IOWA HOSPITAL PLAN

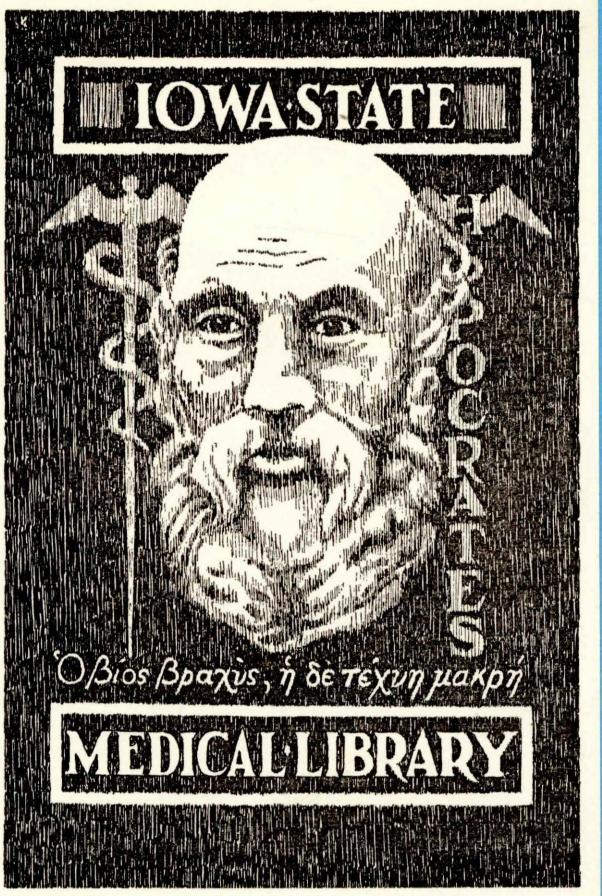
14TH REVISION

1 JULY 1961

A PROGRAM FOR

HOSPITALS AND RELATED HEALTH FACILITIES

IOWA STATE DEPT OF HEALTH
DIV OF HOSPITAL SERVICES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STATE OF IOWA

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Amanda Stahl, R.N., B.S.	Consultant Nurse
H. W. Stricker, B.S.	Chief Engineer

Offices

State Office Building

Des Moines 19, Iowa

1961

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Iowa
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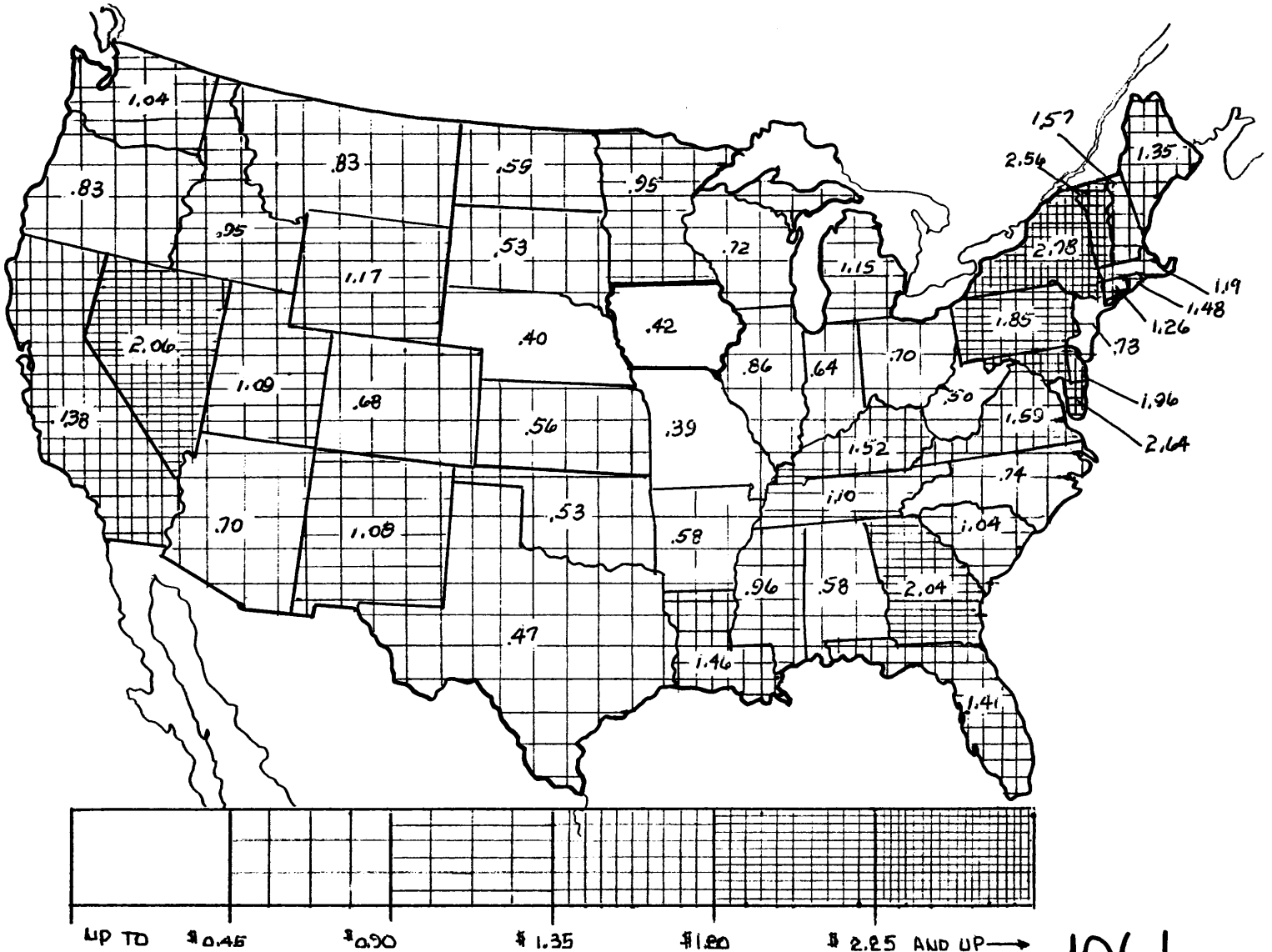
INTRODUCTION

