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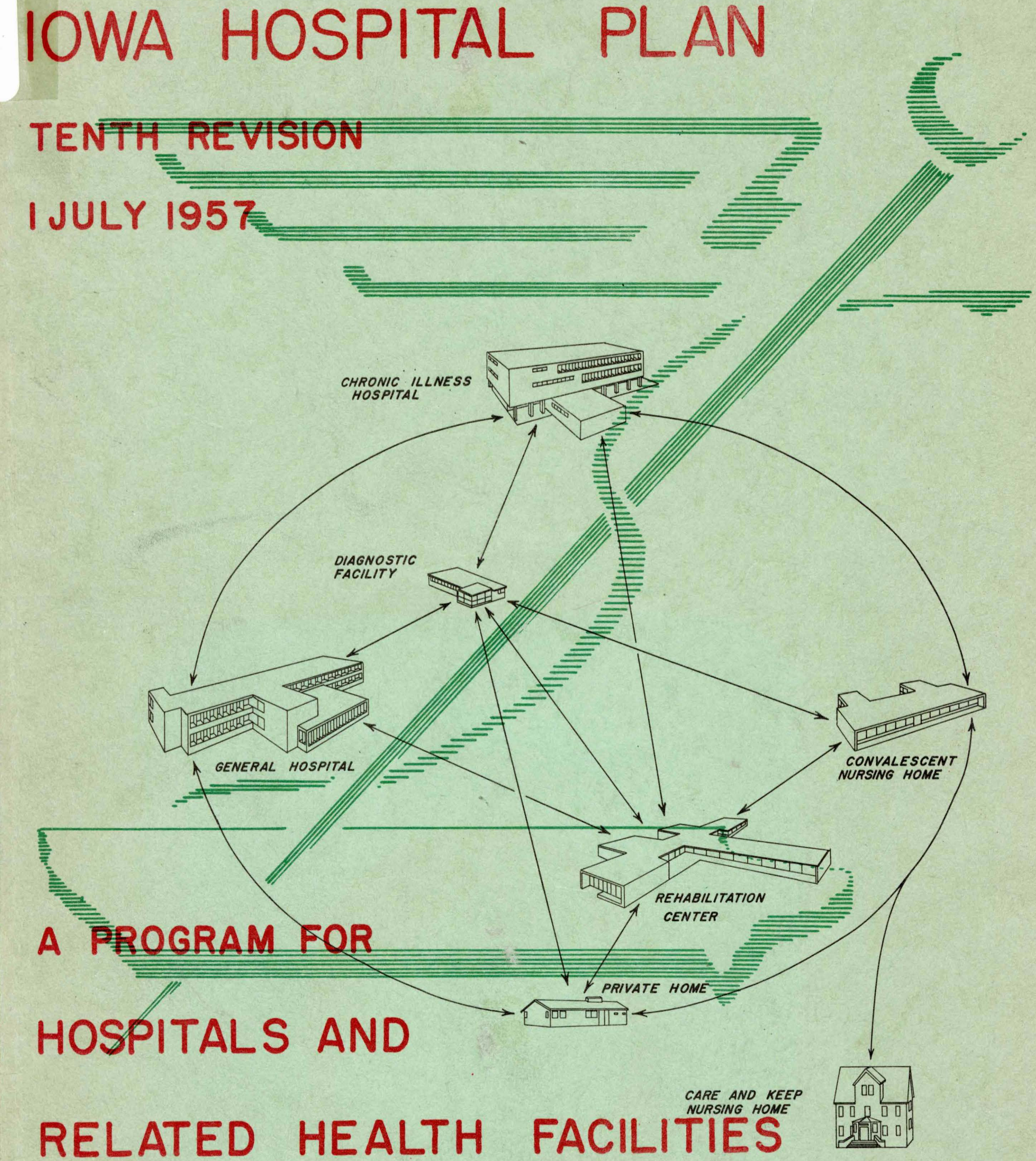
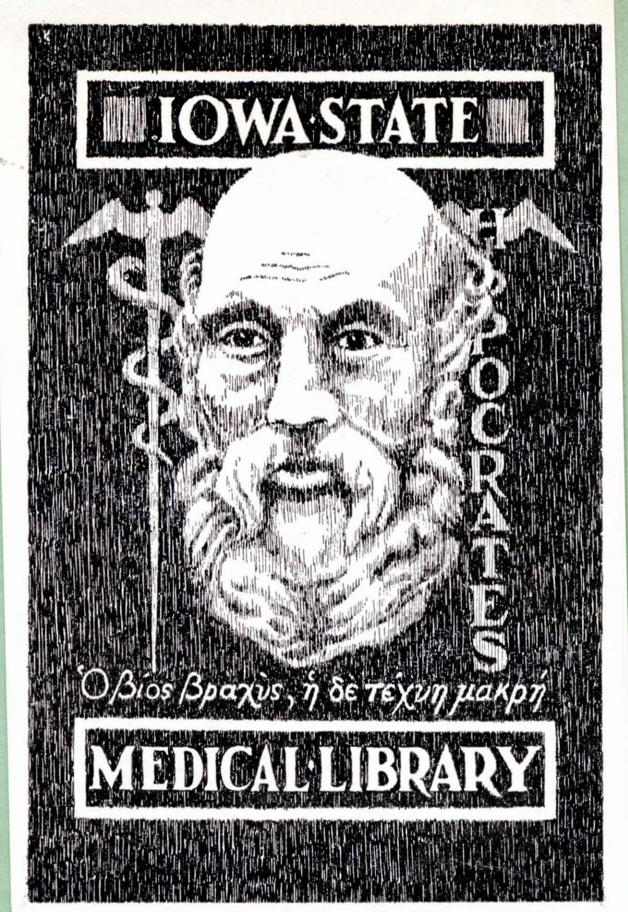
IOWA HOSPITAL PLAN

TENTH REVISION

1 JULY 1957



A PROGRAM FOR HOSPITALS AND RELATED HEALTH FACILITIES



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STATE OF IOWA

STATE BOARD OF HEALTH

EX'OFFICIO	APPOINTIVE (By Governor)
Herschel C. Loveless, Governor	Donald C. Conzett, M. D., Dubuque
Melvin D. Synhorst, Secretary of State	Franklin H. Top, M. D., Iowa City
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Clyde Spry, Secretary of Agriculture	Samuel P. Leinbach, M. D., Belmond

Edmund G. Zimmerer, M.D.

Commissioner of Public Health

STATE DEPARTMENT OF HEALTH

EDMUND G. ZIMMERER, M.D., COMMISSIONER

DIVISION OF HOSPITAL SERVICES

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Winifred W. Cleveland, R. N., B. S.	Associate Director
H. W. Stricker, B. S.	Chief Engineer
W. W. Lane, B. S.	Engineer
Amanda Stahl, R. N.	Consultant Nurse
Annetta M. Austin, R. N.	Consultant Nurse
Myrtle V. Burgert, R. N.	Consultant Nurse

OFFICES

State Office Building

Des Moines 19, Iowa

Oct 9, 1957 Iowa St. Dept. Health Copy

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DEFINITIONS

ACUTE SHORT-TERM GENERAL HOSPITAL AND COMMUNITY CLINIC. A general hospital is "Any hospital for in-patient medical or surgical care of acute illness or injury and for obstetrics, of which not more than 50 percent 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." Facilities with a capacity of less than 20 beds are defined as community clinics.

ALLIED SPECIAL HOSPITALS. Cardiac, eye-ear-throat, isolation, maternity, children's orthopedic, and skin and cancer, as well as other hospitals providing similar specialized types of care commonly given in general hospitals. The term excludes mental, tuberculosis, and chronic illness hospitals.

ANCILLARY SERVICES. Ancillary services are those adjunct facilities normally associated with the diagnostic/treatment fields of patient care and which are available to out-patient/in-patient 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 of 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 deseases, 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 the services provided in the facility are available to the general public in accordance with these regulations."

CONVALESCENT 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"

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 provide 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."

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 out-patient departments and clinics of public or non-profit hospitals. 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 non-profit 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."

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, out-patient 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 in-patient 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, Allied, 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.

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 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 are 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

FORM PHS-708
REV. 7/55

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUDGET BUREAU NO. 68-R388.1

ANNUAL REVISION OF STATE PLAN

A. DESIGNATION OF STATE AGENCY

1. Give the name of the State Agency and the administrative unit responsible for administering the State Plan.

2. Has the organization of the State Agency been changed since the existing State Plan was approved? ☐ YES ☒ NO

(If "yes," attach a chart 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 ☒ NO

(If "yes," attach a copy 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 or the manner in which consultation services for rehabilitation is to be provided to the State Agency? ☒ YES ☐ NO

(If "yes," attach a statement showing the names, present positions, and interests or professions represented by each new member and the names of the members replaced or the groups or organizations concerned with rehabilitation.)

See Page 11 of the State Plan

D. DEVELOPMENT OF HOSPITAL AND MEDICAL FACILITIES CONSTRUCTION PROGRAM

Attach new Forms PHS-5; 5-1; 5-2; 5-3; 7; 10; 10-1; 10-2; 11; 11-3; and 12, 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 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 to replace the form approved in the existing State Plan. 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? ☒ YES ☐ NO

(If "no," attach revised or additional pages 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
/s/	Edmund G. Zimmerer, M.D., MPH	1 July, 1957

Commissioner of Public Health

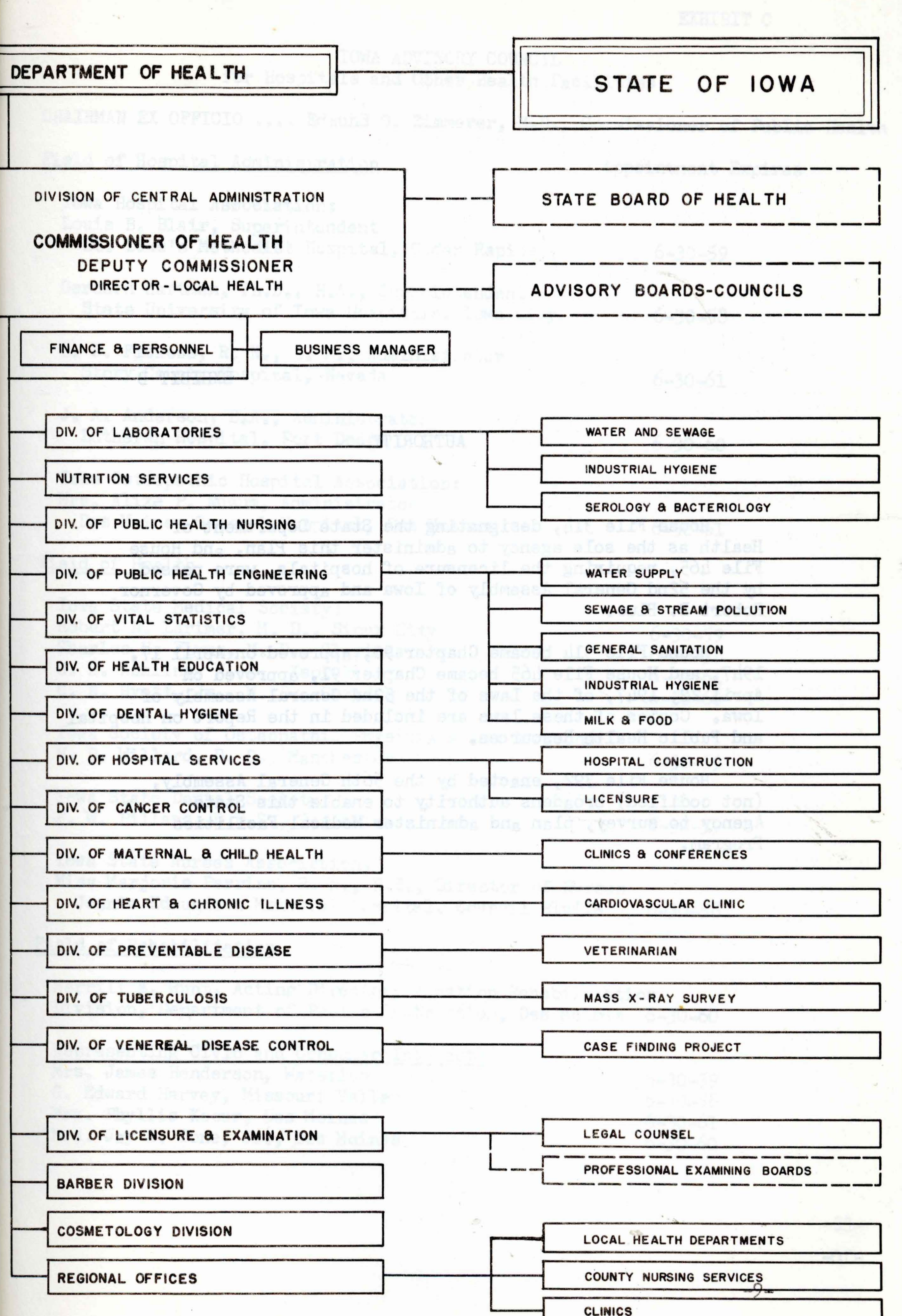

DEPARTMENT OF HEALTH
STATE OF IOWA
DIVISION OF CENTRAL ADMINISTRATION
COMMISSIONER OF HEALTH
DEPUTY COMMISSIONER
DIRECTOR - LOCAL HEALTH
STATE BOARD OF HEALTH
ADVISORY BOARDS-COUNCILS
FINANCE & PERSONNEL
BUSINESS MANAGER
DIV. OF LABORATORIES
WATER AND SEWAGE
INDUSTRIAL HYGIENE
SEROLOGY & BACTERIOLOGY
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, designating the State Department of Health as the sole agency to administer this Plan, and House File 465, requiring the licensure of hospitals, were passed by the 52nd General Assembly of Iowa and approved by Governor Robert D. Blue.

House File 314 became Chapter 90, approved on April 17, 1947, and House File 465 became Chapter 91, approved on April 22, 1947, of the Laws of the 52nd General Assembly of Iowa. Copies of these laws are included in the Report on Hospital and Public Health Resources.

House File 392, enacted by the 56th General Assembly, (not codified) broadens authority to enable this State Agency to survey, plan and administer Medical Facilities Program.

EXHIBIT C

IOWA ADVISORY COUNCIL
for Hospitals and Other Health Facilities

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

Field of Hospital Administration	Appointment Expires
Iowa Hospital Association: Louis B. Blair, Superintendent St. Luke's Methodist Hospital, Cedar Rapids	6-30-59
Gerhard Hartman, Ph.D., H.A., Superintendent State University of Iowa Hospitals, Iowa City	6-30-58
B. D. Fickess, R. N., B. A., Administrator Story County Hospital, Nevada	6-30-61
J. A. Anderson, B.A., Administrator Lutheran Hospital, Fort Dodge	6-30-60
Iowa Osteopathic Hospital Association: Mrs. Alixe P. Nuzum, Administrator Des Moines General Hospital, Des Moines	6-30-61
Field of Health	
Iowa State Medical Society:	
Robert N. Larimer, M. D., Sioux City	6-30-59
Charles H. Flynn, M. D., Clarinda	6-30-58
G. H. Ashline, M. D., Keokuk	6-30-61
C. N. Hyatt, Jr., M. D., Corydon	6-30-60
Iowa Society of Osteopathic Physicians and Surgeons: H. B. Willard, D. O., Manchester	6-30-59
Iowa State Dental Society: F. W. Pillars, D.D.S., Des Moines	6-30-59
Iowa State Nurses Association: Miss Marjorie Perrine, R. N., B.S., Director of Nurses Jennie Edmundson Memorial Hospital, Council Bluffs	6-30-58
Field of Rehabilitation	
Merrill E. Hunt, Acting Director, Vocation Rehabilitation Division, Department of Public Instruction, Des Moines	6-30-60
Representing Civic and Consumer Interests	
Mrs. James Henderson, Waterloo	6-30-59
G. Edward Harvey, Missouri Valley	6-30-58
Mrs. Phyllis Kocur, Des Moines	6-30-61
Mrs. Jay S. Tone, Jr., Des Moines	6-30-60

MEDICAL
SPHERE

Rehabilitation
Center

Diagnostic
Facility

Nursing Home
Convalescent
Infirmary
Sanitoria

General Hospital

Specialized
Hospital
Chronic
Mental
T. B.

Private Home

Foster Home

Custodial
Homes for Aged

SOCIAL
HOUSING
SPHERE

County Home

Boarding Homes
Children

Child
Care
Institution

Veteran's Homes

EXHIBIT D

DEVELOPMENT OF HOSPITAL AND MEDICAL FACILITIES PROGRAM

In considering the availability and need for hospital facilities, the general public immediately thinks of the community hospital serving the acute general hospital need. The average person relies upon this hospital to meet his need, and seldom considers the over-all medical care program and the need for special services provided by tuberculosis, mental, and chronic illness hospitals.

Because of the acute nature of accidents, illness, and obstetrical care, and the necessity for immediate attention, the provision of acute general hospital facilities readily accessible to the general public, is considered primarily. For the purpose of this Plan, we first considered the adequacy and distribution of hospitals, and in subsequent parts, the special facilities.

Hospitals in General

A thorough and exhaustive survey of existing hospital facilities and public health measures was made, reported, and discussed in detail in Report of Hospitals and Public Health Resources prior to the development of the first Iowa Hospital Plan. Included in the study were:

1. Determination of hospital needs
2. Need for coordinated hospital system
3. Factors pertinent to hospital service areas

In accordance with the Federal Act, this information is maintained current through an annual inventory of facilities recognizing new construction both with and without Federal assistance, alteration and changes in existing facilities, and the loss through the closing of facilities.

The development of the proposed hospital service area and hospital region maps was discussed in detail in the above mentioned report. The maps include the location of existing or proposed hospitals, the boundaries, population, and identification of each service area, regional hospital area boundaries, and proposed relationship between hospitals. The factors used in delineating these areas are re-evaluated annually and the areas adjusted accordingly.

Medical Facilities

Upon expanding the scope of the Hill-Burton Program to include medical facilities, survey activity has been extended to determine the availability and adequacy of the related health facilities. Note that chronic illness hospitals are included in the expanded program as are convalescent nursing homes, diagnostic facilities, and rehabilitation centers.

Since the 57th General Assembly adjourned, the Governor has signed House File 572, an act defining nursing homes for licensure purposes. This act becomes effective July 5, 1957 and will be guided by a survey of care institutions related to Convalescent Nursing Homes. No effort has been made to induce this material into this tenth revision, Iowa Hospital Plan, until the entire study is completed and realistically evaluated.

ACCEPTABLE AND NON-ACCEPTABLE HOSPITAL REPORTS

The annual inventory of general and allied special hospitals in the State is presented in tabular form in the Acceptable and Non-Acceptable Hospital Reports. Military and prison hospitals and institutions furnishing primarily domiciliary care, or which do not provide a community service, are not included.

It will be noted that the hospital beds are divided into acceptable and non-acceptable beds in this report. A hospital bed is considered non-acceptable 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 checked by the records of the Iowa Insurance Service. This information was further substantiated by conferences with designing architects, hospital administrators, and the State Fire Marshal.

The bed capacities reported in this inventory represent the normal designed capacity of the facility. The normal designed capacity is determined by a review of architectural plans whenever available. In hospitals where plans are not available, the normal designed capacity of the building is determined by Division personnel surveying the building using the space requirements of 100 sq. ft. for single rooms, 80 sq. ft. per bed in multiple rooms or wards, 40 sq. ft. per bed for pediatric beds or cribs, and 20 sq. ft. per bassinet in newborn nurseries as established by the State Hospital Licensing Law.

The normal designed capacity may, and frequently does, disagree with the bed complement reported by the hospital administrator. This condition results from the hospital necessarily providing additional beds (to satisfy demand for hospital services) than the hospital was originally designed to accommodate. The percent of occupancy has been adjusted to agree with the normal designed capacity.

Suitability Report

Medical facilities are classified as suitable or unsuitable in terms of whether or not they constitute a public hazard. However, some establishments in fire-resistant structures are declared replaceable if one or more of the following conditions exist:

1. The facility is not reasonably accessible
2. The structure, because of obsolescense, original design, or general arrangement, cannot economically or reasonably be corrected.
3. Admission policies are restrictive
4. By virture of admission policies, the care rendered classifies the institution as a domiciliary unit

It is pointed out that a number of replaceable units do render an appreciable service in their communities. If these institutions expand their skilled care program and/or modify their admission policies, they will be reclassified as suitable facilities.

Legislative Intent

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

SUMMARY OF PROGRAM TO DATE

REMARKS	CATEGORIES OF HOSPITALS			
	General	T.B.	Mental	Chronic
Construction of Hospital Beds with assistance in 1948	253			
1949	444		26	
1950	794			
1951	204		138	
1952	201		33	74
1953	158			
Reclassification of University of Iowa Hospital in terms of usage	(-681)			(+681)
1954	141			58
1955	267		25	177
1956	152		48	101
Total beds built with aid	2,614	0	270	410
Acceptable beds available in 1947	6,633	672	3,113	0
(Adjustment in Tabulation)	(-681)	(-76)		(+681)
Beds built without aid	1,910	--	617	--
Total Acceptable beds available 1 July 1956	10,476	596	4,000	1,091
Beds proposed to meet Iowa's present needs	2,280			3,204
Proposed beds set forth in current Iowa Plan	12,756	596	13,450	4,295
Percent of Unmet Need	17.87	0.00	70.26	74.60

Note: The above data applies also to tabulation of page (111)
All totals reflect net changes in bed count. It does not identify bed loss due to conversion to service areas or to other categories.

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."

TEACHING FACILITIES

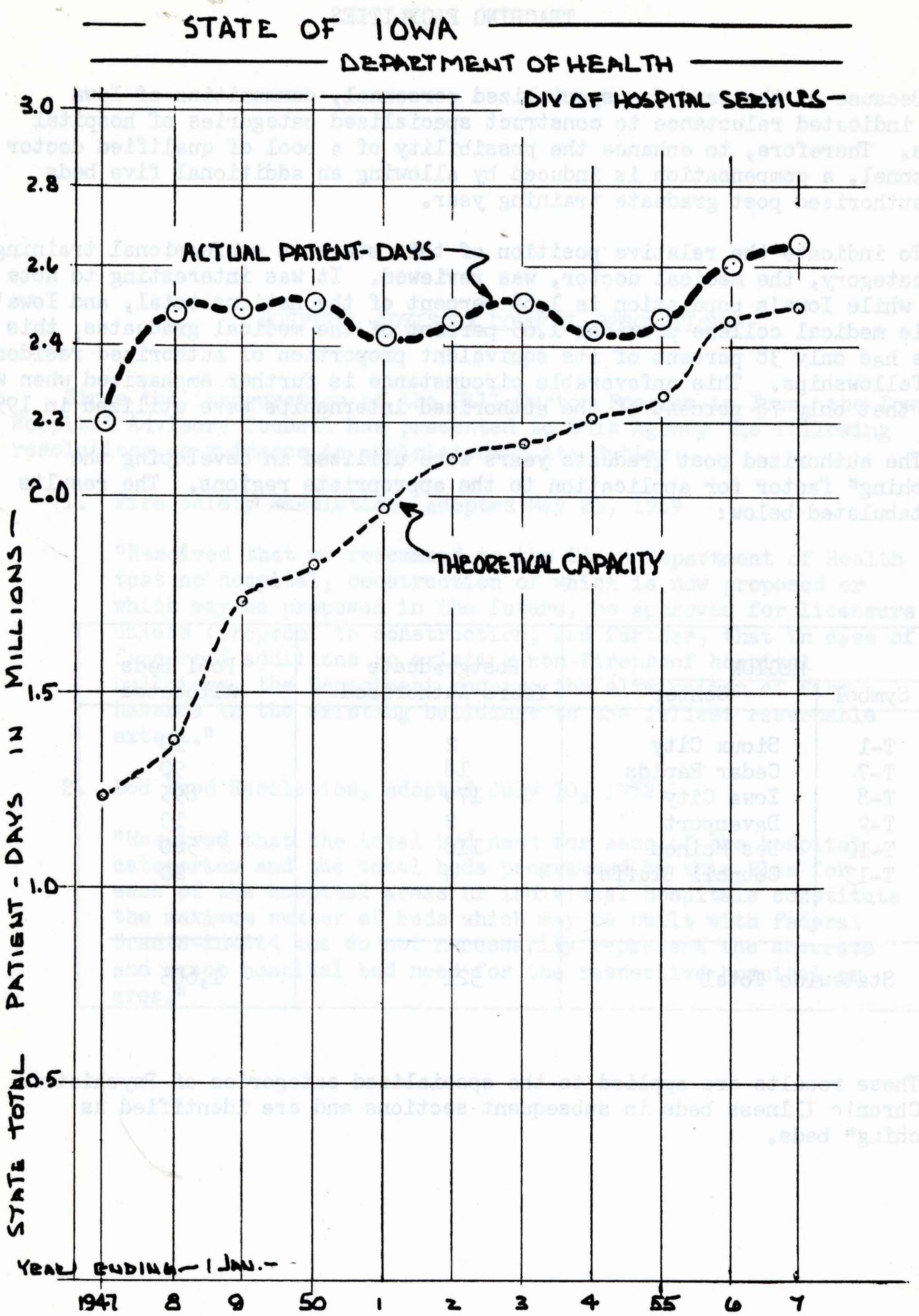
Because of the need for specialized personnel, communities of Iowa have indicated reluctance to construct specialized categories of hospital units. Therefore, to enhance the possibility of a pool of qualified doctor personnel, a compensation is induced by allowing an additional five beds per authorized 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 percent of the nations total, and Iowa's single medical college provides 1.65 percent of the medical graduates, this state has only 38 percent of its equivalent proportion of authorized residencies and fellowships. This unfavorable circumstance is further emphasized when we note that only 78 percent 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	Pool Beds
Symbol	Center	Years Authorized	Allocated
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.



