL SUMMARY

"H" REGION Davenport

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
I-8	DeWitt Clinton - Jane Lamb Mem. St. Joseph Mercy	55,060	(48) 220	72+104/2 124 32-0 40-49 0-55	268	144	46.27
I-10	Muscatine Davenport - Mercy St. Luke's Osteopathic	163,785	(187) 655	483+90/2 528 139-0 224-0 52-90 68-0	842	314	62.71
Subtotals Region "H" Davenport		218,845	(235) 875	555-194 652	1,110	458	

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ACUTE GENERAL HOSPITAL SUMMARY

"I" REGION Burlington

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-45		44,207	110	116+162/2 197	197	0	100
	Fort Madison			61-60			
	Keokuk - Graham			0-76			
	St. Joseph			55-26			
I-12		65,750	(22) 263	281+106/2 334	334	0	100
	Mt. Pleasant			56-0			
	Burlington - Burlington			206-0			
	Mercy			19-106			
				397+268/2			
Subtotals Region "I" Burlington		109,957	(22) 373	397-268 531	531	0	

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ACUTE GENERAL HOSPITAL SUMMARY

"J" REGION Iowa City

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-35	Washington	19,406	49	0+45/2 0-45 22	49	27	44.90
B-1	Iowa City - Mercy Univ. Hospitals	57,376	(84) 258	431+668/2 765 190-0 241-668	765	0	100
Subtotals Region "J" Iowa City		76,782	(84) 307	431+713/2 431-713 787	814	27	

IOWA STATE DEPARTMENT OF HEALTH
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ACUTE GENERAL HOSPITAL SUMMARY

"K" REGION Ottumwa

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9		TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-34		39,094	98	34+60/2	64	98	34	65.31
	Sigourney			34-0				
	Oskaloosa			0-60				
R-39	Fairfield	15,818	40	58-0	58	58	0	100
R-43	Centerville	16,015	40	82-0	82	82	0	100
R-44		18,977	47	87+0	87	87	0	100
	Bloomfield			71-0				
	Keosauqua			16-0				
I-11		56,589	226	315+0	315	315	0	100
	Albia			37-0				
	Ottumwa - Ottumwa			139-0				
	St. Joseph			139-0				
				576-60/2				
Subtotals Region "K" Ottumwa		146,493	451	576-60	606	640	34	

IOWA STATE DEPARTMENT OF HEALTH
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ACUTE GENERAL HOSPITAL SUMMARY

"L" REGION Des Moines

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-22	Boone	28,037	70	100-0 100	100	0	100
R-23	Nevada Story City Ames	49,327	(28) 123	147+96/2 195 50-0 16-0 81-96	195	0	100
R-29	Guthrie Center	13,607	34	38-0 38	38	0	100
R-30	Newton Grinnell - Grinnell Comm. St. Francis	52,084	(16) 138	94+61/2 125 94-0 0-41 0-20	154	29	81.17
R-32	Greenfield Winterset	23,188	58	68+0 68 29-0 39-0	68	0	100
R-33	Knoxville Pella	25,886	65	64+0 64 30-0 34-0	65	1	98.46
R-37	Creston	13,712	34	0-0 0	34	34	0.00
R-38	Chariton	10,923	27	35-0 35	35	0	100
R-41	Mt. Ayr	7,910	20	30-0 30	30	0	100

(Continued on following page)

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA

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ACUTE GENERAL HOSPITAL SUMMARY

"L" REGION Des Moines (Cont'd.)

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-42	Leon	10,539	26	0-30 15	26	11	57.69
R-47	Osceola	8,222	20	32-0 32	32	0	100
R-48	Corydon	9,800	24	34-0 34	34	0	100
I-6	Marshalltown	57,288	(20) 229	163+62/2 194	249	55	56.22
	Mercy			29-62			
	Evangelical			134-0			
B-2		311,267	(459) 1,401	1,017+357/2 1195	1860	665	64.25
	Perry			38-0			
	Dexter			14-0			
	Redfield			14-0			
	Des Moines						
	Broadlawns			0-147			
	Iowa Lutheran			90-135			
	Iowa Methodist			343-0			
	Mercy			310-0			
	Wilden Osteopathic			35-0			
	Still Osteopathic			0-75			
	Des Moines General			70-0			
	Doctors'			103-0			
				1,822+606/2			
Subtotals Region "L" Des Moines		621,788	(523) 2,269	1,822-606 2,125	2,920	795	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA
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ACUTE GENERAL HOSPITAL SUMMARY

"M" REGION Council Bluffs

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9		TOTAL BEDS ALLOWED BY PL 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED NEED MET 12
R-19	Denison	18,569	46	50-0	50	50	0	100
R-20	Manning Carroll	23,431	59	0+29/2 0-15 0-14	15	59	44	25.42
R-26	Missouri Valley	17,600	44	30-0	30	44	14	68.18
R-27	Harlan	15,825	40	50-0	50	50	0	100
R-28	Atlantic Audubon	28,838	72	66+32/2 36-32 30-0	82	82	0	100
R-36	Corning Red Oak	21,935	55	84+0 41-0 43-0	84	84	0	100
R-40	Clarinda Shenandoah	41,593	104	53+46/2 0-46 53-0	76	104	28	73.08
I-9	Council Bluffs Jennie Edmundson Mercy	96,152	(128) 385	168+60/2 154-60 14-0	198	513	315	38.60
Region"M" Council Bluffs - Subtotals		263,943	(128) 805	501+167/2 501-167	585	986	402	
STATEWIDE -- GRAND TOTALS		2,757,535	1732 9501	8,007-3,717	9,866	12,575	2,709	
	Pool beds in reserve --					891	891	
	Compensated Totals --					13,466	3,600	

13. ~~State Ratio (4.5)(2,757,535)= 12,409~~
14. ~~Excess Beds-Orig. State Plan=+ 1,057~~
15. Total Beds Allowed = 13,466

Replaceable Beds
Suitable Beds
Beds From Population Increase Factor

RELATIVE PRIORITY FOR ACUTE GENERAL HOSPITALS - IOWA

16TH REVISION

AREAS WITH UNMET NEED

AREA	CENTER	% NEED MET
R-37	Creston	0.00
R-20	Carroll	25.42
I-9	Council Bluffs	38.60
R-35	Washington	44.90
I-8	Clinton	46.27
I-4	Waterloo	54.51
I-6	Marshalltown	56.22
R-42	Leon	57.69
I-7	Cedar Rapids	61.37
I-10	Davenport	62.71
R-6	New Hampton	63.56
R-31	Marengo	63.83
B-2	Des Moines	64.25
R-34	Oskaloosa	65.31
R-26	Missouri Valley	68.18
R-13	Iowa Falls	70.94
R-40	Clarinda	73.08
R-30	Newton	81.17
R-24	Anamosa	89.83
R-2	Sibley	90.91
R-9	Cherokee	93.01
I-2	Mason City	95.26
R-4	Algona	96.82
R-33	Pella	98.46

100% AREAS WITH PART OF NEED MET WITH REPLACEABLE BEDS

AREA	CENTER	RATIO	PERCENT REPLACEABLE
B-1	Iowa City	334/765	43.66
R-45	Keokuk	81/197	41.12
R-5	Charles City	36/99	36.36
B-3	Sioux City	182/620	39.35
R-12	Webster City	16/62	25.80
I-3	Fort Dodge	101/392	25.77
R-23	Ames	48/195	24.61
I-5	Dubuque	69/418	16.50
I-12	Burlington	53/334	15.87
I-1	Spencer	21/150	14.00
R-10	Storm Lake	6/106	5.66
R-1	Orange City	4/86	4.65

(A) Replaceable beds/Total beds or % of existing beds which are replaceable

THE FOLLOWING HAVE TOTAL BED-NEED MET AND WITH 100% SUITABLE BEDS

I-11	Ottumwa	R-27	Harlan
R-3	Estherville	R-29	Guthrie Center
R-7	Postville	R-32	Greenfield
R-8	LeMars	R-36	Red Oak
R-11	Humboldt	R-38	Chariton
R-14	Grundy Center	R-39	Fairfield
R-15	Oelwein	R-41	Mt. Ayr
R-17	Manchester	R-43	Centerville
R-18	Onawa	R-44	Bloomfield
R-19	Denison	R-46	Britt
R-21	Jefferson	R-47	Osceola
R-22	Boone	R-48	Corydon
R-25	Maquoketa		

EXHIBIT D

PART II TUBERCULOSIS HOSPITALS

You will note that all facilities for treating tuberculosis in Iowa are operated by political subdivisions. All are county institutions except the state facility at Oakdale, which serves also as a training establishment correlated with the College of Medicine, State University of Iowa.

A continued statewide case finding program has been very successful in locating new cases and bringing them under treatment expeditiously. Sound statistics are available on Iowa's experience in this category for considering future construction needs.

ANNUAL RESIDENT DEATH RATE - IOWA - CALENDAR YEARS

Year	Number
1940	421
1941	370
1942	395

Annual Average Death Rate - 374.8

Maximum Beds Allowed - 2.5 Beds/Death
- (2.5) (374.8)
- 946 Beds

TOTAL ACTIVE AND PROBABLY ACTIVE NEW CASES FOUND - IOWA - BY CALENDAR YEAR

Year	Number
1955	364
1956	311

Average Number - 339.5

Minimum Beds Indicated - 1.5 Beds/New Cases
-(1.5) (339.5)
- 506 Beds

Occupancy - Statewide - of all beds available was 72.8 per cent.

PATIENT LOAD - STATEWIDE - HAS BEEN AS FOLLOWS:

Calendar Year	Total Patient Days Service
1952	240,826
1953	215,667
1954	184,251
1955	168,815
1956	156,169
1957	151,329
1958	146,759
1959	138,870
1960	132,080
1961	112,725

In the light of past experience and usage trends, there is no indicated need for construction of tuberculosis beds,and the category is placed in the lowest priority.

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT Tuberculosis HOSPITAL BEDS AND/OR FACILITIES REGION STATEWIDE

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			Avrg. Length of Stay	% Occupancy	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REGULAR	UNSUIT			PATIENT-DAYS	ADMISSIONS
	State Sanatorium	Johnson	Oakdale	STATE	64	285	0	301	74.3	94,673	315
	Broadlawns Polk County	Polk	Des Moines	COUNTY	0	0	12	24	79.4	3,479	148
	Sunnyslope Sanatorium	Wapello	Ottumwa	COUNTY	63	0	0	297	63.4	14,573	49
	STATEWIDE TOTALS -- TUBERCULOSIS				127	285	12	220	72.8	112,725	512

NR - REPORT DELINQUENT - DATA ESTIMATED
NA - NOT APPLICABLE OR REALISTIC

PART III NERVOUS AND MENTAL HOSPITALS

The field of mental health has been subjected to much discussion in Iowa during the past fifteen years. A series of studies and corrective programs were inaugurated during that time. Historically, Iowa was unique and creditable during earlier decades. In the 1880's, Iowa was outstandingly aggressive and was looked upon with great favor by the authorities in the mental field. The governing body chose to commit the state to the position of assuming responsibility for its mentally ill, thus leaving all other institutions and agencies free to apply their resource and effort toother fields of illness. That program was a universal milestone, observed with great enthusiasm internationally in the mental health field.

This original pattern was leaned upon for fifty years without any regard for advancements being made in the care of the mental patient. Iowa fell far behind because of this lack of change.

In 1945 another of a series of studies was inaugurated and in turn, corrective programs were recommended and publicized. It is interesting to note that during the ten years following the war, approximately 20 million dollars were appropriated for capital improvement of the state mental institutions -- while the values of inventories of these institutions increased only seven million dollars. During this same period of so-called improvements, the record of performance of state institutions continued to decline, if such a thing were possible.

In 1956 still another study was inaugurated and was supported by the guidance of recognized authorities of the field. The voluminous findings of the study were consolidated to a summary along with a recommended pattern of corrective action. The consolidation was reproduced under the title "A Mental Health Program for Iowa," and was dated 20 December 1956. The recommendations were sound and not contradictory to the skeleton program which had been a part of earlier hospital plan revisions of this agency.

The 13th and 14th revisions incorporated refinements which were proposed in the recommendations of the American Psychiatric Association in the above mentioned report. In addition to the specifics of the narrative, the numerical elements in terms of beds were induced into the tabulations of this plan revision.

This 15th revision will not belabor the details of the past studies and their conclusions, inasmuch as they were rather thoroughly extracted and reflected in preceding plan revisions.

The lack of progress in the mental field within this state is not unique to Iowa. Many other states are in a comparable situation. However, this is hardly justification to ignore the fact that there are some states who are proceeding in an aggressive manner and are demonstrating the tremendous possibilities, dollar-wise, which can be realized when subterfuge is overridden and facts are approached aggressively. Because of the dominance of the retrograde states in the nation and because the problem nationally is becoming so very acute, an effort was made through the Surgeon General, U. S. Public Health Service, to provide corrective guidance for the benefit of all. The Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities did pursue the subject through a committee made up of representative spokesmen from all phases, bodies and agencies related to the subject. The results of this committee's activity are published by the U. S. Department of Health, Education and Welfare, and dated January 1961. The purpose of the study and report "is to offer a guide to states in developing adequate mental health facilities." Emphasis is given to the absolute necessity of each state developing a plan which is comprehensive and is coordinated with every other health planning program of the state, including the community mental health services. While the report as a whole is a complete and detailed

approach to this problem, we can do no more than reflect its highlights in this presentation. A summary of the recommendations resulting from this national study are not inconsistent with the basic principles which have been repeated annually in previous revisions of this State Plan. Briefly, this most current study's points include:

(1) The establishment of an authoritative planning body by the governor of the state for the purpose of taking whatever steps are necessary to stimulate development of a comprehensive plan for the mentally ill. The body could be either an existing agency or a new agency, provided there be proper representation of professional and lay groups to truly reflect the users' interest and exclusive of partisanship or patronage.

(2) Establishing priorities and incorporating guide lines and principles for action to be taken toward the accomplishment of a total program and its specific objectives. The program should encompass the entire complex of mental health facilities in a properly integrated manner. In turn, the mental program should be coordinated with all fields of public health and mental health in the state, considering complete inpatient and outpatient psychiatric treatment, care and rehabilitation. Incorporated in their aims would be proper consideration for providing psychiatric service units closer to the using groups while reducing the size of existing ineffectual centralized plants.

(3) This total State Plan should be based upon a comprehensive survey of all existing facilities and services with realistic evaluation of their place in a total program, and from that determine the unmet need. This phase of the analysis should give proper consideration to proposed community mental health activities, existing services, state population patterns and movement, and logical service areas. Simultaneously, thoroughly evaluate existing legislation and administrative procedures preparatory to guiding such legislation as would be essential to permit freedom of adjustment for the upgraded program. In turn, certain areas of need should be given a primary priority for execution to make early expenditures immediately responsive. This same body should be appropriately authorized to preclude splinter activities expending scarce resource locally unless expenditure does complement the total pattern being inaugurated.

(4) Permit inauguration of a well-coordinated and properly oriented program. The political, social, and economic factors should be properly evaluated as they pertain to mental health, preparatory to pursuing means of eliminating any barriers which might impede implementation of a thorough program. Special consideration must be given to the legislative and administrative procedures, realistic financing, provision of qualified and appropriate personnel, and, most important of all, social acceptance by the using population.

(5) In addition to proper execution by the agency proposed above, the program must be supported by a pattern of implementation through stimulating the public interest, public education on the need for adequate financing, the economic advantage of the program, as well as the anticipation of specialized personnel needs.

In general, the above mentioned report, resulting from the Surgeon General's Ad Hoc Committee, has sharpened the detail of recommendations by previous study committees in Iowa outlined in previous revisions. The 1956 Study Committee's recommendations are not inconsistent with the Federal Agency's current skeleton formula.

At this point with the guidance of the several special studies and the conclusions set forth by them, the State Mental Institutions are proceeding toward a

program of intensive treatment. Budget limitations are still stringent and do limit the amount of intensive treatment. Simultaneously, the State Mental Institutions are rescreening their patients and are unloading a considerable volume of these patients into county facilities and nursing homes as defined by Iowa Statutes. It is sincerely hoped that the 60th General Assembly, State of Iowa, will provide legislation that will permit accentuating the intensive treatment phase and will provide funds in keeping with the true needs for accelerating the intensive treatment program.

This State Plan continues to set forth the same conditions for participation in Federal funds to stimulate construction of psychiatric facilities as units adjunct to acute general hospitals so that the construction dollar will serve from 2 to 30 times as many admissions as the equivalent expenditure in our long term care institutions.