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

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

The following is the 14th Revision of the Iowa Hospital Plan for construction of hospitals and other health facilities. Based upon current inventory and survey data, the proposal provides suitable and adequate statewide hospital and related health facilities reasonably and realistically accessible to all residents of Iowa.

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



GRAPHIC COMPARISON OF ALL STATES FOR 1961

$ DOLLARS $ PER CAPITA PER YEAR APPROPRIATED FOR PUBLIC HEALTH

AS RECAPPED BY U S P H S

IOWA STATE DEPT OF HEALTH
DIV OF HOSPITAL SERVICES

DEFINITIONS

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

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

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

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

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

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

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

CUSTODIAL HOME "Custodial home means any institution, place, building or agency which is devoted primarily to the maintenance and operation of facilities for the housing, for a period exceeding twenty-four (24) hours, and for care in excess of food, shelter, laundry or services incident thereto for, two (2) or more nonrelated individuals who are not in need of nursing care or related medical services but who,

by reason of age, illness, disease, injury, convalescence or physical or mental infirmity are unable to care for themselves. Custodial home does not mean hospitals or nursing homes." (Not qualified for grants participation)

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

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

DOMICILIARY CARE "Institutions furnishing primarily domiciliary care. The primary purpose of these facilities is to furnish food, shelter, and other nonmedical services and wherein medical treatment or nursing care is incidental to boarding care. (2) A "nursing home" which provides personal services only, or such limited medical attention as the individual would normally receive if he were living in a private home is not eligible for Federal aid."

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

HOSPITAL BED A bed for an adult or child patient. Bassinets for the newborn in a nursery, beds in labor rooms and in health centers, included in this definition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STATE PLAN

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

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

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

IOWA STATE DEPARTMENT OF HEALTH

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

DIVISION OF HOSPITAL SERVICES

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

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

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

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

Check one

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

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

_____
(FILL IN DATE)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IOWA STATE DEPT. OF HEALTH

DIVISION OF HOSPITAL SERVICES

Des Moines, Iowa

ANNUAL REVISION OF STATE PLAN

A. DESIGNATION OF STATE AGENCY

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

IOWA STATE DEPARTMENT OF HEALTH

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

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

B. AUTHORITY OF THE STATE AGENCY

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

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

C. DESIGNATION OF STATE ADVISORY COUNCIL

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

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

D. DEVELOPMENT OF HOSPITAL CONSTRUCTION PROGRAM

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

E. RELATIVE NEED DETERMINATIONS

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

F. METHODS OF ADMINISTRATION

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

[X Yes] [No]

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

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

SIGNATURE	TYPE NAME AND TITLE	EFFECTIVE DATE OF REVISION
Edmund G. Zimmerer	Edmund G. Zimmerer, M.D. Commissioner	1 JULY 1961