A COMPARISON OF ACTUAL PATIENT-DAYS AND—
THEORETICAL PAT-DAY CAPACITY OF TOTAL STATE ACCEPTABE BEDS
(INCLUDING BEDS UNDER CONSTRUCTION)
WHEN OPERATED AT OPTIMUM (65%) OCCUPANCY

Division of Hospital Services
Iowa State Department of Health

PART 1. ACUTE GENERAL HOSPITAL BEDS

To determine the acute general hospital bed need and the number of facilities, an extensive survey of the entire State was made. The survey included information on the existing hospitals and related facilities, population distribution, road systems, trade patterns, financial resources, geographical factors, community patterns, industrialization, political sub-division, etc.

Based upon a careful evaluation of these many factors, including the location of present hospital facilities and the needed facilities, the State was divided into hospital service areas as shown on Hospital Service Area Map (Page 22). The integration of these facilities and services into a desirable coordinated hospital system is shown on the Hospital System Map (Page 23).

From the survey schedule, definite information was obtained regarding the present hospitals and their use. This information includes the acceptable and total number of beds, the percent of occupancy, and the average daily census as shown on Acceptable and Non-Acceptable Hospital Report (Pages 24 through 37).

The State average bed-birth, bed-death ratio of 3.4 beds per thousand population as developed in the Report on Hospital and 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 beds, 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 bed 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 needs in certain areas, particularly the larger cities, because these areas now receive a large number of hospital patients from population outside their immediate areas. In fact, many hospital centers now have occupied beds in excess of the humber 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, Page 38).

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 Plan provides that the University Hospital shall treat during the fiscal year the number of committed indigent patients from each county which shall bear the same relation to the total number of committed indigent patients admitted during the year from all counties as the population of such county shall bear to the total population of the State, according to the latest official census.

Recognizing this statewide service to the entire population, the total bed need of each area was reduced by its proportionate share of the University of Iowa Hospital 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 Hospital 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 larger areas.

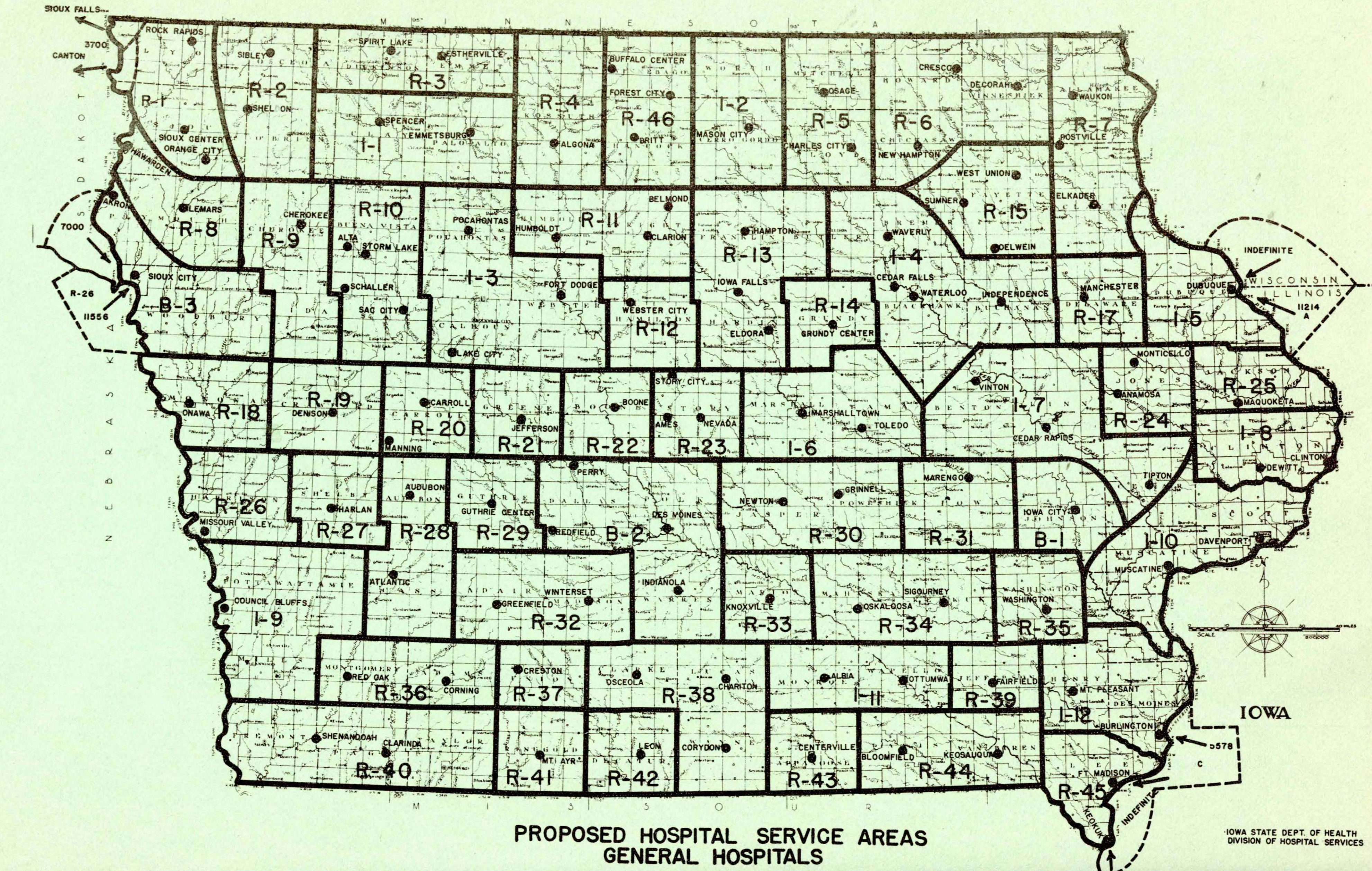
A previous revision of the Iowa State Plan permitted the construction of general hospital beds (Total Beds Needed, General Bed Distribution Report) in excess of the State ratio (General Bed Distribution Report) on the basis that the State population had increased over the population used in the development of the Plan. Population figures based upon the 1950 census of population indicate that this assumption was correct. The 1950 census of population was used in this revision and certain adjustment of pool beds was deemed necessary to prevent the over-building of acute general hospital beds in the State of Iowa. The previously submitted work sheets, allocation of beds, and number of facilities apply in general to this revision. Only differences resulting from changes in population, total bed count in existing facilities, and new facilities constructed both with and without Grants-in-Aid were made. The new allocation will be found in the General Hospital Summary.

The Division of Hospital Services of the Iowa State Department of Health made a study of the out-of-state population together with the state agencies of the several surrounding states. The State of Iowa is unique in that in excess of 50 percent 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 the border states 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 the 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.

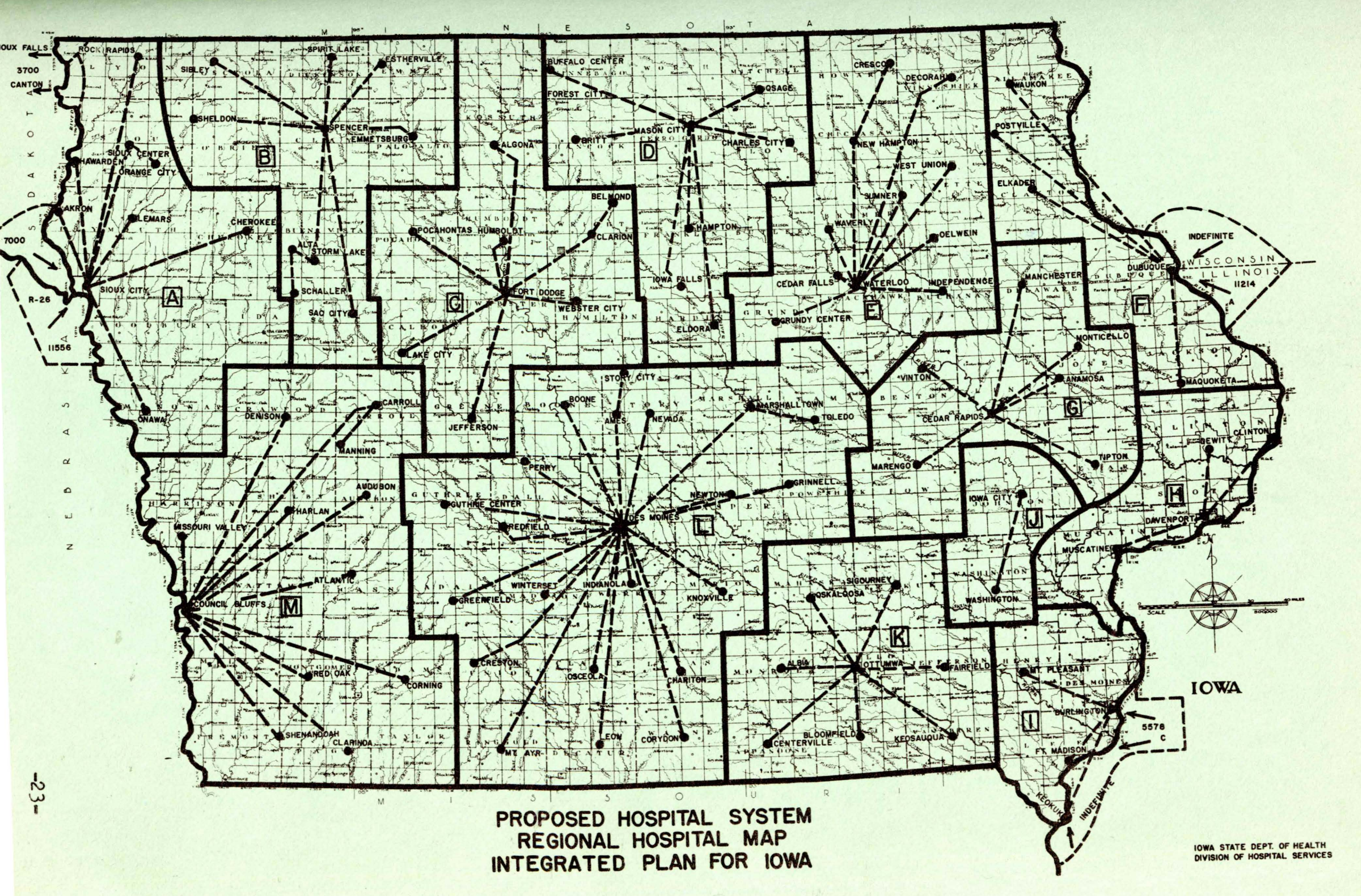
The excess existing general hospital beds in certain areas are due to out-of-state population. Since it is impossible to justify the existence of these beds without acquiring additional out-of-state population, a pool bed adjustment is necessary to eliminate this excess and prevent the over-building 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 will develop because of normal obsolescence, unique developments in a particular community, or transition in population characteristics. Where ancillary services are demanded, but are inadequate to meet immediate local needs or the referral load which results from integration of medical services, special consideration is available even though it may be beyond the needs indicated by the relative priority based on beds. The Iowa Hospital Advisory Council will recognize a sponsor's presentation of such special problems provided a complete and factual statement is made before a formal meeting of the Council and provided specific facts and studies are available for review. Special studies may be called for to clarify details of the program to the satisfaction of the Council and the State Agency. In the light of the facts presented orally and by written report, the merits of the program will be weighed and the Council will determine the relative priority to be assigned the proposal in the annual allotment of Federal funds.

Additional criteria exist for those communities that are with no un-met bed need because of existing acceptable proprietary hospital facilities. Consideration will not be given to these communities unless their application is supported by a firm and legally binding voluntary commitment, properly executed by the proprietor, in a manner that cannot be altered by heirs or subsequent owners, to the effect that said acceptable facilities will, without qualification, forever cease to be used as hospital facilities while the replacement hsopital facilities are in operation. When the above conditions have been met, and the normal elements of the application are fulfilled, due consideration will be accorded the applicant.



PROPOSED HOSPITAL SERVICE AREAS
GENERAL HOSPITALS



PROPOSED HOSPITAL SYSTEM
REGIONAL HOSPITAL MAP
INTEGRATED PLAN FOR IOWA

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE
HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "A" Sioux City

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-1	Grossman	Sioux	Orange City	IND	GEN	10	5	4	99.2	5,431	580
R-1	Sioux Center Community	Sioux	Sioux Center	NPA	GEN	26	0	9	46.8	4,446	814
R-1	Rock Rapids	Lyon	Rock Rapids	IND	GEN	0	17	5	72.2	4,483	506
R-1	Merrill Pioneer Community	Lyon	Rock Rapids	NPA	GEN	32	0	12	Iowa-58 Under Constr.		
R-8	Sacred Heart	Plymouth	LeMars	CH	GEN	68	0	16	62.3	15,471	1,729
R-8	Hawarden Community	Sioux	Hawarden	CITY	GEN	14	0	6	70.6	3,608	654
R-9	Ida Grove	Ida	Ida Grove	CITY	GEN	0	18	6	63.2	4,154	543
R-9	Sioux Valley	Cherokee	Cherokee	NPA	GEN	77	0	15	53.2	14,965	2,381
R-18	Onawa Hospital, Inc.	Monona	Onawa	IND	GEN	0	22	5	81.4	6,535	1,141
B-3	Akron	Plymouth	Akron		GEN	21	0	8	12.3	940	139
B-3	Lutheran	Woodbury	Sioux City	CH	GEN	138	21	15	68.8	39,942	4,935
B-3	Methodist	Woodbury	Sioux City	CH	GEN	141	0	15	NR	37,064	5,157
B-3	St. Joseph Mercy	Woodbury	Sioux City	CH	GEN	326	0	44	73.3	87,271	10,518
B-3	St. Vincent's	Woodbury	Sioux City	CH	GEN	140	0	13	93.2	47,606	6,088
B-3	Sioux City Osteopathic	Woodbury	Sioux City	IND	GEN	25	0	6	53.6	4,888	786
			REGIONAL TOTAL			1,018	83	179	xxx	276,804	35,971

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "B" Spencer

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-2	Community Memorial	O'Brien	Sheldon	NPA	GEN	32	0	8	70.0	6,138	873*
R-2	Ward Memorial	O'Brien	Primghar	CITY	GEN	0	9	5	60.8	1,334	297
R-2	Osceola Hospital, Inc.	Osceola	Sibley	IND	GEN	0	35	9	38.7	4,942	865
R-3	Holy Family	Emmet	Estherville	CH	GEN	100	0	20	76.9	19,658	3,187**
R-3	Marcus Snyder Memorial	Dickinson	Spirit Lake	PART	GEN	0	22	6	61.1	4,907	690
R-3	Dickinson County Memorial	Dickinson	Spirit Lake	CO	GEN	35	0	10	Project Iowa-72		
R-10	Loring	Sac	Sac City	CITY	GEN	32	0	8	59.5	6,953	817
R-10	Alta Memorial	B. Vista	Alta	NPA	GEN	19	0	7	35.3	2,447	101
R-10	Schaller	Sac	Schaller	IND	GEN	7	0	4	77.7	1,986	260
R-10	Sioux Rapids	B. Vista	Sioux Rapids	IND	GEN	0	10	3	122.8	4,481	157
R-10	Buena Vista County	B. Vista	Storm Lake	CO	GEN	50	0	12	69.1	12,614	1,834
R-10	Swallum	B. Vista	Storm Lake	IND	GEN	50	0	10	47.2	8,617	126
I-1	Palo Alto Memorial	P. Alto	Emmetsburg	NPA	GEN	18	24	9	61.8	9,469	1,265
I-1	Hand	O'Brien	Hartley	IND	GEN	0	12	5	53.4	2,338	381
I-1	Spencer Municipal	Clay	Spencer	CITY	GEN	72	0	12	60.8	15,977	2,370
	REGIONAL TOTAL					415	112	128	xxx	101,861	13,223
	STATE TOTAL								xxx		

* Project Iowa-71 Occupancy based on 24 existing beds
** Project Iowa-73 Data based on 70 existing beds

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE
HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "C" Fort Dodge

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-4	St. Ann	Kossuth	Algona	CH	GEN	61	0	12	32.0	7,122	1,152
R-4	Algona Osteopathic Clinic	Kossuth	Algona	IND	GEN	0	1	1	12.3	45	45
R-11	Community Memorial	Wright	Clarion	CITY	GEN	28	0	6	54.8	5,598	1,002
R-11	Belmond Community	Wright	Belmond	CITY	GEN	26	0	8	67.0	6,362	1,008
R-12	Hamilton County Public	Hamilton	Webster City	CO	GEN	78	0	11	58.4	16,623	2,048
R-21	Greene County	Greene	Jefferson	CO	GEN	57	0	14	56.8	11,814	1,827
I-3	St. Joseph Mercy	Webster	Fort Dodge	CH	GEN	151	0	25	90.3	49,792	5,861
I-3	Lutheran of Fort Dodge	Webster	Fort Dodge	CH	GEN	272	0	24	50.9	50,480	6,781
I-3	McCrary-Rost	Calhoun	Lake City	IND	GEN	0	15	5	96.2	5,268	964
I-3	McVay Memorial	Calhoun	Lake City	PART	GEN	12	2	5	60.5	3,089	536
	REGIONAL TOTAL					685	18	111	xxx	156,193	21,224

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

1. PAGE 5 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "E" Waterloo

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-6	St. Joseph Mercy	Howard	Cresco	CH	GEN	0	26	8	84.1	7,978	908
R-6	Decorah Lutheran	Winneshk.	Decorah	NPA	GEN	21	19	10	65.3	10,712	1,260
R-6	St. Joseph's	Chicksw.	New Hampton	CH	GEN	52	0	12	62.4	11,842	1,835
R-14	Grundy County Memorial	Grundy	Grundy Ctr.	CO	GEN	40	0	8	52.7	7,688	1,078
R-15	Palmer Memorial	Fayette	West Union	CITY	GEN	22	0	8	70.3	5,646	1,039
R-15	Mercy	Fayette	Oelwein	CH	GEN	55	0	15	69.5	13,960	2,209
R-15	Community Memorial	Bremer	Sumner	NPA	GEN	28	0	9	75.9	7,754	582
I-4	People's	Buchanan	Independence	CITY	GEN	42	11	10	69.2	10,602	1,274*
I-4	St. Joseph's Mercy	Bremer	Waverly	CH	GEN	0	46	10	55.0	9,237	1,164
I-4	Allen Memorial	B. Hawk	Waterloo	NPA	GEN	213	0	25	58.8	45,725	6,477
I-4	Schoitz	B. Hawk	Waterloo	NPA	GEN	134	0	26	94.2	46,085	6,797
I-4	St. Francis	B. Hawk	Waterloo	CH	GEN	124	0	26	84.8	38,377	6,149
I-4	Sartori Memorial	B. Hawk	Cedar Falls	CITY	GEN	74	0	10	50.9	13,741	2,221
				REGIONAL TOTAL		805	102	177	xxx	229,347	32,993

* Based on 42 existing beds prior to construction

DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "F" Dubuque

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-7	Veteran's Memorial	Allamak.	Waukon	CITY	GEN	22	0	8	84.6	6,790	1,067
R-7	Postville Community	Allamak.	Postville	CITY	GEN	0	18	6	87.7	5,760	534
R-7	McGregor Community	Clayton	McGregor		GEN	0	15	3	58.6	3,209	275
R-25	Jackson County Public	Jackson	Maquoketa	CO	GEN	60	0	10	106.3	14,741	2,845*
I-5	Riverview	Clayton	Guttenburg	IND	GEN	0	12	4	45.1	1,976	466
I-5	Finley	Dubuque	Dubuque	NPA	GEN	57	56	18	73.0	30,099	3,689
I-5	St. Joseph Mercy	Dubuque	Dubuque	CH	GEN	350	58	35	48.2	71,763	5,415
I-5	Xavier	Dubuque	Dubuque	CH	GEN	100	0	22	99.3	36,235	5,124
I-5	Bellevue	Jackson	Bellevue	NPA	GEN	0	19	8	53.6	3,717	369
			REGIONAL TOTAL			589	178	114	xxx	174,290	19,784
			STATE TOTAL						xxx		

* Project Iowa-63 Occupancy based on 38 existing beds

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "G" Cedar Rapids

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-17	Delaware County Memorial	Delaware	Manchester	CO	GEN	66	0	10	68.7	10,784	1,711*
R-17	Willard General	Delaware	Manchester	IND	GEN	8	17	8	26.5	2,423	408
R-24	John McDonald	Jones	Monticello	NPA	GEN	35	0	10	84.0	10,734	1,587
R-24	Mercy	Jones	Anamosa	CH	GEN	0	23	9	69.2	5,809	1,008
R-31	Marengo Memorial	Iowa	Marengo	CITY	GEN	28	0	10	37.7	2,617	477**
R-31	Closed Unit as of 9/24/56									(1,200)	(190)
I-7	Virginia Gay	Benton	Vinton	CITY	GEN	36	0	10	54.4	7,148	1,080
I-7	Mercy	Linn	Cedar Rapids	CH	GEN	182	79	32	84.4	61,274	9,021**
I-7	St. Luke's Methodist	Linn	Cedar Rapids	CH	GEN	331	0	46	73.9	86,000	12,293*/
I-7	Closed Unit as of 9/24/56									(700)	(120)
I-7	Closed Unit as of 9/24/56									(75)	(15)
	REGIONAL TOTAL					686	119	135	xxx	188,764	27,910

* Project Iowa-61 Occupancy based on 43 beds
** Project Iowa-56 Occupancy based on 248 days operation
*** Project Iowa-74 Occupancy based on 199 beds existing
/ Project Iowa-75 Occupancy based on 319 existing beds

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

1. PAGE 8 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "H" Davenport

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
I-8	Jane Lamb Memorial	Clinton	Clinton	NPA	GEN	89	69	24	38.6	22,256	3,490
I-8	St. Joseph Mercy	Clinton	Clinton	CH	GEN	55	27	25	99.6	29,808	4,174
I-8	DeWitt Community	Clinton	DeWitt	NPA	GEN	32	0	8	62.7	7,322	991
I-10	Muscatine General	Muscatine	Muscatine	CO	GEN	139	0	24	34.4	17,463	3,051
I-10	Bellevue	Muscatine	Muscatine	Closed	- - -	- - -	- - -	- - -	- - -	11,514	1,145
I-10	Mercy	Scott	Davenport	CH	GEN	224	0	56	60.2	49,248	8,568
I-10	St. Luke's	Scott	Davenport	CH	GEN	142	0	22	98.2	50,898	7,000
I-10	Davenport Osteopathic	Scott	Davenport	CORP	GEN	35	0	12	63.4	8,096	1,469
I-10	Isolation	Scott	Davenport	CO	CONT.	26	0	0	14.9	1,416	182
				REGIONAL TOTAL		742	96	171	xxx	198,021	30,070
				STATE TOTAL					xxx		