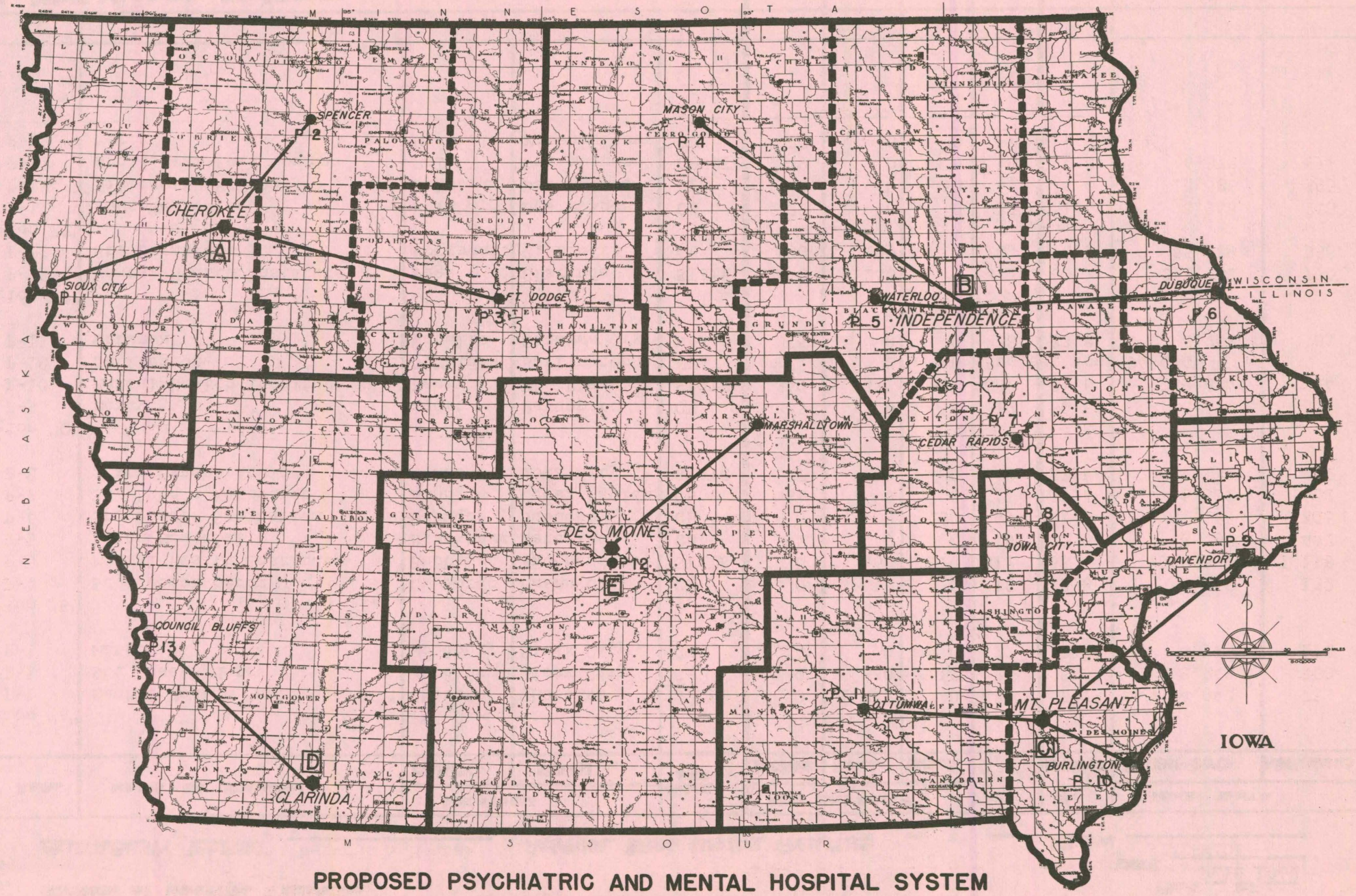
Federal assistance will be available only to facilities which will present, upon application, a total program approvable in the light of current standards for intensive treatment units, and proof that the means for administering, staffing and financing the operational phase of such an undertaking exists. In no instance will program funds be made available for long-term domiciliary facilities. Unless the proposal positively provides the means for a well-qualified staff to aggressively administer intensive treatment in accord with the best standards available today, the moneys will be diverted to other categories. The qualifications of each proposal will be indicated in a presentation by the sponsors. The application must be supplemented by the detailed program being planned for the proposed facility. This principal shall govern in the case of proposed replacement of structures which are presently declared unsuitable. Outright replacement would merely insure continuance of the grossly inadequate and uneconomical care which currently dominates the mental illness program in Iowa.

SUMMARIZATION OF RECOMMENDATIONS FROM
"A MENTAL HEALTH PROGRAM FOR IOWA"
BY GOVERNOR'S COMMITTEE ON MENTAL HEALTH

The following recapitulation reflects the recommendations made by the Governor's Study Committee for application to the state mental institutions. The qualifications necessary for an approvable application for grants-in-aid have already been set forth in terms of intensive treatment program, available qualified staff and sound financial means for executing the total program.

LOCATION OF FACILITY	EXISTING SUITABLE PLUS REPL. BEDS	PROPOSED BEDS FOR SPECIAL PURPOSES					TOTAL BEDS PROPOSED
		DISTURBED CHILDREN'S UNIT	CRIMINALLY "INSANE" UNIT	T.B. DISTURBED UNIT	TO REPLACE UNSUITABLE EXISTING FACILITIES	FOR UNMET BED-NEED EXISTING & KNOWN	
Cherokee	1,272	50	0	0	0	0	1,322
Independ.	560	50	0	0	520	17	1,147
Mt. Pleasant	621	0	0	0	559	0	1,180
Clarinda	1,246	0	0	0	0	0	1,246
Des Moines	0	50	75	75	0	0	200
STATEWIDE	3,699	150	75	75	1,079	17	5,095
Beds Indicated in Need Report	3,699		Total of Combined 1,396		Beds to be Added		5,095

The recommendations of the Study Committee also entailed a pattern of coordination in Polk County between state, county, city, charitable and non-profit institutions which, in the judgment of this agency, is extremely remote at this time. Accordingly, no effort was made to induce such thinking into the current revision. A bed reserve is withheld to permit future modification of the State Plan in a manner that will realistically correlate new developments into the total pattern.



PROPOSED PSYCHIATRIC AND MENTAL HOSPITAL SYSTEM

STATE OF IOWA

IOWA

● PSYCHIATRIC UNITS

⬢ STATE MENTAL HOSPITALS WITH INTENSIVE AND LONG TERM

IOWA STATE DEPT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA
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DATE 1 July 1962

SUITABILITY REPORT Nervous & Mental HOSPITAL BEDS AND/OR FACILITIES REGION STATEWIDE

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			Avrg. Length of st	% OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REGULAR	UNSUIT			PATIENT-DAYS	ADMISSIONS
Region "A"											
P-1	Mental Health Institute	Cherokee	Cherokee	STATE	0	1,272	0	483	76.3	354,042	733
P-1	St. Joseph Mercy	Woodbury	Sioux City	CH	0	30	12	23	53.8	8,243	360
P-1	Methodist	Woodbury	Sioux City	CH	14	0	0	27	89.5	4,575	172
Region "B"											
P-4	St. Joseph Mercy	C. Gordo	Mason City	CH	0	16	0	19	43.8	2,555	132
P-5	Mental Health Institute	Buchanan	Independence	STATE	0	560	520	312	88.4	348,391	1,118
P-5	Allen Memorial	Blackhawk	Waterloo	CH	32	0	0	79	72.6	8,482	442
P-6	St. Joseph Sanitarium	Dubuque	Dubuque	CH	0	0	230	45	21.5	36,145	806
P-7	St. Luke's Methodist	Linn	Cedar Rapids	CH	31	0	0	11	55.7	6,312	600
P-8	State Psychopathic	Johnson	Iowa City	STATE	27	60	0	48	87.4	19,131	402
Region "C"											
P-9	Mercy	Scott	Davenport	CH	35	0	0	12	50.6	6,472	527
P-10	Mental Health Institute	Henry	Mt. Pleasant	STATE	240	381	587	437	81.6	359,684	824
P-10	Burlington	D.Moines	Burlington	NPA	22	0	0	Project Iowa		94 C/GN	
P-11	Ottumwa	Wapello	Ottumwa	NPA	25	0	0	28	23.8	2,258	81
Region "D"											
P-13	Mental Health Institute	Page	Clarinda	STATE	0	1,246	0	375	60.2	273,842	730
P-13	St. Bernard's	Pottawat.	C. Bluffs	CH	100	100	0	103	76.1	55,519	538
Region "E"											
P-12	Iowa Methodist	Polk	Des Moines	CH	22	0	0	37	111.4	8,948	240
P-12	Hillcrest (Retreat)	Polk	Des Moines	NPA	0	0	50	45	74.4	13,586	305
P-12	Broadlawns Polk County	Polk	Des Moines	COUNTY	19	0	0	10	91.8	6,373	671
P-12	Mercy	Marshall	Marshalltown	CH	22	0	0	Project Iowa-95			
	STATEWIDE TOTALS --				589	3,665	1,399	174	73.8	1,514,568	8,681
						5,653					

NR - REPORT DELINQUENT - DATA ESTIMATED
NA - NOT APPLICABLE OR REALISTIC

IOWA STATE DEPARTMENT OF HEALTH — 15TH REVISION

DIVISION OF HOSPITAL SERVICES — 1 JULY 1962

RELATIVE PRIORITY TABLE - NERVOUS/MENTAL FACILITIES — PAGE 1 OF 1

BASIC REGIONAL DATA				PRIORITY ANALYSIS			BED ANALYSIS TO BE ADDED			% NEED MET
AREA	CENTER	POPULATION	EXIST. BEDS SUIT./REGNL.	RURALITY FACTOR	INCOME FACTOR	GROSS FACTOR	TREAT.	T'CH'G	TOTAL	
INTENSIVE TREATMENT FACILITIES										
P-2	Spencer	135,588	0-0	1.4433	0.9737	2.4170	136	0	136	0.00
P-3	Fort Dodge	170,295	0-0	1.3623	1.0012	2.3636	170	0	170	0.00
P-6	Dubuque	138,746	0-0	1.0769	1.0778	2.1547	139	0	139	0.00
				Henceforth, equivalent existing beds						
P-4	Mason City	169,909	0-16		8		162	0	170	4.71
P-12	Des Moines	621,788	63-0		63		559	580	1,202	5.24
	Iowa Meth. 22-0									
	Broadlawns 19-0									
	Marshalltn. 22-0									
P-8	Iowa City	76,782	27-60		57		20	895	972	5.86
P-7	Cedar Rapids	227,996	31-0		31		197	90	318	9.75
P-5	Waterloo	269,715	32-0		32		238	0	270	11.85
P-1	Sioux City	207,548	14-30		29		179	10	218	13.30
	St. Joseph 0-30									
	Methodist 14-0									
P-9	Davenport	218,845	35-0		35		184	10	229	15.28
P-11	Ottumwa	146,493	25-0		25		121	0	146	17.12
P-10	Burlington	109,975	22-0		22		88	0	110	20.00
P-13	Council Bluffs	263,943	100-100		150		114	20	284	52.81
SUBTOTAL -- INTENSIVE TRTMT.			349-206		452		2,307	1,605	4,364	
LONG-TERM MENTAL FACILITIES										
A	Cherokee	513,441	0-1272		1,272		50	0	1,322	
B	Independence	806,276	0-560		560		615	0	1,175	
C	Mt. Pleasant	552,087	240-381		621		559	0	1,180	
D	Clarinda	263,943	0-1246		1,246		0	0	1,246	
E	Des Moines	621,788	0-0		0		200	0	200	
SUBTOTAL -- LONG-TERM FACIL.			240-3459		3,699		1,424	0	5,123	
CONTINGENCY POOL BEDS: This reservoir is withheld from specific assignment to permit extension of this Plan into the area of State Institutions without disturbing local planning. When State facilities are functioning autonomously under professional guidance, staffed realistically for total intensive treatment, financed soundly and assure reasonable continuity by national standards, this area will be reviewed for extending the program in keeping with the prevailing circumstances.										
SUBTOTAL -- CONTINGENCY/POOL BEDS							4,001	300	4,301	
STATEWIDE TOTALS--		2,757,535	589-3665		4,151		7,732	1,905	13,788	

PART IV. PUBLIC HEALTH CENTERS

The definite need for adequate public health facilities in each state is recognized in the Federal Act as a part of the coordinated hospital system.

In addition to providing hospital and medical care for those who are ill, considerable effort and funds should be expended in improving and protecting the health of the people.

Health centers are buildings furnishing office space for the local health officer and other personnel, laboratories, and other facilities required to carry on a proper public health program. The health center building must be publicly owned.

In order to provide adequate local public health services to all people of the state, the State Department of Health has proposed the establishment of 27 county or multi-county health departments, and a public health center is recommended for each of these departments, as shown on the following Public Health Centers Report.

The one acceptable public health center at Burlington, Iowa is indicated by the letters EPHC. All others are proposed public health centers. These facilities were discussed in detail in the "Report on Hospital and Public Health Resources," dated December 8, 1947.

Existing state laws do not permit political subdivisions to levy specific taxes for the support of health activities. Further, the present law does not permit cities and counties and contiguous counties to pool resources in order to maintain, jointly, a full-time health service. Anticipating the remedying of this situation in the next legislature, a definite program for the construction of public health centers is established.

Priority will be given to public health centers upon application after the city, city-county or multi-county health department presents evidence that it will maintain an adequately staffed and full-time department in accordance with criteria established by the Iowa State Department of Health.

The public health centers proposed for Iowa fall into two categories based upon the principal problems confronting the unit; namely:

1. County health departments dealing with the problems resulting from a rapidly growing urban community, and

2. Multi-county health departments dealing with the health problems of a fairly stable or even slightly decreasing rural population.

In view of the fact that only one public health center exists in this state, all proposed health centers were evaluated and priorities were based upon factors affecting public health.

The public health problems of a densely populated and growing urban community are more intense than those of a rural area. This fact is demonstrated by the existence of several part-time health departments in counties with a rapidly growing city. It is felt that the experience gained by counties with part-time health services and recognition of the possibilities offered by a full-time health service

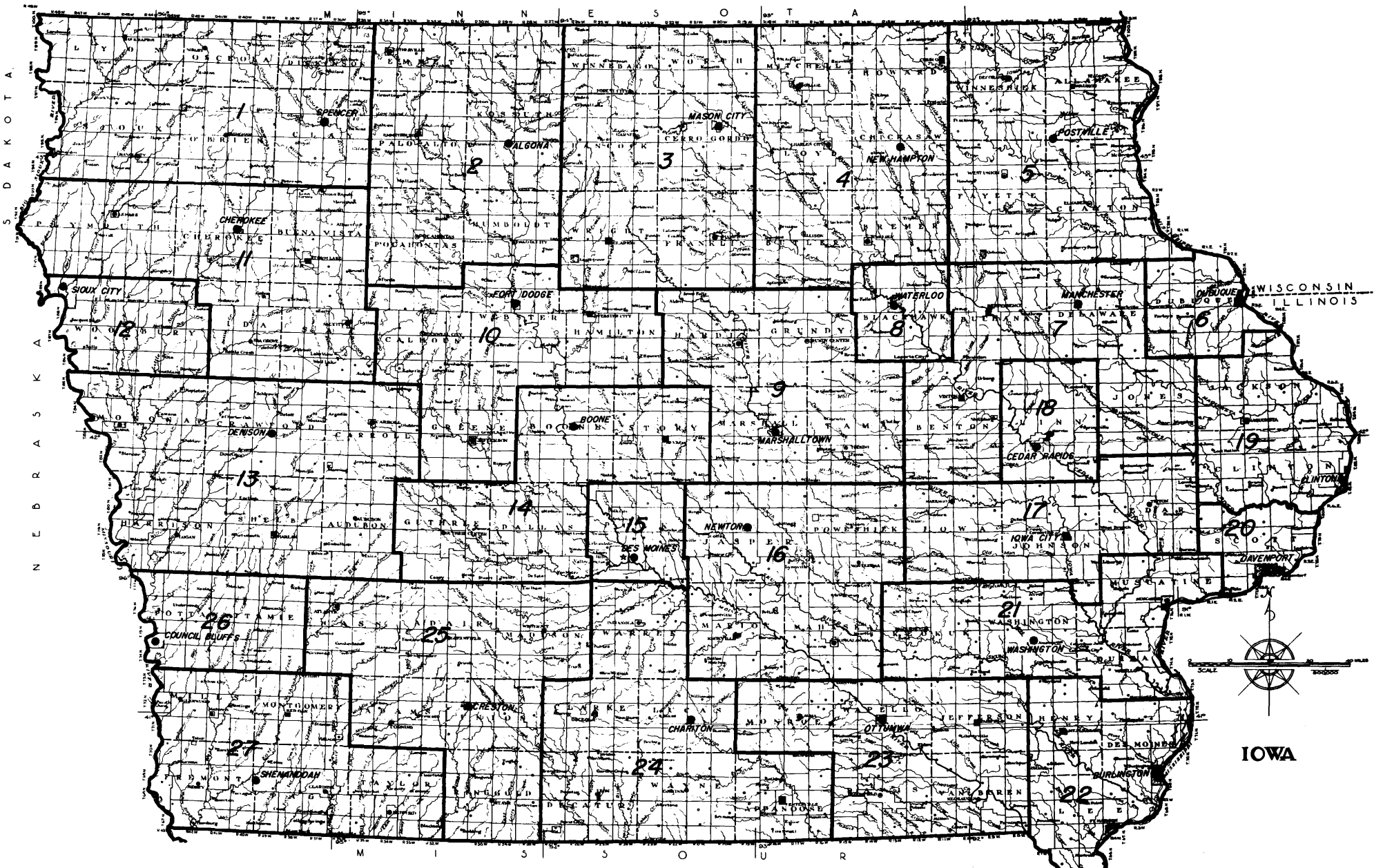
will cause these counties to organize a full-time county health service first.

In an effort to accomplish the greatest good for the greatest population with the limited funds available, the county health departments are given preference in programming. The priority within the county unit category is based upon population growth, population density, and the taxable property factor. The area with the greatest rate of population increase, greatest population density, and the least per capita taxable property value receives the highest priority. These factors were weighed equally and are relative to the state average.

The results and relative priorities are tabulated in the Relative Need Report for Public Health Centers.

The organization of multi-county health departments will be influenced by the degree of rurality, per capita wealth and per capita income. Public health problems will be greatest in the low income and low per capita property value areas. Solution of these problems will be most difficult and time consuming in the rural areas; therefore, the area with the highest priority would be the most rural area with the lowest per capita wealth and income. These three factors were given equal weight. Relative priority of the 20 multi-county health units programmed is tabulated in the Relative Need Report.

It is impossible to anticipate the location of future wars, industries in the state and the impact such industries may have upon the public health problems of the community. Rather than make erroneous decisions at this time, it is proposed that these situations be handled as they develop while reserving the right to correct the public health center priorities accordingly.