CP-3915

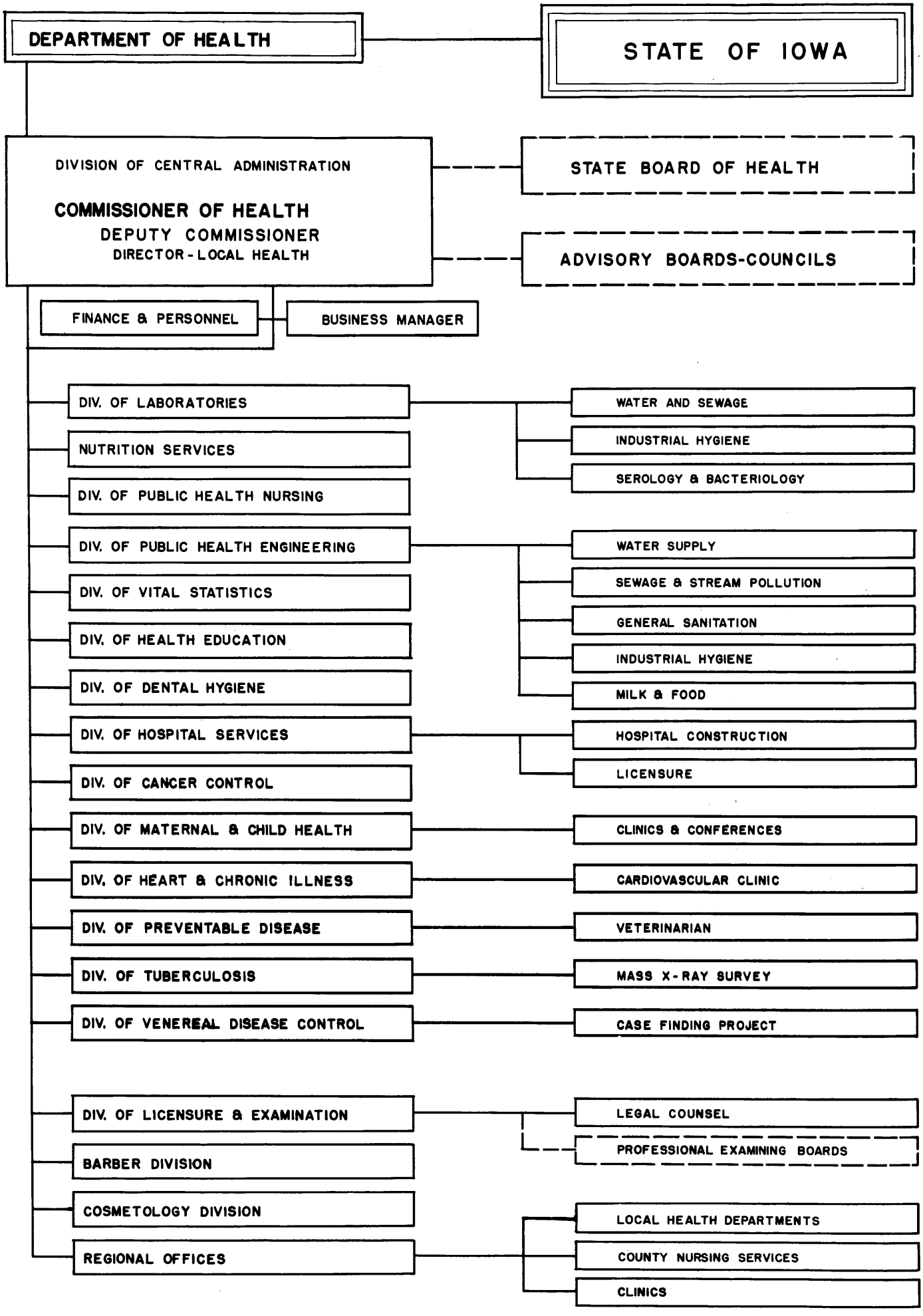

DEPARTMENT OF HEALTH
STATE OF IOWA
DIVISION OF CENTRAL ADMINISTRATION
COMMISSIONER OF HEALTH
DEPUTY COMMISSIONER
DIRECTOR - LOCAL HEALTH
STATE BOARD OF HEALTH
ADVISORY BOARDS-COUNCILS
FINANCE & PERSONNEL
BUSINESS MANAGER
DIV. OF LABORATORIES
WATER AND SEWAGE
INDUSTRIAL HYGIENE
SEROLOGY & BACTERIOLOGY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

EXHIBIT B

AUTHORITY

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

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

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

EXHIBIT C

IOWA ADVISORY COUNCIL
for Hospitals and Related 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	6-30-63
Leon A. Bondi, Administrator St. Luke's Hospital, Davenport	6-30-62
B. D. Fickess, R.N., Administrator Story County Hospital, Nevada	6-30-64
J. A. Anderson, Administrator Lutheran Hospital, Fort Dodge	6-30-64
Iowa Osteopathic Hospital Association:	
John Schwartz, Sr., D.O. Des Moines General Hospital, Des Moines	6-30-64

FIELD OF HEALTH	
Iowa State Medical Society:	
Robert N. Larimer, M.D., Sioux City	6-30-63
Wendell L. Downing, M.D., LeMars	6-30-62
Samuel Leinbach, M.D., Belmond	6-30-64
C. N. Hyatt, Jr., M.D., Corydon	6-30-64
Iowa Society of Osteopathic Physicians & Surgeons:	
H. B. Willard, D.O., Davenport	6-30-63
Iowa State Dental Society:	
F. W. Pillars, D.D.S., Des Moines	6-30-63
Iowa State Nurses Association:	
Miss Marian Maschmann, Ottumwa	6-30-62

FIELD OF REHABILITATION	
Merrill E. Hunt, Acting Director, Vocational Rehabilitation Division, Department of Public Instruction, Des Moines	6-30-64

REPRESENTING CIVIC AND CONSUMER INTERESTS:	
Mrs. James Henderson, Waterloo	6-30-63
Mrs. Marjory Field, Waterloo	6-30-62
Benjamin F. Carter, Jr., Forest City	6-30-64
Mrs. Jay S. Tone, Jr., Des Moines	6-30-64

EXHIBIT D

DEVELOPMENT OF HOSPITAL AND MEDICAL FACILITIES PROGRAM

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

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

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

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

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

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

SCOPE OF HEALTH FACILITY NEEDS

The forerunner of this hospital program goes back to a national study of hospitals and health facilities. An element of this national study was a survey of Iowa's hospitals and public health resources conducted prior to the original

Iowa Hospital Plan. The basic study was in terms of hospital needs and the usage patterns of hospital service areas.

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

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

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

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

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

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

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

SUITABILITY OF FACILITIES

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

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

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

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

The classification "replaceable" has become necessary to give recognition to the attrition of time and obsolescence and to designate the degree of unacceptableness attributable to causes other than flagrant structural fire hazards. We refer to physical features in so called fire-resistant structures such as structural ducts through a multi-story building coated with 40 years of kitchen grease, of poorly graded wiring in questionable conduit and deteriorated insulation, which, in all probability was initially underdesigned and is constantly overloaded. Other features such as worn out heat distribution systems, questionable sanitary drainage systems, worn out water distribution systems, are becoming increasingly apparent.

To give recognition to such hazards, the classification "unacceptable" has been broadened to encompass this "gray zone" with the term "replaceable facilities" and is expressed in terms of beds. For this reason such beds, though within the scope of "unacceptable," are incorporated at a 50% value in the summary tabulation of "acceptable" beds for purposes of gradation in priority. Specific points for classifying certain facilities as "replaceable" are as follows:

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

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

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

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

It must be pointed out that a number of replaceable units render an appreciable service in their community. However, having been designated to outmoded standards or for another purpose, they too frequently attempt a volume of patient days of service in excess of that which their adjunct facilities can properly support. Using the accepted criteria for optimum square feet per bed per service as a common denominator, a number of sample studies have been made in Iowa. Conclusions from these sample studies have been compared with their counterpart results reflected in this 14th Revision on the basis of discounting all replaceable beds by 50% and evaluating the remainder as equivalent to "suitable" beds. Such comparison indicates equivalent conclusions. It probably should also be pointed out that charging off 50% of such facilities is conservative when evaluating such an approach in terms of per cent of future expectancy. A more practical valuation would indicate that the average attrition has left no more than 20 or 25 per cent of the original years of life expectancy of these structures.