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

IOWA STATE DEPT. OF HEALTH

DIVISION OF HOSPITAL SERVICES

DES MOINES, IOWA

1. PAGE 9 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "I" Burlington

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-45	(Irregular Facility)									6,774	450
R-45	Sacred Heart	Lee	Ft. Madison	CH	GEN	121	0	24	55.9	24,594	3,763
R-45	Graham	Lee	Keokuk	NPA	GEN	76	18	15	69.2	23,751	3,186
R-45	St. Joseph	Lee	Keokuk	CH	GEN	72	64	31	56.8	28,219	3,011
I-12	Henry County Memorial	Henry	Mt. Pleasant	CO	GEN	56	0	20	86.5	10,424	1,543*
I-12	Burlington	D. Moines	Burlington	NPA	GEN	147	37	20	58.1	39,027	5,025
I-12	Mercy	D. Moines	Burlington	CH	GEN	125	0	25	77.9	35,527	4,161
I-12	St. Francis	D. Moines	Burlington	CH	GEN	59	25	0	63.6	19,512	1,282
				REGIONAL TOTAL		656	144	135	xxx	187,828	22,421
				STATE TOTAL					xxx		

* Project Iowa-55 Occupancy based on 33 existing beds

ACCEPTABLE AND NON-ACCEPTABLE
HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "J" Iowa City

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-35	Washington County	Wash'gtn	Washington	CO	GEN	54	0	12	49.3	9,710	1,292
B-1	Mercy	Johnson	Iowa City	CH	GEN	190	0	34	71.0	57,503	7,555*
B-1	University Hospitals	Johnson	Iowa City	STATE	GEN	219	0	54	68.0	55,100	7,983*
B-1	(Irregular Facility)									3,408	933
	REGIONAL TOTAL					463	0	100	xxx	125,721	17,763
	STATE TOTAL								xxx		

* Project Iowa-69 Occupancy based on 222 existing beds
** Project Iowa-54 Occupancy actually higher during continuing adjustment of areas during construction

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "K" Ottumwa

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNER-SHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-34	Mahaska County	Mahaska	Oskaloosa	CO	GEN	60	0	15	55.4	12,145	2,434
R-34	Mercy	Mahaska	Oskaloosa	PART	GEN.	28	7	7	67.9	8,675	1,495
R-34	Keokuk County	Keokuk	Sigourney	CO	GEN	34	0	10	45.8	5,678	731
R-39	Jefferson County	Jeffrsn.	Fairfield	CO	GEN	46	0	11	72.7	12,211	1,881
R-43	St. Joseph Mercy	Appan'se.	Centerville	CH	GEN	82	0	11	44.4	13,299	2,558
R-44	Davis County	Davis	Bloomfield	CO	GEN	75	0	12	96.7	14,116	1,787*
R-44	Van Buren County Memorial	VanBuren	Keosauqua	CO	GEN	23	0	7	63.1	5,298	740
I-11	Ottumwa	Wapello	Ottumwa	NPA	GEN	139	0	28	81.0	41,111	5,804**
I-11	St. Joseph	Wapello	Ottumwa	CH	GEN	100	0	20	91.5	33,393	4,266
I-11	Monroe County	Monroe	Albia	CO	GEN	37	0	8	87.9	4,490	772**
I-11	Smith	Monroe	Albia	IND	GEN	0	26	5	24.6	2,334	595
	REGIONAL TOTAL					624	33	134	xxx	152,750	23,063

* Project Iowa-62 Occupancy based on 40 existing beds
** Project Iowa-60 Occupancy based on 139 existing beds
*** Construction Program Occupancy based on 14 existing beds

ACCEPTABLE AND NON-ACCEPTABLE
HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "L" Des Moines

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-22	Boone County	Boone	Boone	CO	GEN	100	0	20	87.0	22,215	2,953*
R-23	Story County	Story	Nevada	CO	GEN	50	0	12	44.0	8,024	998
R-23	Story City Memorial	Story	Story City	CITY	GEN	16	0	4	62.9	3,673	703
R-23	Mary Greeley Memorial	Story	Ames	CITY	GEN	68	0	20	92.2	22,876	3,669
	Irregular Facility									2,375	784
R-29	Guthrie County	Guthrie	Guthrie Ctr.	CO	GEN	38	0	10	29.0	4,027	615
R-30	Mary Frances Skiff Memorial	Jasper	Newton	CITY	GEN	94	0	10	91.2	16,636	3,357**
R-30	Grinnell Community	Poweshk.	Grinnell	NPA	GEN	41	0	15	49.4	7,397	958
R-30	St. Francis	Poweshk.	Grinnell	CH	GEN	37	0	10	81.5	11,006	1,379
R-32	Adair County Memorial	Adair	Greenfield	CO	GEN	29	0	8	54.9	5,818	909
R-32	Madison County Memorial	Madison	Winterset	CO	GEN	39	0	8	51.5	7,334	977
R-33	Collins Memorial	Marion	Knoxville	IND	GEN	30	0	6	68.0	7,442	1,436
R-37	Greater Community	Union	Creston	CO	GEN	31	19	14	60.9	11,107	2,142
R-38	Clarke County Public	Clarke	Osceola	CO	GEN	32	0	9	58.3	6,813	1,490
R-38	Yocom	Lucas	Chariton	IND	GEN	21	0	7	70.6	5,415	619
R-38	Wayne County	Wayne	Corydon	CO	GEN	34	0	8	33.8	4,200	534
R-41	Ringgold County	Ringgold	Mt. Ayr	CO	GEN	30	0	8	44.0	4,822	770
	REGIONAL TOTAL								xxx		
	STATE TOTAL								xxx		

* Project Iowa-51 Occupancy based on 70 existing beds
** Project Iowa-53 Occupancy based on 50 existing beds

(Continued on page 13 of 14)

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 13 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "L" Des Moines (cont.)

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION: COUNTY	LOCATION: CITY OR TOWN	OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY: ACCEPTABLE	BED CAPACITY: NON-ACCEPTABLE	NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF: PATIENT DAYS	NUMBER OF: PATIENTS ADMITTED
R-42	Decatur County	Decatur	Leon	CO	GEN	30	0	5	60.9	6,672	1,387
I-6	St. Thomas Mercy	Marshall	Marshalltown	CH	GEN	55	31	11	61.8	19,410	2,140
I-6	Evangelical	Marshall	Marshalltown	CH	GEN	142	8	20	60.8	33,295	4,268
B-2	Dallas County	Dallas	Perry	CO	GEN	38	0	12	57.9	8,027	1,244
B-2	Clinic	Dallas	Dexter	PART	GEN	0	16	3	95.3	5,570	507
B-2	Broadlawns Polk County	Polk	Des Moines	CO	GEN	147	14	24	75.5	44,357	4,093
B-2	Iowa Lutheran	Polk	Des Moines	CH	GEN	244	0	25	87.1	63,605	8,229/
B-2	Iowa Methodist & Blank Mem.	Polk	Des Moines	CH	GEN	365	0	25	87.1	116,026	15,920
B-2	Mercy	Polk	Des Moines	CH	GEN	305	0	50	115.5	70,418	9,417*
B-2	Wilden Osteopathic	Polk	Des Moines	CORP	GEN	35	11	8	69.3	11,642	2,372
B-2	Still Osteopathic	Polk	Des Moines	CORP	GEN	75	0	20	57.0	15,601	2,487
B-2	Des Moines General	Polk	Des Moines	CORP	GEN	70	33	10	54.0	15,830	2,919/
B-2	Redfield Hospital & Clinic	Dallas	Redfield	IND	GEN	8	0	3	66.2	1,932	302
				REGIONAL TOTAL		2,204	132	385	xxx	563,565	79,578

*** Project Iowa-66 Occupancy based on 167 existing beds
/* New addition Occupancy based on 34 beds/120 days, 103 beds/245 days
/** Project: Occupancy based on 200 existing beds

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "M" Council Bluffs

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE General HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
R-19	Crawford County Memorial	Crawford	Denison	CO	GEN	50	0	12	48.9	8,919	1,709
R-20	St. Anthony	Carroll	Carroll	CH	GEN	109	0	32	57.5	22,896	3,888
R-20	Manning General	Carroll	Manning	IND	GEN	15	0	6	59.7	3,269	672
R-26	Community Memorial	Harrison	Mo. Valley	NPA	GEN	30	0	10	Project Iowa-70		
R-27	Myrtue Memorial Hospital	Shelby	Harlan	CO	GEN	47	0	20	62.0	10,628	1,667
R-28	Atlantic Memorial	Cass	Atlantic	NPA	GEN	68	0	12	57.3	14,224	2,043
R-28	Audubon County Memorial	Audubon	Audubon	CO	GEN	30	0	10	40.4	4,425	726
R-36	Rosary	Adams	Corning	CH	GEN	41	0	8	38.5	5,756	1,049
R-36	Murphy Memorial Hospital	Montgmry.	Red Oak	CITY	GEN	43	0	12	62.3	9,776	1,676
R-40	Community Hospital, Inc.	Fremont	Hamburg	CITY	GEN	0	25	10	47.7	4,350	746
R-40	Clarinda Municipal	Page	Clarinda	CITY	GEN	52	0	13	62.3	11,825	1,775
R-40	Hand Community	Page	Shenandoah	NPA	GEN	56	0	17	38.5	7,875	1,488
I-9	Jennie Edmundson Memorial	Pottawat.	Council Blfs.	NPA	GEN	192	0	20	59.2	41,474	6,846
I-9	Mercy	Pottawat.	Council Blfs.	CH	GEN	220	0	26	69.2	46,694	6,475*
	REGIONAL TOTAL					953	25	208	xxx	192,111	30,760
	STATE TOTAL					10,476	1,090	2,133	xxx	2,671,870	371,919

* Project Iowa-59. Occupancy based on 185 existing beds

2. Date July 1, 1957

REVIEW OF POPULATION TRENDS--IOWA
and Interpolation Into Acute General Beds - for 20 Year Period

COUNTY	POPULATION 1955**	POPULATION 1950	POPULATION INCR/DECR.%	POPULATION INCR. BEYOND STATE AVER'G NET INCR 5 YEARS	EST. INCR. 20 YEARS	REGION	NET BEDS
Adair	11,878	12,292	- 3.37				
Adams	8,021	8,753	- 8.36				
Allamakee	15,820	16,351	- 3.25				
Appanoose	18,336	19,683	- 6.84				
Audubon	11,503	11,579	- 0.66				
Benton	22,636	22,656	- 0.09				
B. Hawk	116,549	100,448	16.03*	16,101	64,404	I-4	258
Boone	24,324	28,139	-13.56				
Bremer	19,782	18,884	4.76*	898	3,592	I-4	14.3
Buchanan	19,930	21,927	- 9.11				
B. Vista	22,225	21,113	5.27*	1,112	4,448	R-10	11.1
Butler	17,116	17,394	- 1.59				
Calhoun	16,505	16,925	- 2.48				
Carroll	23,420	23,065	1.54				
Cass	18,555	18,532	0.01				
Cedar	17,032	16,910	0.07				
C. Gordo	48,118	46,053	4.48*	2,065	8,260	I-2	33
Cherokee	16,310	18,662	-12.60				
Chickasaw	15,315	15,228	0.57				
Clarke	9,054	9,369	- 3.36				
Clay	18,459	18,103	1.97				
Clayton	21,378	22,522	- 5.08				
Clinton	53,951	49,664	8.63*	4,287	17,148	I-8	68.6
Crawford	19,348	19,741	- 2.00				
Dallas	23,145	23,661	- 2.18				
Davis	9,400	9,959	- 5.61				
Decatur	12,009	12,601	- 4.70				
Delaware	17,294	17,734	- 2.48				
D. Moines	46,232	42,056	9.93*	4,176	16,704	I-12	66.8
Dickinson	13,258	12,756	3.94*	502	2,008	R-3	8
Dubuque	78,871	71,337	10.56*	7,534	30,136	I-5	120.5
Emmet	14,683	14,102	4.12*	581	2,324	R-3	5.8
Fayette	27,861	28,294	- 1.53				
Floyd	22,547	21,505	4.85*	1,042	4,168	R-5	10.4
Franklin	16,285	16,268	0.01				
Fremont	11,418	12,323	- 7.36				
Greene	14,978	15,544	- 3.64				
Grundy	13,945	13,722	1.63				
Guthrie	14,333	15,197	- 5.69				
Hamilton	19,598	19,660	- 0.32				
Hancock	14,956	15,077	- 0.80				
Hardin	21,840	22,218	- 1.70				
Harrison	17,856	19,560	- 8.71				
Henry	17,051	18,708	- 8.86				
Howard	12,911	13,105	- 1.48				
Humboldt	12,964	13,117	- 1.17				
Ida	10,515	10,697	- 1.70				
Iowa	15,082	15,835	- 4.76				
Jackson	18,245	18,622	- 2.02				
Jasper	33,198	32,305	2.76*	893	3,572	R-30	8.9
Jeffersn.	15,742	15,696	0.29				
Johnson	52,286	45,756	14.27*	6,530	26,120	B-1	130.6
Jones	17,494	19,401	- 9.83				
Keokuk	15,903	16,797	- 5.32				
Kossuth	26,134	26,241	- 0.41				

REVIEW OF POPULATION TRENDS--IOWA
and Interpolation Into Acute General Beds - for 20 Year Period

COUNTY	POPULATION 1955**	POPULATION 1950	POPULATION INCR/DECR.%	POPULATION INCR. BEYOND STATE AVER'G NET INCR 5 YEARS	EST. INCR. 20 YEARS	REGION	NET BEDS
Lee	42,868	43,102	- 0.54				
Linn	118,365	104,274	13.51*	14,091	56,364	I-7	225
Louisa	10,975	11,101	- 1.14				
Lucas	11,079	12,069	- 8.20				
Lyon	14,312	14,697	- 2.62				
Madison	12,452	13,131	- 5.17				
Mahaska	23,499	24,672	- 4.75				
Marion	25,350	25,930	- 2.24				
Marshall	35,271	35,611	- 0.95				
Mills	10,704	14,064	-23.89				
Mitchell	13,905	13,945	- 0.29				
Monona	15,352	16,303	- 5.83				
Monroe	10,634	11,814	- 9.99				
Montgom.	15,768	15,685	0.53				
Muscatine	32,979	32,148	2.58*	831	3,324	I-10	13.3
O'Brien	18,857	18,970	- 0.60				
Osceola	9,944	10,181	- 2.33				
Page	21,311	24,238	-12.08				
P. Alto	15,793	15,891	- 0.62				
Plymouth	23,216	23,252	- 0.15				
Pocahon.	15,108	15,496	- 2.50				
Polk	251,817	226,010	11.42*	25,807	103,228	B-2	516.1
Pottawat.	72,624	69,682	4.22*	2,942	11,768	I-9	47.1
Poweshk.	19,842	19,344	2.57*	498	1,992	R-30	5
Ringgold	8,826	9,528	- 7.37				
Sac	17,532	17,518	0.08				
Scott	114,341	100,698	13.55*	13,643	54,572	I-10	218.2
Shelby	15,519	15,942	- 2.65				
Sioux	25,985	26,381	- 1.50				
Story	49,466	44,294	11.68*	5,172	20,688	R-23	51.7
Tama	20,980	21,688	- 3.26				
Taylor	11,558	12,420	- 6.94				
Union	15,316	15,651	- 2.14				
V. Buren	10,304	11,007	- 6.39				
Wapello	49,945	47,397	5.38*	2,547	10,188	I-11	40.8
Warren	17,918	17,758	0.90				
Washingtn.	19,342	19,557	- 1.10				
Wayne	10,908	11,737	- 7.06				
Webster	46,681	44,241	5.52*	2,440	9,760	I-3	39
Winnebg.	13,182	13,450	- 1.99				
Winneshk.	21,314	21,639	- 1.50				
Woodbury	104,855	103,917	0.90				
Worth	10,891	11,068	- 1.60				
Wright	19,513	19,652	- 0.71				
TOTALS	2,690,000	2,621,000	2.63				

*Counties in which the five year increase in population exceeded the five year increase for the State during the period June 1, 1950 to June 1, 1955.

**County population for 1955 estimated by Division of Vital Statistics based on births, deaths, migration (inter/intra state) and compensated to show mental and penal institution population with county of origin and collegiate population at seat of learning.

BED INCRASE DUE TO POPULATION INCREASE FACTOR

Previous revisions of the Iowa State Hospital Plan have utilized arbitrary means for reconciling the unique circumstances in our population, its trends, and the effect on hospital utilization patterns. The most notable irregularities are:

(a) The fact that most of the population centers are located on State borders because 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.

The result of these several factors is that while hospital services have been increased to the permissible limits determined by prescribed formulae based on population and usage, many communities have never been able to reasonably meet demands for hospital services. For these reasons, an additional element, a population increase factor, has been induced into determining the allowable number of hospital beds for Iowa's areas.

Each county was examined individually. The 1950 population data is that of the federal census. The 1955 data is that county determination by the Division of Vital Statistics, this Department, based on birth, death, and migration data ascertained from official reports and experience. The total for the State was compensated directly against all counties to conform with that official estimate by the Bureau of Census which is prescribed by the Federal Agency. The rate of population increase by county was calculated during this five year period and all counties with a rate of increase exceeding the State's over-all increase were deemed qualified for additional consideration. Their population increase, projected on a straight line basis for 20 years, was converted to beds at the rate of 2.5, 4, and 4.5 beds per 1,000 depending on whether the area was an "R", "I", or "Base" area. This increment of beds was added to the current area ratio in arriving at the total of allowable beds.

The general hospital summary reflects bed increase resulting from the population increase factor. (See column 8, Area Ratio, and the bed identified by parenthesis).

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "A" Sioux City

GENERAL HOSPITAL SUMMARY

AREA (5)	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED (6)	CIVILIAN POPULATION (7)	BED ALLOWANCE BASED ON AREA RATIO (8)	EXISTING ACCEPTABLE BEDS (9)	TOTAL BEDS ALLOWED UNDER P.L.725 (10)	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION (11)	PERCENT OF NEED MET (12)
R-1		22,213	56	68	68	0	100.0
	Orange City			10	10	0	
	Sioux Center			26	26	0	
	Rock Rapids			32	32	0	
	OSA- To R-45	3,700	(17)				
R-8		21,771	54	82	82	0	100.0
	LeMars			68	68	0	
	Hawarden			14	14	0	
R-9	Cherokee	26,825	67	77	77	0	100.0
R-18	Onawa	15,352	38	0	38	38	0.0
B-3		110,805	499	791	791	0	100.0
	Akron			21	21	0	
	Sioux City						
	Lutheran			138	138	0	
	Methodist			141	141	0	
	St. Joseph Mercy			326	326	0	
	St. Vincent's			140	140	0	
	Sioux City Osteopathic			25	25	0	
	Subtotal "A"	200,666	714	1,018	1,056	38	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ______ 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 2 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "B" Spencer

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9	TOTAL BEDS ALLOWED UNDER P.L.725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	PERCENT OF NEED MET 12
R-2		31,610	79	32	79	47	40.51
	Sheldon			32	32	0	
	Sibley			0	47	47	
R-3		29,750	74	135	135	0	100.0
	Estherville		(+6)	100	100	0	
	Spirit Lake (A)		(+8)	35	35	0	
R-10		39,757	99	158	158	0	100.0
	Sac City			32	32	0	
	Alta			19	19	0	
	Schaller			7	7	0	
	Storm Lake		(+11)				
	Buena Vista County			50	50	0	
	Swallum			50	50	0	
I-1		37,385	150	90	150	60	60.0
	Emmetsburg			18	48	30	
	Spencer			72	102	30	

2. DATE July 1, 1957

3. STATE Iowa

4. REGION "C" Fort Dodge

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9	TOTAL BEDS ALLOWED UNDER P.L.725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	PERCENT OF NEED MET 12
R-4	Algona	26,134	65	61	65	4	93.84
R-11		32,477	81	54	89	35	60.67
	Clarion			28	28	0	
	Belmond			26	26	0	
	Humboldt			0	35	35	
R-12	Webster City	19,598	49	78	78	0	100.0
R-21	Jefferson	14,978	37	57	57	0	100.0
I-3		78,294	313	435	498	63	87.34
	Fort Dodge		(+39)				
	St. Joseph Mercy			151	151	0	
	Lutheran			272	272	0	
	Lake City						
	McVay			12	0	(-12)	
	Lake City Municipal			0	40	40	
	Pocahontas			0	35	35	
	Subtotal "C"	171,481	545	685	787	102	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ______ 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 4 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "D" Mason City

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9	TOTAL BEDS ALLOWED UNDER P.L.725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	PERCENT OF NEED MET 12
R-5		36,452	91	104	104	0	100.0
	Osage			32	32	0	
	Charles City		(+10)	72	72	0	
R-13		46,283	116	119	119	0	100.0
	Eldora			36	36	0	
	Iowa Falls			35	35	0	
	Hampton			48	48	0	
R-46		28,138	70	71	71	0	100.0
	Britt			32	32	0	
	Forest City			25	25	0	
	Buffalo Center			14	14	0	
I-2	Mason City	59,009	236	342	342	0	100.0
	St. Joseph Mercy		(+33)	286	286	0	
	Park			56	56	0	
	Subtotal "D"	169,882	513	636	636	0	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) 14. EXCESS BEDS FROM ORIGINAL PLAN 15. TOTAL BEDS ALLOWED (13 + 14)

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9	TOTAL BEDS ALLOWED UNDER P.L.725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	PERCENT OF NEED MET 12
R-6		47,758	119	73	138	65	52.90
	Cresco			0	35	35	
	Decorah			21	51	30	
	New Hampton			52	52	0	
R-14	Grundy Center	13,945	35	40	40	0	100.0
R-15		35,664	89	105	105	0	100.0
	West Union			22	22	0	
	Oelwein			55	55	0	
	Sumner			28	28	0	
I-4		167,340	669	587	941	354	62.38
	Waterloo			42	62	20	
	Waverly		(+14)	0	50	50	
	Cedar Falls			74	74	0	
	Waterloo		(+258)				
	Allen Memorial			213	213	0	
	Schoitz Memorial			134	194	60	
	St. Francis			124	124	0	
	Unassigned			0	224	224	
	Subtotal "E"	264,707	912	805	1,224	419	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ________ 14. EXCESS BEDS FROM ORIGINAL PLAN ________ 15. TOTAL BEDS ALLOWED (13 + 14) ________

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 6 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "F" Dubuque

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9	TOTAL BEDS ALLOWED UNDER P.L.725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	PERCENT OF NEED MET 12
R-7		36,795	92	22	92	70	23.91
	Waukon			22	22	0	
	Postville			0	45	45	
	Elkader			0	25	25	
R-25	Maquoketa	15,032	38	60	60	0	100.0
I-5		84,438	338	507	507	0	100.0
	Dubuque		(+121)				
	Finley			57	57	0	
	St. Joseph Mercy			350	350	0	
	Xavier			100	100	0	
	Subtotal "F"	136,265	468	589	659	70	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ____ 14. EXCESS BEDS FROM ORIGINAL PLAN ____ 15. TOTAL BEDS ALLOWED (13 + 14) ____

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "G" Cedar Rapids

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9		TOTAL BEDS ALLOWED UNDER P.L.725 10		ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11		PERCENT OF NEED MET 12
R-17	Manchester	17,294	43		74		74		0	100.0
R-24		17,494	44		35		85		50	41.18
	Monticello			35		50		15		
	Anamosa			0		35		35		
R-31	Marengo	18,199	46		28		46		18	60.87
I-7		148,390	594		549		819		270	67.03
	Vinton			36		36		0		
	Cedar Rapids		(+225)							
	Mercy			182		302		120		
	St. Luke's			331		411		80		
	Unassigned			--		35		35		
	Tipton			0		35		35		
	Subtotal "G"	201,377	727		686		1,024		338	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ______ 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 8 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "H" Davenport

GENERAL HOSPITAL SUMMARY

AREA (5)	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED (6)	CIVILIAN POPULATION (7)	BED ALLOWANCE BASED ON AREA RATIO (8)	EXISTING ACCEPTABLE BEDS (9)	TOTAL BEDS ALLOWED UNDER P.L.725 (10)	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION (11)	PERCENT OF NEED MET (12)
I-8		53,951	216	176	285	109	61.75
	DeWitt			32	32	0	
	Clinton		(+69)				
	Jane Lamb Memorial			89	133	44	
	St. Joseph Mercy			55	120	65	
I-10		155,127	621	566	852	286	66.43
	Muscatine		(+13)	139	139	0	
	Davenport		(+218)				
	Mercy			224	224	0	
	St. Luke's			142	232	90	
	Davenport Osteopathic			35	35	0	
	Isolation			26	26	0	
	Unassigned			0	196	196	
	Subtotal "H"	209,078	837	742	1,137	395	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ______ 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "H" Davenport