IOWA

PROPOSED PUBLIC HEALTH CENTERS

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES
PUBLIC HEALTH CENTER REPORT
MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS IN STATE IS 87

1 JULY 1962

IOWA

15TH REVISION

POLITICAL SUBDIVISION WHICH EXISTING/PROPOSED FACILITY WILL SERVE	POLITICAL SUBDIVISION POPULATION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES				DESCRIPTION OF AUXILIARY FACILITIES
			EXISTING SUITABLE		PROGRAMMED		
			P.H.C.	AUXILIARY	P.H.C	AUXILIARY	
SPENCER	100,825						
Clay County	18,504						
Dickinson County	12,574						
Lyon County	14,468	Multi-County					
O'Brien County	18,840	Health Department	0	0	1	0	
Osceola County	10,064	No. 1					
Sioux County	26,375						
ALGONA	82,311						
Emmet County	14,871						
Humboldt County	13,156	Multi-County					
Kossuth County	25,314	Health Department	0	0	1	0	
Palo Alto County	14,736	No. 2					
Pocahontas County	14,234						
MASON CITY	122,775						
Cerro Gordo County	49,894						
Franklin County	15,472	Multi-County					
Hancock County	14,604	Health Department	0	0	1	0	
Winnebago County	13,099	No. 3					
Worth County	10,259						
Wright County	19,447						

IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

PUBLIC HEALTH CENTER REPORT

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS IN STATE IS 87

1 JULY 1962

IOWA

15TH REVISION

POLITICAL SUBDIVISION WHICH EXISTING/PROPOSED FACILITY WILL SERVE	POLITICAL SUBDIVISION POPULATION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES				DESCRIPTION OF AUXILIARY FACILITIES
			EXISTING SUITABLE		PROGRAMMED		
			P.H.C.	AUXILIARY	P.H.C.	AUXILIARY	
HAMPTON	101,488						
Bremer County	21,108						
Butler County	17,467						
Chickasaw County	15,034	Multi-County					
Floyd County	21,102	Health Department	0	0	1	0	
Howard County	12,734	No. 4					
Mitchell County	14,043						
POSTVILLE	88,176						
Allamakee County	15,982						
Clayton County	21,962	Multi-County					
Fayette County	28,581	Health Department	0	0	1	0	
Winneshiek County	21,651	No. 5					
DUBUQUE							
Dubuque County	80,048	Co. Health Dept. #6	0	0	1	0	
MANCHESTER	84,891						
Benton County	23,422						
Buchanan County	22,293	Multi-County					
Delaware County	18,483	Health Department	0	0	1	0	
Jones County	20,693	No. 7					

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IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

PUBLIC HEALTH CENTER REPORT

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS IN STATE IS 87

1 JULY 1962

IOWA

15TH REVISION

POLITICAL SUBDIVISION WHICH EXISTING/PROPOSED FACILITY WILL SERVE	POLITICAL SUBDIVISION POPULATION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES				DESCRIPTION OF AUXILIARY FACILITIES
			EXISTING SUITABLE		PROGRAMMED		
			P.H.C.	DIVISION	P.H.C	DIVISION	
WATERLOO							
Black Hawk County	122,482	Co. Health Dept. #8	0	0	1	0	
MARSHALLTOWN	96,062						
Grundy County	14,132						
Hardin County	22,533	Multi-County					
Marshall County	37,984	Health Department	0	0	1	0	
Tama County	21,413	No. 9					
FORT DODGE	98,144						
Calhoun County	15,923						
Greene County	14,379	Multi-County					
Hamilton County	20,032	Health Department	0	0	1	0	
Webster County	47,810	No. 10					
CHEROKEE	90,969						
Buena Vista County	21,189						
Cherokee County	18,598	Multi-County					
Ida County	10,269	Health Department	0	0	1	0	
Plymouth County	23,906	No. 11					
Sac County	17,007						

IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

PUBLIC HEALTH CENTER REPORT

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS IN STATE IS 87

1 JULY 1962

IOWA

15TH REVISION

POLITICAL SUBDIVISION WHICH EXISTING/PROPOSED FACILITY WILL SERVE	POLITICAL SUBDIVISION POPULATION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES				DESCRIPTION OF AUXILIARY FACILITIES
			EXISTING SUITABLE		PROGRAMMED		
			P.H.C.	CLINIC(S)	P.H.C.	CLINIC(S)	
SIOUX CITY							
Woodbury County	107,849	Co. Health Dept. #12	0	0	1	0	
DENISON	100,260						
Audubon County	10,919						
Carroll County	23,431						
Crawford County	18,569	Multi-County					
Harrison County	17,600	Health Department	0	0	1	0	
Monona County	13,916	No. 13					
Shelby County	15,825						
BOONE	115,094						
Boone County	28,037						
Dallas County	24,123	Multi-County					
Guthrie County	13,607	Health Department	0	0	1	0	
Story County	49,327	No. 14					
DES MOINES							
Polk County	266,315	Co. Health Dept. #15	0	0	1	0	
NEWTON	104,070						
Jasper County	35,282						
Mahaska County	23,602	Multi-County					
Marion County	25,886	Health Department	0	0	1	0	
Poweshiek County	19,300	No. 16					

IOWA STATE DEPARTMENT OF HEALTH

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POLITICAL SUBDIVISION WHICH EXISTING/PROPOSED FACILITY WILL SERVE	POLITICAL SUBDIVISION POPULATION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES				DESCRIPTION OF AUXILIARY FACILITIES
			EXISTING SUITABLE		PROGRAMMED		
			P.H.C.	DIVISION	P.H.C.	DIVISION	
IOWA CITY	87,850						
Cedar County	17,791	Multi-County					
Johnson County	53,663	Health Department	0	0	1	0	
Iowa County	16,396	No. 17					
CEDAR RAPIDS							
Linn County	136,899	Co. Health Dept. #18	0	0	1	0	
CLINTON	75,814						
Clinton County	55,060	Multi-County Health	0	0	1	0	
Jackson County	20,754	Department No. 19					
DAVENPORT							
Scott County	119,067	Co. Health Dept. #20	0	0	1	0	
WASHINGTON	79,028						
Keokuk County	15,492						
Louisa County	10,290	Multi-County					
Muscatine County	33,840	Health Department	0	0	1	0	
Washington County	19,406	No. 21					

IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

PUBLIC HEALTH CENTER REPORT

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IOWA

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POLITICAL SUBDIVISION WHICH EXISTING/PROPOSED FACILITY WILL SERVE	POLITICAL SUBDIVISION POPULATION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES				DESCRIPTION OF AUXILIARY FACILITIES
			EXISTING SUITABLE		PROGRAMMED		
			P.H.C.	DIVISION	P.H.C.	DIVISION	
BURLINGTON	106,999						
Des Moines County	44,605	Multi-County					
Henry County	18,187	Health Department	1	0	0	0	
Lee County	44,207	No. 22					
OTTUMWA	91,384						
Davis County	9,199						
Jefferson County	15,818	Multi-County					
Monroe County	10,463	Health Department	0	0	1	0	
Van Buren County	9,778	No. 23					
Wapello County	46,126						
CHARITON	76,328						
Appanoose County	16,015						
Clarke County	8,222	Multi-County					
Decatur County	10,539	Health Department	0	0	1	0	
Lucas County	10,923	No. 24					
Warren County	20,829						
Wayne County	9,800						

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

PUBLIC HEALTH CENTER REPORT

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS IN STATE IS 87

1 JULY 1962
IOWA
15TH REVISION

POLITICAL SUBDIVISION WHICH EXISTING/PROPOSED FACILITY WILL SERVE	POLITICAL SUBDIVISION POPULATION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES				DESCRIPTION OF AUXILIARY FACILITIES
			EXISTING SUITABLE		PROGRAMMED		
			P.H.C.	DIVISION	P.H.C.	DIVISION	
CRESTON	70,197						
Adair County	10,893						
Adams County	7,468	Multi-County					
Cass County	17,919	Health Department	0	0	1	0	
Madison County	12,295	No. 25					
Ringgold County	7,910						
Union County	13,712						
COUNCIL BLUFFS							
Pottawattamie County	83,102	Co. Health Dept. #26	0	0	1	0	
Shenandoah	69,110						
Fremont County	10,282						
Mills County	13,050	Multi-County					
Montgomery County	14,467	Health Department	0	0	1	0	
Page County	21,023	No. 27					
Taylor County	10,288						
STATE TOTAL --	2,757,537		1	0	26	0	

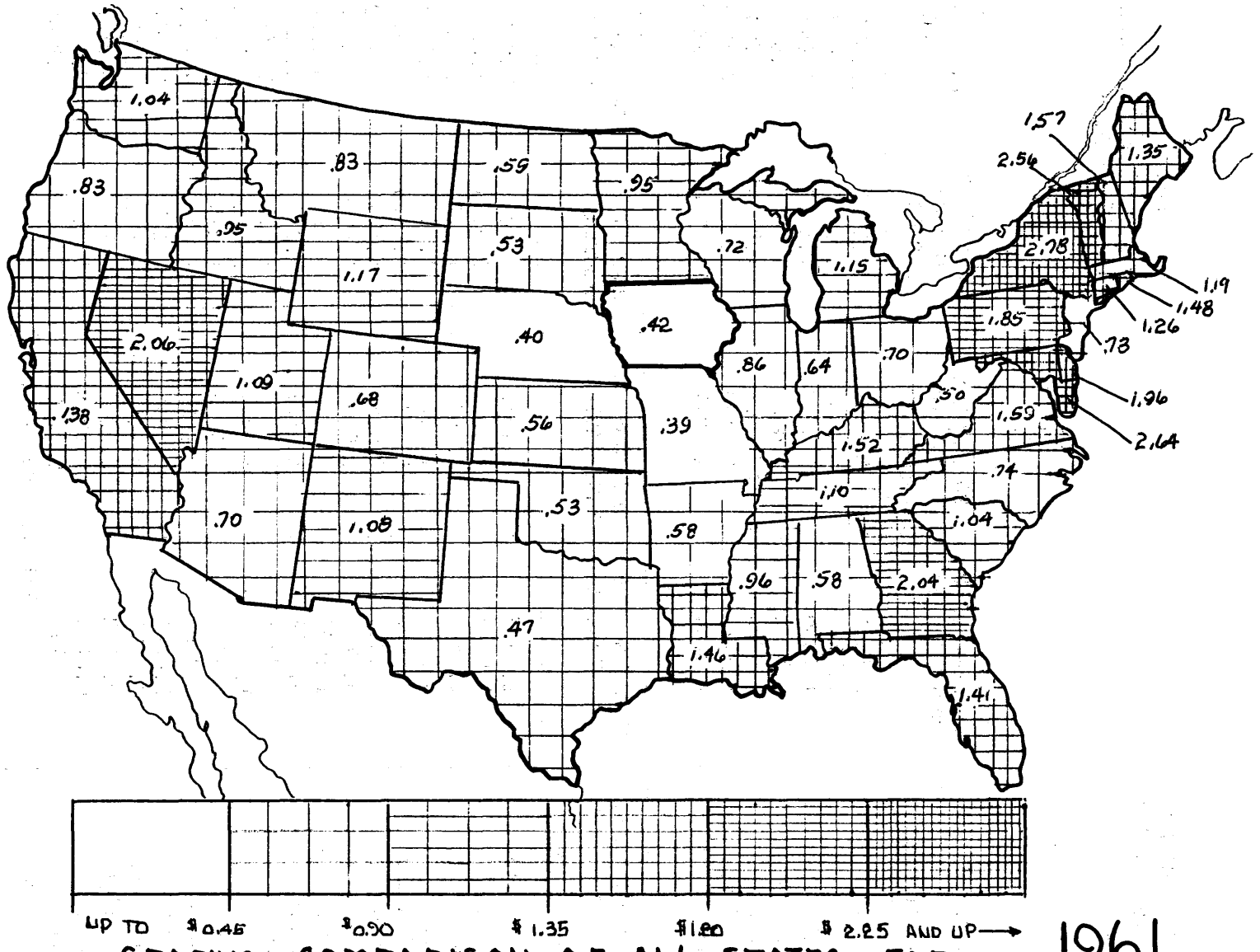
IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

RELATIVE NEED REPORT
PUBLIC HEALTH CENTERS
15th Revision

1. Page 1 of 1
2. Date July 1, 1962
3. State Iowa

CITY-COUNTY UNITS		TAXABLE PROPERTY FACTOR	POPULATION DENSITY FACTOR	POPULATION INCREASE FACTOR	PRIORITY FACTOR
NO.	LOCATION				
15	Des Moines	1.1661	8.8227	1.0857	11.0745
20	Davenport	1.1224	5.2531	1.1065	7.4820
8	Waterloo	1.2360	4.2780	1.1307	6.6447
18	Cedar Rapids	1.1011	3.4559	1.1061	5.6631
6	Dubuque	1.4263	2.6997	1.0774	5.2034
12	Sioux City	1.2472	2.5199	0.9832	4.7503
26	Council Bluffs	1.2464	1.5977	1.0156	3.8597

MULTI-COUNTY UNITS		TAXABLE PROPERTY FACTOR	PER CAPITA INC. FACTOR	RURALITY FACTOR	PRIORITY FACTOR
NO.	LOCATION				
24	Centerville	1.1945	1.2612	1.4893	3.9450
5	Postville	1.0148	1.1593	1.6315	3.8056
14	Boone	1.0597	0.9620	1.7454	3.7671
25	Creston	0.9450	1.1376	1.5341	3.6167
4	New Hampton	0.9672	1.2139	1.3116	3.4927
13	Denison	0.8385	1.0599	1.5455	3.4439
1	Spencer	0.7754	0.9694	1.6376	3.3824
23	Ottumwa	1.3096	1.1118	0.9742	3.3956
7	Manchester	0.8858	1.1127	1.3299	3.3284
2	Algona	0.7528	0.9453	1.5513	3.2494
16	Newton	1.0031	1.0541	1.1617	3.2189
21	Washington	0.9995	0.9752	1.2353	3.2110
11	Cherokee	0.7203	0.9372	1.4989	3.1564
17	Iowa City	1.0241	0.8995	1.1770	3.1006
9	Marshalltown	0.8013	0.9447	1.3511	3.0971
10	Fort Dodge	0.8202	0.9738	1.2210	3.0150
3	Mason City	0.8284	0.9308	1.2171	2.9763
19	Clinton	1.0728	0.9763	0.8457	2.8948
22	Burlington	--Existing Facility--			



GRAPHIC COMPARISON OF ALL STATES FOR 1961

$ DOLLARS $ PER CAPITA PER YEAR APPROPRIATED FOR PUBLIC HEALTH

AS RECAPPED BY U S P H S

IOWA STATE DEPT OF HEALTH
DIV OF HOSPITAL SERVICES

PART V HOSPITALS FOR THE CHRONICALLY ILL

Another category of hospital, facilities for serving the chronically ill, is becoming increasingly important. Its possibilities are apparent as more refined evaluation of hospital usage becomes available, and the development of the role of progressive care is recognized. Included within the chronic category would be the consideration for gerontology and geriatrics, the study of the aging process, one more phase of chronic illness. In the case of Iowa it is an extremely important element, inasmuch as 12 per cent of our population is over the age of 65.

The mission of this plan, as was stated previously, is to provide a pattern of hospital facilities serving portions of the state's population as effectively as possible and, simultaneously, economical expenditure of available talent, community resource, and the individuals' resource toward maximum effectiveness. The pattern of progressive care proposed is still another consideration in this mission. The chronic illness facility is that element of progressive care which is capable of meeting the requirements of patients who have need for intensive care but a lesser amount of same. Included in these needs, quite probably, will be the long-term medical supervision, skilled nursing care, therapies, diagnostic facilities, and whatever else may be indicated, with particular emphasis on the rehabilitation program. The intent of this treatment program will be to re-establish the person with the maximum degree of self-sufficiency which his limitations will permit. This is not to be construed as being a facility which will merely sustain the patient in anticipation of continuous nursing care.

Because the relative need between categories indicates greatest need for this classification, chronic illness projects proposed will enjoy the highest priority among hospital categories. Such facilities shall be centered on population groups and coincide with the elements of the over-all referral pattern proposed for general hospitals so as to assure reasonable accessibleness of these unique facilities and the related special talents.

The applicant, upon acquainting himself with the above discussion, should take particular note regarding the proper difference between nursing home, as defined for this particular program, and the chronic illness facilities described. For obvious reasons such differential will be emphasized lest it be construed that an applicant could exercise the chronic illness priority in an effort to realize a nursing home facility. The intent of the basic legislation for this program was to give appropriate preference to the most needed facilities. To assure such recognition and application of this intent, means were created for recourse in the event a finished facility is utilized for purposes other than that which was indicated in the course of placing an application.

Sponsors seeking a grant for construction of a chronic illness unit shall submit a comprehensive narrative description of their total proposed program in support of the basic documentation involved. Included will be:

(1) An accurate description of the proposed nursing unit, the supportive facilities which are to be created, as well as those supportive services which already exist.

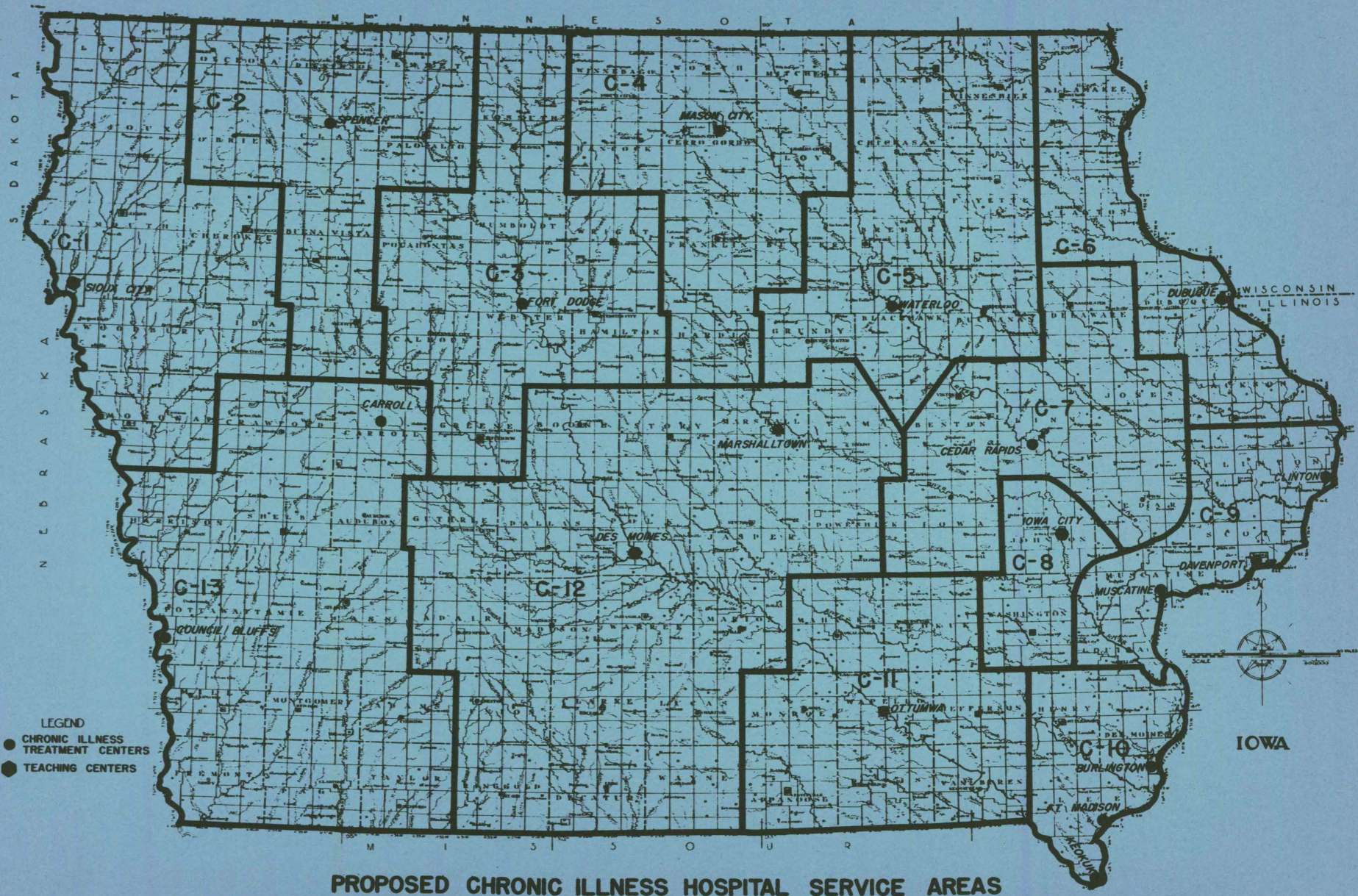
(2) A description of the related and appropriately contiguous services and facilities which are pertinent for a total chronic unit, including diagnosis, treatment, therapy, and the other basic considerations.