Because of the stimulation from the Federal Agency and the current executive administration, the program is being accelerated by applying the above expedient formula to permit prompt presentation of this 14th Revision. This State Agency will execute a statewide re-evaluation on the basis of square feet per bed per service in ascertaining accurately the net bed capacity available in the state in future revisions.

Applications for fiscal 1962 funds responding to this 14th Revision, Iowa Hospital Plan, shall be supported by a thorough analysis of existing replaceable elements in terms of optimum square feet per bed per service and the evaluation will be an element of consideration in ascertaining the merits of the total presentation.

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

Legislative Intent

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

SUMMARY OF TOTAL HILL-BURTON PROGRAM IOWA

1 JULY 1961

LINE ITEM	CATEGORIES OF PATIENT BEDS				
	GENERAL	T. B.	NERV / MENTAL	CHRON. ILL.	NRS'G HOME
Annual Hospital Bed Construction during 1948	253	---	---	---	---
1949	444	---	26	---	---
1950	794	---	---	---	---
1951	204	---	138	---	---
1952	201	---	33	86	---
1953	158	---	---	---	---
University Hospitals Classified to usage ---	(-681)			(+681)	
1954	141	---	---	57	---
1955	267	---	25	46	---
1956	152	---	48	163	31
1957	127	---	---	26	0
1958	392	---	32	---	156
1959	198	---	45	---	200
1960	141	---	---	137	164
Total Beds Built W/Grants-in-Aid	3,472	---	347	515	551
Beds Available in 1947	6,663	672	3,113	0	0
Deletions/Reclassification/Closing	(-1,321)	(-260)	(-85)	(+681)	0
Beds Built Without Aid	2,101	0	884	76	2,182
Total Suitable Plus Replacable Beds	10,985	412	4,259	1,272	2,733
Less "Replaceable" Factor	(-1,715)				
Number of Beds to be Added	4,196	---	9,529	3,092	5,712
Total Beds Proposed	13,466	412	13,788	4,364	8,445
Per Cent of Need Met	68.84	100	30.89	29.15	32.36

HOSPITAL ADVISORY COUNCIL RESOLUTIONS

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

1. Fire Safety Resolution, adopted May 23, 1949

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

2. Bed Need Resolution, adopted July 10, 1952

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

3. Chapel Facilities Resolution, adopted September 30, 1960

"Resolved that space identifiable as being for Chapel purposes is not qualified for participation and that the elementary cost of constructing and equipping such space shall be excluded from consideration in determining the project cost eligible for participation."

4. Budget Increase Resolution, adopted September 30, 1960

"Resolved that:

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

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

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

TEACHING FACILITIES

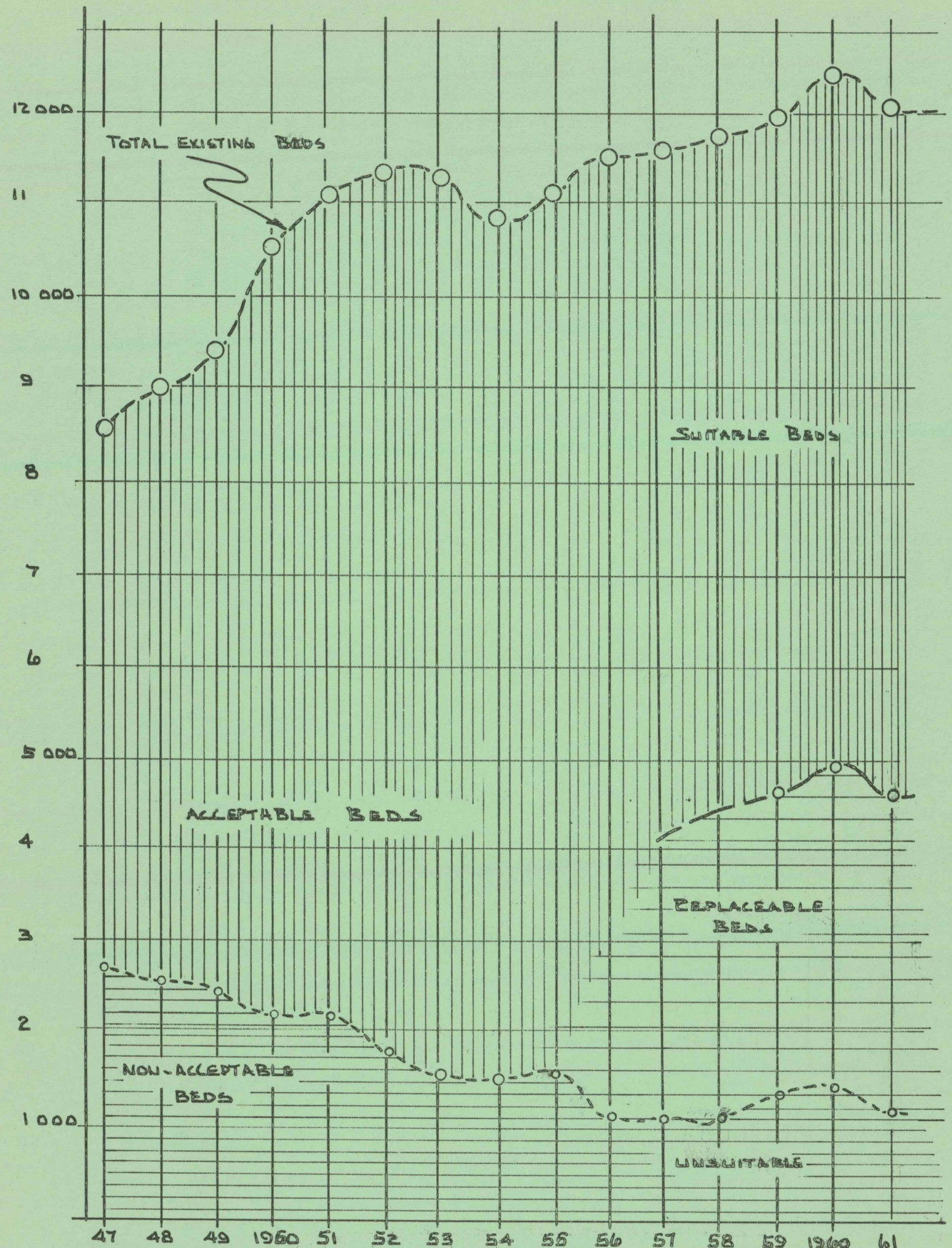
Because of the need for specialized personnel, communities of Iowa have indicated reluctance to construct specialized categories of hospital units. Therefore, to enhance the possibility of a pool of qualified doctor personnel, a compensation is induced by allowing an additional five beds per authorized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