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9	TOTAL BEDS ALLOWED UNDER P.L.725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	PERCENT OF NEED MET 12
I-8		53,951	216	176	285	109	61.75
	DeWitt			32	32	0	
	Clinton		(+69)				
	Jane Lamb Memorial			89	133	44	
	St. Joseph Mercy			55	120	65	
I-10		155,127	621	566	852	286	66.43
	Muscatine		(+13)	139	139	0	
	Davenport		(+218)				
	Mercy			224	224	0	
	St. Luke's			142	232	90	
	Davenport Osteopathic			35	35	0	
	Isolation			26	26	0	
	Unassigned			0	196	196	
	Subtotal "H"	209,078	837	742	1,137	395	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) 14. EXCESS BEDS FROM ORIGINAL PLAN 15. TOTAL BEDS ALLOWED (13 + 14)

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "I" Burlington

GENERAL HOSPITAL SUMMARY

AREA (5)	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED (6)	CIVILIAN POPULATION (7)	BED ALLOWANCE BASED ON AREA RATIO (8)	EXISTING ACCEPTABLE BEDS (9)	TOTAL BEDS ALLOWED UNDER P.L.725 (10)	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION (11)	PERCENT OF NEED MET (12)
R-45		42,868	107	269	333	64	80.78
	Fort Madison			121	121	0	
	Keokuk						
	Graham			76	100	24	
	St. Joseph			72	112	40	
	ISO from Area R-1 (3,700)		17				
I-12		68,716	275	387	387	0	100.0
	Mount Pleasant			56	56	0	
	Burlington		(+67)				
	Burlington			147	147	0	
	Mercy			125	125	0	
	St.Francis			59	59	0	
	Subtotal "I"	111,584	399	656	720	64	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ______ 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH

DIVISION OF HOSPITAL SERVICES

DES MOINES, IOWA

2. DATE July 1, 1957

3. STATE Iowa

4. REGION "J" Iowa City

GENERAL HOSPITAL SUMMARY

AREA (5)	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED (6)	CIVILIAN POPULATION (7)	BED ALLOWANCE BASED ON AREA RATIO (8)	EXISTING ACCEPTABLE BEDS (9)	TOTAL BEDS ALLOWED UNDER P.L.725 (10)	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION (11)	PERCENT OF NEED MET (12)
R-35	Washington	19,342	48	54	54	0	100.0
B-1	Iowa City	56,099	252	409	409	0	100.0
	Mercy		(+131)	190	190	0	
	University			219	219	0	
	Subtotal "J"	75,441	300	463	463	0	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 11 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "K" Ottumwa

GENERAL HOSPITAL SUMMARY

AREA (5)	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED (6)	CIVILIAN POPULATION (7)	BED ALLOWANCE BASED ON AREA RATIO (8)	EXISTING ACCEPTABLE BEDS (9)	TOTAL BEDS ALLOWED UNDER P.L.725 (10)	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION (11)	PERCENT OF NEED MET (12)
R-34		39,402	99	122	122	0	100.0
	Sigourney			34	34	0	
	Oskaloosa						
	Mahaska County			60	60	0	
	Mercy			28	28	0	
R-39	Fairfield	15,742	39	46	46	0	100.0
R-43	Centerville	18,336	46	82	82	0	100.0
R-44		19,704	49	98	98	0	100.0
	Bloomfield			75	75	0	
	Keosauqua			23	23	0	
I-11		60,579	242	276	316	40	87.34
	Albia			37	37	0	
	Ottumwa		(+41)				
	St. Joseph			100	140	40	
	Ottumwa			139	139	0	
	Subtotal "K"	153,763	475	624	664	40	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ______ 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

2. DATE July 1, 1957
3. STATE Iowa
4. REGION "L" Des Moines

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9	TOTAL BEDS ALLOWED UNDER P.L.725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	PERCENT OF NEED MET 12
R-22	Boone	24,324	61	100	100	0	100.0
R-23		49,466	124	134	176	42	76.14
	Nevada			50	50	0	
	Story City			16	16	0	
	Ames		(+52)	68	110	42	
R-29	Guthrie Center	14,333	36	38	38	0	100.0
R-30		49,923	125	172	172	0	100.0
	Newton		(+9)	94	94	0	
	Grinnell		(+5)				
	Grinnell Community			41	41	0	
	St. Francis			37	37	0	
R-32		24,330	61	68	68	0	100.0
	Greenfield			29	29	0	
	Winterset			39	39	0	
R-33	Knoxville	25,350	63	30	63	33	47.62
R-37	Creston	15,316	38	31	38	7	81.58
R-38		31,041	78	87	87	0	100.0
	Osceola			32	32	0	
	Chariton			21	21	0	
	Corydon			34	34	0	

(cont. on page 13 of 14)

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ______ 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 13 OF 14
2. DATE July 1, 1957
3. STATE Iowa
4. REGION "L" Des Moines (continued)

GENERAL HOSPITAL SUMMARY

AREA (5)	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED (6)	CIVILIAN POPULATION (7)	BED ALLOWANCE BASED ON AREA RATIO (8)	EXISTING ACCEPTABLE BEDS (9)	TOTAL BEDS ALLOWED UNDER P.L.725 (10)	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION (11)	PERCENT OF NEED MET (12)
R-41	Mt. Ayr	8,826	22	30	30	0	100.0
R-42	Leon	12,009	30	30	30	0	100.0
I-6	Marshalltown	51,851	207	197	257	60	76.65
	St. Thomas Mercy			55	85	30	
	Evangelical			142	142	0	
	Toledo			0	30	30	
B-2		292,880	1,318	1,287	1,834	547	70.01
	Perry			38	38	0	
	Des Moines		(+516)				
	Broadlawns			147	147	0	
	Iowa Lutheran			244	244	0	
	Iowa Methodist			365	365	0	
	Mercy			305	305	0	
	Wilden Osteopathic			35	35	0	
	Still Osteopathic			75	75	0	
	Des Moines General			70	70	0	
	Redfield			8	8	0	
	Unassigned			0	547	547	
	Subtotal "L"	599,649	2,163	2,204	2,893	689	

13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) ______ 14. EXCESS BEDS FROM ORIGINAL PLAN ______ 15. TOTAL BEDS ALLOWED (13 + 14) ______

IOWA STATE DEPT. OF HEALTH

DIVISION OF HOSPITAL SERVICES

DES MOINES, IOWA

2. DATE July 1, 1957

3. STATE Iowa

4. REGION "M" Council Bluffs

GENERAL HOSPITAL SUMMARY

AREA 5	COMMUNITY IN WHICH EXISTING SUITABLE/PROPOSED FACILITY IS/WILL BE LOCATED 6	CIVILIAN POPULATION 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING ACCEPTABLE BEDS 9	TOTAL BEDS ALLOWED UNDER P.L.725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	PERCENT OF NEED MET 12
R-19	Denison	19,348	48	50	50	0	100.0
R-20		23,420	59	124	124	0	100.0
	Carroll			109	109	0	
	Manning			15	15	0	
R-26	Missouri Valley	17,856	45	30	45	15	66.67
R-27	Harlan	15,519	39	47	47	0	100.0
R-28		30,058	75	98	98	0	100.0
	Atlantic			68	68	0	
	Audubon			30	30	0	
R-36		23,789	60	84	84	0	100.0
	Corning			41	41	0	
	Red Oak			43	43	0	
R-40		44,287	111	108	111	3	97.30
	Clarinda			52	55	3	
	Shenandoah			56	56	0	
I-9	Council Bluffs	83,328	333	412	412	0	100.0
	J. Edmundson Memorial		(+47)	192	192	0	
	Mercy			220	220	0	
	Beds Held in Reserve				406	406	
	TOTAL	2,690,000	9,225	10,476	13,162	2,686	

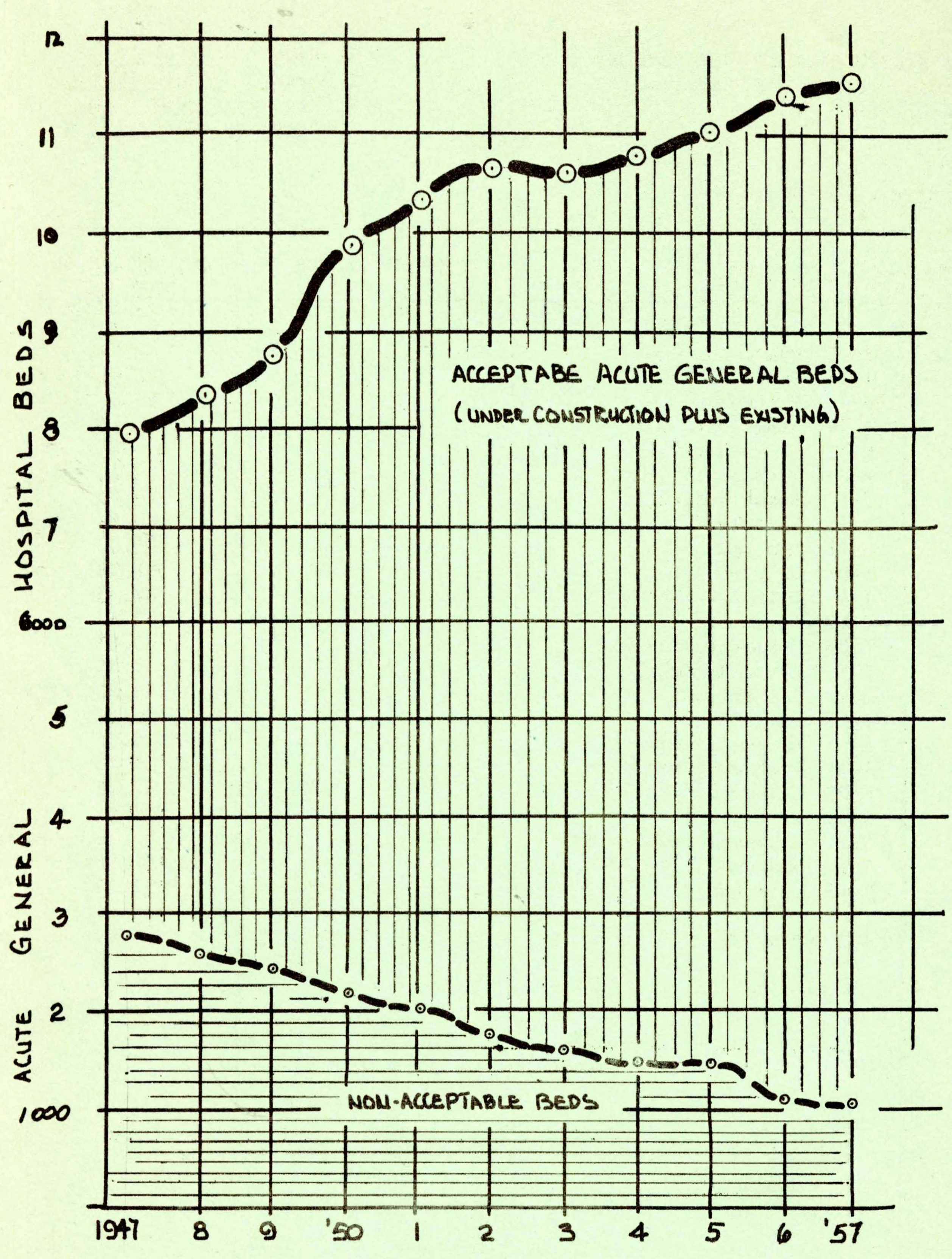
13. BEDS ALLOWED BY STATE RATIO (POP. X STATE RATIO) 12,105 14. EXCESS BEDS FROM ORIGINAL PLAN 1,057 15. TOTAL BEDS ALLOWED (13 + 14) 13,162

IOWA STATE DEPARTMENT OF HEALTH
Division of Hospital Services
Form HSF-13

1. Page 1 of 1
2. Date July 1, 1957
3. State Iowa
4. Category General

RELATIVE NEED REPORT

PRIORITY	AREA		PRIORITY FACTOR	PERCENTAGE OF NEED MET
A	R-18	Onawa	0	
B	R-7	Postville		23.91
B	R-2	Sibley		40.51
B	R-24	Anamosa		41.18
C	R-33	Knoxville		47.62
C	R-6	Cresco		52.90
C	I-1	Emmetsburg		60.0
D	R-11	Humboldt		60.67
D	R-31	Marengo		60.87
D	I-8	Clinton		61.75
D	I-4	Waterloo		62.38
D	I-10	Davenport		66.43
D	R-26	Missouri Valley		66.67
D	I-7	Cedar Rapids		67.03
D	B-2	Des Moines		70.01
D	R-23	Ames		76.14
D	I-6	Marshalltown		76.65
D	R-45	Fort Madison		80.78
D	R-37	Creston		81.58
D	I-11	Ottumwa		87.34
D	I-3	Pocahontas-Lake City		87.35
D	R-4	Algona		93.84
D	R-40	Clarinda		97.30
	All other areas			100.00



ACUTE GENERAL HOSPITAL BEDS - IOWA

COMPARISON OF THE STATEWIDE TOTAL OF ACCEPTABLE AND NON-ACCEPTABLE BEDS

Division of Hospital Services
Iowa State Department of Health

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
1943	361
1944	327

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 less than 68 per cent.
Occupancy - Statewide - if all patient load had been cared for in acceptable units would have been less than 72 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

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.

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 1 OF 1
2. DATE July 1, 1957
3. STATE Iowa
4. REGION Statewide

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE Tuberculosis HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
	Pine Knoll Tuberculosis	Scott	Davenport	CO	TB	50	20	--	27.2	6,961	18
	State Sanatorium	Johnson	Oakdale	ST	TB	343	0	--	84.2	105,516	344
	Sunny Crest Sanatorium	Dubuque	Dubuque	CO	TB	70	0	--	19.7	5,038	16
	Broadlawns Polk County	Polk	Des Moines	CO	TB	45	0	--	87.4	14,364	95
	River Heights Sanatorium	Woodbury	Sioux City	CO	TB	25	14	--	32.5	4,626	18
	Sunnyslope Sanatorium	Wapello	Ottumwa	CO	TB	63	0	--	85.5	19,664	81
			REGIONAL TOTAL						xxx		
			STATE TOTAL			596	34		xxx	156,169	572

EXHIBIT D

PART III NERVOUS AND MENTAL HOSPITALS

Previous plan revisions have anticipated the findings of the study committee before programing the field of nervous and mental hospital facilities. The results of such a study have been published and are the basis of the current presentation.

Because of the tremendous demand by service groups, individual citizens, and professional organizations, the Governor of Iowa, in 1956, did establish a study committee as well as funds for a detailed analysis of the total mental health picture in Iowa. The well-qualified services of the American Psychiatric Association were retained to assure the best guidance available today for such a project. The findings, analysis, and recommendations were set forth in draft form and later were consolidated under the publication titled "A Mental Health Program for Iowa," Chapter II, Summary and Recommendations, dated December 20, 1956. In general terms, the findings and recommendations of this body correspond closely with the recommendations of the several previous responsible study committees. (1) We have taken the liberty of extracting direct quotations from the above mentioned Summary and Recommendations to set forth that which is pertinent to this State Hospital Plan.

Of General Hospitals it was said, "Every community with a General Hospital without psychiatric services should examine the reasons why that hospital is thus limiting its functions. A General Hospital should be a hospital for all kinds of illness, including mental illness. Last year saw 276,000 psychiatric patients admitted to general hospitals in the U.S., which is about the same number admitted to all state hospitals, Veterans Administration hospitals, and private mental hospitals. This may turn out to be the most useful, in point of numbers, of new devices to relieve state mental hospitals."

With regard to the proposed scope of mental programs in Iowa, "An Iowa mental health program which is adequate --- includes a steadily broadening range of services. Services in Iowa lag well behind what is recognized to be successful and necessary."

With regard to the direction of Iowa's program by the Board of Control, they point out that, "Qualifications for appointment are political and geographical." "The six mental institutions are by law under the direction of the Board which hires the 'Director of Institutions' as an advisor.--- The Director's duties gave him sharply limited direct authority and responsibility --- the Director has no real authority or responsibility. He is subject to the authority of the Board, serves at their pleasure ---."

---

(1) Specifically, (a) Reorganization Study by Brookins Institute, 1933, (b) Barrett Report of 1937, (c) Iowa State Planning Board Study of 1939, (d) Mental Hospital Survey Report of 1946.

"Iowa has a policy of hospitalizing certain mental patients, and transferring others to county homes or other county non-psychiatric institutions. Under a law dating back to 1860 --- superintendents are instructed to transfer 'incurable and harmless' patients to county care --- The policy is in opposition to currently accepted medical practice. It results in a duel and inequitable system of treatment for Iowa's mental patients. The determination --- is based on whether he will be docile and undemanding, or provide a cheap source of labor in the county home. --- This is a tragic commentary on the mental health situation. The policy is based not on the needs of the mentally ill, but on a desire to keep hospital populations and budgetary demands down. --- In none of the county homes is there any psychiatric supervision of the patients. Iowa has approximately 2600 patients forgotten in county homes. With proper care and treatment a considerable number of these could be rehabilitated."

"There is no evidence indicating that the states differ in the incidence or prevalence of mental illness. Such differences as exist (are) explained by a State's failure to provide adequate treatment services, so that people hesitate to use existing custodial beds."

With regard to staff, the committee feels, "While there has been some improvement, the numbers on the staff are still far below the minimum standards established by the American Psychiatric Association, and little psychiatric treatment is offered. Most of the staff is untrained in psychiatry.."

"Some 2400 mental patients --- are now being cared for in county homes, and an undetermined number in other types of county care. These patients are not being given psychiatric treatment or rehabilitation services, --- The county homes are no better than poor-houses."

After summarizing and analyzing the basic data, the Governor's Committee on Mental Health did make specific recommendations that would provide an effective administrative organization. Specifically, the recommendations which could be initiated by a single legislative program are as follows:

"(1) The state hospitals, schools for mental defectives, institutions for psychotic criminals and delinquent defectives, state operations in the field of out-patient clinics, and the new services proposed should be placed in a single department.

"(2) The services should be headed by a well qualified psychiatrist with administrative experience, at a salary slightly above that now paid to hospital superintendents.

"(3) The department might be organized in various ways, provided the director (or commissioner) has the authority and responsibility to guide the mental health programs of the state along professional lines. It should be counseled by an advisory board.

"(4) The functions of such a board should not be administrative. It should advise the Governor and the Commissioner on policy, and should also be charged with keeping the public informed of policy matters.

"(5) The line of authority should run from the Commissioner to the superintendents of the hospitals, schools for defectives, and heads of other institutions.

"(6) The Commissioner should be supported by a deputy commissioner and consultants in psychology, psychiatric social work, nursing, rehabilitation therapy, and other specialties.

"(7) The present policy of transferring unrecovered mental patients out of state hospitals as a means of providing space for new admissions should be stopped. Space can best be provided through more rapid turnover resulting from prompt, intensive treatment.

"(8) Crippling budget and personnel restrictions should be removed. The commissioner and superintendents must be allowed to make their decisions on medical grounds, within the framework of the resources which the state can make available."

The committee gave specific consideration to several phases of mental illness. A governing policy was outlined in their recommendations and was stated as follows:

"(1) Fundamental to progress in Iowa's provisions for psychiatric treatment services is a policy decision that proper treatment will be made available to all who require it. This is a goal which cannot be achieved immediately, but a beginning can be made, and progress can be expected as a result of the policy decision and the necessary implementing steps.

"(2) Improved treatment should be sought by all possible methods (including more intensive treatment in the hospitals, which makes more efficient use of available space), the provision of auxiliary services such as branch hospitals, colonies, day and night treatment centers, wider use of community resources such as general hospitals and psychiatric clinics, improved social service work to facilitate discharge, improved screening of patients, etc.

"(3) Buildings listed in the CIB reports as unsatisfactory should be replaced as rapidly as possible. Those which are dangerous should have first priority for the necessary structural changes, fireproofing, etc.

"(4) Addition of new beds should be limited to the number that would relieve existing overcrowding and provide for all patients sent in, many of whom now are returned to county care as 'harmless and incurable'. Provision for additional patients should depend on the results of more effective use of beds as a result of improved staffing.

"(5) The vocational rehabilitation program of the state should be expanded to permit collaboration with hospital staffs in the pre-discharge rehabilitation of patients, and in provision for post-discharge assistance.

"(6) A unit for psychotic criminals, and one for delinquent defectives, should be established away from the correctional institutions and under psychiatric guidance.

"(7) A unit for active tuberculosis cases should be set up, separate from the four hospitals, and near a medical center.

"(8) Assistance in planning and recruitment of staff should be given to general hospitals wishing to set up psychiatric services.

"(9) Assistance from state funds should be provided for mental hygiene clinics, and assistance in recruitment of psychiatrically trained personnel made available.

"(10) Those directing clinic policy should strengthen the psychiatric orientation of the clinics.

"(11) Close coordination between in-service and extra-mural facilities should be provided.

"(12) A follow-up service should be established in each hospital, with the assistance of local clinics.

"(13) Plans should be undertaken to develop the better county homes as branch hospitals or rehabilitation units.

"(14) Patients should no longer be discharged to county homes....

"(15) A modern department for the care of mentally ill criminals, defective delinquents, and dangerous patients from the Mental Health Institute, should be established at the proposed mental health center in Des Moines.

"(16) The facilities provided should be so planned that classification of different types of patients is possible. Facilities for work and recreations should be provided in addition to those for all forms of modern psychiatric treatment.

"(17) The services of a visiting psychiatrist should be provided at the present unit as soon as possible.

"(18) The non-psychotic aggressive and hostile inmates of Anamosa should be carefully examined and if possible recommendations for other disposition made.

"(19) When the new department becomes available the population of all of the penal institutions should be carefully screened and all discovered mental cases transferred to it.

"(20) The complex of services described in the section on Polk County needs should be established, and its results tested before any plans are made for construction of a new state hospital.

"(21) Employees should be assigned from the hospital to the County Welfare Board to assist in follow-up of patients and in liaison with the county homes."

The committee then gave consideration to specific categories. With regard to the field of emotionally disturbed children they set forth the following recommendations:

"(1) The state's deficiencies in child psychiatry need to be made up, starting with at least a part-time child psychiatrist in the central office, and the development of a broad-scale program for training of child psychiatrists at the University.

"(2) Preparations for establishing at the University in-patient services for disturbed children and mental defectives need to be speeded up.

"(3) The development of a children's unit at Independence should be encouraged by providing the necessary space and equipment. At least 50 beds should be set up promptly, and others added as experience indicates.

"(4) Consideration should be given to the establishment of a residential treatment unit in the western part of the state.

"(5) Out-patient diagnostic and treatment facilities need to be expanded at various locations throughout the state, under the direction of a trained psychiatrist experienced in work with children."

Because the problem of the aging is of major importance in the state of Iowa, specific consideration was given to this population segment in terms of mental illness. The recommendations set forth to meet this problem are as follows:

"(1) A policy change is needed, and the law requiring transfer to county care of 'harmless and incurable' patients should be repealed.....

"(2) Unrecovered patients could be sent to branch hospitals under the supervision of the hospital superintendent; these branch hospitals could be in some of the best of county homes, but they must be adequately staffed for rehabilitation purposes.

"(3) Each superintendent should see that the mentally ill patients now in county care in his district are examined, and those who are seriously ill returned to the hospital.

"(4) Day centers should be established in and by local communities, as a preventive measure.

"(5) Local communities and agencies should set up programs for aging persons, aimed at keeping them active in community life as long as possible, a very successful preventive measure.

"(6) Coordination should be established with the State Committee on Aging."

The committee gave particular emphasis to the training of psychiatric personnel to assure a reservoir of talent. To quote, "The emotional and social aspects of illness are becoming more prominent in medical training. The general

practitioner needs to be able to diagnose and treat minor emotional illnesses, or refer patients to a psychiatrist if they require more care than he is able to give. The Department of Psychiatry at Iowa (should, with the College of Medicine) ... participate in a program of comprehensive medical teaching primarily with patients now hospitalized for other services in University Hospitals...(and) collaborate ... in joint research projects involving psychosomatic illnesses."