(3) The narrative shall specifically describe the adequacy and availability of well-qualified specialized personnel in keeping with the needs of the proposed unit.

(4) The entire presentation shall include a realistic analysis of the funds and resource which will be available for the initial construction of the unit and, successively, a realistic evaluation of foreseeable income with which to operate the finished unit.

The approvable application received in this office will be comprehensively reviewed by the Iowa Advisory Council for Hospitals and Related Health Facilities. In the event that body requires additional specific information to clarify the initial application, it will be necessary to supplement your presentation with such data, either orally or in writing, as may be specified. The application will be thoroughly evaluated on the basis of its merits and in the light of your total presentation in determining the approvableness of the application.

The following map indicates the regional designation for chronic illness facilities. Subsequently, the inventory and the relative priority table reflect the basis and the sequence of priority in which applications for grants will be considered, and also sets forth such limitations as may be applicable.



PROPOSED CHRONIC ILLNESS HOSPITAL SERVICE AREAS

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA
PAGE 1 OF 1
DATE July 1, 1962

SUITABILITY REPORT Chronic Illness HOSPITAL BEDS AND/OR FACILITIES REGION STATEWIDE

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			Avr'g Length of sta	4/4 OCCUPANCY	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REMOD.	UNSUIT			PATIENT-DAYS	ADMISSIONS
C-2	Buena Vista County	B. Vista	Storm Lake	CO	49	0	0		Project Iowa-110		
C-8	University Hospitals	Johnson	Iowa City	STATE	192	0	0		Project Iowa-112		
C-8	U.Sch. f/Severely Handic.Ch.	Johnson	Iowa City	STATE	51	0	0	70	71.7	13,340	191 (1)
C-8	Mercy	Johnson	Iowa City	CH	43	0	0	16	139.3	21,859	1,395
C-9	Mercy	Scott	Davenport	CH	86	0	0	91	67.0	21,030	231
C-10	St. Joseph's	Lee	Keokuk	CH	26	0	0		Project Iowa-91		
C-11	Ottumwa	Wapello	Ottumwa	NPA	46	0	0	170	77.0	3,542	21
C-12	Iowa Methodist	Polk	Des Moines	CH	120	0	0	43	23.6	10,321	242
	(1) Project Only Operates 295 Days of Year.										
	STATEWIDE TOTALS --				613	0	0	33.2	NA	69,092	2,080

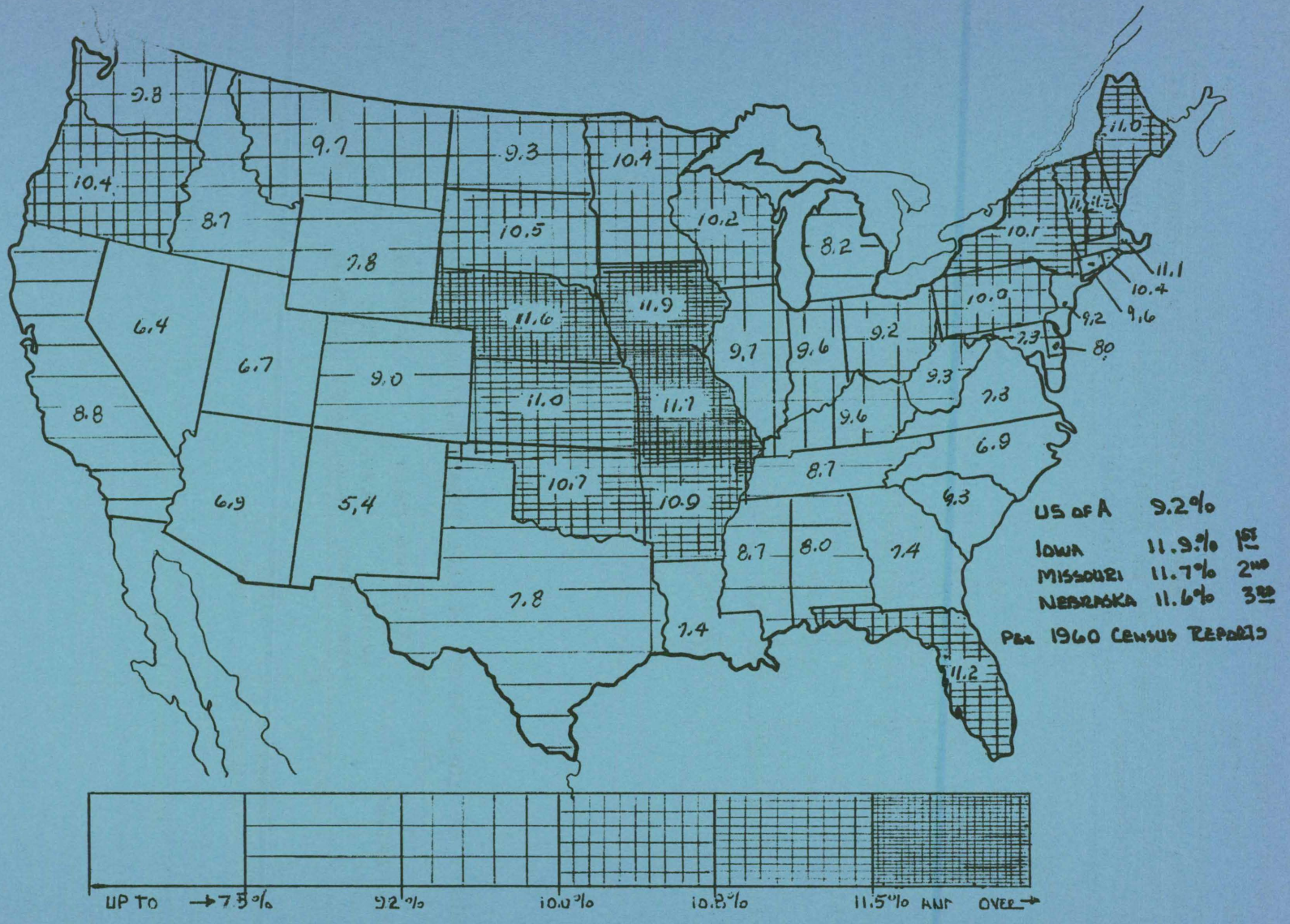
R - REPORT DELINQUENT - DATA ESTIMATED
NA - NOT APPLICABLE OR REALISTIC

RELATIVE NEED REPORT — IOWA
15TH REVISION - IOWA HOSPITAL PLAN — 1 JULY 1962
CHRONIC ILLNESS FACILITIES — PAGE 1 OF 1

BASIC REGIONAL DATA				BED ANALYSIS				"D" % PRIORITY ANALYSIS		
				TO BE ADDED						
AREA	CENTER	POPULATION	EXIST'G SUIT-ABLE	TREAT.	T'CH'G	TOTAL	% NEED MET	RURALITY FACTOR	INCOME FACTOR	GROSS FACTOR
C-3	Fort Dodge	170,295	0	170	0	170	0	1.0013	1.3623	2.3636
C-13	Council Bluffs	263,943	0	264	20	284	0	1.1055	1.2261	2.3322
C-4	Mason City	169,809	0	170	0	170	0	0.9981	1.2490	2.2471
C-6	Dubuque	138,746	0	139	0	139	0	1.0778	1.0769	2.1547
C-5	Waterloo	269,715	0	270	0	270	0	1.0225	0.9636	1.9861
C-1	Sioux City	207,548	0	208	10	218	0	0.9737	0.9959	1.9696
C-7	Cedar Rapids	227,996	0	228	90	318	0	0.9513	0.9333	1.8846
C-12	Des Moines	621,788	120	502	580	1,202	9.98			
C-10	Burlington	109,957	26	84	0	110	23.63			
C-8	Iowa City	76,782	286	37	649	972	29.42			
C-11	Ottumwa	146,493	46	100	0	146	31.51			
C-2	Spencer	135,588	49	87	0	136	36.03			
C-9	Davenport	218,845	86	133	10	229	37.72			
STATEWIDE TOTALS--		2,757,535	613	2,392	1,359	4,364	14.05%			

COMPOSITE SUMMARY OF LONG-TERM SKILLED TREATMENT/NURSING BEDS

CATEGORIES OF RATIOS		EXISTING BEDS: WITHIN AREA RATIOS	EXISTING BEDS: BEYOND AREA RATIOS	PROPOSED BEDS TO BE BUILT	TOTAL BEDS PROPOSED
Chronic Beds					
Treatment=1/1000 Population		370	0	2,389	2,759
Teaching =5/Post.Grad Man-Year		243	0	1,362	1,605
Nursing Homes					
3/1000 Population		1,891	112	6,382	8,385
Pool Beds					
Basic 1/1000 Pop.=	2,758				
Less Teaching	- 1,605				
Less Beds Beyond Area Ratios	- 112				
Less Fraction Adj.	- 2				
	1,039	---	---	1,039	1,039
STATEWIDE TOTALS --		2,504	112	11,172	13,788



GEOGRAPHIC COMPARISON - BETWEEN STATES - OF % OF POPULATION OVER 65 YEARS OLD

IOWA STATE DEPT. OF HEALTH
DIV. OF HOSPITAL SERVICES

MEDICAL FACILITIES

The preceding sections and paragraphs have discussed the subject of hospitals, both general and specialized units, in keepingwith the definitions set forth.

During the past 100 years there has been a considerable evolution in the area of hospital facilities. Each step has been directly attributable to easily recognized circumstances. Early hospitals were the means of collecting the ill to permit administering skilled care by nurses, as well as to create a less unfavorable environment in which the doctors could treat their patients.

In our own instance, hospitals came into being with increase in density of population. Another facet was that a form of hospital permitted the doctor to concentrate his patients, thus reducing demands on travel time and permitting more of his available time being applied to caring for the ill.

This evolution went further when specialized facilities were created to care for the tubercular patient, an outgrowth of the pest house, reducing the opportunity for contagion to others. The mentally ill were brought together to avail these patients of the services of specialists in this field. Because of the catastrophic financial burden involved, the State, with creditable aggressiveness, did establish the pattern and precedent of assuming a financial responsibility for the care of mental patients.

Only recently have other long-term illnesses been more specifically identified with a view toward providing specialized facilities to meet these needs. The chronic illness hospital is that facility which will fulfill needs for long-term nursing care and the extended treatment program indicated.

It has already been pointed out that resource available for the caring of the illnesses does have limits and that it is mandatory for communities to exercise maximum economy. This applies to the community's resource, in providing facilities to meet health needs, as well as to consumers, in applying their individual resource toward realizing maximum effect. Iowa's particular case deserves special attention by virtue of its high percentage of aged population and the fact that this trend is accelerating. It is proposed that a total program be pursued which will realize maximum effectiveness in the expenditure of community resource, so that in turn the user's individual resource will go fartherest in meeting his needs. Pertinent factors which must be provided are:

(1) The inauguration of a preventative program toward sustaining the able-bodied to that possible maximum capability.

(2) A program diagnosis to detect needed treatment which can be administered on an outpatient basis to re-establish patients in that maximum level which is possible.

(3) Review the reasonableness of retirement age, and permitting persons to extend their productive period, thus protecting their right to serve their needs and maintain their maximum of self-sufficiency.

(4) For the patient whose acute needs have been fulfilled but who does need long-term treatment and care in realizing the maximum of his self-sufficiency, provide the means for administering extended treatment in facilities designed

to provide a lesser amount of intensive nursing, thus reducing the cost to the patient.

(5) Create the monetary means which will become available to those patients whose individual resources have been expended before realizing their goal of maximum renewal of their capabilities and self-sufficiency.

Earlier discussions have made reference to progressive care and the need for providing services in keeping with the requirements during several stages of recovery. In the light of these gradations of progressive care are related facets which were recognized and are being emphasized through a modification of the Federal Grants Program. Specific categories identified in the program are diagnostic and treatment, rehabilitation, chronic illness and nursing home facilities, which aim to reduce the demands on the hospital's intensive nursing care facilities by designing services directly in keeping with patients' needs. Their respective purpose, to provide diagnostic and treatment facilities on an outpatient basis, is self-evident. Without duplication, these same facilities become available for evaluating inpatients' needs to facilitate prescribing the most effective treatment for a prolonged period. Likewise, rehabilitation services for retraining, to the maximum of their capabilities, those patients who have suffered impairment, can apply to either inpatients or outpatients. These facets can go far in supplementing the hospital pattern toward meeting a greater portion of patients' needs.

Permissive legislation enabled this state to participate in the broadened federal program so that these categorical grants could become available in qualifying communities.

The following pages discuss these four categories of health facilities as they pertain to this state's needs. The projected program pursues the missions in a manner that will permit the greatest number of people to avail themselves of the needed services while realizing maximum economy in the limited professions, skills and techniques.

The federal grants are less than generous for fulfilling these needs. Accordingly, the facilities proposed in this plan are intended to provide services to the greatest number of people with maximum economy in terms of both operational dollars and related skills. To preclude duplication it is proposed that existing ancillary services be utilized to a maximum and correlated with these specialized health facilities.

The added facets beyond the acute general, the psychiatric, the tuberculosis and chronically ill facilities are incorporated in such a total plan through Part "G" of the Hill-Burton Program. Categorical grants are available (in limited amounts) to provide adjunct services in the fields in rehabilitation, diagnostic and treatment facilities, and nursing homes. A combination of all of these elements in proper proportion will provide an effective answer for meeting the total need while utilizing existing resource and personnel at maximum economy.

The following sections deal with the complementing categories which are allied to hospital services discussed in earlier chapters.

PART IV NURSING HOMES

A nursing homes is defined as "a facility which is operated in connection with a hospital, or in which nursing care and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery in the state, for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who do require skilled nursing care and related medical services. The term 'nursing home' shall be restricted to those facilities, the purpose of which is to provide skilled nursing care and related medical services for a period of not less than 24 hours per day to individuals admitted because of illness, disease, or physical or mental infirmity and which provide a community service."

This excludes institutions furnishing primarily domiciliary care, whose primary purpose is to furnish food, shelter, and other nonmedical services and wherein medical treatment or nursing care is incidental to boarding care.

A "nursing home" which provides personal services only, or such limited medical attention as the individual would normally receive if he were living in a private home is not within the definition applicable to this program.

The term "nursing home" as used by the public is applied to a broad variety of establishments as the result of earlier definition by Iowa Statutes. While current definition in the Iowa Code describes a more refined facility than the earlier version, it still does not conform with the type of facility as intended in the proposed legislation considered by the Congress and by the insuring bodies who concern themselves with prepayment of health costs and true community service. This discussion will restrict itself to nursing homes as defined in an earlier chapter and as described in proposed legislation.

It might be well to review the history and evolution of nursing homes. Many can recall that during the past decade considerable emphasis has been placed on providing for the needs in the area of acute general hospital care. This effort has resulted in the upgrading of hospital facilities while making same available to a greater portion of the state's population. During this progression it became increasingly evident that a portion of this impact on acute general hospitals was attributable to long-term patients whose needs for intensive care were considerably less than was being provided for in the general hospital. These long-term patients, however, were only a portion of this total patient group. The bulk of these needs were being met by custodial facilities providing something less than optimum nursing care. Medical supervision in most cases was non-existant. The void was filled by a somewhat compromised form of nursing home.

During the past seven years this problem has been recognized at all governmental levels. The Federal Grants Program was amended to incorporate a provision for related health facilities. Iowa's unique population group over age 65 stimulated considerable concern among her interested groups and leaders. However, the problems of the aged were not precisely evaluated in terms of their several elements, resulting in a confusion between social needs and medical needs. Iowa Statutes continue to define a form of institution which is referred to as a nursing home. Only recently has a start been made toward appropriate evaluation of all facets related to the aged. During the interim this program and plan concerns itself only with the medically oriented facility and pointedly avoids concern with the social aspects and housing. The criteria within this program, as defined in an earlier chapter, are further described by the following considerations:

A nursing unit which provides beds for the long-term patient requiring medical and nursing care supervision. The individual patient shall be under the care of a duly licensed physician in keeping with the patient's needs at any time. Acceptable medical records shall be maintained for each patient including a medical history, admission examination, diagnosis, the prescribed treatment, progressive reporting, and such orders as may be appropriate. The nursing service shall be under the supervision of a registered nurse or licensed practical nurse, as well as supportive nursing service to meet the patient's needs at all times. Appropriate diagnostic services including x-ray, laboratory, and related supportive services shall be readily available and well correlated with the nursing home operation. Properly supervised dietary service in keeping with all patients' needs shall be provided. There shall be evidence of formal affiliation with a licensed hospital and its organized staff, reliable and prompt referral, and appropriate supportive services which will properly and continuously serve the patient's best interest.

The above is not to be construed as the complete and over-all answer for meeting all problems of the aging, but is only intended to describe that element of a medically oriented progressive care program which is applicable to the long-term care patient in need of a reduced amount of intensive nursing care while completing the treatment prescribed within a total program of evaluation and treatment. This does not imply that there is no need for socially oriented housing for aged groups. Neither does it imply that there is no need for custodial facilities to serve another segment within the aged population group.

Experience indicates, however, that improper recognition is being given to ultimate problems which will result from programs providing primarily housing for specific age groups. It shall be realized that by accumulating and accommodating, unnaturally, certain segments of our population into a single community, we are unbalancing the load proportions being applied to certain communities' local health facilities. Our aged group is more vulnerable to the chronic illnesses and their individual health needs, comparatively, are much greater. Therefore, such housing is entitled to some profound study with a view toward developing specific answers that will be defensible 10 or 20 years from now and which are not so inflexible as to preclude adjustment to whatever future needs may become apparent. Simultaneously, we are aware that much stimulation for purely housing facilities and custodial facilities is generated by an implied but deceptive demand which is created in the minds of potential residents, the result of their observation of trends during past years. Heretofore, many persons committed themselves somewhat irrevocably to admission in a housing facility on the assumption that being accepted while in good health will automatically assure them of appropriate care if and when their need for medical care arises during their remaining years. Such suppositions imply, but falsely a demand which does not truly exist. Ultimately, these housing facilities find themselves in an accelerating need for the long-term nursing care facility but unable to provide appropriate nursing service economically within the inflexible facilities that they have.

It is the firm belief of this Agency that the total problem can be most economically attacked initially by providing expandable and flexible nursing care and treatment facilities to meet the needs of a portion of the long-term patients--the chronically ill. When this phase has been accomplished to some degree, the housing element for meeting other needs of the aged can then be more accurately re-evaluated. There will then be a better indication of needs in this area.