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

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

REGION		Postgraduate Years Authorized	Pool Beds Allocated
Symbol	Center		
		2	10
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.



ACUTE GENERAL HOSPITALS
IOWA
STATE DEPT. OF HEALTH
DIV. OF HOSPITAL SERVICES

GRAPHIC COMPARISON OF QUALITY + TRENDS DURING POST WAR PERIOD - IN TERMS OF
SUITABLE
REPLACEABLE
UNSUITABLE

PART I. ACUTE GENERAL HOSPITAL BEDS

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

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

The state average bed-birth, bed-death ratio of 3.4 beds per thousand population as developed in the Report on Hospital & Public Health Resources in Iowa, was the basis for determining the occupied bed need of the several hospital service areas. When the occupied bed need, based on the population and bed-birth, bed-death ratio, indicated a bed need between 0 and 74 occupied beds, 0.5 of the need was allocated to the area. Similarly, between 75 and 149 occupied, 0.6; between 150 and 224, 0.7; between 225 and 300, 0.8; all over 300, 1.0. The remaining occupied beds not allotted by this criterion were allotted to the intermediate and base area hospitals. The area occupied needs were converted to a total bed need for each facility by the following formulae: $4\sqrt{ADC} + ADC$ (low level occupancy--under 100 beds) and $3\sqrt{ADC} + ADC$ (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 intermediate areas. In fact, many hospital centers now have occupied beds in excess of the number which would be indicated by applying the bed birth-death ratio to their respective areas. In these areas, the present average daily census of the existing facilities was used as an indication of their need, and converted to total beds needed by use of the above mentioned high level/low level occupancy formulae. This recognizes the crowded conditions in the present hospitals and expands them to permit a normal occupancy.

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

The University Hospital, State University of Iowa, Iowa City, provides statewide comprehensive hospital and medical care of indigent, clincial 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 discal year, the number of committee 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.

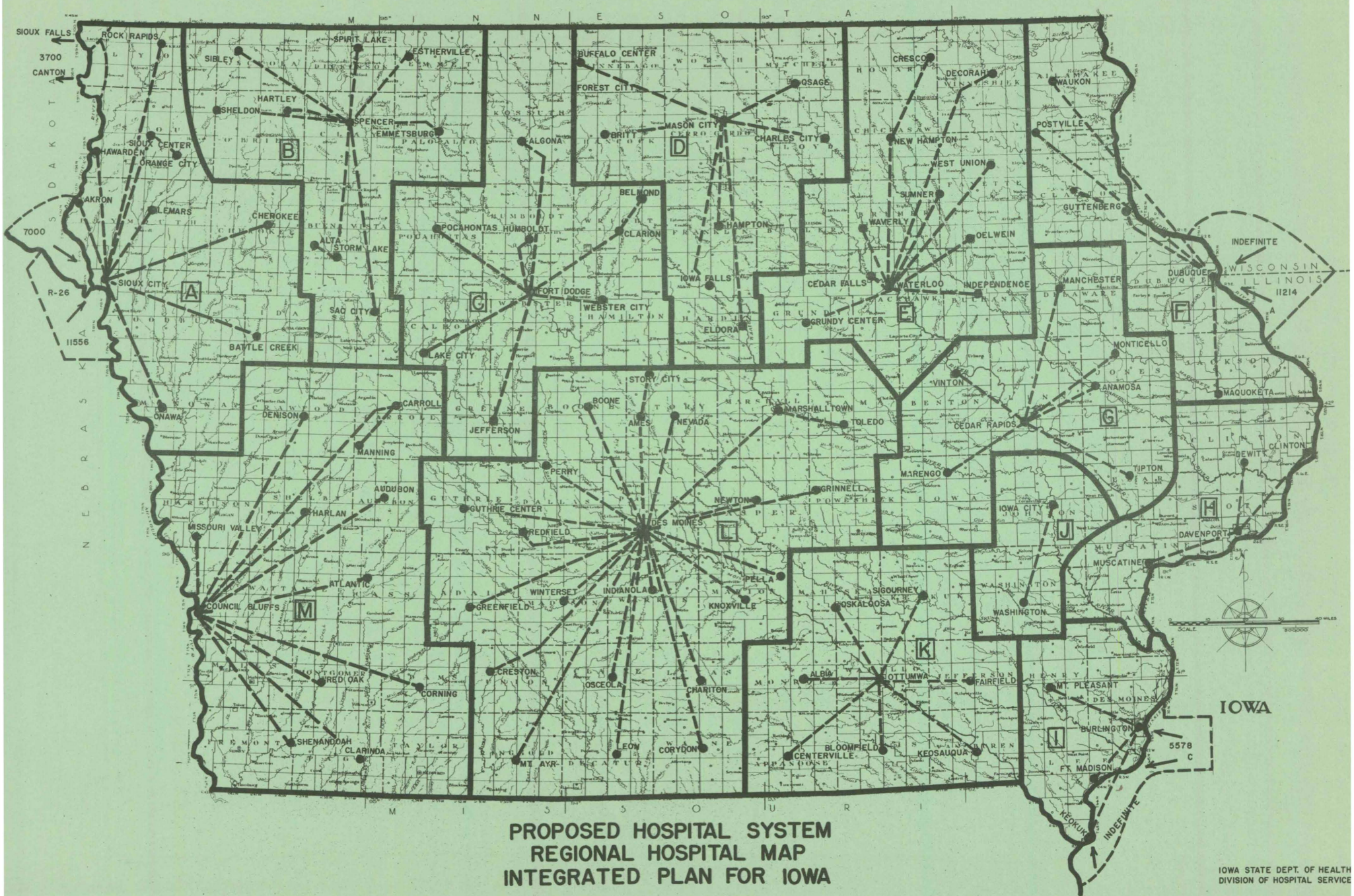
The occupied beds remaining after allocating 0.5, 0.6, 0.7 and 0.8 to each area were practically balanced by the needs in the largest areas.