"Facilities are needed in University Hospital for this purpose. Office space is needed as a base of operations. Ultimately there should be a unit of 30 to 40 beds for teaching comprehensive medicine and developing collaborate research with other clinical departments. Patients from other services whose illness is classified as psychosomatic would be admitted to this unit for more extensive study."

The narrative analysis on teaching facilities then sets forth its recommendations. Those which refer to facilities are as follows:

> "The state should declare a policy of financial assistance to training institutions to insure the availability of personnel for treatment and training purposes. This is where money will pay the biggest dividends."
>
> "Provision should also be made in the State University to implement the plan of expansion outlined in this chapter. This will include the addition of ... adequate office and laboratory space, and the establishment of psychiatric services in the University Hospitals."
>
> "The University must expand its output of various types of children's specialists, especially child psychiatrists. Substantial expansion will be needed in the plans for the research center for emotionally disturbed and retarded children."
>
> "Expansion of the children's center should include provision for in-patient services." (50 beds)
>
> "Support for research needs to be greatly increased, both financially and as a matter of institution policy."
>
> "Research support is necessary at the University of Iowa. The proposed program will cost about $400,000 of which $200,000 can be had from Federal government if it is sought promptly".

The report of the Governor's Committee on Mental Health dealt with all phases of the nervous and mental field. Those elements pertaining to state facilities have been extracted for incorporation in this State Hospital Plan. They have been summarized in a tabulation reflecting specific hospital beds proposed throughout the state to fulfill the very urgent recommendations of the study committee for providing the services which will delete overcrowding, non-acceptable beds, and county care. The summary on state institutions alone is covered in the refined recapitulation and is again stated in the total statewide summary as it pertains to all types of nervous or mental facilities.

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 unacceptable. 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

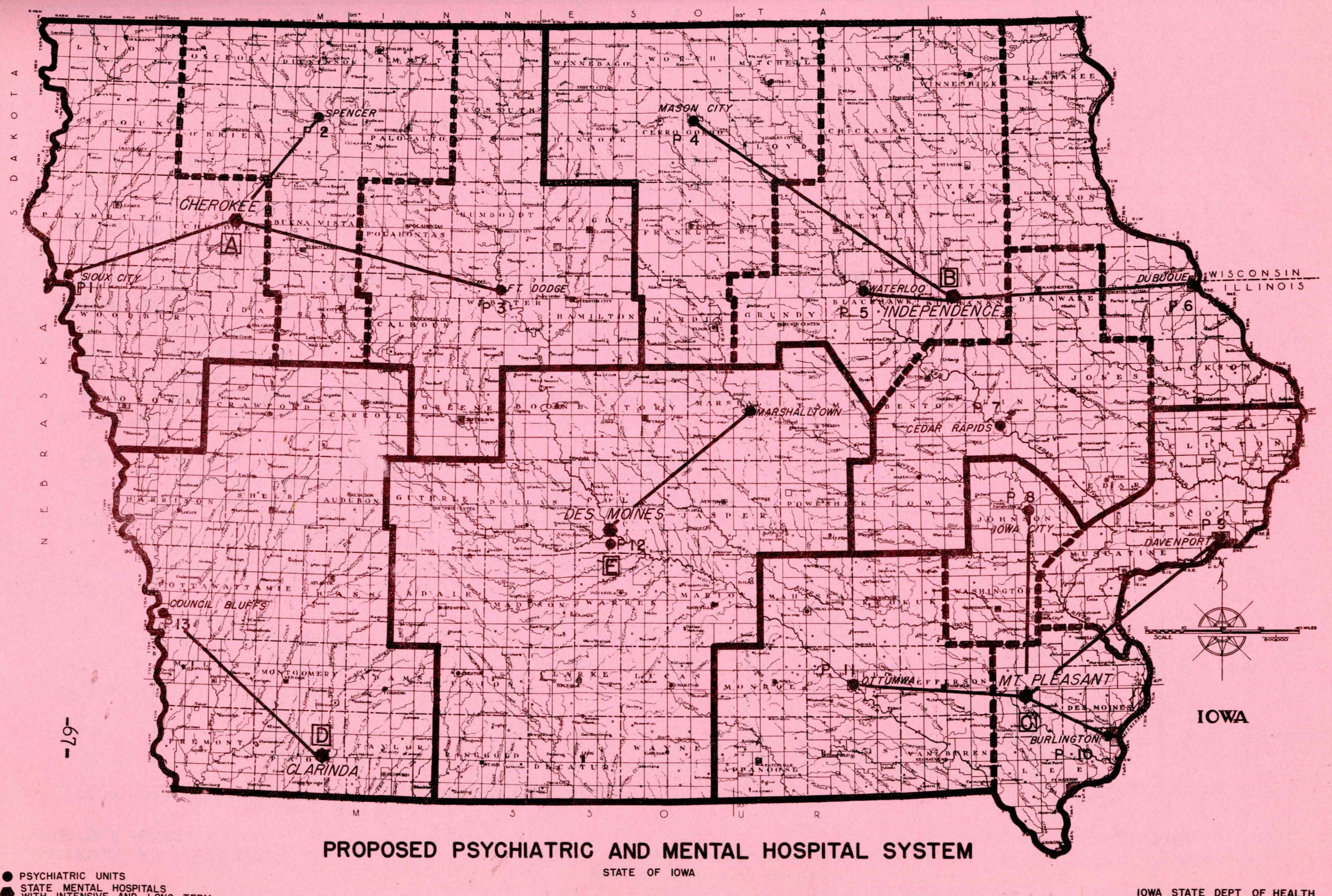
"A MENTAL HEALTH PROGRAM FOR IOWA"

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 Accept. Beds	Proposed Services and Beds					Total Beds Proposed
		Disturbed Children Unit	Crimin'l "Insane" Unit	Tubercul Disturbed	Replace Non-Accep. Beds	Addt'l. Beds Unmet Need	
Cherokee	1,272	50	0	0	0	183	1,505
Independence	560	50	0	0	520	177	1,307
Mt. Pleasant	381	0	0	0	827	365	1,573
Clarinda	1,246	0	0	0	0	283	1,529
Des Moines	0	50	75	75	0	0	200
Statwide	3,459	150	75	75	1,347	1,008	6,114
As Recapped to State Plan	3,459			2,655			6,114

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 judgement 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

● PSYCHIATRIC UNITS
⬣ STATE MENTAL HOSPITALS WITH INTENSIVE AND LONG TERM TREATMENT FACILITIES

IOWA STATE DEPT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

1. PAGE 1 OF 1
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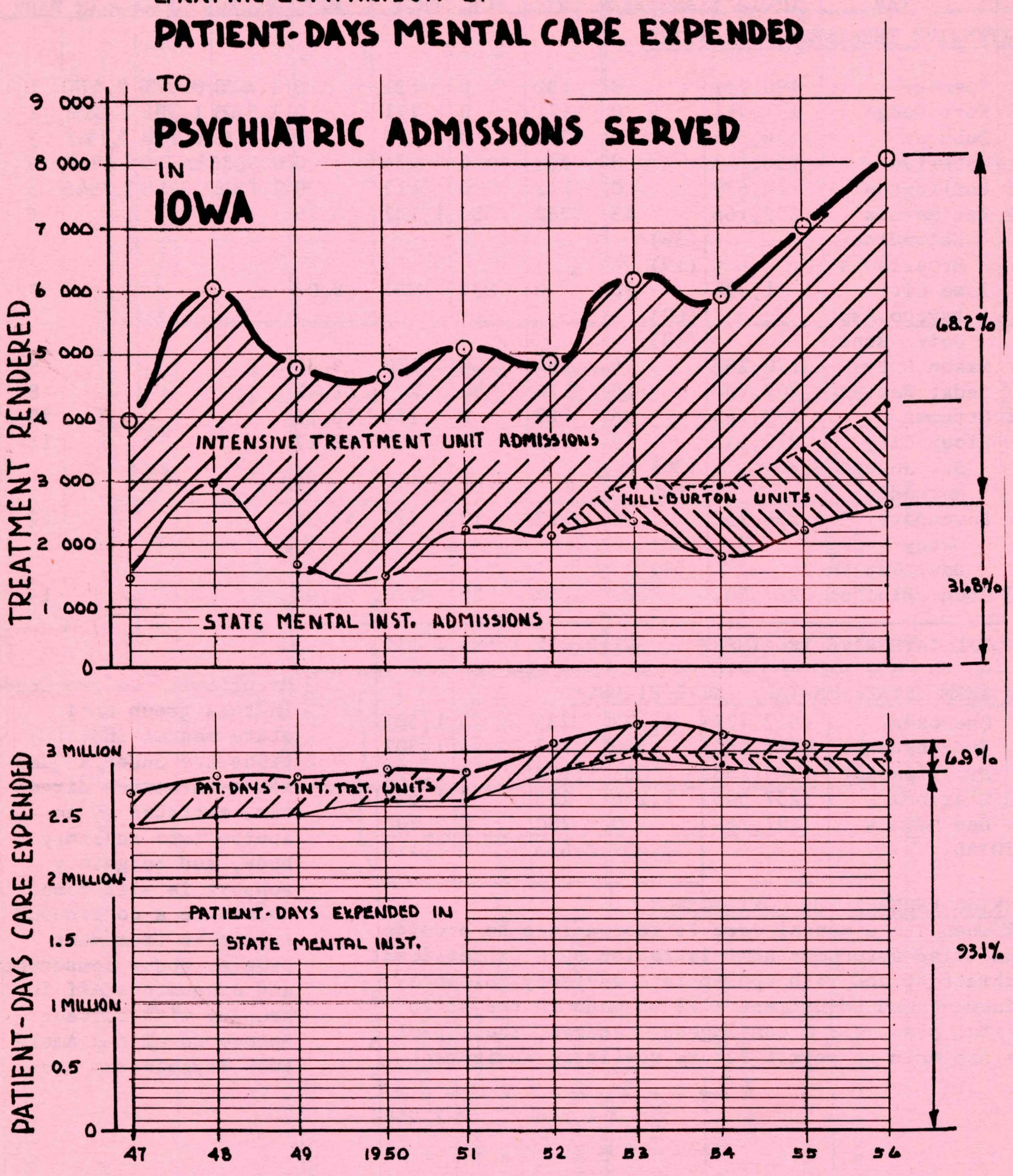
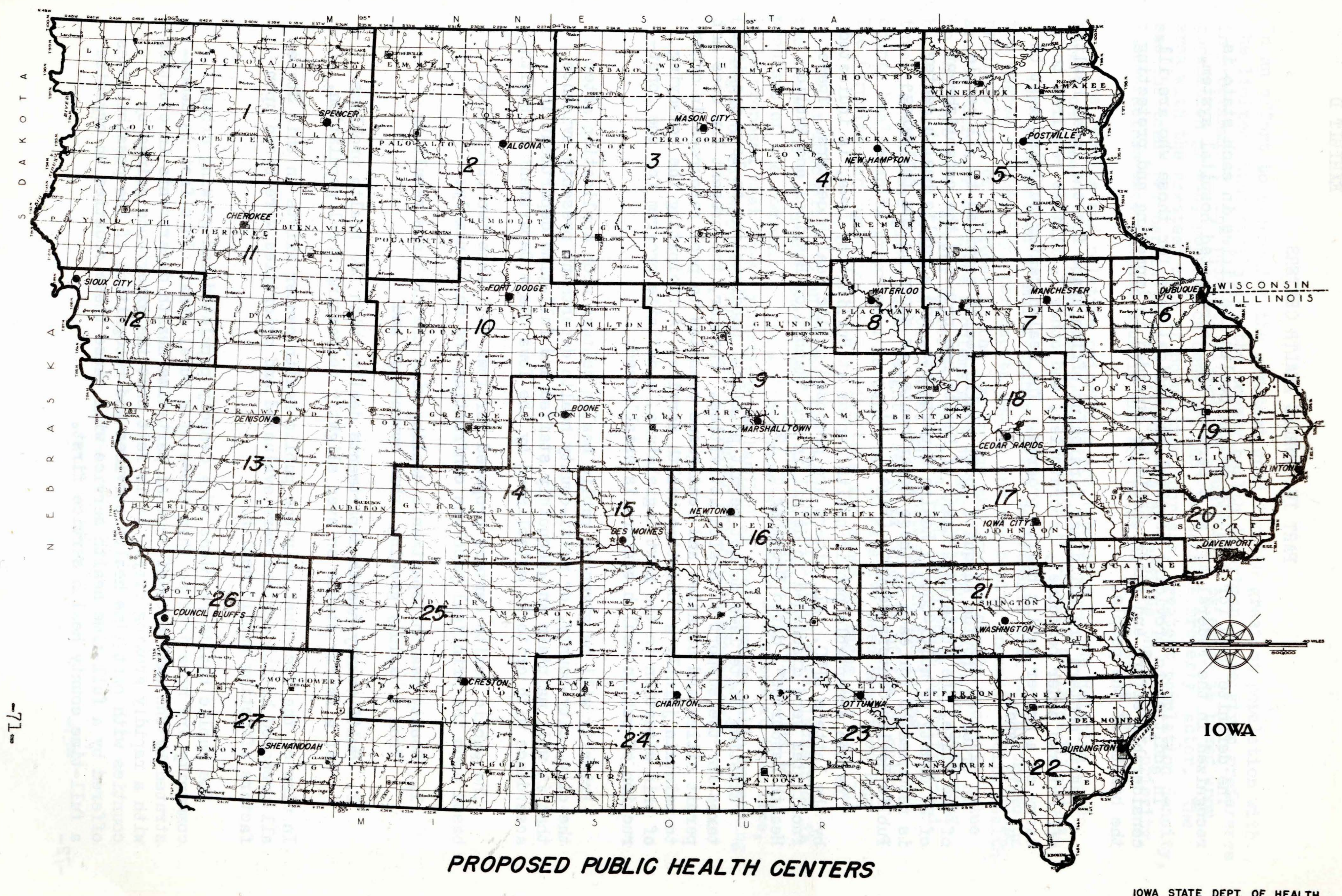
4. REGION

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE Psychiatric-Mental HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
REGION "A"											
P-1	Mental Health Institute	Cherokee	Cherokee	ST	N/M	1,272	0		98.7	458,366	593
P-1	St. Joseph Mercy	Woodbury	Sioux City	CH	N/M	30	12		55.5	(8,514)	(306)
P-1	Methodist	Woodbury	Sioux City	CH	N/M	19	0		NR	(7,320)	(244)
REGION "B"											
P-4	St. Joseph Mercy	C. Gordo	Mason City	CH	N/M	16	0		NR	(5,256)	(117)
P-5	Mental Health Institute	Buchanan	Independence	ST	N/M	560	520		104.5	412,038	892
P-6	St. Joseph Sanatorium	Dubuque	Dubuque	CH	N/M	0	230		61.9	51,998	670
P-7	St. Luke's Methodist	Linn	Cedar Rapids	CH	N/M	34	0		85.1	5,638	598*
P-8	State Psychopathic	Johnson	Iowa City	ST	N/M	60	0		71.3	15,604	298
P-8	Disturbed Children's D&T Unit	Johnson	Iowa City	ST	N/M	18	0	Project Iowa-68			
REGION "C"											
P-10	Mental Health Institute	Henry	Mt. Pleasant	ST	N/M	381	827		108.4	478,103	462
P-9	Mercy	Scott	Davenport	CH	N/M	35	0		(19.1)	2,438	176
P-9	Forest Park	Scott	Davenport	IND	N/M	59	0		59.3	12,775	200
P-11	Ottumwa	Wapello	Ottumwa	NPA	N/M	25	0	Project Iowa-60 Under Constr.			
REGION "D"											
P-13	Mental Health Institute	Page	Clarinda	ST	N/M	1,246	0		102.9	468,149	695
P-13	St. Bernard's	Pott.	Council Blfs.	CH	N/M	200	0		86.8	63,341	780
REGION "E"											
P-12	Iowa Methodist	Polk	Des Moines	CH	N/M	26	0		96.6	9,176	196
P-12	Hillcrest (Retreat)	Polk	Des Moines	IND	N/M	0	50		92.5	16,886	400
P-12	Broadlawns Polk County	Polk	Des Moines	CO	N/M	19	0		29.3	2,031	449**
	* Project Iowa-75 Occupancy based on 18 existing beds										
	** Newly opened unit										
			REGIONAL TOTAL						xxx		
			STATE TOTAL			4,000	1,639		98.0	2,017,633	7,076



Division of Hospital Services
Iowa State Department of Health



PROPOSED PUBLIC HEALTH CENTERS

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

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. (Page)

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 on Page 81 . The manner of computation is defined on Pages 113 and 114 .

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 most 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 Relative Need Report on Page The formulae for computing these prioriteis are shown on Pages 113 and 114

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 STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

PUBLIC HEALTH CENTERS REPORT

1. PAGE 1 OF 7
2. DATE July 1, 1957
3. STATE Iowa

4. MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS ALLOWED BY STATE RATIO 87

POLITICAL SUBDIVISION WHICH EXISTING OR PROPOSED FACILITY WILL SERVE	POPULATION OF POLITICAL SUBDIVISION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES: EXISTING ACCEPTABLE		FACILITIES: PROGRAMMED		DESCRIPTION OF AUXILIARY FACILITIES
			P.H.C.	AUXIL.	P.H.C.	AUXIL.	
SPENCER							
Clay County	18,459						
Dickinson County	13,258						
Lyon County	14,312	Multi-County					
O'Brien County	18,857	Health Department	0	0	1	0	
Osceola County	9,944	No. 1					
Sioux County	25,985						
ALGONA							
Emmet County	14,683						
Humboldt County	12,964	Multi-County					
Kossuth County	26,134	Health Department	0	0	1	0	
Palo Alto County	15,793	No. 2					
Pocahontas County	15,108						
MASON CITY							
Cerro Gordo County	48,118						
Franklin County	16,285	Multi-County					
Hancock County	14,956	Health Department	0	0	1	0	
Winnebago County	13,182	No. 3					
Worth County	10,891						
Wright County	19,513						
STATE TOTAL							

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

PUBLIC HEALTH CENTERS REPORT

1. PAGE 2 OF 7
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4. MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS ALLOWED BY STATE RATIO 87

POLITICAL SUBDIVISION WHICH EXISTING OR PROPOSED FACILITY WILL SERVE	POPULATION OF POLITICAL SUBDIVISION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES				DESCRIPTION OF AUXILIARY FACILITIES
			EXISTING ACCEPTABLE		PROGRAMMED		
			P.H.C.	AUXIL.	P.H.C.	AUXIL.	
HAMPTON							
Bremer County	19,782						
Butler County	17,116						
Chickasaw County	15,315	Multi-County					
Floyd County	22,547	Health Department	0	0	1	0	
Howard County	12,911	No. 4					
Mitchell County	13,905						
POSTVILLE							
Allamakee County	15,820						
Clayton County	21,378	Multi-County					
Fayette County	27,861	Health Department	0	0	1	0	
Winneshiek County	21,314	No. 5					
DUBUQUE							
Dubuque County	78,871	Co. Health Dept. No. 6	0	0	1	0	
MANCHESTER							
Benton County	22,636						
Buchanan County	19,930	Multi-County					
Delaware County	17,294	Health Department	0	0	1	0	
Jones County	17,494	No. 7					
STATE TOTAL							

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

PUBLIC HEALTH CENTERS REPORT

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4. MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS ALLOWED BY STATE RATIO 87

POLITICAL SUBDIVISION WHICH EXISTING OR PROPOSED FACILITY WILL SERVE	POPULATION OF POLITICAL SUBDIVISION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES: EXISTING ACCEPTABLE P.H.C.	FACILITIES: EXISTING ACCEPTABLE AUXIL.	FACILITIES: PROGRAMMED P.H.C.	FACILITIES: PROGRAMMED AUXIL.	DESCRIPTION OF AUXILIARY FACILITIES
WATERLOO							
Blackhawk County	116,549	Co. Health Dept. No. 8	0	0	1	0	
MARSHALLTOWN							
Grundy County	13,945						
Hardin County	21,840	Multi-County					
Marshall County	35,271	Health Department	0	0	1	0	
Tama County	20,980	No. 9					
FORT DODGE							
Calhoun County	16,505						
Greene County	14,978	Multi-County					
Hamilton County	19,598	Health Department	0	0	1	0	
Webster County	46,681	No. 10					
CHEROKEE							
Buena Vista County	22,225						
Cherokee County	16,310	Multi-County					
Ida County	10,515	Health Department	0	0	1	0	
Plymouth County	23,216	No. 11					
Sac County	17,532						
STATE TOTAL							

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

PUBLIC HEALTH CENTERS REPORT

1. PAGE 4 OF 7
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4. MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS ALLOWED BY STATE RATIO 87

POLITICAL SUBDIVISION WHICH EXISTING OR PROPOSED FACILITY WILL SERVE	POPULATION OF POLITICAL SUBDIVISION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES: EXISTING ACCEPTABLE		FACILITIES: PROGRAMMED		DESCRIPTION OF AUXILIARY FACILITIES
			P.H.C.	AUXIL.	P.H.C.	AUXIL.	
SIOUX CITY							
Woodbury County	104,855	Co. Health Dept. No.12	0	0	1	0	
DENISON							
Audubon County	11,503						
Carroll County	23,420						
Crawford County	19,348	Multi-County					
Harrison County	17,856	Health Department	0	0	1	0	
Monona County	15,352	No. 13					
Shelby County	15,519						
BOONE							
Boone County	24,324						
Dallas County	23,145	Multi-County					
Guthrie County	14,333	Health Department	0	0	1	0	
Story County	49,466	No. 14					
DES MOINES							
Polk County	251,817	Co. Health Dept. No.15	0	0	1	0	
NEWTON							
Jasper County	33,198						
Mahaska County	23,499	Multi-County					
Marion County	25,350	Health Department	0	0	1	0	
Poweshiek County	19,842	No. 16					
STATE TOTAL							

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
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PUBLIC HEALTH CENTERS REPORT

1. PAGE 5 OF 7
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4. MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS ALLOWED BY STATE RATIO 87

POLITICAL SUBDIVISION WHICH EXISTING OR PROPOSED FACILITY WILL SERVE	POPULATION OF POLITICAL SUBDIVISION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES: EXISTING ACCEPTABLE		FACILITIES: PROGRAMMED		DESCRIPTION OF AUXILIARY FACILITIES
			P.H.C.	AUXIL.	P.H.C.	AUXIL.	
IOWA CITY							
Cedar County	17,032	Multi-County					
Johnson County	52,286	Health Department	0	0	1	0	
Iowa County	15,082	No. 17					
CEDAR RAPIDS							
Linn County	118,365	Co. Health Dept. No.18	0	0	1	0	
CLINTON							
Clinton County	53,951	Multi-County Health	0	0	1	0	
Jackson County	18,245	Department No. 19					
DAVENPORT							
Scott County	114,341	Co. Health Dept. No.20	0	0	1	0	
WASHINGTON							
Keokuk County	15,903						
Louisa County	10,975	Multi-County					
Muscatine County	32,979	Health Department	0	0	1	0	
Washington County	19,342	No. 21					
STATE TOTAL							

IOWA STATE DEPT. OF HEALTH
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4. MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS ALLOWED BY STATE RATIO 87

POLITICAL SUBDIVISION WHICH EXISTING OR PROPOSED FACILITY WILL SERVE	POPULATION OF POLITICAL SUBDIVISION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES: EXISTING ACCEPTABLE P.H.C.	FACILITIES: EXISTING ACCEPTABLE AUXIL.	FACILITIES: PROGRAMMED P.H.C.	FACILITIES: PROGRAMMED AUXIL.	DESCRIPTION OF AUXILIARY FACILITIES
BURLINGTON							
Des Moines County	46,232	Multi-County					
Henry County	17,051	Health Department	1	0	0	0	
Lee County	42,868	No. 22					
OTTUMWA							
Davis County	9,400						
Jefferson County	15,742	Multi-County					
Monroe County	10,634	Health Department	0	0	1	0	
Van Buren County	10,304	No. 23					
Wapello County	49,945						
CHARITON							
Appanoose County	18,336						
Clarke County	9,054	Multi-County					
Decatur County	12,009	Health Department	0	0	1	0	
Lucas County	11,079	No. 24					
Warren County	17,918						
Wayne County	10,908						
STATE TOTAL							