The basic point which must be borne in mind at all times is that community resource does have its limitations and every dollar spent must be applied to make the most effective long-term answer possible. As further resources become available to the community, their mission can then be broadened into the area of housing. By so doing, the risk of misdirected community effort can be greatly diminished and a more accurate evaluation can be made of what the eventual needs really are. The

above philosophy and theme for Iowa is the result of successive studies made by representative groups seeking answers for meeting the needs of the aged. Such studies continue in anticipation of foreseeable legislation which may become permissive toward providing improved answers.

This Plan will not attempt to reiterate the findings of previous studies but does recognize the findings of these reports and incorporates the indications in this program and plan.

Previous Plan revisions and narratives discussed the importance of broadening the pattern of progressive care as it relates to hospital service, with a view toward providing those long-term treatment and care facilities which can improve nursing service to the patient. The point has been made consistently that in the light of scarce professional talents and trained personnel, maximum economy and utilization is a must to preserve the quality of treatment and care while holding the line on cost or reducing the charges made to the patient.

During the past two years we have witnessed the advent of a series of Federal Loan Programs which purport to assist in the provision of nursing homes. Though each of these programs is governed by a comparable definition of "nursing home," they do induce their own interpretation to the physical structure and impose such guidance in the planning as to dictate certain operational aspects of the facility. Technicalities of actual performance are foreign to them. This State Agency feels that the pattern and guidance resulting from the activity of these loan agencies is inducing undesirable features which have been proven inadvisable through the experience encountered in the Hill-Burton Grants Program since 1956 and in resultant operational service rendered. Little originality is produced in the functional features of design. This pattern has repeatedly been brought to the attention of the several federal agencies but without results, improvement, or clarification. By implication, this State Agency is the agency held responsible for establishing community need and to determine relative need. However, several agencies have demonstrated no inclination to recognize state prerogative except upon threat of withholding license. Even then, the layouts and functional arrangements produced through these programs barely comply with the moderate minimum standards for a state license, and do not strive for the optimum design which will postpone obsolescence to a maximum. This agency has attempted to correlate the proposed construction of beds in keeping with the apparent need. However, variation in interpretation of definition, and discrepancy in viewpoints on actual need is resulting in a "scatter gun" answer that imposes illogical uneconomical burdens on limited community resource and which probably will not be reasonably adaptable to the local needs ten years hence.

Because this disjointed approach fails to conform with the intended program proposed for the state of Iowa, this agency will not claim to be capable of an accurate evaluation of the effectiveness of facilities being created through Federal Housing Administration, the Housing and Home Finance Agency, the Community Facilities Agency, or the Small Business Administration. It is our understanding that there has been liaison between these several agencies at the Washington level in attempting to broaden the common ground for providing answers to community problems. These apparently have been anything but fruitful. In the light of this background it is hardly the obligation or the prerogative of this State Agency to resolve the impasse between the several federal administrations. We would welcome the opportunity of being heard in the hopes of making our particular experience available for consideration and to permit our expressing viewpoints resulting from six years of study. This deliberate background and continued study appears to be a more appropriate approach toward developing sound answers and realistic guidance for communities of Iowa.

This Plan does propose only skilled nursing home facilities adjunct to existing

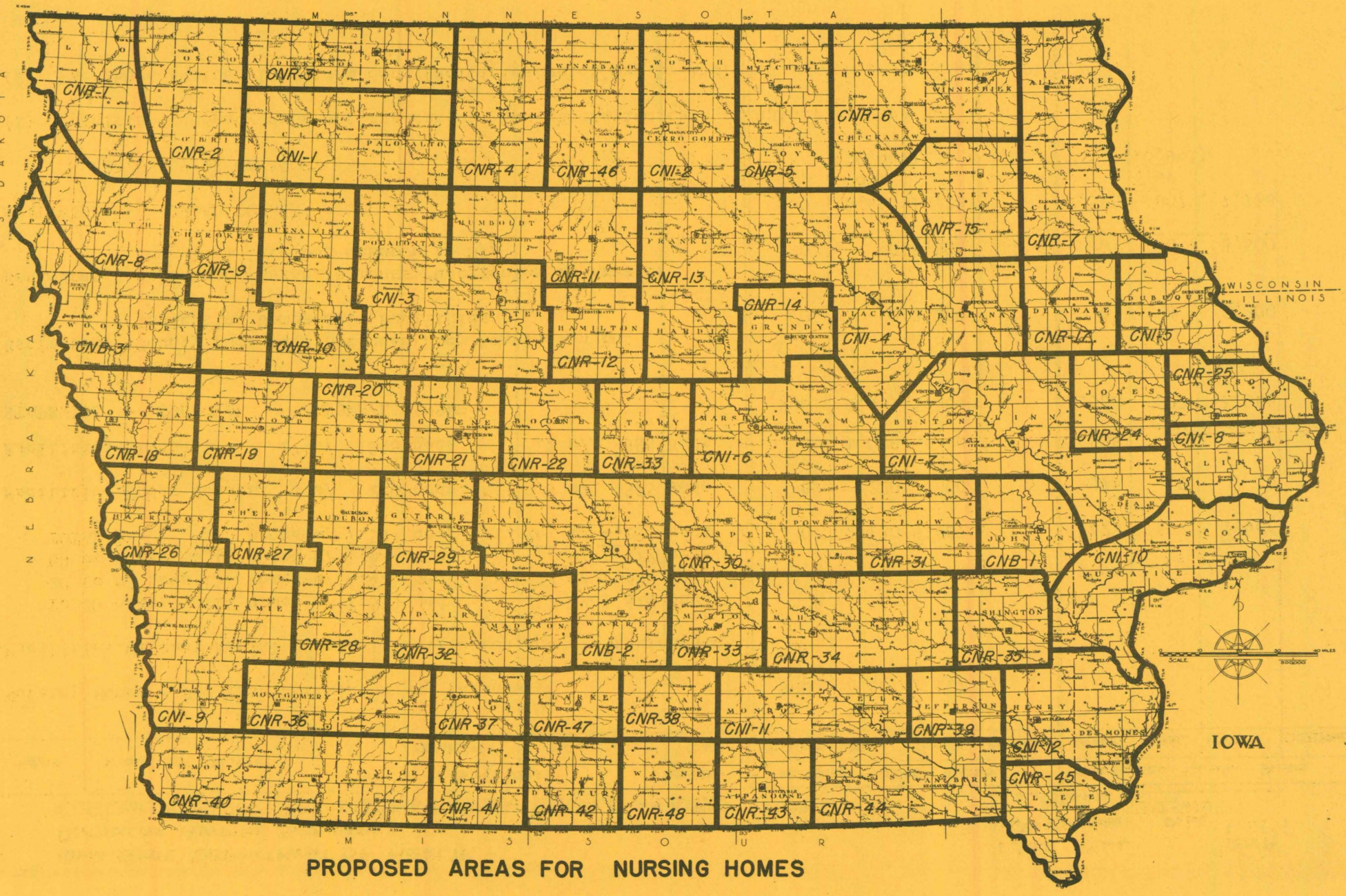
hospital facilities of a suitable standard. By this we mean that the nursing home shall be contiguous to the existing facilities, thus permitting common utilization of the available administrative pattern, utilities, dietary service, treatment and diagnosis service, therapy facilities, and most importantly, the organized medical staff functioning under well-established and proven by-laws and ground rules. This conceivably could permit application for funds by a publicly owned hospital in spite of the existance of a facility by a similar name, constructed through loan guarantees of a Federal underwriting agency. However, the publicly owned facility would have to reflect the mandate of the community by virtue of a bond issue or some similar referendum. The other facility, conceivably, was a decision by a relatively small and unrepresentative group heading a non-profit association or a proprietary group without the support of the majority. A referendum would indicate the public's will regarding a hospital connected facility. In other words, this Plan does feel that an existing facility created by the Federal Government which circumvents the intent of the majority of the community should not preclude the community seeking a best answer. If the existing facility is preferred by the majority, referendum will preclude a hospital-connected facility being constructed.

It is the intent of this Plan to utilize only nursing home facilities contiguous to hospitals in ascertaining the percentage of need met, and in developing a table of relative priority. It is conceded by most factions that long-term care, from the most intensive nursing and treatment facilities to the least refined care and keep facilities, requires a minimum of 8 or 9 beds per thousand population. This Plan programs only 3 beds per thousand population to meet initially the needs for that treatment with skilled nursing care which can realize the discharge of the treatable patient. Qualified related facilities are prorated toward these 3 beds per 1000 population. The intent is to provide the means for restoring these patients to their maximum capacity for self-sufficiency that their particular limitations will permit.

The precise needs are not known at this time. By providing a conservative amount of true treatment nursing home facilities during this interim while answers are being sought and/or refined, this program will not burden a community with inflexibly designed facilities which are irrevocably committed.

It must also be emphasized that categorical grants money available to Iowa is very limited. These funds can be applied with greatest effect if applied to treatment facilities which are capable of supporting appreciable outpatient and day care service.

Further detail regarding principals for classification and inventory, as they relate to priority development, are described in earlier paragraphs.



PROPOSED AREAS FOR NURSING HOMES

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES
SUITABILITY REPORT FOR NURSING HOMES & RELATED FACILITIES — SUMMARY

1 JULY 1962 — 15TH REVISION — IOWA — PAGE 1 of 1 — REGION STATEWIDE

AREA	NAME OF FACILITY	LOCATION: COUNTY	LOCATION: TOWN	OWNERSHIP	NURSING HOME BEDS: SUITABLE	NURSING HOME BEDS: REPLAC.	NURSING HOME BEDS: UNSUIT	NURSING HOME BEDS: OCCUPANCY	CUSTODIAL HOME BEDS: SUITABLE	CUSTODIAL HOME BEDS: REPLAC.	CUSTODIAL HOME BEDS: UNSUIT.	CUSTODIAL HOME BEDS: OCCUPANCY
Nursing Homes - Per Plan Definition and Inventory					900	67	117					
Facilities Without Formal Hospital Affiliation and Staff-Licensed												
	To 20 beds 114 homes w/ 1,599 beds		217 w/ 1,874 beds									
	20 to 60 beds 153 homes w/ 4,421 beds		32 w/ 1,052 beds									
	60 or over 18 homes w/ 1,627 beds		12 w/ 1,272 beds									
	TOTAL --- 285 homes w/ 7,597 beds		261 w/ 4,198 beds		0	2,130	5,467		1,625	607	1,966	
Facilities Under Constr. 9 w/ 220 beds			9 w/ 375 beds		0	220	0		375	0	0	
Facilities Planned 27 w/ 1048 beds			12 w/ 588 beds		0	1,048	0		588	0	0	
STATEWIDE -- SUBTOTAL -- KNOWN/LICENSED					900	3,465	5,584		2,588	607	1,966	
Estimated: County Home Beds Excluded From Regulation But Indicating Comparable Facilities					0	0	3,200		0	0	2,300	
Estimated: Unlicensed Establishments Functioning in Area of Long-Term Care But Unknown to S/A					0	0	1,500		0	0	3,500	
STATEWIDE -- GRAND TOTALS					900	3,465 or (14,649)	10,284		2,588	607 or (10,961)	7,766	
SUBTOTALS BY CATEGORY ---												

(1) Specific occupancy data not available. Spotchecks indicate occupancy exceeds 90%

(2) The above exclude long-term care facilities which may be included in other sections of Plan.

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES
SUITABILITY REPORT FOR NURSING HOMES & RELATED FACILITIES

1 JULY 1962 IOWA
15TH REVISION PAGE 1 of 1
REGION STATEWIDE

AREA	NAME OF FACILITY	LOCATION		OWNER-SHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	TOWN		SUITABLE	REPAIR.	UNSUIT.	OCCUPANCY	SUITABLE	REPAIR.	UNSUIT.	OCCUPANCY
NR-1	Sioux Center Comm. Hospital	Sioux	Sioux Center	NPA	60	0	0					
NR-1	Orange City Municipal Hosp.	Sioux	Orange City	CITY	0	18	0					
NB-3	St. Joseph Mercy Hospital	Woodbury	Sioux City	CH	0	25	50					
NR-2	Community Memorial Hospital	O'Brien	Sheldon	NPA	40	0	0					
NR-3	Holy Family Hospital	Estherville	Emmet	CH	24	0	0					
NI-4	Allen Memorial Hospital	Waterloo	Black Hawk	NPA	72	0	0					
NI-5	St. Joseph Mercy Hospital	Dubuque	Dubuque	CH	0	0	67					
NI-7	Virginia Gay Hospital	Benton	Vinton	CITY	48	0	0					
NI-7	Hallmar	Linn	Cedar Rapids	CH	30	0	0					
NI-10	Kahl Memorial Home	Scott	Davenport	CH	134	0	0					
NI-12	St. Francis Cont. Care Ctr.	D.Moines	Burlington	CH	126	0	0					
NI-12	Klein Memorial	D.Moines	Burlington	NPA	160	0	0					
NR-44	Van Buren Co. Mem. Hospital	Van Buren	Keosauqua	CO	28	0	0					
NR-30	St. Francis Hospital	Poweshiek	Grinnell	CH	0	24	0					
NR-33	Pella Community Hospital	Marion	Pella	NPA	30	0	0					
NR-20	St. Anthony Hospital	Carroll	Carroll	CH	80	0	0					
NR-36	Murphy Memorial Hospital	Montgom.	Red Oak	CITY	40	0	0					
NR-40	Hand Memorial Hospital	Page	Shenandoah	NPA	28	0	0					
	TOTAL HOSPITAL-ORIENTED NURSING HOME BEDS --				900	67	117					

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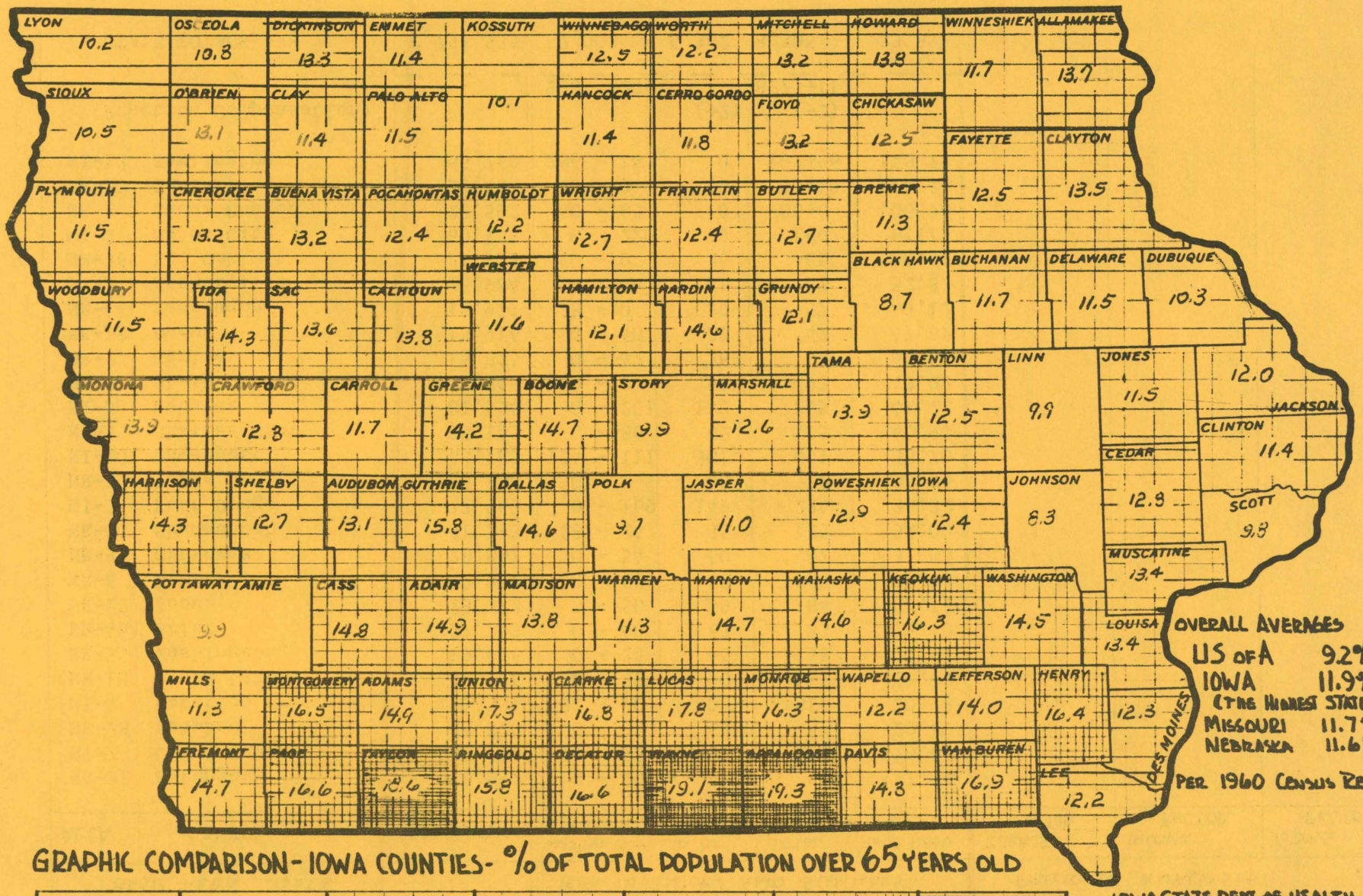
IOWA STATE DEPT OF HEALTH
DIVISION OF HOSPITAL SERVICES
RELATIVE NEED REPORT AND SUMMARY FOR NURSING HOMES AND RELATED FACILITIES