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

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

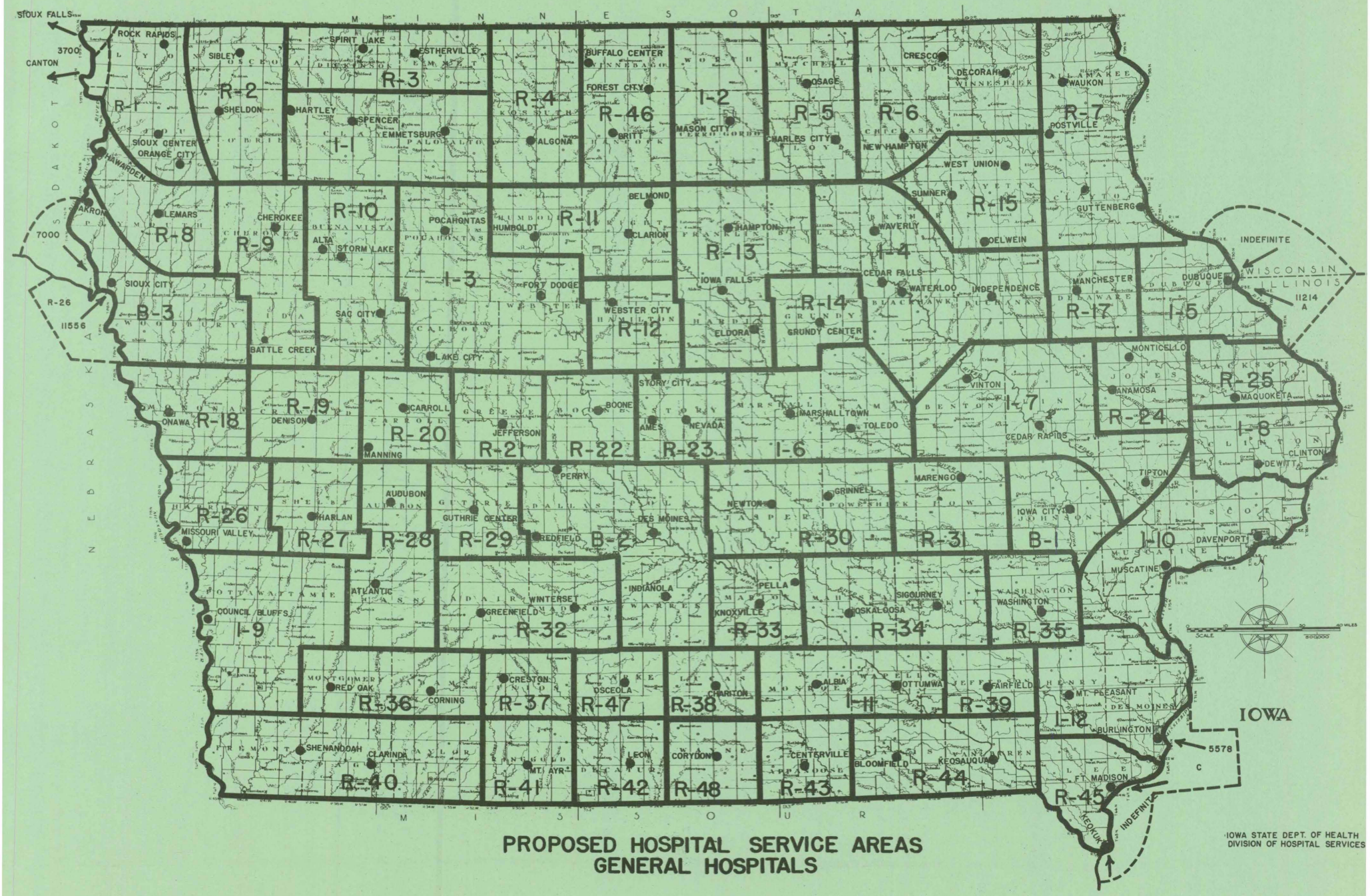
The excess existing general hospital beds in certain areas are due to out-of-state population. A pool bed adjustment is necessary to eliminate this excess and prevent the over-building of general hospital beds for the state. In effect, this pool bed adjustment is the number of beds needed in Iowa to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