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

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3. STATE Iowa

4. MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS ALLOWED BY STATE RATIO 87

POLITICAL SUBDIVISION WHICH EXISTING OR PROPOSED FACILITY WILL SERVE	POPULATION OF POLITICAL SUBDIVISION	NAME OF LOCAL HEALTH UNIT SERVING POLITICAL SUBDIVISION	FACILITIES: EXISTING ACCEPTABLE		FACILITIES: PROGRAMMED		DESCRIPTION OF AUXILIARY FACILITIES
			P.H.C.	AUXIL.	P.H.C.	AUXIL.	
CRESTON							
Adair County	11,878						
Adams County	8,021	Multi-County					
Cass County	18,555	Health Department	0	0	1	0	
Madison County	12,452	No. 25					
Ringgold County	8,826						
Union County	15,316						
COUNCIL BLUFFS							
Pottawattamie County	72,624	Co. Health Dept. No. 26	0	0	1	0	
SHENANDOAH							
Fremont County	11,418						
Mills County	10,704	Multi-County					
Montgomery County	15,768	Health Department	0	0	1	0	
Page County	21,311	No. 27					
Taylor County	11,558						
STATE TOTAL	2,690,000		1	0	26	0	

IOWA STATE DEPARTMENT OF HEALTH

Division of Hospital Services

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RELATIVE NEED REPORT
PUBLIC HEALTH CENTERS
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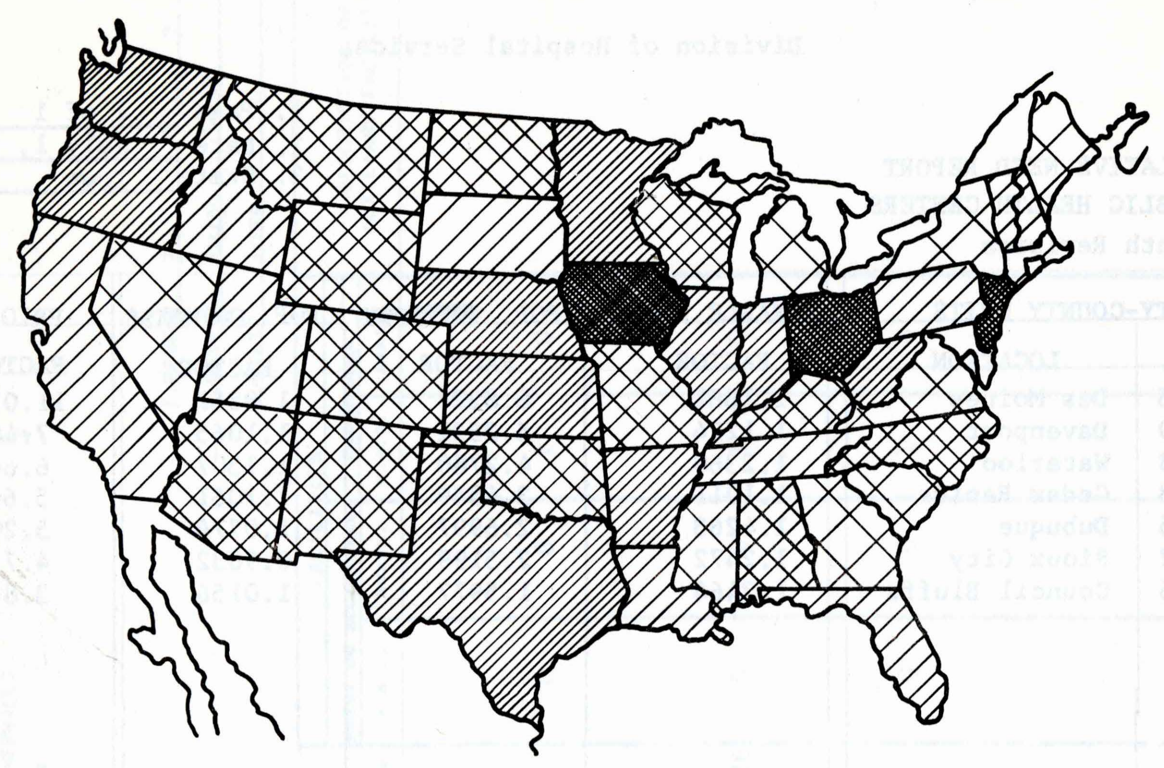
CITY-COUNTY UNITS		TAXABLE PROPERTY	POP. DENSITY	POP. INCREASE	PRIORITY
NO.	LOCATION	FACTOR	FACTOR	FACTOR	FACTOR
15	Des Moines	1.1661	8.8227	1.0857	11.0745
20	Davenport	1.1224	5.2531	1.1065	7.4820
8	Waterloo	1.2360	4.2780	1.1307	6.6447
18	Cedar Rapids	1.1011	3.4559	1.1061	5.6631
6	Dubuque	1.4263	2.6997	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 PROP.	PER CAP. INC.	RURALITY	PRIORITY
NO.	LOCATION	FACTOR	FACTOR	FACTOR	FACTOR
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
23	Ottumwa	1.3096	1.1118	0.9742	3.3956
1	Spencer	0.7754	0.9694	1.6376	3.3824
7	Manchester	0.8858	1.1127	1.3299	3.3284
2	Algona	0.7528	0.9453	1.5513	3.2494
27	Shenandoah	0.8330	1.1393	1.2578	3.2301
16	Newton	1.0031	1.0541	1.1617	3.2189
21	Washington	0.9995	0.9762	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		



DOLLAR EXPENDITURES PER CAPITA FOR HEALTH

COMPARISON OF STATE EXPENDITURES – FISCAL 1950

PER CAPITA

- UP TO $0.50
- $0.50 TO $0.74
- $0.75 TO $1.05
- $1.06 TO $1.39
- $1.40 TO $1.99
- $2.00 OR MORE

DIV. OF HOSPITAL SERVICES
IOWA STATE DEPT. OF HEALTH

EXHIBIT D

PART V. HOSPITALS FOR CHRONICALLY ILL AND IMPAIRED

The term chronic illness has in the past been recognized by authorities in rather general terms. However, the transition in age group trends of our country is rapidly bringing a crucial problem into sharp focus. Because our more productive age groups, when expressed in terms of percent of total population, are shrinking alarmingly, the National Congress and administration have placed great emphasis on stimulating corrective action. The Hill-Burton Program was amended in 1954 to provide additional incentive in this direction. Previous legislation and appropriations permitted grants-in-aid for long term care facilities, but the public was not receptive. There has been an inclination to associate such facilities with the existing quasi-social "commercial homes" and comparable care-and-keep establishments for indigents. The crux of the matter is that many persons with an appreciable life span remaining are indigent because their expended individual resources were not sufficient to complete a pattern of treatment which would have permitted sufficient curative results and return to partial productivity or total self-sufficiency.

Preliminary observations during the course of the program's operation made the possibilities in the field of chronic illness and impairment increasingly evident to both State and Federal Agencies. At this point, chronic illness hospitals are emphasized in both Public Law 725 and 482.

The impact of chronic illness has already been felt in our national economic pattern. The problem in Iowa is even more acute in that we have verged from a "young" state to the union's oldest, in terms of age groups. This aspect is even more serious when we review the trends in the State's economy. Physical impairment is increasing alarmingly, along with older age groups, as a result of increased development and mechanical revolution of the past few years in agriculture. At this point, accident rates have caused qualified observers to consider farming more hazardous than industrial vocations.

In an effort to program realistically in terms of qualified professional personnel and available economic resources, a plan is set forth to provide specialized chronic illness units in population centers appropriately located geographically and in proportion with population of the regions being served. The pattern is correlated directly with the acute general hospital pattern already existing.

Relative priority for funds under both appropriations is based on degree or rurality and per capita resource, the most rural region with the lowest per capita income being given the greatest preference. Basis for each factor is defined in Exhibit E (Determination of Priority Factors).

Nursing areas in acute general and chronic illness hospital units are very similar. However, a chronic priority cannot be used to build such nursing facilities with the ulterior purpose of ultimately using the finished facility for acute general purposes. The intent of the Congress was to specifically give priority preference to categories of greatest need and did create a means of recourse in the event a finished structure is utilized for purposes other than that implied or intended in the design and construction of the project.

A sponsor's application for a chronic illness project shall be supported by a total narrative program and shall include:

1. description of appropriate nursing area proposed

2. description of complete related services realistically continguous to the primary activity

3. availability of qualified professional staff

4. indication of acceptable and appropriate personnel available for operation of unit

5. prospectus of resources for construction <u>and</u> operation of the ultimate facility in the manner set forth as the proposed mission

The Iowa Advisory Council for Hospitals and Related Health Facilities will review and evaluate the application. In the event questions exist, the sponsor will be invited to elaborate on the presentation, in writing and/or verbally, toward clarification. The council's determination will be based on its evaluation of the applicant's total presentation.

PROPOSED CHRONIC ILLNESS HOSPITAL SERVICE AREAS

MINNESOTA
SOUTH DAKOTA
NEBRASKA
WISCONSIN
ILLINOIS
MISSOURI
IOWA

C-1 SIOUX CITY
C-2 SPENCER
C-3 FORT DODGE
C-4 MASON CITY
C-5 WATERLOO
C-6 DUBUQUE
C-7 CEDAR RAPIDS
C-8 IOWA CITY
C-9 CLINTON
DAVENPORT
C-10 BURLINGTON
FT. MADISON
KEOKUK
C-11 OTTUMWA
C-12 DES MOINES
MARSHALLTOWN
C-13 COUNCIL BLUFFS
CARROLL
MUSCATINE

LEGEND
- CHRONIC ILLNESS TREATMENT CENTERS
- TEACHING CENTERS

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACCEPTABLE AND NON-ACCEPTABLE HOSPITALS REPORT

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
DES MOINES, IOWA

1. PAGE 1 OF 1
2. DATE July 1, 1957
3. STATE Iowa
4. REGION Statewide

5. LIST OF ACCEPTABLE AND NON ACCEPTABLE Chronic HOSPITAL FACILITIES AND HOSPITAL BEDS

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP OR CONTROL	MEDICAL TYPE	BED CAPACITY		NUMBER OF BASSINETS	% OCCUPANCY	NUMBER OF	
		COUNTY	CITY OR TOWN			ACCEPTABLE	NON-ACCEPTABLE			PATIENT DAYS	PATIENTS ADMITTED
C-1	St. Joseph Mercy	Woodbury	Sioux City	CH	CHR	0	50		NR	(15,513)	(282)
C-7	St. Luke's Methodist	Linn	Cedar Rapids	CH	CHR	58	0	Project Iowa-75 Under constr.			
C-8	University Hospitals	Johnson	Iowa City	CH	CHR	738	0		82.7	222,743	15,088
C-8	Mercy	Johnson	Iowa City	CH	CHR	43	0	Project Iowa-69 Under constr.			
C-9	Mercy	Scott	Davenport	CH	CHR	86	0		54.1	16,982	410**
C-11	Ottumwa	Wapello	Ottumwa	CH	CHR	46	0	Project Iowa-60 Under constr.			
C-12	Iowa Methodist	Polk	Des Moines	CH	CHR	120	0	Project Iowa-65GC Under constr.			
	**Newly Opened Project										
				REGIONAL TOTAL					xxx		
				STATE TOTAL		1,091	50			255,238	15,780

IOWA STATE DEPARTMENT OF HEALTH

Division of Hospital Services

RELATIVE NEED REPORT
CHRONIC ILLNESS FACILITIES
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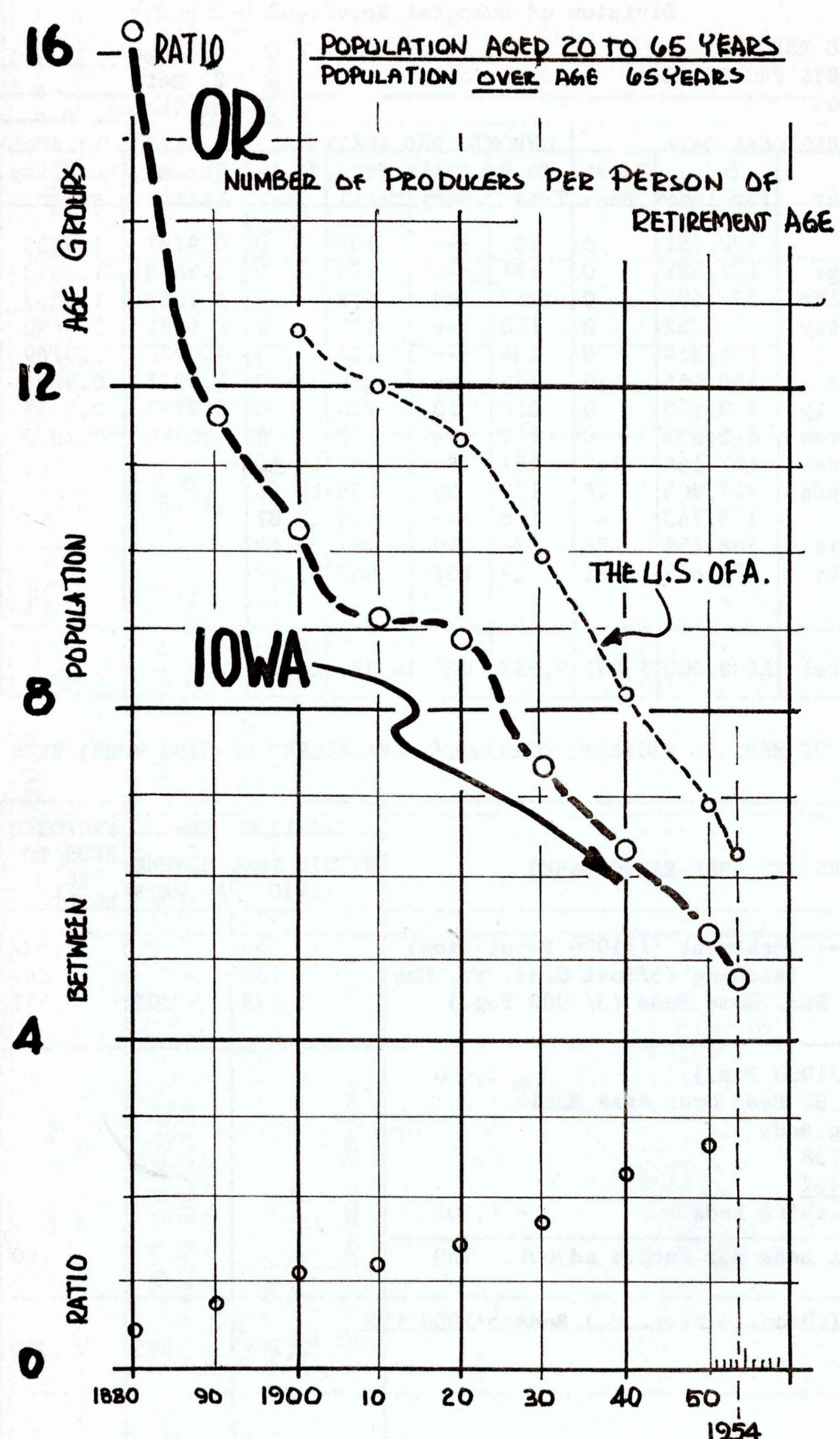
BASIC REGIONAL DATA			CHRONIC BED ANALYSIS					ZERO AREA ANALYSIS		
Code	Center	Population	Exist. Beds	To Be Treat.	Built Tchs	Prop. Total	% need met	Income Factor	Rurality Factor	Priority Factor
C-2	Spencer	130,751	0	131	---	131	0	0.9737	1.4433	2.4170
C-3	Ft. Dodge	171,481	0	171	---	171	0	1.0013	1.3623	2.3636
C-13	Coun. Blfs.	257,605	0	258	20	278	0	1.1055	1.2267	2.3322
C-4	Mason City	170,282	0	170	---	170	0	0.9981	1.2490	2.2471
C-6	Dubuque	134,314	0	134	---	134	0	1.0778	1.0769	2.1547
C-5	Waterloo	256,165	0	256	---	256	0	1.0225	0.9636	1.9861
C-1	Sioux City	210,545	0	210	10	220	0	0.9737	0.9959	1.9696
C-10	Burlington	111,639	0	112	---	112	0	1.0218	0.7328	1.7546
C-12	Des Moines	607,166	120	487	580	1,187	10.11			
C-7	Cedar Rpds.	207,903	58	150	90	298	19.46			
C-11	Ottumwa	153,763	46	108	---	154	29.87			
C-9	Davenport	206,758	86	121	10	217	39.63			
C-8	Iowa City	71,628	781	29	157	967	80.77			
Statewide Total		2,690,000	1,091	2,337	867	4,295	25.40			

SUMMARY OF MEDICAL FACILITY (CHRONIC/CONVALESCENT NURSING HOME) BEDS

CATEGORIES AND AREA RATIO BASES	EXISTING BEDS WITHIN AREA RATIO	EXISTING BEDS BEYOND A. RATIO	PROPOSED BEDS TO BE BUILT	STATE TOTAL BEDS PROPOSED
Chronic Beds---Treatment (1/1000 Population)	353		2,337	2,690
Teaching (5/Post Grad. Yr. Man)	738		867	1,605
Convalescent Nur. Home Beds (3/1000 Pop.)	1,693	305	6,377	8,375
Pool Beds (1/1000 Pop.) 2,690 Less Conv. N.H. Beds Over Area Ratio - 305 Less Teaching Beds Existing 738 To Be Blt 867 Total Teaching Beds - 1,605				
Remain'g Pool Beds for future adjust. 780			780	780
STATE TOTAL (Chron. + Nrsg. H.) Beds 5/1000 POP.	2,784	305	10,361	13,450

Determining factor in evaluating application for grants-in-aid will be relative priority of the area and the completeness of the construction program presented, so long as total beds conform to the beds assigned to area.



GRAPHIC COMPARISON OF TRENDS: IN RATIO BETWEEN IOWA'S AGE GROUPS

DIV OF HOSPITAL SERVICES
IOWA STATE DEPT-HEALTH

MEDICAL FACILITIES

Previous paragraphs have discussed resources and needs in terms of hospital facilities, both acute general and specialized, as we find them tody. Permit us to review the development in medical care during the past 100 years, and how such developments were guided.

Initially, the frontier home was an all-purpose institution which, because of necessity, adapted itself to all contingencies. Expedient answers were utilized for almost all things, because no other means were available. The child was born, illness was cared for in whatever manner was possible, the duties of elders were taken over by children, and care for the infirm was administered by the younger generations.

Because the demand for the doctor's services and time became excessive, he provided a central point to accumulate his patients for increased personal attention and better usage of his professional talents. This "home away from home" grew into our present acute general hospital. The State, generally speaking, has been provided quite admirably in this regard, while removing this activity from the home.

The next phase of care to demand attention was care for the mentally ill. The earliest legislative bodies of Iowa gave due consideration to this subject to reduce the impact it had on family and home life. The State, thereupon, assumed responsibility in this field and, upon advice of the best consultants, provided means and funds for psychiatric treatment. Unfortunately for Iowa, the established responsibilities have been neglected and the 1870 goal has been aborted. The basic pattern appears to exist and the home no longer attempts to provide an expedient in this sphere.

This same transition has been brought about for the tuberculosis patient. To preclude exposure of other members of the family, a separate facility has come into being. Iowa is extremely fortunate, in terms of tuberculosis beds, for its total needs are cared for. Only a few facets of the complete program remain to be provided.

A previous section touched upon chronic illness and physical impairment, and what current trends are indicating to us. Industrialization, mechanization, and population age are major contributions to the impending problem. Its importance is demonstrated through recent action taken by the Federal agencies and bodies. Our entire economic and social pattern demands that immediate consideration be given to the problem by industry, all echelons of government, and by leaders of the various population groups. The National government is gravely concerned with the population trends of the country as a whole. Iowa is faced with circumstances and trends which are even more ruinous than those of the nation.

A corrective plan must apply effort in several directions:

1. Inauguration of preventive steps which will maintain the able bodied to the maximum extent.

2. Treat and cure human ailments in their earliest stages.

3. Reconsider (and probably extend) age of retirement to permit producers to continue to the extent of their ability, so that their self-sufficiency and productivity are prolonged.

4. Treat and rehabilitate the chronically ill and impaired and encourage their economic self-sufficiency to the maximum extent that their capabilities will permit.

5. Utilize individual resource for treatment to its maximum extent, and thereafter provide public means for completing the program to ultimate success.

Such a program must utilize facilities and personnel resources to a maximum. Much of our present problem is attributable to expedient provisions of the past which, though outmoded, have been carried into the present and are accepted without question. The domiciliary type of institution has accumulated a tremendous number of persons classed as indigent. No effort has been made to provide treatment and care which would re-establish these persons as productive members of their communities, partially or wholly self-sufficient, and as taxpayers.

Considerable emphasis has been placed on economy in administering all echelons of government. This inclination has resulted in eliminating treatment and providing minimal accommodations in the care-and-keep type of institution serving indigents. A more realistic and economical pattern would be to utilize the individual's resources toward corrective treatment to the extent possible, and for governmental agencies to provide continued treatment which would ultimately rehabilitate the individual. He could then be re-established in his community as a producer and taxpayer, rather than a ward of the public. The cost to the taxpayer would be materially reduced. Our labor pool would be enhanced in terms of productive ability, and our tax base would be broadened.

There are other major elements necessary to complete the care pattern. These are the diagnostic and treatment facility, the convalescent nursing home and the rehabilitation center which are elaborated upon in later sections. Each of these plays an enormous role in terms of economical application of professional talent and the facilities which will most reasonably serve the purpose. They <u>must</u> be incorporated in a total program to best apply available of monetary resources and professional talent.

For similar reasons, the chronic illness unit has come forward with means outside the scope of the acute general hospital. Maximum acute treatment facilities and extensive skilled nursing care can be displaced by less intense specialized and a range of therapy facilities, arranged to economize on personnel and the individual's resource while realizing maximum curative results. Location near population centers will permit maximum availability of outpatient facilities. The goal is establishing individuals to a productive role. The mission of the hospital for the chronically ill and impaired is to provide long-term treatment economically, and thereby extend effectiveness of individual resources toward ultimate rehabilitation. (See discussion in Part V).

PART VI CONVALESCENT NURSING HOMES

A convalescent nursing home 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 within 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 (convalescent) '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 community service."

The terminology "convalescent nursing home" should not be confused with the classification "nursing home" and "custodial home" as defined by Iowa statutes and regulations for the purpose of issuing license, inasmuch as there is a notable difference in the standards for facilities, staff, and services. While existing statutes have provided criteria toward a realistic standard for physical facilities, the standards for nursing care are marginal, and standards for medical care are non-existent.

In evaluating other aspects of an institution to determine whether it qualifies as a convalescent nursing home, consideration must also be given to such features as their admission policy. For instance, quite a number of establishments deliberately seek to admit residents on the basis of providing a domiciliary service. County institutions are a deliberate means of providing a residence for indigent persons who have no other means of housing or living. Quite similarly, many proprietary institutions have been created with a view toward receiving estates while providing the care requirements of the individual during their remaining senior years. It becomes apparent neither of these forms of home are designed to treat, care, and rehabilitate individuals, thereby re-establishing them in a productive capacity as a community element.

In developing a plan for the State of Iowa, an inventory was made of those known facilities which presently accomodate persons who probably are in need of services such as would be rendered by convalescent nursing homes. Consideration was given to the fire-resistant qualities of the physical plant. Lack of standards in the State have not demanded services of the calibre indicated by the definition of the convalescent nursing home. Records maintained by the nursing homes and related institutions do not conform to any standard. As a result, existing records do not realistically offer a direct means of determining the actual patient days involved. To realize a representative total, the patients on hand at the time of survey were projected toward a probable total of each institution's patient days for the year. It is not considered unrealistic to assume that such errors as may occur in individual homes surveyed will tend to compensate each other, and that the State total of patient days is indicative and representative of the total need within the State for this service.