1 JULY 1962

BASIC AREA DATA			BED INVENTORY AND SUMMARY				PRIORITY ANALYSIS		
AREA	CENTER	POPULATION	EXISTING BEDS SUIT. - REQ.	TO BE BUILT	TOTAL PROPOSED	% OF NEED MET	RURALITY FACTOR	INCOME FACTOR	GROSS FACTOR
NR-42	Leon	10,539	0 - 0	32	32	0	1.9130	1.4679	3.3809
NR-48	Corydon	9,800	0 - 0	29	29	0	1.9081	1.4674	3.3755
NR-47	Osceola	8,222	0 - 0	25	25	0	1.9030	1.4670	3.3700
NR-29	Guthrie Center	13,607	0 - 0	41	41	0	1.9130	1.3652	3.2782
NR-14	Grundy Center	14,132	0 - 0	42	42	0	1.9130	1.0284	2.9414
NR-32	Winterset	23,188	0 - 0	70	70	0	1.6448	1.2523	2.8971
NR-41	Mount Ayr	7,910	0 - 0	24	24	0	1.4893	1.2612	2.7505
NR-25	Maquoketa	19,248	0 - 0	58	58	0	1.4711	1.2630	2.7341
NR-6	Decorah	47,225	0 - 0	142	142	0	1.3844	1.2793	2.6637
NR-43	Centerville	16,015	0 - 0	48	48	0	1.1727	1.4900	2.6627
NR-17	Manchester	18,483	0 - 0	55	55	0	1.4826	1.1549	2.6375
NR-38	Chariton	10,923	0 - 0	33	33	0	1.4378	1.1743	2.6121
NR-34	Oskaloosa	39,094	0 - 0	117	117	0	1.4020	1.1929	2.5949
NR-19	Denison	18,569	0 - 0	56	56	0	1.4711	1.1183	2.5894
NR-21	Jefferson	14,379	0 - 0	43	43	0	1.3812	1.1380	2.5192
NR-15	Oelwein	36,827	0 - 0	110	110	0	1.3812	1.1091	2.4903
NR-12	Webster City	20,032	0 - 0	60	60	0	1.5227	0.9525	2.4752
NR-4	Algona	25,314	0 - 0	76	76	0	1.5189	0.9519	2.4708
NR-24	Anamosa	20,693	0 - 0	62	62	0	1.2435	1.2045	2.4480
NR-13	Iowa Falls	46,803	0 - 0	140	140	0	1.4093	0.9966	2.4059
NR-23	Ames	49,327	0 - 0	148	148	0	1.3478	0.9570	2.3048
NR-39	Fairfield	15,818	0 - 0	47	47	0	0.8895	1.2377	2.1272
NI-6	Marshalltown	57,288	0 - 0	172	172	0	1.1241	1.0000	2.1241
NR-37	Creston	13,712	0 - 0	41	41	0	0.8972	1.1750	2.0722
NI-11	Ottumwa	56,589	0 - 0	170	170	0	0.9640	1.0108	1.9748
NB-1	Iowa City	57,376	0 - 0	172	172	0	0.7748	0.9452	1.7200
NI-8	Clinton	55,060	0 - 0	165	165	0	0.6409	0.9488	1.5897
NR-45	Fort Madison	44,207	0 - 0	133	133	0	0.5337	1.0495	1.5832
NI-9	Council Bluffs	96,152	0 - 48	264	288	8.33			
NI-1	Spencer	37,562	0 - 20	103	113	8.85			
NR-11	Clarion	32,603	0 - 19	88	98	10.20			
NB-2	Des Moines	311,267	0 - 199	834	934	10.71			
NR-7	Postville	37,944	0 - 32	98	114	14.04			
NR-30	Newton	52,084	0 - 50	131	156	16.03			

RELATIVE NEED REPORT + SUMMARY - NURSING HOMES + RELATED FACILITIES (CONTINUED)

BASIC AREA DATA			BED INVENTORY AND SUMMARY				PRIORITY ANALYSIS		
AREA	CENTER	POPULATION	EXISTING BEDS SUIT-REPLAC.	TO BE BUILT	TOTAL PROPOSED	% OF NEED MET	RURALITY FACTOR	INCOME FACTOR	GROSS FACTOR
NR-31	Marengo	18,894	0 - 20	47	57	17.54			
NI-7	Cedar Rapids	169,926	78 - 55	405	510	20.68			
NR-28	Audubon	28,828	0 - 36	69	87	20.69			
NI-4	Waterloo	171,531	72 - 70	408	515	20.78			
NR-10	Storm Lake	38,196	0 - 49	90	115	21.74			
NR-35	Washington	19,406	0 - 25	45	58	22.41			
NR-46	Britt	27,703	0 - 40	63	83	24.10			
NR-22	Boone	28,073	0 - 50	59	84	29.76			
NR-8	LeMars	22,997	0 - 42	48	69	30.43			
NR-9	Cherokee	28,867	0 - 54	60	87	31.03			
NR-40	Shenandoah	41,593	28 - 24	85	125	32.00			
NI-3	Fort Dodge	77,967	0 - 169	149	234	36.32			
NR-33	Pella	25,886	30 - 0	48	78	38.46			
NI-10	Davenport	163,785	134 - 111	301	491	38.70			
NR-5	Charles City	35,145	0 - 86	62	105	40.95			
NI-5	Dubuque	81,554	0 - 201	149	245	41.22			
NR-2	Sheldon	30,846	40 - 0	53	93	43.02			
NR-27	Harlan	15,825	0 - 42	26	47	44.68			
NR-18	Onawa	13,916	0 - 40	22	42	47.62			
NR-44	Keosauqua	18,977	28 - 0	29	57	49.12			
NR-3	Estherville	28,984	24 - 44	41	87	52.87			
NR-36	Red Oak	21,935	40 - 0	26	66	60.61			
NI-2	Mason City	60,153	0 - 220	70	180	61.11			
NR-1	Sioux Center	28,592	60 - 63	0	86+6	106.98			
NR-20	Carroll	23,431	80 - 0	0	70+10	114.28			
NI-12	Burlington	65,750	286 - 14	0	197+96	148.73			
	(Fraction Compensation)			(+2)	(-2)				
			900 - 2206		8273+112				
	STATE TOTALS ---	2,757,535	2,003	6,382	8,385	23.89%			

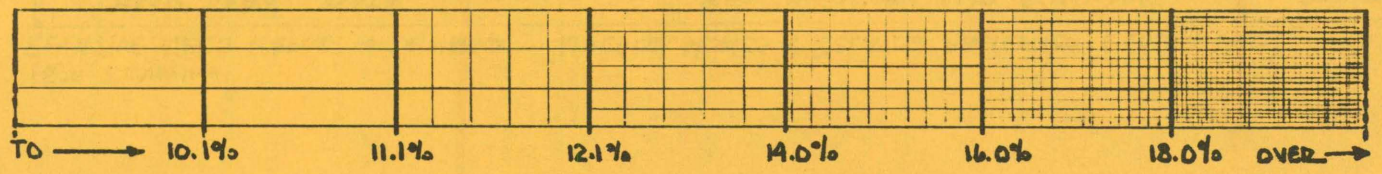


OVERALL AVERAGES

US OF A	9.2%
IOWA	11.9%
(THE HIGHEST STATE)	
MISSOURI	11.7%
NEBRASKA	11.6%

PER 1960 CENSUS REPORTS

GRAPHIC COMPARISON - IOWA COUNTIES - % OF TOTAL POPULATION OVER 65 YEARS OLD



IOWA STATE DEPT. OF HEALTH
DIV. OF HOSPITAL SERVICES

EXHIBIT D

PART VII. DIAGNOSTIC AND TREATMENT CENTERS

Section 53.1 (s) of the Federal Regulations defines a diagnostic or treatment center as a facility providing community service for the diagnosis and treatment of ambulatory patients, which is operated in connection with a hospital, or in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the state, or, in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the state. The definition includes outpatient departments of public or non-profit hospitals.

In accordnace with State Statutes, the State Agency did meet with the sub-committee of the Hospital and Medical Facilities Advisory Council for the purpose of evaluating the inventory of existing diagnostic and diagnostic and treatment centers and determining the need for additional centers.

Before the existing centers could be properly evaluated, it was necessary to further define the facility. For the purpose of this study, it was determined that a diagnostic and diagnostic and treatment center varies from the normal diagnostic and treatment aids found in the offices of practicing doctors, (doctors of medicine, osteopathy and dentistry) to the most complex diagnostic/treatment facilities found in the State University Hospitals at Iowa City. Accordingly, it was decided that the inventory should recognize all existing offices of medical doctors, doctors of osteopathy and dentists.

The State Agency conducted a survey of all hospitals, public and non-profit clinics, health centers, laboratories and dispensaries in the state. With the cooperation of the respective professional societies, a survey, but not an inventory, was made of the offices of practicing medical doctors, doctors of osteopathy and dentists. The information obtained from this survey was shown on Form PHS5-2, "Inventory of Diagnostic and Diagnostic and Treatment Centers," Ninth Revision. Hospital service areas were used to identify and locate the facilities inventoried. Needs were determined on a statewide basis and proposed projects programmed on this basis.

In an effort to give full consideration to the services rendered by many of the marginal facilities, hospitals without organized outpatient departments, industrial clinics and dispensaries limited to employees, and dispensaries of schools and colleges limited to students, were incorporated in the inventory. These facilities were not classified as suitable, replaceable or unsuitable, but were used, together with the services rendered by the offices of doctors and dentists, in determining the need for additional facilities.

Facilities which clearly meet the definition of a diagnostic and diagnostic and treatment center, as set forth by Federal Regulations, were classified as suitable, replaceable or unsuitable. It must be made quite clear that the structure was evaluated in determining suitability, and not the quality of service rendered by the facility. In accordance with the criteria established by the State Agency, all facilities classified as unsuitable were housed in non-fire resistant buildings which were deemed as constituting a public hazard.

Based upon the inventory, the following conclusions were drawn:

1. All of the facilities surveyed play a significant part in rendering diagnostic and treatment service to the people of Iowa.

2. The geographic distribution of the various facilities generally follows the concentration of population, thus providing reasonably disseminated services. To demonstrate this fact, the map shows the geographic distribution of the offices of 2,634 practicing medical doctors, 478 doctors of osteopathy, 1,648 dentists and 171 hospitals.

3. The existing facilities (offices of doctors and dentists, hospitals rendering a significant community service without an organized outpatient service, and clinics and dispensaries restricted to specific population groups) are presently rendering the degree of diagnostic and treatment service necessary to meet most of the needs of all of the people of Iowa. Any further enlargement of the diagnostic and diagnostic and treatment facilities at the local level could not be economically justified at this time.

4. Current study indicates a need for additional diagnostic and treatment services in basically four instances. The proposed four projects will render a service fulfilling the detectable need remaining in the state. Their relative priority is in the order of their effectiveness in serving existing needs.

(a) The available diagnostic and treatment service of the University Hospitals is intended for all residents of the state and includes diagnostic procedures which are not available at any other center in the state. The continued and expanded service of this facility is vital to the total medical care program in Iowa. It is given the highest relative priority.

(b) The dental clinic at the State University of Iowa serves as a diagnostic and treatment center for unusual and complex dental conditions, as well as a training center for dentists. The number of dentists that can be trained is limited by the size of the clinic. In order to make this dental service available to more people of the state and to provide more training facilities, this project was given second priority.

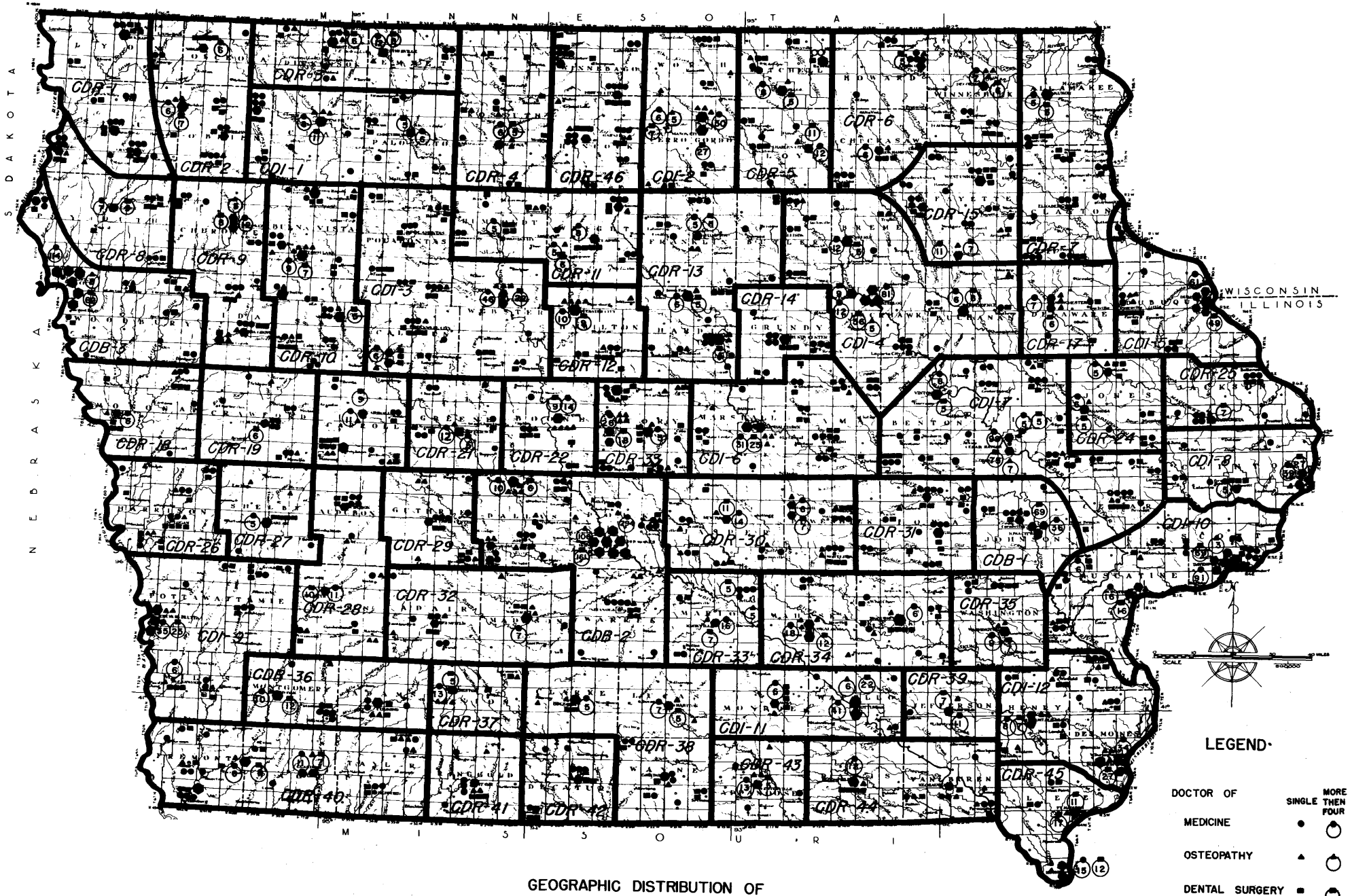
(c) The Study Committee on Mental Illness gave particular attention to the inadequacies in the area of emotionally disturbed children, and urged immediate steps toward providing facilities and staff at Des Moines and Iowa City. In keeping with this intent, the Iowa Advisory Council did approve projects for Iowa Methodist, Des Moines; and the Psychopathic Hospital in Iowa City. In each instance the council made particular mention of the limited scope of the proposals and went on record to the effect that vigorous efforts should continue toward expanding this phase of diagnosis and treatment facilities, and that maximum priority and encouragement be given to true emotionally disturbed children's units proposed by any sponsor in Iowa.

(d) The remaining need which has been recognized in the past is for the expansion of cardiovascular diagnostic and treatment at Sioux City. The unit proposed, limited to a particular illness, will meet an unfulfilled need. For these reasons, it was given the lowest of the four priorities under consideration.

This does not preclude consideration of other worthy proposals, provided they are appropriately substantiated to the satisfaction of the Advisory Council as to their applicability in providing needed diagnostic or treatment facilities.

Any sponsor making application for grants-in-aid for the construction of a diagnostic or diagnostic and treatment center must submit, as part of the application, a complete and detailed program of admission, service to be rendered and program for staffing. This information will be reviewed by the Iowa Advisory Council for Hospitals and Related Health Facilities and its sub-committee on Diagnostic and Treatment Centers, and will be considered in granting approval of the application. All potential project sponsors are encouraged to consult with the council early in the project planning.

IOWA



GEOGRAPHIC DISTRIBUTION OF
PROFESSIONAL PERSONNEL AND MEDICAL FACILITIES

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
INVENTORY SUMMARY OF DIAGNOSTIC AND TREATMENT FACILITIES

1 JULY 1962
15TH REVISION
IOWA

LINE ITEMS		OWNERSHIP OR CONTROL	SERVICES: GENERAL	SERVICES: SPECIAL: GENERAL	SERVICES: SPECIAL: CANCER	SERVICES: SPECIAL: DENTAL	SERVICES: SPECIAL: NERVOUS & MENTAL	SERVICES: SPECIAL: ORTHOPEDIC	SERVICES: SPECIAL: T.B.	SERVICES: SPECIAL: OTHER	DIAGNOSTIC SERVICE: X-RAY	DIAGNOSTIC SERVICE: CLIN-LAB	HOSPITAL O.P.D.	CLASSIFICATION: SUITABLE	CLASSIFICATION: REPLACEABLE	CLASSIFICATION: UNSUITABLE
Diagnostic Facilities Which Pertain Directly to All Community Service in Iowa --																
Iowa T.B. & Heart Assn. (Statewide Case Finding)		NPA			X				X							
Hospitals (All Categories)	171 in state	VARIED		X	X		X	X	X		X	X	X			
M.D. Practitioners	2,210 in state	IND		X	X		X	X	X	X	X	X				
D.O. Practitioners	470 in state	IND		X	X		X	X	X	X	X	X				
D.D.S. Practitioners	1,576 in state	IND				X					X	X				
Note: The above professional people are located in some 560 towns/cities of Iowa.																
Industrial Infirmaries	Statewide	IND		X			X	X		X						
Institutional Infirmaries	Statewide	VARIES		X	X	X	X	X	X		X	X				

(a) Dissemination of the above facilities is graphically illustrated on the map on the preceding page.

(b) Refer to pages 99 thru 113, Eighth Revision, Iowa Hospital Plan, 1 July 1955, for state survey of Diagnostic and Treatment Facilities for basis of conclusion that aggregate facilities and their distribution are adequate to meet the normal needs of the state's population. Also see related comments on preceding pages.

PART VIII. REHABILITATION CENTERS

Section 53.1 (5) of the Regulations provides definitions related to rehabilitation as follows:

(1) REHABILITATION FACILITY "A facility providing community service which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of meeical, psychological, social, and vocational evaluation and services under competent professional supervision. The major portion of such evaluation and services must be furnished within the facility; and the facility must be operated either in connection with a hospital or as a facility in which all medical and related health services are prescribed by, or under the general direction of, persons licensed to practice medicine or surgery in the State."

(2) REHABILITATION "An integrated program brings together, as a team, specialized personnel from the medical, psychological, social, and vocational areas for the purpose of pooling information, interpretations and opinions for the development of a rehabilitation plan of services in which the disabled individual is viewed as a whole. When members of the team contribute to the diagnosis and treatment of illness. their contributions must be coordinated under medical responsibility. These integrated services may be provided in a facility to care for many types of disabilities or a single type of disability."

(3) DISABLED PERSONS "A disabled person is an individual who has a physical or mental condition which, to a material degree, limits, contributes to limiting, or if not corrected, will probably result in limiting, the individual's performance or activities to the extent of constituting a substantial physical, mental, or vocational handicap."