Special problems are constantly developing because of normal obsolescence, unique developments in a particular community, transition in population characteristics, and/or the overloading of ancillary facilities when evaluated in terms of beds they are attempting to serve. It has become necessary to properly recognize the degree of obsolescence in the classification of our beds. Representative sampling on a number of institutions indicates that when applying the rules of thumb on specific services within general hospitals there are many instances where the number of beds being served by available services is completely unrealistic. These findings have been applied to a former evaluation of the suitability of beds inventoried. It is consistently found that the services available are adequate to serve no more than 50% of the replaceable beds they presently are attempting to serve. On this basis it is very reasonable to use the rule of thumb that all beds classified as "replaceable" cannot be interpreted as being suitable, but that more properly they qualify only as "unacceptable" beds. To preclude massive overbuilding, 50% of the unacceptable beds falling within the sphere of "replaceable" are being induced into our tabulations as acceptable to accurately reflect the relative degree of urgency into the relative priority of each community. Still another question which may exist in these marginal facilities is where ancillary services are demanded but existing facilities are inadequate to meet immediate local needs and/or referral load resulting from integration of medical services. A special consideration is available to prospective sponsors, even though it may be beyond the needs implied by the relative priority table which is based on beds. The Advisory Council will recognize a sponsor's presentation of such a special problem, provided a complete and factual narrative statement and program are submitted with their application and the owner will present himself upon request before a formal meeting of the Advisory Council. The sponsor should be prepared to provide detailed and specific information and a record of studies to support his viewpoint. If requested, he will provide such special studies as may be called for by the Advisory Council to clarify certain details of the proposed program for specific consideration by the council and the State Agency when evaluating the application. In the light of the facts which will have been presented orally and/or written, the merits of the specific program will be evaluated to determine the relative priority which will be assigned to the proposal.



PROPOSED HOSPITAL SYSTEM
REGIONAL HOSPITAL MAP
INTEGRATED PLAN FOR IOWA

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICE



PROPOSED HOSPITAL SERVICE AREAS
GENERAL HOSPITALS

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

SUMMARY (STATEWIDE) OF

1 JULY 1961 IOWA

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SUITABILITY REPORT ON ACUTE GENERAL HOSPITAL BEDS AND OR FACILITIES

SUMMARY REGION STATEWIDE

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
A	Sioux City				641	392	40	174		285,195	36,672
B	Spencer				358	54	86	99		101,002	14,160
C	Fort Dodge				536	233	29	114		159,564	22,580
D	Mason City				317	353	60	144		154,829	23,148
E	Waterloo				553	362	105	166		256,317	37,643
F	Dubuque				525	178	148	118		163,994	21,755
G	Cedar Rapids				700	150	113	119		221,116	33,506
H	Davenport				555	229	27	148		221,794	29,759
I	Burlington				395	270	18	85		184,216	23,367
J	Iowa City				190	273	0	98		118,649	15,985
K	Ottumwa				550	60	21	129		172,787	24,561
L	Des Moines				1,682	755	187	389		641,249	89,355
M	Council Bluffs				553	121	333	120		247,360	33,894
	STATEWIDE - IOWA - GRAND TOTALS				7,555	3,430	1,167	1,903		2,928,072	406,385

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

1 JULY 1961 IOWA
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SUITABILITY REPORT ON General HOSPITAL BEDS AND OR FACILITIES "A" REGION Sioux City

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-1	Orange City Municipal	Sioux	Orange City	CITY	27	8	0	6	43.67	5,579	444
R-1	Sioux Center Community	Sioux	Sioux Center	NPA	26	0	0	6	46.40	4,403	749
R-1	Merrill Pioneer Community	Lyon	Rock Rapids	NPA	32	0	0	10	43.2	5,040	680
R-8	Sacred Heart	Plymouth	LeMars	CH	68	0	0	16	71.8	17,819	1,899
R-8	Hawarden Community	Sioux	Hawarden	CITY	14	0	0	6	66.2	3,384	538
R-9	Hartley Memorial	Ida	Battle Creek	CITY	0	15	0	4	51.9	2,839	319
R-9	Ida Grove	Ida	Ida Grove	CITY	0	0	18	6	66.0	4,470	466
R-9	Sioux Valey Memorial	Cherokee	Cherokee	NPA	42	35	0	12	60.9	17,120	2,574
R-18	Onawa Hospital, Inc.	Monona	Onawa	IND	0	0	22	5	113.1	9,078	1,273
B-3	Akron	Plymouth	Akron	NPA	21	0	0	8	51.6	3,953	393
B-3	Lutheran	Woodbury	Sioux City	CH	72	66	0	15	80.5	40,548	4,807
B-3	Methodist	Woodbury	Sioux City	CH	141	0	0	15	82.0	42,189	5,623
B-3	St. Joseph Mercy	Woodbury	Sioux City	CH	156	145	0	44	70.6	77,576	10,101
B-3	St. Vincent's	Woodbury	Sioux City	CH	42	98	0	16	90.6	46,314	6,297
B-3	Gordon Memorial	Woodbury	Sioux City	NPA	0	25	0	6	53.5	4,883	509
	Region "A" Sioux City - Subtotals				641	392	40	174	xxxxx	285,195	36,672