The evolution of the "nursing home" as defined by Iowa law goes back a number of years. Initially, a similar facility was created by county administrators to provide care for indigents. Ultimately, during periods of expansion

by our State Mental Institutions, an expedient means of relieving the crowdedness of the state institutions was to authorize counties to receive non-violent mental patients, who had been released by the State Mental Institution after five years of residence, if they were declared "incurable". The homes provided no treatment that might permit improvement. County administrations were quite willing to utilize their county homes for housing returnees, inasmuch as a monetary allowance was granted in return for this "accommodation" or custodial care without any treatment facilities.

Public conscience sought an alternative for afflicted members, either physical or mental. As a result, private citizens were induced to provide homes which offered improved custodial care. Because there were no minimum standards existent for such establishments, "nursing homes" soon became a popular field of enterprise. In time, not all nursing homes rendered services that were admirable and humane. The profit motive, at times, was the dominant consideration. This became a point of official record in 1946. While reporting their findings during a study of mental facilities in Iowa, a Study Committee of the 51st General Assembly proposed a system of licensure because " - - - the particular conditions that exist in some (nursing) homes would require that all submit to certain standards and inspections by the proper authorities to see that the aged are properly cared for and the element of personal profit is not over emphasized." One misleading assumption is apparent above, in that the legislative committee suggested that all residents of custodial and nursing homes were aged persons. To better evaluate aspects of the situation, consultants of this agency did analyze the age of occupants in county institutions and nursing homes several years ago, and found that the number of residents of the lower age groups was amazingly high.

During the course of this current survey, pertinent to convalescent nursing homes, it has become evident that there are a number of establishments other than licensed nursing homes which offer domiciliary accommodations for persons who can reasonably be classed as victims of chronic illness or impairment. This is not a failure in enforcing existing regulations, but does indicate existance of that area just outside the zone of licensing activities. The primary difference lies in whether residents are ambulatory rather than bedridden. For this reason, the largest of these domiciliary institutions (over ten beds and caring for recipients of public assistance) were incorporated in the study to indicate the extent to which treatment and care facilities are needed. This also includes the county homes which are still actively in the picture in Iowa, in spite of the progress which has been realized in the nation as a whole. More specific information as to the adequacy of county institutions has already been given through quotations from, and extracts of, reports by qualified technical committees during previous years (see Nervous and Mental Section, Part III).

By way of summary, we offer the following points. The combined total of existing beds pertinent to convalescent nursing homes is 16,359; of which 14,345 beds <u>(87.7%) are housed in non-fire-resistant structures.</u> As for the usage of these beds, 83% of their maximum capacity during the entire year was necessary to meet the actual patient days of accommodation within the State. In other words, of the total 13,578 patients (the daily average throughout the year) 11,906 patients were being cared for in wood-framed structures which are only partially staffed during the most dangerous hours of the night. You will note that none of the facilities were classed "Suitable" on the basis of service rendered. This is not to be construed as a criticism of the nursing home field.

The point is that a standard has not been established by statute or regulation to indicate the minimum requirements for facilities, staff or services for convalescent nursing homes. Heretofore, there appeared to be much interest being displayed by a number of existing representative nursing homes regarding standards. It appeared that the interest was directed toward up-grading their plant and services to realize the possibilities in this field. The result was passage of a Bill by the 57th General Assembly, effective 5 July 1957. At this point standards have not been authorized and the statute's regulatory power and effectiveness remains untried.

The funds which are being made available at this point through the Federal Program are quite limited when compared with the overall need. The one accomplishment which can be realized in this field with this limited resource would be that a few representative establishments will be created to illustrate the tremendous possibilities of the convalescent nursing home in meeting the demands of the State.

At first glance, the most obvious point of application is the possibility of creating convalescent nursing homes in conjunction with existing hospitals in rural areas. In time, these institutions could receive a great many of the patients presently residing in county homes, who, after the appropriate diagnosis, acute treatment, and the eventual long-term convalescence indicated, could probably be re-established as individual citizens capable of being wholly or partially self-sufficient. While their earning ability might not be maximum, they will be capable of a degree of productivity and thus be able to enjoy some individualism. This is not a dreamy myth! It is a proven point which has not been exploited to any degree in this State. The field is tremendous. The rapid aging of this State's population is an obvious point worthy of some very profound thought at both state and local levels.

As for preference among the areas of this State, the following pages reflect the relative need for convalescent nursing homes, based on current population data and the unmet need. Because approximately 2/3 of this State's service areas have no existing suitable or replacable facilities (0.0% need met) the zero areas were further analyzed on the basis of per capita income and the degree of rurality. Thus the most rural community with the lowest income is given the greatest preference toward receiving Grants-in-Aid assistance.

Specific locations for nursing homes have not been indicated in the following tabulations, inasmuch as the field is virtually untouched and there is little indication as to what category of service groups in an individual community will motivate development of a project. Therefore, a maximum consideration will be given to that convalescent nursing home which is proposed as an adjunct to an existing acceptable hospital within that area. Next consideration will be given to a proposed convalescent nursing home not an adjunct to the acceptable hospital, but located in the same town and with a program of operation directly correlated with the existing hospital. Final consideration for proposals from the ranking area will be for the home not in the same town, but near, which will program in a manner that will appropriately relate to the available hospital services. Should there be two proposals with comparable circumstances and programs, the sponsors shall submit details and data to the Advisory Council for their consideration and evaluation for determining maximum effectiveness in terms of community service. In any event, a proposed convalescent unit must present a complete program and give indication of a workable relationship and referal program with an existing hospital with suitable services and adequate staff. Appropriate

statewide publicity will be given to announce a schedule for this program at a given point. All applications received will be reviewed to determine whether or not they are approvable. Ultimately, applications will be evaluated in terms of its area's relative need to determine the order of preference in allocating grants-in-aid assistance.

The goal is again maximum utilization of individual resource toward appropriate treatment, rehabilitation, and return to a productive position in the community. The mission of the nursing home is to provide the required skilled nursing care required for long-term convalescense--thus extending the individual's resources toward realizing ultimate re-establishment as a producer.

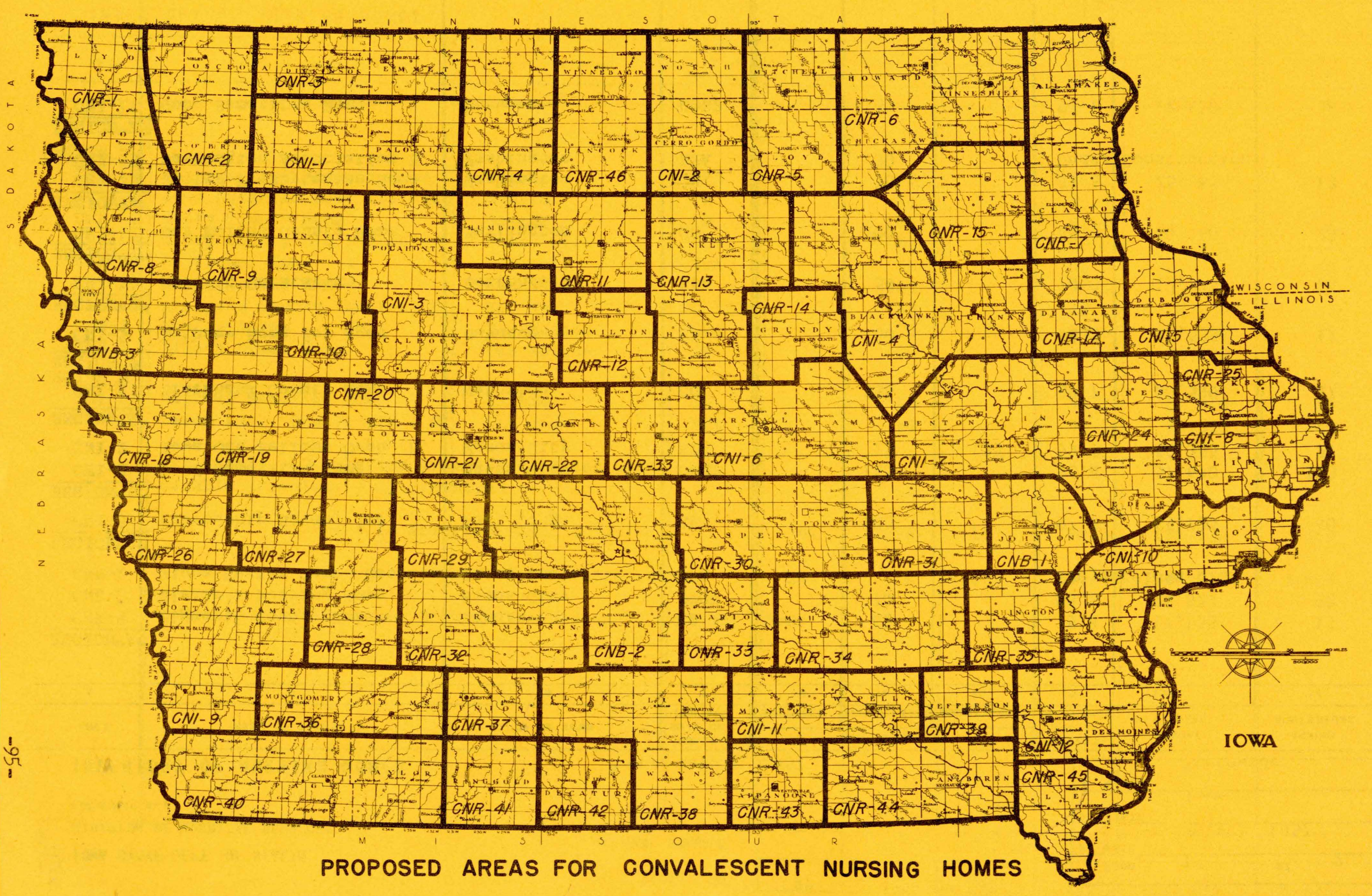
In evaluating the convalescent nursing home demand of the State, it was concluded that those tabulated as "replacable" fall into three general categories.

1. The proprietary licensed nursing home complies with maximum requirements, is housed in a fire-resistant structure, and could qualify as a convalescent nursing home if admission procedures, degree of skilled nursing care, and medical supervision were established/up-graded to conform with the standards of the Federal Register. The structures themselves are readily adaptable and acceptable as convalescent nursing homes.

2. The licensed nursing homes operated by charitable or non-profit organizations are housed in fire-resistive structures which conform with convalescent home needs. If admission procedures, care policies, degree of skilled nursing care, and medical supervision are modified and up-graded, these can be classified as convalescent nursing homes.

3. The County Home housed in a fire-resistant structure cannot be interpreted as being readily modified to the convalescent nursing home. Location is away from town and a hospital. While the structure is partitioned to provide wards, these concievably could be sub-divided to provide appropriate rooms. Medical supervision and skilled nursing care are sufficient for the domiciliary intent and do not resemble treatment.

For the above reasons, replacement, up-grading, expansion and/or relocation are in order for the "replacable" units reflected in the inventory, before care and treatment can be considered adequate to render approvable community service.



IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

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IOWA STATE DEPT. OF HEALTH

DIVISION OF HOSPITAL SERVICES

FORM HSF 5-1

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2. DATE July 1, 1957
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INVENTORY OF NURSING HOMES

5. DATED July 1, 1957

AREA	NAME OF FACILITY	CITY OR TOWN	OWNERSHIP OR CONTROL	BED CAPACITY			PERCENTAGE OF OCCUPANCY	ANNUAL PAT. DAYS	ANNUAL ADMISSIONS
				SUITABLE	REPLACEABLE	UNSUITABLE			
6	7	8	9	10	11	12	13	13A	14
REGION "A"									
CNR-8	Plymouth County Home	LeMars	CO		62		75.8	17,155	13
CNB-3	Elaine's Nursing Home	Sioux City	PROP		70		88.6	24,820	92
CNR-1	Sioux Center Comm. Hospital	Sioux Center	NPA	28			Project Iowa-67GN		
REGION "C"									
CNI-3	Friendship Haven, Inc.	Fort Dodge	CH		185		97.3	65,700	40
REGION "D"									
CNI-2	Good Samaritan Home	Mason City	CORP		165		95.8	57,670	123
CNI-2	Iowa Odd Fellows Orph. H.	Mason City	NPA		15	135	99.3	54,385	24
REGION "E"									
CNI-4	Blackhawk County Home	Waterloo	CO		238		69.7	60,590	27
REGION "F"									
CNI-5	Bethany Home for Aged	Dubuque	CH		60		98.3	21,535	12
REGION "H"									
CNI-10	Masonic Sanatarium	Bettendorf	NPA		50		70.0	12,775	14
REGION "I"									
CNI-12	Des Moines County Home	Burlington	CO		200		88.0	64,260	28
REGION "J"									
CNR-35	United Presbyterian Home	Washington	CH		70		98.6	25,185	13
CNR-35	Washington Association H.	Washington	NPA		30		Under Construction		
REGION "K"									
CNI-11	Good Samaritan Home	Ottumwa	CORP		35		97.1	12,410	36
			REGIONAL SUBTOTAL						
			STATE TOTAL						

CP-3916 STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES
FORM HSF 5-1

2. DATE July 1, 1957
3. STATE Iowa
4. REGION Statewide

INVENTORY OF NURSING HOMES

5. DATED July 1, 1957

AREA	NAME OF FACILITY	CITY OR TOWN	OWNERSHIP OR CONTROL	BED CAPACITY			PERCENTAGE OF OCCUPANCY	ANNUAL PAT. DAYS	ANNUAL ADMISSIONS
				SUITABLE	REPLACEABLE	UNSUITABLE			
6	7	8	9	10	11	12	13	13A	14
REGION "L"									
CNR-22	Eastern Star Masonic Home	Boone	NPA		93		94.6	32,120	13
CNR-22	Iowa Lutheran Home for Aged	Madrid	CH		90		98.9	32,485	27
CNR-23	Story County Home	Nevada	CO		100		97.0	33,945	14
CNR-23	Story County Old People's H.	Story City	NPA		85		100.0	31,025	24
CNR-30	Mayflower Home	Grinnell	NPA		30		96.7	10,585	12
CNR-38	Lucas County Home	Chariton	CO		100		96.0	35,040	13
CNR-41	Ringgold County (Horton) H.	Mt. Ayr	CO/PROP		45		48.9	8,030	17
CNB-2	Wesley Acres	Des Moines	NPA		50	20	108.6	27,740	11
CNB-2	Bishop Drumm Home	Des Moines	CH	56	90		97.8	32,120	12*
REGION "M"									
CNR-27	Baptist Memorial Home	Harlan	CH		75		98.7	27,010	11
CNR-27	Salem Luth. Old People's H.	Elk Horn	NPA		60		98.3	21,525	43
	Sub Totals - Population Groups/Facilities with notable chronically ill/impaired --------								
	-------- in fire-resistant structures			84	1,998	155	88.84	698,120	619
	-------- non fire-resistant structures			0	0	14,636	80.95	4,324,927	5,838
	REGIONAL SUBTOTAL								
	STATE TOTAL			84	1,998	14,791	81.96	5,023,047	6,457

* Construction Program Occupancy based on 90 existing beds

CP-3916

IOWA STATE DEPARTMENT OF HEALTH

Division of Hospital Services

CONVALESCENT NURSING HOME SUMMARY

RELATIVE NEED REPORT

1. Page 1 of 2
2. Date July 1, 1957
3. State Iowa
4. Region Statewide

BASIC AREA DATA AND IDENTIFICATION			BED SUMMARY AND STATUS				PRIORITY ANALYSIS		
SYMBOL	CENTER	POPULATION	EXISTING ACC. REPL	TO BE ADDED	TOTAL PROPOSED	% NEED MET	RURALITY FACTOR	INCOME FACTOR	PRIORITY FACTOR
CNR-42	Leon	12,009	0	36	36	0.00	1.9130	1.4679	3.3809
CNR-29	Guthrie Center	14,333	0	43	43	0.00	1.9130	1.3652	3.2782
CNR-7	Waukon	36,795	0	110	110	0.00	1.7577	1.3191	3.0768
CNR-44	Bloomfield	19,704	0	59	59	0.00	1.6676	1.3779	3.0455
CNR-31	Marengo	18,199	0	55	55	0.00	1.9130	1.0738	2.9868
CNR-14	Grundy Center	13,945	0	42	42	0.00	1.9130	1.0284	2.9414
CNR-32	Winterset	24,330	0	73	73	0.00	1.6448	1.2523	2.8971
CNR-26	Missouri Valley	17,856	0	54	54	0.00	1.5667	1.2305	2.7972
CNR-46	Britt	28,138	0	84	84	0.00	1.7272	1.0327	2.7599
CNR-25	Maquoketa	15,032	0	45	45	0.00	1.4711	1.2630	2.7341
CNR-3	Estherville	29,750	0	89	89	0.00	1.7471	0.9562	2.7033
CNR-18	Onawa	15,352	0	46	46	0.00	1.5017	1.1853	2.6870
CNR-40	Shenandoah	44,287	0	133	133	0.00	1.4401	1.2254	2.6655
CNR-6	Decorah	47,758	0	143	143	0.00	1.3844	1.2793	2.6637
CNR-43	Centerville	18,336	0	55	55	0.00	1.1727	1.4900	2.6627
CNR-17	Manchester	17,294	0	52	52	0.00	1.4826	1.1549	2.6375
CNR-34	Oskaloosa	39,402	0	118	118	0.00	1.4020	1.1929	2.5949
CNR-19	Denison	19,348	0	58	58	0.00	1.4711	1.1183	2.5894
CNR-36	Red Oak	23,789	0	71	71	0.00	1.4022	1.1354	2.5376
CNR-21	Jefferson	14,978	0	45	45	0.00	1.3812	1.1380	2.5192
CNR-15	Oelwein	35,664	0	107	107	0.00	1.3812	1.1091	2.4903
CNR-12	Webster City	19,598	0	59	59	0.00	1.5227	0.9525	2.4752
CNR-4	Algona	26,134	0	78	78	0.00	1.5189	0.9519	2.4708
CNR-28	Atlantic	30,058	0	90	90	0.00	1.3221	1.1277	2.4498
CNR-24	Anamosa	17,494	0	53	53	0.00	1.2435	1.2045	2.4480
CNR-2	Sheldon	31,610	0	95	95	0.00	1.4826	0.9543	2.4369
CNR-10	Storm Lake	39,757	0	119	119	0.00	1.4534	0.9539	2.4073
CNR-13	Iowa Falls	46,283	0	139	139	0.00	1.4093	0.9966	2.4059
CNR-9	Cherokee	26,825	0	81	81	0.00	1.4180	0.9476	2.3656
CNR-20	Carroll	23,420	0	70	70	0.00	1.3965	0.9618	2.3583
CNI-1	Spencer	37,385	0	112	112	0.00	1.2926	1.0451	2.3377
CNR-33	Knoxville	25,350	0	76	76	0.00	1.0235	1.2938	2.3173
CNR-5	Charles City	36,452	0	109	109	0.00	1.1828	1.0896	2.2724

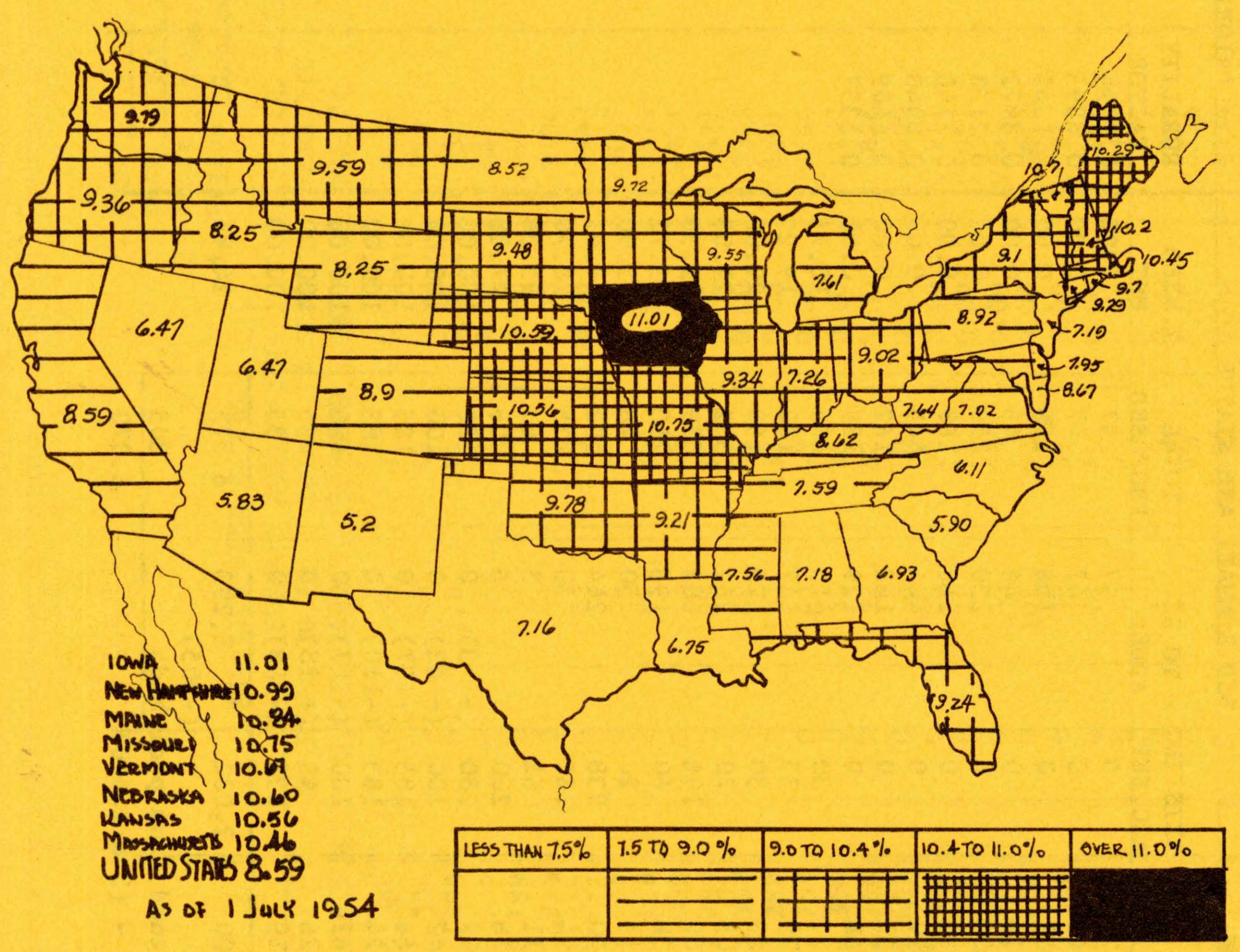
IOWA STATE DEPARTMENT OF HEALTH

Division of Hospital Services

CONVALESCENT NURSING HOME SUMMARY

2. Date July 1, 1957
3. State Iowa
4. Region Statewide

BASIC AREA DATA AND IDENTIFICATION			BED SUMMARY AND STATUS				PRIORITY ANALYSIS		
SYMBOL	CENTER	POPULATION	EXISTING ACC. REP.	TO BE ADDED	TOTAL PROPOSED	% NEED MET	RURALITY FACTOR	INCOME FACTOR	PRIORITY FACTOR
CNR-11	Clarion	32,477	0	97	97	0.00	1.2974	0.9712	2.2686
CNR-39	Fairfield	15,742	0	47	47	0.00	0.8895	1.2377	2.1272
CNI-6	Marshalltown	51,351	0	156	156	0.00	1.1241	1.0000	2.1241
CNR-37	Creston	15,316	0	46	46	0.00	0.8972	1.1750	2.0722
CNI-9	Council Bluffs	83,328	0	250	250	0.00	0.7158	1.0451	1.7609
CNB-1	Iowa City	56,099	0	168	168	0.00	0.7748	0.9452	1.7200
CNI-7	Cedar Rapids	148,390	0	445	445	0.00	0.6940	0.8978	1.5918
CNI-8	Clinton	53,951	0	162	162	0.00	0.6409	0.9488	1.5897
CNR-45	Fort Madison	42,868	0	129	129	0.00	0.5337	1.0495	1.5832
CNI-10	Davenport	155,127	50	415	465	10.75			
CNI-11	Ottumwa	60,579	35	147	182	19.23			
CNR-30	Newton	49,923	30	120	150	20.00			
CNB-3	Sioux City	110,805	70	262	332	21.08			
CNB-2	Des Moines	292,880	196	683	879	22.30			
CNI-5	Dubuque	84,438	60	193	253	23.72			
CNR-1	Sioux Center	25,915	28	50	78	35.90			
CNI-4	Waterloo	167,340	238	264	502	47.41			
CNI-3	Fort Dodge	78,294	185	50	235	78.70			
CNR-8	LeMars	21,771	62	3	65	95.38			
CNI-12	Burlington	68,716	200	6	206	97.08			
CNI-2	Mason City	59,009	180	(- 3) 0	180	100.00			
CNR-35	Washington	19,342	100	(- 42) 0	100	100.00			
CNR-23	Ames	49,466	185	(- 37) 0	185	100.00			
CNR-22	Boone	24,324	183	(-110) 0	183	100.00			
CNR-38	Chariton	31,041	100	(- 7) 0	100	100.00			
CNR-41	Mount Ayr	8,826	45	(- 18) 0	45	100.00			
CNR-27	Harlan	15,519	135	(- 88) 0	135	100.00			
	Totals - State of Iowa	2,690,000	2,082	6,293 (-305)	8,375	24.86			
	Less Beds beyond area ratios assigned from pool beds				305				
	Total beds per area ratio - State - (3 x 2,690)				8,070				



GEOGRAPHIC COMPARISON
PERCENT TOTAL POPULATION OVER 65 YEARS OF AGE

Division of Hospital Services
Iowa State Department of Health

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 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. The definition includes out-patient departments of public or non-profit hospitals.