Rehabilitation is the process of assisting an individual with a disability to realize his potentialities and goals physically, mentally, socially, and vocationally. Facilities contemplated by this program would be available to disabled persons of all ages, including those who are capable of becoming able to care for themselves, as well as those who are being rehabilitated for employment. The evaluation and services offered by the facilities cannot be solely medical, social, psychological or vocational; nor can there be a combination of services from only two or three of these areas. Provision must be made within the facility for a rehabilitation program in which each of the four basic areas assumes its significant role, depending on the fundamental needs of the individual served.

Services available to the state in this field are extremely inadequate, when measured in terms of total need. This generalization became quite evident when basic survey data was reviewed. While a number of organizations have attempted to serve the needs of the disabled, very few are able to provide the essential elements in the four areas of service for a coordinated program, let alone meet their total need. These splinter operations are usually limited by restrictive budget available for either/both facilities and/or staff. In only a few instances are the four areas of service completely provided.

In setting forth the available resources, certain ground rules were established to permit a pattern of inventory. As a result, only those facilities with adequate elements in each of the four areas of rehabilitation were classified as being suitable, replaceable, or unsuitable. Marginal operations which do administer an appreciable amount of service in three or four of the areas of rehabilitation were listed to

reflect the service rendered and the existing demand. These, in turn, represent certain special talents which might readily be adapted to an expanded program to provide a sound and complete service if the financial means were to become available.

The source of basic data was quite complete and represents the close association of field personnel in the Division of Vocational Rehabilitation with the varied efforts put forth by charity and non-profit organizations. The interpretation placed upon the basic data shall not be construed as criticism of those organizations who are active in rehabilitation. More realistically, it represents the public reluctance to recognize the needs in this field and illustrates the impact this failing is having on tax dollars. When the public realizes how many individuals, without sufficient resource and dependent on political subdivisions for care, could be re-established as producers and taxpayers, we may witness converted programs realistically financed. The splinter operations of today are accomplishing an educational mission which will eventually bring about public recognition of the spectacular results which can be realized, if pursued.

The proposed program is on a statewide basis. Teaching centers and population centers are indicated as sites for proposed rehabilitation centers to gain maximum opportunity for providing staff while making resources available to a maximum number of people. The grants-in-aid available for rehabilitation are extremely inadequate. Because the foreseeable moneys for this category are limited, the proposed program is restricted at the present. When more indication exists on what the source of funds will be, the program will be elaborated upon. In any event, several potential contingencies can give major guidance to future programming. Educational facilities, for instance, could readily influence the pattern of service which would best meet needs. The rates of disabling accidents are changing quite rapidly. The mechanization of agriculture is an influence in the origin of the rehabilitatable groups. Obviously the influence of disability causes, the existing backlog, the extreme lack of existing facilities, and the absence of a positive source of financial support are reasons for proposing a moderate program at this time with a view toward refining a statewide plan at a later date when better information will offer more guidance. The present lack of facilities virtually makes it impossible to overbuild if duplication is avoided.

Priority of projects is dependent upon several basic conditions. Primary consideration will be given to a multiple disability center in conjunction with the medical college. Next, consideration will be for a proposal which will offer a statewide service. Thereafter, projects proposed for population centers will be considered in terms of fields of disability to be served, favoring multiple disability units over single disability units.

The entire program will be correlated at all times with the planning and long-range projects which are being developed by the Division of Vocational Rehabilitation, Department of Public Instruction.

IOWA STATE DEPARTMENT OF HEALTH
Division of Hospital Services

15TH REVISION IOWA HOSPITAL
PLAN 1 JULY 1962

INVENTORY OF REHABILITATION FACILITIES

NAME OF FACILITY	LOCATION	CLASSIFICATION (CODE)	OWNERSHIP OR CONTROL	AV. DAILY CASELOAD: IN PATIENT	AV. DAILY CASELOAD: OUTPATIENT	NO. OF PERSONS SERVED ANNUALLY	AGE GROUPS SERVED: UNDER 18	AGE GROUPS SERVED: OVER 18	DISABILITY GROUPS SERVED: DEAF	DISABILITY GROUPS SERVED: BLIND	DISABILITY GROUPS SERVED: T.B.	DISABILITY GROUPS SERVED: CARDIAC	DISABILITY GROUPS SERVED: ORTHOPEDIC	DISABILITY GROUPS SERVED: NEUROLOGICAL	DISABILITY GROUPS SERVED: OTHER	SERVICES: MEDICAL	SERVICES: PSYCHOPATHIC	SERVICES: SOCIAL	SERVICES: VOCATIONAL
Ia. Voc. Rehab. Center	Des Moines	S	STATE	20	40	178		X	X		X	X	X	X		ABCDEFGHLM	N	OPQR	STUV
Ia. Soc. for Crippled Children & Adults	Des Moines	S	NPA		18	220	X	X	X	X		X	X	X		ABCDEFHM	N	OPQR	STUVWY
Iowa Methodist Hospital	Des Moines	S	CH	80	120	(730)	X	X	X	X		X	X	X	X	Complete	N	OPQR	STUV
University Hospitals	Iowa City	S	STATE	25		278	X	X	X	X		X	X	X	X	ABCDEFGHJ KLM	N	OPQR	STV
Em. Dist. Children's U.	Iowa City	S	STATE	48	12	480							X	X		ABCDEGHI JKLM	N	OPQR	STUV
Iowa Braille & Sight Saving School	Vinton	U	STATE	172		172	X	X		X						ABDFGHJKLM	N	OPQR	STVWZ
Decorah Rehab. Center	Decorah	S	NPA				X	X					X		X	ABCDJKLM		R	S
Oakdale Sanatorium	Oakdale	S	STATE	80		180	X	X			X					ABDJILM	N	OPQR	STUVW
United Cerebral Palsy C.	Cedar Rpds.	S	NPA		28	60	X	X						X		ABCDELM	N	OPR	S
St. Luke's Meth. Hosp.	Cedar Rpds.	S	CH	NR	NR	NR	X	X	X	X		X	X	X	X	AM	N	OPQR	STUV
Linn Co. Soc. for Crippled Children	Cedar Rpds.	S	NPA			60	X	X					X			ABCLM		R	ST
Burlington Hospital	Burlington	S	NPA (Under Construct.)				X	X			X	X	X	X	X	Complete	N	OPQR	STUV
Sunnyslope Sanatorium	Ottumwa	S	CO	63		63	X	X			X					ABDJLM		OPQR	STVW
Iowa School for Deaf	C. Bluffs	S	STATE	350		350	X	X	X							ABEFGHIKLM	N	OPQR	STUVWY
Siouxland Rehab. Center	Sioux City	S	NPA	0	40	680	X	X	X	X		X	X			ACDEFGHJLM	N	OPQR	STUV

1. CLASSIFICATION CODE
S-Suitable
R-Replaceable
U-Unsuitable

2. CODE FOR COLUMNS 21 THRU 24

MEDICAL
A-Phys.& Med.Eval.
B-Med. Supervision
C-Phys. Therapy
D-Occup. Therapy
E-Speech Therapy
F-Audi-Ser. Incl.Lip Reading
G-Prosthetics Brace
H-Psychiatric
I-Dental
J-Nursing
K-Phys. Education
L-Med. Consultant
M-Rec. Therapy

PSYCHO.
N-Evaluation

SOCIAL
O-Evaluation
P-Soc. Caswk.
Q-Soc.Grpwork.
R-Rec.(Non-Med.)

VOCATIONAL
S-Evaluation
T-Voc. Counsel
U-Pre.Voc. Exp.
V-Spec. Education
W-Voc. Trng.
Y-Sheltered Emp.
Z-Travel Trng.for Blind

IOWA STATE DEPARTMENT OF HEALTH

Division of Hospital Services

1. Page 1 of 1

2. Date July 1, 1962

3. State Iowa

REHABILITATION FACILITIES SUMMARY

4. Population

2,757,537

5. Total facilities allowed by the state ratio

(9) (6 disabilities) - 57 disability services

6. Additional Facilities Proposed - 44 Disability Services

COMMUNITY A.	DESCRIPTION OF FACILITIES AND SERVICES TO BE PROVIDED B.
Iowa City Davenport Waterloo	Facilities will vary in keeping with available talent, resources, and demonstrated community support. Preference will be given to multiple disability units and the program proposed. Evaluation will be based on degree of service attainable with the approvable proposal.

Location of proposed rehabilitation services will be at points that are established for statewide service, or at population centers readily accessible to an appreciable segment of population.

EXHIBIT E

DETERMINATION OF RELATIVE NEED

Priority of Categories

The program at this point follows two correlated patterns. The basic hospital program is in keeping with precedent of previous plans and revisions, while the related health facility phase conforms to the intent of the Congress in providing means for the complementing facilities not provided for earlier. The two parts of the program will be considered separately.

Priority of Hospital Categories (Public Law 725)

During the early years, the program sought to stimulate preference in the specialized categories by giving such projects the first opportunity to participate in grants-in-aid. In spite of the incentive, few communities were moved to develop a project in a specialized category. This reluctance has been attributable to several factors in the communities. Hospital personnel were reluctant to approach long-term treatment programs, such as psychiatric or chronic illness, because normally individual resources were considered insufficient for complete treatment and care. These hospital costs, it appeared, would have to be spread onto the costs for acute care. The citizens of communities were equally reluctant to encourage such projects or to provide funds for such construction because the care of such patients has been considered the responsibility of the state. In addition, the need for these services has not been brought to the attention of the taxpayers in terms of long-range tax burden or in terms of population trends and their effect on the productive abilities of communities.

As a result, the unbalance of hospital categories has been accentuated. When no application was made by specialized projects, the lower priority acute general hospitals applied for, and were granted available funds. During the last few years, interest in chronic and psychiatric units has developed in several areas with very favorable results. Educational effort continues and it is foreseeable that the balance will be improved. In the meantime, impressive advances are being made in treatment procedures in specialized fields, which will, in their turn, further guide the public in the need for and possibilities of these special facilities.

In evaluating the categories, the facilities are considered in terms of beds and the classification with the greatest unmet need will receive greatest consideration. Within the categories, the area or region with greatest unmet need will be given preference. The following table gives the basis and determination of priority among categories.

CATEGORY	EXISTING "ACCEPTABLE" BEDS			PROPOSED TO BE ADDED	TOTAL BEDS PROP.	% NEED MET
	SUITABLE	REPLACE-ABLE	EQUIVALENT ACCEPTABLE			
Chronic	613	0	613	3,751	4,364	14.05
Mental	589	3,665	2,422	9,637	13,788	17.57
General	8,007	3,717	9,866	3,600	13,466	73.27
Tuberculosis	407	0	407	0	407	100.0

Public health centers are evaluated in terms of number of establishments. Of a total programmed need for 27 centers, only one (3.704%) exists. The preventive phases in safeguarding public health can be accomplished through this category. Unfortunately, however, existing state statutes preclude construction in this field by virtue of legislation which prohibits tax levies for direct health purposes. Further, no more than 10% of an annual state allotment may be made available for public health centers within a given state.

Relative priority of hospital categories within the scope of Public Law 725 will be as follows:

I Public Health Centers (up to 10% of Iowa's annual appropriation)
II Hospitals for chronically ill or impaired
III Psychiatric Hospitals
IV Acute General Hospitals
V Tuberculosis Hospitals

Federal Grants-in-Aids funds are available to projects in the highest priority category first. Priority within the category will be determined by the Relative Need Report for the respective classification (Exhibit D, Parts I through V.) It is conceivable that a project will entail several categories of service within a single construction program. The project may not combine a low priority category with a high priority category in order to gain full Federal participation in the project, unless the priority of the lowest category is reached in the respective allotment. In the event the low priority category/categories is/are not reached in the area, only that portion of the project comprising the special service, and a fair portion of the adjunct facilities essential to the proper operation of the service, will be eligible for participation. Such a project will be considered for fractional participation. The rate of participation will be determined on the basis of full cost of the special service, its adjunct facilities pertinent only to the special service, plus a fractional cost of related adjunct facilities common with other services in the hospital. The fraction used to determine participatable costs of the adjunct facilities common to several services will be based upon the number of beds in the special service divided by the total number of beds in the hospital upon completion.

Projects in a lower priority category will not be considered until all applications in the higher priority groups have been evaluated.

In keeping with the resolution by the Advisory Council, the policy of this agency is to disapprove programs and applications for Federal Grants which propose to add to existing unsuitable facilities or replaceable facilities which have inherent fire hazards. Consideration will only be given when such inadequacy is or will be acceptably corrected within the project to comply with current standards within the proposed narrative program of the application. Correction shall be by elimination of the unsuitable facility so that it cannot be diverted to a use allied to hospital service or shall be corrected by a renovation deemed reasonable and practical by the State Agency in a manner that will result in a structure complying with the requirements for a new structure.

Priority of Related Health Facility Categories (Public Law 482)

While the same general principles outlined earlier are followed within categories concerned with the appropriation for Public Law 482, the moneys are identified as being specifically for chronic illness hospitals, convalescent nursing homes, and diagnostic and treatment centers. Only after pointed effort to develop an appropriate

project can application be made for transferring unutilized funds from one category to another. The grant for rehabilitation cannot, under any circumstance, be transferred to or from another category. The only permissible transfer of rehabilitation moneys would be from one state to another in a joint program properly qualified.

The funds for chronic illness hospitals will be guided by the priority table set forth in Part V. Funds established for convalescent nursing homes will be granted in keeping with priority table in Part VI. Greatest unmet need is the primary consideration. In areas with no need met, greatest rurality and lowest per capita income give preference. Both diagnostic centers and rehabilitation centers are placced on a statewide basis and with the guidance of the Iowa Advisory Council. A project is restricted to one or the other of the appropriations.

Intent of Project Sponsors

It has already been indicated that the Advisory Council will evaluate projects on the basis of information submitted by prospective sponsors. Such information will be presented at the time of application in the form of an interview, by written presentation of the proposed program, and by such supplemental data as may be requested to clarify and interpret the intent and the ability of the sponsors to execute the proposed program.

By way of general information, it is pointed out that the basic legislation makes a specific provision for recourse in the event the sponsors, after having received grants-in-aid, dispose of the property improperly or fail to utilize a facility as programmed during the succeeding 20 years. The recourse provides a means for recovering the Federal share of the "then-value" which is reimbursable to the Treasurer of the United States.

Service Area Priority

In service areas with existing acceptable beds, the per cent of bed need met is computed by dividing the number of existing suitable beds in the area by the total computed bed need of the area. The service areas were then ranked in the order of the per cent of need met as shown on the Relative Need Reports. The priority applies to the entire area rather than individual projects within the area (so long as the total bed need is not exceeded). The list of general hospital service areas was further divided into four groups on the basis of patient need met. They are as follows: Group A - 0.0% to 9.9%; B - 10% to 44.9%; C - 45% to 59.9%; D - 60% to 100%.

Those service areas with 100% bed need met but only by consideration of equivalent beds realized through replaceable beds are with further gradation in terms of "% replaceable." Those hospitals with the greatest number of replaceable beds will be given earliest consideration in evaluation of their possible application.

In service areas without existing acceptable beds or facilities, formulae were developed to establish a priority on rural and income factors which are elaborated upon in the following paragraphs.

In determining relative need within each category, the factors applied were given equal weight. In each ease only those factors which directly apply were utilized. The elements of each factor were those of the entire area or population involved, making the application as reasonable and justifiable as was possible.

The specific formulae are outlined below:

Determination of Priority Factors

Rurality Factor:

$$\frac{\text{Area Rural Population}}{\text{Area Rural Population}} = \text{Per cent area rural population}$$

$$\frac{\text{State Rural Population}}{\text{State Rural Population}} = \text{Per cent state rural population}$$

$$\frac{\text{Area \% Rural Population}}{\text{State \% Rural Population}} = \text{Rurality Factor}$$

Per Capita Income Factor:

$$\frac{\text{State Average Per Capita Income}}{\text{Area Average Per Capita Income}} = \text{Per capita income factor}$$

Population Density Factor:

$$\frac{\text{Area Total Population}}{\text{Area Total Square Miles}} = \text{Area average density}$$

$$\frac{\text{State Total Population}}{\text{State Total Square Miles}} = \text{State average density}$$

$$\frac{\text{Area Average Density}}{\text{State Average Density}} = \text{Population density factor}$$

Population Increase Factor:

$$(100)\ \frac{\text{1960 Area Population}}{\text{1950 Area Population}} = \text{\% area population increase + 100}$$

$$(100)\ \frac{\text{1960 State Population}}{\text{1950 State Population}} = \text{\% state population increase + 100}$$

$$\frac{\text{\% Area Population Increase + 100}}{\text{\% State Population Increase + 100}} = \text{Population increase factor}$$

Per Capita Taxable Property Factor:

Taxable Value of all Property + Actual Value of Moneys, Credits, Bank Stocks = Taxable property value

$$\frac{\text{Area Taxable Property Value}}{\text{Area Population}} = \text{Per capita taxable property value}$$

$$\frac{\text{State Total Taxable Property Value}}{\text{State Total Population}} = \text{State per capita taxable property value}$$

$$\frac{\text{State Per Capita Taxable Prop. Value}}{\text{Area Per Capita Taxable Prop. Value}} = \text{Per capita taxable property value factor}$$

Replaceable Bed Priority Factor:

$$\frac{\text{Number of Replaceable Beds}}{\text{Suitable Beds Plus Replaceable Beds}} = \text{Replaceable Bed Factor}$$

Source of Basic Factor Data:

Area and population data taken from 1950 and 1960 census as published by the U. S. Department of Commerce.

Per Capita Income Data is from monthly publication, "Sales Management," dated May 10, 1957.

Taxable Property Value as published by the State Tax Commission in the Annual Report, 1950.

EXHIBIT F

METHOD OF ADMINISTRATION

Publication of the State Plan

1. A general description of the proposed State Plan was publicized in the Des Moines Sunday Register on December 21, 1947, and a public hearing on the Plan was held on December 29, 1947, in the State House at Des Moines, Iowa.

2. After approval of this current revision of the State Plan by the Iowa Advisory Council for Hospitals and Related Health Facilities, the Iowa State Department of Health did take steps to insure publication of a general description of the State Plan in the Des Moines Register & Tribune on 7 June 1962. In addition, societies, organizations, and associations were urged to cooperate in bringing the essential portions and provisions of the State Plan to the attention of interested and affected parties, persons, organizations and associations in their respective communities.

3. One approved copy of the State Plan will be available at all times in the offices of the Iowa State Department of Health, Des Moines, Iowa, for public examination.

4. In keeping with State Statutes, copies of the Plan will be disseminated to persons and organizations with a legitimate interest.

Federal Share Determination

In accordance with the amended Hospital Survey and Construction Act (Section 631 (k) (2); Public Law 725, Public Law 380, and Public Law 482, the "Federal Share" as defined in the above mentioned Acts has been determined as 33 1/3 per centum for all projects proposed to be constructed under these Acts in the State of Iowa during the fiscal year commencing July 1, 1962, except for rehabilitation. In keeping with the Health Grants Manual, paragraph 23-2.10 B-2 (b); Participation in rehabilitation projects under Part "G" shall be at the rate of 50% of the total project cost as set forth by approved application.

Non-Discrimination Statement

No application for Grants-in-Aid toward hospital or related health facilities will be approved under this Plan unless the applicant includes therein the following statement:

> "The applicant hereby assures the State Department of Health that no person in the area will be denied admission as a patient to the facility on account of race, creed or color."

Project Construction Schedule

After approval of the State Plan by the U. S. Public Health Service, this Department will develop Project Construction Schedules which will list the projects for which construction can be commenced immediately. The schedules will be developed by soliciting applications from sponsoring agencies in areas of the greatest unfilled need and in the order of the area priorities shown. The number of projects included on the Project Construction Schedules will depend on the amount of the Federal funds allotted annually to the state for each program.

Changes in Area Priority

When a Part I of Project Construction Application for the construction of a project in any area is approved by the Regional Office of the U. S. Public Health Service, the per cent of need met in the respective area shall immediately be adjusted by adding to the existing suitable beds in the area, the number of beds in the project, and recomputing the new per cent of need met. Further, when construction contracts are let for a project proceeding without Federal Grants-in-Aid, the area per cent of bed need met will be immediately adjusted to reflect the suitable beds in the project. Projects constructed without Federal assistance will be considered as existing suitable beds during construction. If construction of the project is terminated short of completion for one reason or another, the beds will be considered non-existant and bed count adjusted accordingly.

The total suitable beds existing in an area together with the suitable beds under construction, both with and without Grants-in-Aid, will be used to determine the priority of the area each year.

Factors Determining Project Construction Schedule

Projects will be selected for the Project Construction Schedule after consideration of the following factors:

1. The priority of the project as determined in accordance with the principles outlined in this plan for determination of relative need.

2. The intent of sponsoring agencies to begin construction within the stipulated period.

3. The ability of the sponsoring agency to meet the financial requirements for construction, maintenance, and operation of the proposed facility.

4. The maintenance of an appropriate balance in the construction of the various types of facilities. This balance of facilities need not be reflected in each Project Construction Schedule.

5. The sponsoring agency shall assure this State Agency that no person in the area will be denied admission as a patient to the facility on account of race, creed or color.

6. Evaluation by the State Agency of the program, staffing and operational policies which the sponsors present in the form of interview, written presentation, and such supplemental data as may be requested to clarify and substantiate the intent of the program presented.

7. The Project Construction Schedule pertinent to allotment under

   (a) Public Law 725 will recognize approvable applications in the order of priority of hospital categories, and thereafter in the order of priority within a category.

(b) Public Law 482 will include approvable applications for projects within each category and within the limits of funds allotted for the specific category. If funds for nursing homes, diagnostic and treatment centers, or chronic illness facilities are not applied for, in whole or in part, the funds not applicable to approvable applications will be available for transfer to one or both remaining categories. These transferrable funds will be held a minimum of 30 days pending recommendations of the Iowa Advisory Council.

The Project Construction Schedules will be submiteed to the U. S. Public Health Service, District Office, no sooner than one month after approval of the revised State Plan. This one month period is provided to enable higher priority projects to develop construction interest and furnish essential financial and/or other assurances.

Project Applications

Applications for Federal assistance will be submitted on the Project Construction Application (Parts I through IV) which is prescribed by the U. S. Public Health Service.

If a project is in the highest priority group, Part I of the Project Construction Application may be approved and forwarded prior to approval of the State's Project Construction Schedule. If the project is not in the highest priority group, Part I of the Project Construction Application will be submitted with the Schedule.

To preclude possible abuse of high priority status, a project on a Construction Schedule which fails to complete all elements of the Construction Application within the prescribed time will automatically be disqualified from priority consideration the following year.

To facilitate proper functioning and consistent procedure while fairly considering all applications for funds, the following outline will govern the handling of applications:

1. All high priority areas will receive approximately 30 days notice of the availability of funds, thus allowing prospective sponsors adequate time for preparation of a written presentation of intent.

2. The prospective sponsors will, before the end of the established 30 day period, submit a letter of intent to this Department. Such letter shall, with its evidence of ability, state specifically:

   a. Name of organization sponsoring project with a complete list of officers and board members.

   b. State of funds available and means to procure additional funds if required.

   c. Statement that there will be no discrimination between patients because of race, creed or color.

   d. Name of architect or engineer retained.

   e. A succinct description of the project including the type and size of facility proposed. the population planned for, the program of treatment proposed, and other descriptive data outlining the desires and intent of the applicant.

3. Upon receipt of a letter of intent from the owners, appropriate Part I forms will be supplied to the prospective sponsors for guidance in the preparation of

certain supporting documentation. Items to be included in triplicate in an approvable application are:

a. Part I of Application

b. Evidence of non-profit status as documented by the Bureau of Internal Revenue.

c. Evidence of architectural contract, either reproductions or certified true copies.

d. A complete and detailed narrative description setting forth the proposed program (See appropriate sections for further discussion.)

e. Acceptable schematic drawings by an architect registered in Iowa.

f. A realistic cost estimate signed by the architect which is judged by this agency to be adequate and appropriate for the proposed project and its budget.

g. Summary of sponsor's share of funds and evidence of same, certified to by appropriate authority. The owner's share shall be in terms of an acceptable budget incorporating the architect's estimate and concurred in by this office. Moneys and estimates shall be firm, realistic and acceptable to the State Agency before an application will be considered approvable.

h. The owner and architect shall be prepared to give conclusive evidence that the project will proceed directly through planning and be placed on the market for bidding and contracting before a date specified by letter of invitation. Failure by the owners/architect to provide evidence of suitable progress in keeping with the assurance given the Advisory Council at the time Part I was approved will be grounds for reviewing the application. Such failure will warrant reconsideration and reassignment of funds to a project prepared to proceed directly to contract in keeping with the intent of the program and plan.

i. This Department will review relative progress during design stages to determine compliance with previously stated schedules which were the basis for the assignment of funds.

4. The sponsor or his agents will then prepare and complete the Part I Application forms and submit same in an approvable manner to this department before the end of the 30 day period.

5. Upon the expiration of the 30 day period, all approvable Construction Applications will be compared to determine their relative position in the table of priority.

a. Projects will be given preference in the order set forth in earlier pages. (See Priority of Hospital Categories for order of hospital categories and area priority within the specific categories.)

b. In the event the presented approvable Part I Applications are insufficient to utilize available funds, this office will further publicize the availability of funds to those areas which are next highest in priority and thus go through the priority tables until funds are utilized.

6. This Department, upon determining the approvable Part I Applications falling within the scope of allotted funds, will present to the U. S. Public Health Service Project Construction Schedules and the listed approvable Part I Applications for the subject year. Said Project Construction Schedules will be modified during the course of the administrative year for reasons such as:

a. Minor adjustments when individual budgets, after bidding, vary from estimates set forth in the Part I.

b. Sponsors fail to comply with previous agreements such as:

1. Giving evidence of adequate funds.

2. Failing to comply with design or program standards or regulations, either State or Federal.

3. Failing to comply with the planning schedule which was the basis for approval of Part I.

c. Voluntary withdrawal from program.

d. In the event (a), (b) and/or (c) derive sufficient uncommitted funds, the next approvable and qualified Part I Application may be incorporated into the current modified Project Construction Schedule for participation in the available funds.

Transfer of Funds to Adjacent States

As has been stated earlier, the population growth pattern for Iowa has been guided considerably by the rivers on the east and west borders, resulting in most of our population centers being on state lines. The resultant hospital usage pattern has developed unnormally to induce interstate areas. This State Plan, in turn, provides that transfer of allotments between states (i.e. to/from Iowa) will be considered and inaugurated upon survey and evaluation of case merits. In the event of transfer from Iowa allotment, consultation of the Iowa Advisory Council and authorization by the Governor of Iowa will determine establishment of such request to the Surgeon General, U. S. Public Health Service, in keeping with existing Federal Regulations.

Standards of Construction and Equipment

Construction and the equipping of projects assisted under this program shall comply with the general standards of construction and equipment as outlined in Appendix A (Revised 5 January 1955) of the Regulations promulgated under Public Law 725 and Public Law 482.

Copies of such standards are available for inspection at the State Department of Health, Division of Hospital Services.

Inspection and Certification by the State Department of Health

Upon written request for payment of an installment by a sponsor, the Department shall make an inspection of the project to determine that services have been rendered, work has been performed, wage rates and records are in order, and purchases have been made as claimed by the applicant and in accordance with the approved project applications. In addition, the Department may make such additional inspections as the State Department of Health deems necessary. Reports of each inspection will be retained in the files of this Department. Before a certification for payment is made the inspection

report shall show that:

1. The amount claimed covers payment only for work performed, materials and equipment delivered, and services rendered.

2. Such work, materials, equipment and services are necessary for the carrying out of the project as approved.

3. The cost of work, materials, equipment and services are allowable costs that may be participated in by the Federal Government.

4. Work in place has been performed satisfactorily, is in accordance with the approved plans and specifications, and has a value on which the claim for payment is based.

5. Wages paid and records established are in accord with Federal Regulations.

Certification for Payments

Requests for payments under the construction contracts shall be submitted by applicants to this Department at the time prescribed by Section 53.78 (a) of the Regulations, and which, in general, are as follows:

1. The first installment when no less than 25 per cent of the work of construction of the building has been completed.

2. The second installment when the mechanical work has been substantially roughed in, and the equipment list has been approved.

3. The third installment when work under the construction contract is completed and final inspection made.

Requests for payment of the Federal share of other allowable costs such as architect's fees, inspection cost, and cost of equipment shall be included in requests for payments made at the stages indicated above.

Consideration will be given to the payment of an additional installment prior to payment of the final installment, provided the Department finds there are unusual circumstances. Payments prior to final payment shall total less than 95 per cent of the Federal share of the project. Final payment will be authorized only after verification of all claims by an appropriate Federal Agency audit.

Federal funds shall be deposited with the Iowa State Treasurer in the Hospital Construction Fund in accordance with the State Law, Chapter 135 A, 1954 Code of Iowa, as amended by House File 392, 56th General Assembly.

The State will promptly remit or credit all payments of Federal funds received by the State for payment to applicants for approved construction projects.

Accounting System and Records, Construction Allotments

The Department shall be responsible for establishing and maintaining accounts and fiscal controls of all Federal funds allotted for construction projects. The fiscal records shall be so designed as to show at any given time the Federal funds allotted, encumbered and unencumbered balances.

The Department will comply with the provisions of Section 53.129 of the regulations by maintaining the necessary accounting records and controls, and requiring applicants for Federal funds to maintain adequate fiscal records and controls.

The Department agrees that it will retain on file all documents coming into its possession which relate to any expenditure under Public Law 725 and Public Law 482. In addition, the State Department of Health will require steps necessary and possible to assure that applicants (1) retain all relevant and supporting documents for two years after project completion, and (2) establish suitable property inventory records covering all equipment of more than nominal value.

The Department further agrees that it will require a statement from the applicant agreeing that it will:

1. Prepare accounting records, controls and documents described in the above for a period of at least two years beyond its participation in the program.

2. Take such steps as are necessary and possible to assure that applicants retain the fiscal records, controls, and documents described in the above for a period of at least two years after the final payment of Federal funds.

3. Retain affidavits, wage rolls, and recores pertaining to wages, for a minimum period of two years after final payment.

Annual Revisions of the Over-All Hospital Construction Program

The Department hereby agrees that it will from time to time as is necessary, but at least annually, review the over-all hospital construction program. The State Department of Health further agrees that it will, on/about 1 July of each year, submit to the Surgeon General a report which contains such revision of the over-all hospital construction program as the Department considers necessary.

Personnel Standards

All personnel employed in administering the State Plan will be appointed under and subject to the merit system maintained by the Iowa Merit System Council in compliance with the Act, Section 623 (a) (6). The Iowa Merit System Council will furnish the U. S. Public Health Service with such data and information as is necessary to determine compliance with the Act and Regulations.

Conflict of Interest

No full time officer or employee of the State Agency, or any firm, organization, corporation or partnership which such officer owns, controls or directs, shall receive funds from the applicant, directly or indirectly, in payment for services provided in connection with the planning, design, constructing or equipping of a project.

EXHIBIT G

MINIMUM STANDARDS FOR MAINTENANCE AND OPERATION

The Department has adopted, in accordance with Section 53.127 (c) of the Federal Regulations and Chapter 135 B and 135 C, Code of Iowa (1954), the attached regulations which prescribe minimum standards of maintenance and operation for all hospitals and nursing homes aided under the Hospital and Medical Facilities Survey and Construction Act. The minimum standards are published separately under the titles "Rules and Regulations for Hospitals and Related Institutions," and "Rules, Regulations and Minimum Standards Governing Nursing Homes." The State has not developed standards of operation for "Diagnostic and Diagnostic and Treatment Centers" and "Rehabilitation Centers." (Copies of the established standards will be made available upon request).

EXHIBIT H

FAIR HEARING PROCEDURE

Rules and Regulations of the State Department of Health Governing Hearings to be Provided Applicants

The Department will provide an opportunity for a fair and public hearing to any applicant who has requested Federal Aid in hospital construction and which appeals for a hearing to clear any misunderstanding or dissatisfaction with any action or ruling by the State Department of Health. The applicant shall be entitled to a hearing on any one of the following:

1. Denial of opportunity to make application,
2. Rejection or disapproval of application, and
3. Refusal to reconsider application

Appeals from any action or decision of the State Department of Health must be made by the applicant in writing within 15 days from date of adverse decision or action by the Department.

The appellant may, if so desiring, be represented by friends or counsel or both, and shall have full opportunity to examine all records pertaining to the subject, question witnesses, and present any evidence pertinent to the discussion.

The hearings will be presided over by the Commissioner of Health or his representative.

The decision shall be based on evidence presented at the hearing and shall be made in writing within 30 days of date of said hearing. A stenographic record of the hearings shall be made and transcriptions of such records will be available upon request and payment of cost of transcribing.

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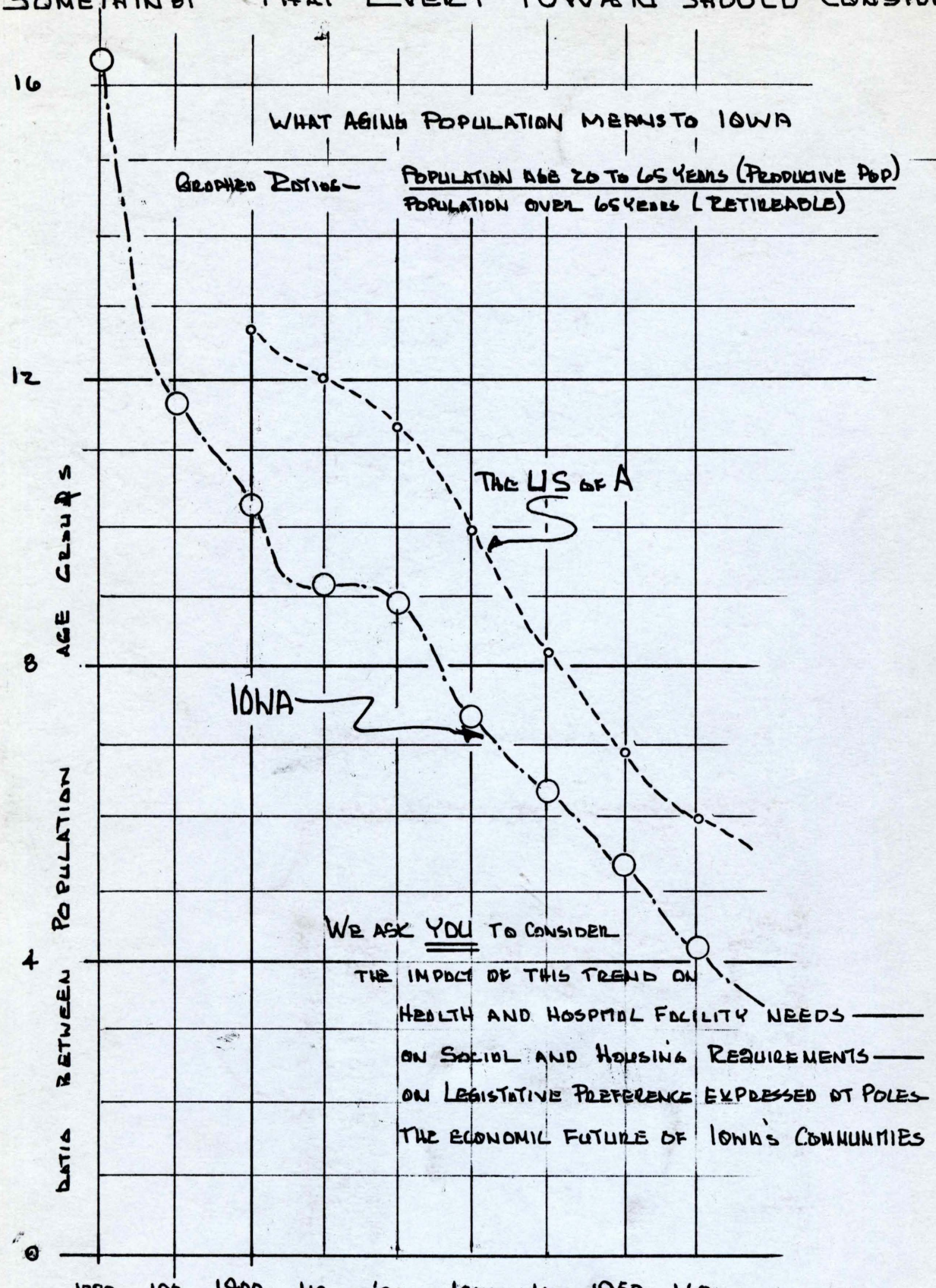
SOMETHING THAT EVERY IOWAN SHOULD CONSIDER

WHAT AGING POPULATION MEANS TO IOWA

GRAPHED RATIOS — POPULATION AGE 20 TO 65 YEARS (PRODUCTIVE POP) / POPULATION OVER 65 YEARS (RETIREABLE)



WE ASK YOU TO CONSIDER

THE IMPACT OF THIS TREND ON

HEALTH AND HOSPITAL FACILITY NEEDS

ON SOCIAL AND HOUSING REQUIREMENTS

ON LEGISLATIVE PREFERENCE EXPRESSED AT POLES

THE ECONOMIC FUTURE OF IOWA'S COMMUNITIES

TRENDS IN POPULATION CHARACTERISTICS IOWA VERSUS U.S.

IOWA DEPT OF HEALTH HOSPITAL SERVICES DIV