In accordance with State statutes, the State Agency did meet with the subcommittee 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, public health centers, laboratories and dispensaries in the State. With the cooperation of the respective professional societies a survey, but not and 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 PHS 5-2 "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 out-patient 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, and, at the same time, the services are disseminated throughout the entire State so as to be quite readily avaliable to all of the people of the State. To further demonstrate this fact, the map on page 104 shows the geographic distribution of the offices of 2,634 practcing 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 out-patient 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 only 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.

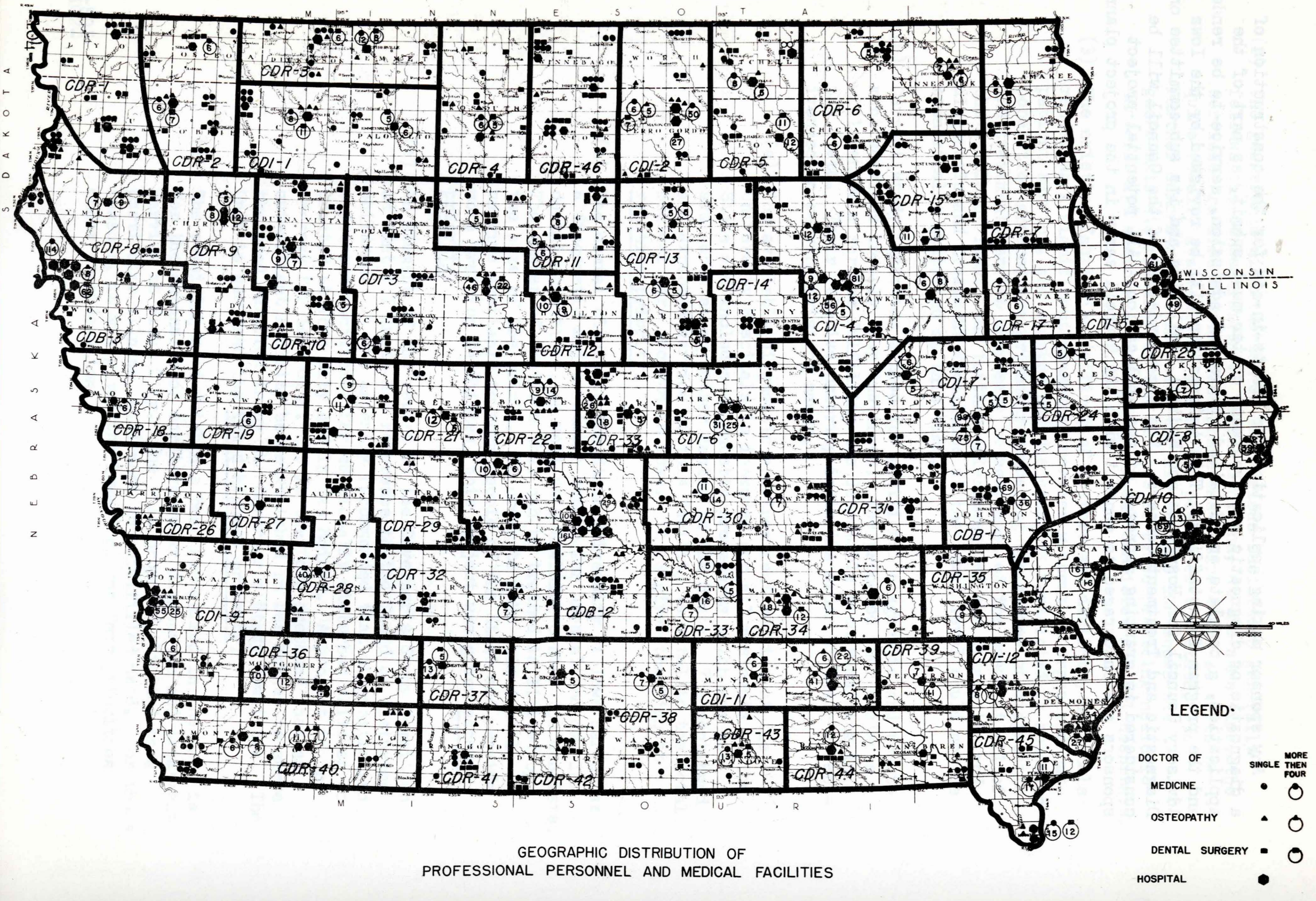
(a) The available diagnostic and treatment service of the University Hospitals is intended for all residents of the State and includes diagnostic procedures which are not available at any other center in the State. The continued and expanded service of this facility is vital to the total medical care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

(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 provide more training facilities, this project was given <u>second priority</u>.

(c) An element of the report by the Governor's Study Committee on Mental Illness had reference to the field of disturbed children. It was urgently recommended that diagnostic and treatment facilities for emotionally disturbed children be created at Iowa City and in Des Moines. A project is in process for Iowa City. It is therfore proposed that an out-patient facility be established in Des Moines to serve the need referred to by the Governor's Study Committee. The Unit is assigned the <u>third highest priority</u>.

(d) The remaining need which has been recognized in the past is for the expansion of cardiovascular diagnostic and treatment service 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.

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 the program for staffing. This information will be reviewed by the Iowa Advisory Council for Hospitals and Medical Facilities and its sub-committee on Diagnostic and Treatment Centers. The recommendation of the Council 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
LEGEND
SINGLE
MORE THEN FOUR
DOCTOR OF MEDICINE
OSTEOPATHY
DENTAL SURGERY
HOSPITAL
IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

FORM HSF 5-2

INVENTORY OF DIAGNOSTIC AND TREATMENT CENTERS

4. DATED July 1, 1957

1. Page 1 of 1
2. DATE July 1, 1957
3. STATE Iowa
4. REGION Statewide

AREA	NAME OF FACILITY	CITY OR TOWN	OWNERSHIP OR CONTROL	VISITS DURING YEAR	SERVICES: GENERAL	SPECIAL: CANCER	SPECIAL: DENTAL	SPECIAL: MENTAL HYGIENE	SPECIAL: ORTHOPEDIC	SPECIAL: T.B.	SPECIAL: OTHER	DIAGNOSTIC SERVICES: X-RAY	DIAGNOSTIC SERVICES: CLINICAL LABORATORY	HOSPITAL O.P.D.	CLASSIFICATION: SUITABLE	CLASSIFICATION: REPLACEABLE	CLASSIFICATION: UNSUITABLE
6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	Diagnostic facilities which pertain directly to all community service in Iowa																
	Iowa Tuberculosis & Heart Association (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				
	REGION		SUB TOTALS														
													STATE TOTALS				

(A) Dissemination of the above facilities is graphically illustrated on the map Page .

(B) Refer to pages 99 through 113, Eighth Revision, Iowa Hospital Plan, 1 July 1955, for state survey of Diagnostic & 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 Pages and .

CP-3916-1

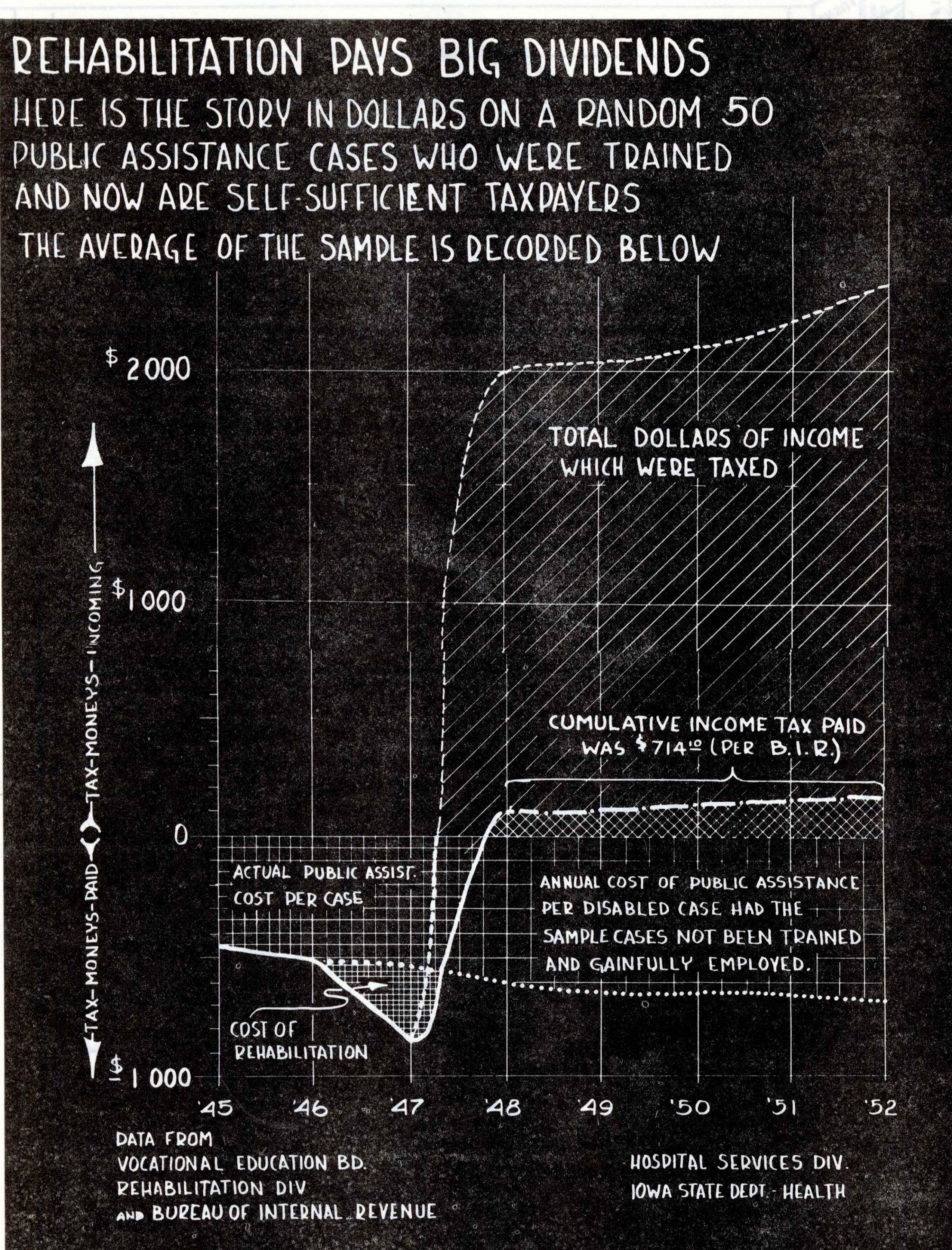

REHABILITATION PAYS BIG DIVIDENDS
HERE IS THE STORY IN DOLLARS ON A RANDOM 50 PUBLIC ASSISTANCE CASES WHO WERE TRAINED AND NOW ARE SELF-SUFFICIENT TAXPAYERS
THE AVERAGE OF THE SAMPLE IS RECORDED BELOW
$2000
$1000
0
-$1 000
TAX-MONEYS-PAID ◄► TAX-MONEYS-INCOMING
TOTAL DOLLARS OF INCOME WHICH WERE TAXED
CUMULATIVE INCOME TAX PAID WAS $714.00 (PER B.I.R.)
ACTUAL PUBLIC ASSIST. COST PER CASE
ANNUAL COST OF PUBLIC ASSISTANCE PER DISABLED CASE HAD THE SAMPLE CASES NOT BEEN TRAINED AND GAINFULLY EMPLOYED.
COST OF REHABILITATION
'45
'46
'47
'48
'49
'50
'51
'52
DATA FROM
VOCATIONAL EDUCATION BD.
REHABILITATION DIV
AND BUREAU OF INTERNAL REVENUE
HOSPITAL SERVICES DIV.
IOWA STATE DEPT.- HEALTH

EXHIBIT D

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 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."

(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 pl f services in which the disabled individual is viewed as a whole. When membe the team contribute to the diagnosis and treatment of illness, their contributi ns 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 by 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 charitable 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 sub-divisions for care, could be re-established as producers and taxpayers, we may witness concerted 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 for 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 in 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 considration 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 plannning and long range projects which are being developed by the Division of Vocational Rehabilitation, Department of Public Instruction.

IOWA STATE DEPT OF HEALTH
DIVISION OF HOSPITAL SERVICES
FORM HSF 5-3

INVENTORY OF REHABILITATION FACILITIES

4. DATED July 1, 1957

1. Page 1 of 1
2. DATE July 1, 1957
3. STATE Iowa

NAME OF FACILITY	LOCATION (city or town)	CLASSIFICATION [1] (code)	OWNERSHIP OR CONTROL (code)	AVERAGE DAILY CASELOAD: INPATIENT	AVERAGE DAILY CASELOAD: OUTPATIENT	NUMBER OF INDIVIDUALS SERVED DURING YEAR	AGE GROUPS SERVED (check): UNDER 18	AGE GROUPS SERVED (check): OVER 18	DISABILITY GROUPS SERVED (check): DEAF	BLIND	TUBERCULOSIS	CARDIAC	ORTHOPEDIC	NEUROLOGICAL	OTHER	SERVICES [2] (code): MEDICAL	PSYCHOLOGICAL	SOCIAL	VOCATIONAL
5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Iowa Vocational Rehabilitation Center	Des Moines	U	STATE		20	178		X	X		X	X	X	X		ABCDEFG HLM	N	OPQR	STUY
Iowa Soc. for Crippled Children & Adults	Des Moines	S	NPA		18	220	X	X	X	X		X	X	X		ABCDEFH M	N	OPQR	STUVWY
State University Hospital	Iowa City	S	STATE	25		278	X	X	X	X		X	X	X	X	ABCDEFG HJKLM	N	OPQR	STV
Children's Hospital	Iowa City	S	STATE	48	12	480							X	X		ABCDEGH IJKLM	N	OPQR	STUV
Iowa Braille & Sight Saving School	Vinton	U	STATE	172		172	X	X		X						ABDFGHJ KLM	N	OPQR	STVWZ
Oakdale Sanatorium	Oakdale	U	STATE	80		180	X	X			X					ABDJILM	N	OPQR	STUVW
United Cerebral Palsy Center	Cedar Rapids		NPA		28	60	X	X						X		ABCDELM	N	OPR	S
Linn Co. Society for Crippled Children	Cedar Rapids		NPA			60	X	X					X			ABCLM		R	ST
Sunnyslope Sanatorium	Ottumwa		CO	63		63	X	X			X					ABDJLM		OPQR	STVW
Iowa School for Deaf	Council Blfs.	S	STATE	350		350	X	X	X							ABEFGHI KLM	N	OPQR	STUVWY

[1] CLASSIFICATION CODE
S - SUITABLE
R - REPLACEABLE
U - UNSUITABLE

[2] CODE FOR COLUMNS 21 THROUGH 24

MEDICAL
A-Phys. and Med. Eval.
B-Medical Supervision
C-Physical Therapy
D-Occupational Therapy
E-Speech Therapy
F-Audio-ser. incl. lip reading
G-Prosthetics Brace Fit.
H-Psychiatric
I-Dental
J-Nursing
K-Physical Education
L-Medical Consult.
M-Recreational Ther.

PSYCHOLOGICAL
N-Evaluation

SOCIAL
O-Evaluation
P-Social Casework
Q-Social Groupwork
R-Recreation (Non-Med.)

VOCATIONAL
S-Evaluation
T-Vocational Counsel
U-Pre-voc-Exp.
V-Special Educ.
W-Voc. Tr.
Y-Sheltered Emp.
Z-Travel Training for Blind

	1. Page
	1 of 1
IOWA STATE DEPARTMENT OF HEALTH	2. Date
Division of Hospital Services	July 1, 1957
	3. State
REHABILITATION FACILITIES SUMMARY	Iowa

4. Population	5. Total Facilities allowed by the state ratio
2,636,000	(9) (6 Disabilities) = 54 Disability Services

6. Additional Facilities Proposed

42 Disability Services

COMMUNITY A.	DESCRIPTION OF FACILITIES AND SERVICES TO BE PROVIDED B.

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.

Des Moines, Iowa Iowa City, Iowa	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.

DETERMINATION OF RELATIVE NEED

Priority of Categories

The program at this point follows two correlated patterns. The basic hospital program is in keeping with precedents of previous plans and revisions, while the related health facility phase conforms with the intent of the Congress in providing 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 insufficient for complete care, and these hospital costs would have to be spread on to the costs for acute care. The citizens of communities were equally reluctant to encourage such projects and 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 in 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 priorities, acute general hospitals, applied for, and were granted, the available funds. During the last two years, interest in chronic and psychiatric units has developed in isolated 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 ACCEPT. BEDS	PROPOSED TO BE ADDED	TOTAL BEDS PROPOSED	% NEED MET
Chronic	1,091	3,204	4,295	25.40
Mental	4,000	9,450	13,450	29.74
General	10,476	2,280	12,756	82.13
Tuberculosis	596	0	596	100.0

Public health centers are evaluated in terms of numbers 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 appropriation may be made available for Public Health Centers.

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 chronicall ill or impaired
III Psychiatric Hospitals
IV Acute General Hospitals
V Tuberculosis Hospitals

Federal Grants-in-Aid funds will be offered 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 1 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 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 the adjunct facilities utilized by other services in the hospital. The fraction used to determine participable costs of the adjunct facilities common to all 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 exhausted.

In an effort to improve the present non-acceptable facilities, as well as enlarge those facilities, it will be the policy of the Department that additions to existing non-acceptable facilities will not be approved except when the non-acceptable facilities are not essential to the operation of the hospital as a whole, and their destruction or loss will not endanger life or render the whole unit inoperable.

Priority of Related Health Facility Categories (Public Law 482)

While the same general principals 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 un-utilized funds from one category to another. The grant for rehabilitation cannot, under any circumstance, be transferred to 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 planned 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. In no case can a single project be spread to acquire participation from appropriations established for both Public Law 725 and Public Law 482.

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 Treasure of the United States.

Service Area Priority

In service areas with existing acceptable beds, the percent of bed need met is computed by dividing the number of existing acceptable beds in the area by the total computed bed need of the area. The service areas were then ranked in the order of the percent 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%.

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 case 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:

$$\frac{\text{Area Rural Population}}{\text{Area Total Population}} = \text{Precent Area Rural Population}$$

$$\frac{\text{State Rural Population}}{\text{State Total Population}} = \text{Percent State Rural Population}$$

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

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:

$$(100)\frac{\text{1955 Area Population}}{\text{1950 Area Population}} = \text{\% Area Population Increase + 100}$$

$$(100)\frac{\text{1955 State Population}}{\text{1950 State Population}} = \text{\% State Population Increase + 100}$$

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

Per Capita Taxable Property Factor:

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

$$\frac{\text{Area Taxable Property Value}}{\text{Area Population}} = \text{Per Capita Taxable Property Value}$$

$$\frac{\text{State Total Taxable Property Value}}{\text{State Total Population}} = \text{State Per Capita Taxable Property Value}$$

$$\frac{\text{State Per Capita Taxable Prop. Value}}{\text{Area Per Capita Taxable Prop. Value}} = \text{Per Capita Taxable Property Value Factor}$$

Source of Basic Factor Data:

Area and population data taken from 1950 census as published by the U. S. Department of Commerce, appropriately modified by births, deaths, migration, and trends in school experience.

Per Capita income data is from monthly publication, "Sales Management". dated Mary 10, 1955.

Taxable property value as published by the State Tax Commission in the Annual Report, 1950.

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 the Tenth Revision of the State Plan by the Iowa Advisory Council for Hospital and Other 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 Sunday Register (cir. 535,000). 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.

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 percentum for all projects proposed to be constructed under these Acts in the State of Iowa during the fiscal year commencing July 1, 1957.

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 upon the amount of the Federal funds allotted annually to the State for each program.

Changes in Area Priority

When a Part 1 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 percent of need met in the respective area shall immediately be adjusted by adding to the existing acceptable beds in the area the number of beds in the project and recomputing the new percent of need met. Further, when construction contracts are let for a project proceeding without Federal Grants-in-Aid, the area percent of bed need met will be immediately adjusted to reflect the acceptable beds in the project. Projects constructed without Federal assistance will be considered as existing acceptable beds during construction. If construction of the project is terminated short of completion for one reason or another, the beds will be considered nonexistent and bed count adjusted accordingly.

The total acceptable beds existing in an area together with the acceptable 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 a reasonable length of time.

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 the Department 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 approval 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 convalescent nursing homes, diagnostic and treatment centers, or chronic illness facilities are not applied for, in whole or in part, the funds not applicable to applications will be available for transfer to one or both remaining categories. These transferable funds will be held a minimum of 30 days pending recommendations of the Iowa Advisory Council.

The Project Construction Schedules will be submitted 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 other assurances.

Project Applications

Applications for Federal assistance will be submitted on the Project Construction Application (Parts 1 through 4) which is prescribed by the U. S. Public Health Service.

If a project is in the highest priority group, part 1 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 1 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 or organization sponsoring project with a complete list of officers and board members.

    b. Statement of funds available and plans 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 short 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. This Department, knowing which communities have partially qualified, will, before the end of the 30 day period, forward the necessary Part 1, Project Construction Application forms to all appropriate sponsors and their architects/engineers.

4. The sponsor or his agents will then prepare and complete the Part 1 Application forms and submit same in an approvable manner to this Department before the end of the 30 day period.

5. This Department, upon the expiration of the 30 day period, will compare all approvable Construction Applications and 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 1 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 1 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 1 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 1.

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

      (1) Giving evidence of adequate funds.

      (2) Failing to comply with design standards or regulations either State or Federal.

      (3) Failing to bid the work within nine months from the date of Part 1 approval by the Federal Agency.

   c. Voluntary withdrawal from program.

   d. In the event (a), (b) and (c) derive sufficient uncommitted funds, the next approvable and qualified Part 1 Application may be incorporated into the current modified Project Construction Schedule for participation in the available funds.

Transfer of Funds to Adjacent States

Funds allotted under Public Law 482, may conceivably best serve the purpose of certain Iowa population groups if utilized in an out-of-state facility serving areas of both States. Upon the recommendations of the Advisory Council, after evaluating considerations presented, the Federal Agency would be requested in writing to approve transfer of funds in accordance with such a coordinated plan. In such event, the plans for both States would be modified to reflect the contemplated transfer.

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 percent 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

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 percent 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 135A, 1954 Code of Iowa as amended by House File 392, 56th 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 possessions 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, 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 one year 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 records pertaining to wages, for a minimum period of three 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.

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 135B and 135C, 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 Instititutions", 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 will be notified in writing of the time and place of the hearing, as determined by the State Department of Health.

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.

DATE DUE

Feb 13'58

Mar 3'59

Oct 1'59

Aug 16'60

51749

IOWA HOSPITAL PLAN
A Program for Hospitals and
Related Health Facilities

32 0 Iowa 1957

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Forfeiture of Privilege. Loss of books or journals without paying for same, defacing or mutilating materials, three requests for postage without results, three requests for return of material without results, or necessity of asking Attorney General's aid to have material returned, bars from future loans.

Transients and those at hotels may borrow books by depositing the cost of the book, or $5.00, which is returned when the book is returned.

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