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

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-2	Community Memorial	O'Brien	Sheldon	NPA	32	0	0	8	52.1	6,081	1,259
R-2	Ward Memorial	O'Brien	Primghar	CITY	0	0	9	3	45.6	1,498	331
R-2	Osceola Hospital, Inc.	Osceola	Sibley	IND	0	0	35	8	32.0	4,082	638
R-3	Holy Family	Emmet	Estherville	CH	103	0	0	16	49.3	18,551	2,987
R-3	Dickinson Co. Mem. 6/15/59	Dickinson	Spriit Lake	CO	48	0	0	8	56.3	9,871	1,301
R-10	Loring	Sac	Sac City	CITY	32	0	0	8	60.5	7,063	854
R-10	Alta Memorial	B. Vista	Alta	NPA	19	0	0	7	60.6	4,204	235
R-10	Sioux Rapids	B. Vista	Sioux Rapids	IND	0	12	18	3	68.6	7,506	130
R-10	Buena Vista County	B. Vista	Storm Lake	CO	49	0	0	10	84.1	15,353	1,904 (1)
I-1	Palo Alto Memorial	Palo Alto	Emmetsburg	NPA	0	18	24	8	62.5	9,574	1,435
I-1	Hand	O'Brien	Hartley	IND	(Closed 1 December 1960)				NA	2,376	334
I-1	Community Memorial	O'Brien	Hartley	NPA	27	0	0	8	NA	99	35 (2)
I-1	Spencer Municipal	Clay	Spencer	CITY	48	24	0	12		14,744	2,717
	Region "B" Spencer - Subtotals				358	54	86	99		101,002	14,160

(1) Project Iowa-110. Occupancy based on 50 existing beds.
Bed variation by reorganization for new chronic unit.

(2) Project Iowa-88. Opened 1 December 1960.

NR- No report submitted by facility
NA- Not applicable or realistic

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

1 JULY 1961 IOWA
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SUITABILITY REPORT ON General HOSPITAL BEDS AND OR FACILITIES "C" REGION Fort Dodge

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-4	St. Ann	Kossuth	Algona	CH	61	0	0	10	42.0	9,339	1,250
R-11	Community Memorial	Wright	Clarion	CITY	54	0	0	6	63.8	6,521	1,066 (1
R-11	Belmond Community	Wright	Belmond	CITY	26	0	0	6	61.2	5,810	887
R-12	Hamilton County Public	Hamilton	Webster City	CO	46	32	0	10	61.7	17,551	2,238
R-21	Greene County	Greene	Jefferson	CO	57	0	0	8	60.5	12,587	1,845
I-3	St. Joseph Mercy	Webster	Fort Dodge	CH	61	90	0	24	67.9	43,578	6,001
I-3	Lutheran of Fort Dodge	Webster	Fort Dodge	CH	189	111	0	32	50.7	55,483	7,958
I-3	McCrary-Rost	Calhoun	Lake City	IND	0	0	15	5	93.2	5,104	997
I-3	McVay Memorial	Calhoun	Lake City	PART	0	0	14	5	70.3	3,591	338
I-3	Stewart Memorial Community	Calhoun	Lake City	NPA	42	0	0	8	Project Iowa-98		

(1) Project Iowa-105. Occupancy based on 28 existing beds.

	Region "C" Fort Dodge -- Subtotals				536	233	29	114	xxxx	159,564	22,580

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

1 JULY 1961 IOWA
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SUITABILITY REPORT ON General HOSPITAL BEDS AND OR FACILITIES "D" REGION Mason City

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-5	Riceville	Mitchell	Riceville	CITY	0	0	12	4	70.9	3,107	118
R-5	Mitchell County Memorial	Mitchell	Osage	CO	63	0	0	8	56.1	12,897	2,348
R-5	Cedar Valley	Floyd	Charles City	CITY	0	72	0	16	69.1	18,155	3,134
R-13	Eldora Memorial	Hardin	Eldora	CITY	0	36	0	8	48.3	6,342	945
R-13	Ellsworth Municipal	Hardin	Iowa Falls	CITY	0	35	0	10	57.6	7,354	1,375
R-13	Lutheran	Franklin	Hampton	CH	0	48	0	8	49.0	8,577	1,302
R-46	Hancock County Memorial	Hancock	Britt	CO	32	0	0	8	40.2	4,689	974
R-46	Forest City Municipal	Winnebago	Forest City	CITY	25	0	0	8	43.6	3,981	594
R-46	Buffalo Center Hosp/Clinic	Winnebago	Buffalo Ctr.	IND	17	0	0	8	69.1	4,288	841
I-2	Park Hospital	C. Gordo	Mason City	NPA	0	56	0	10	87.6	17,906	2,461
I-2	St. Joseph Mercy	C. Gordo	Mason City	CH	180	106	48	56	55.4	67,533	9,056
	Region "D" Mason City -- Subtotals				317	353	60	144	xxxx	154,829	23,148

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

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-6	St. Joseph Mercy (New)	Howard	Cresco	CH	42	0	0	8	Project Iowa-97		
R-6	St. Joseph Mercy (Old)	Howard	Cresco	CH	0	0	26	NA	67.9	6,447	1,014
R-6	Smith Memorial	Winneshk.	Decorah	CH	0	20	18	8	66.2	9,179	1,295
R-6	St. Joseph's	Chickasaw	New Hampton	CH	0	52	0	8	70.3	13,348	1,806
R-14	Grundy County Memorial	Grundy	Grundy Ctr.	CO	40	0	0	8	62.9	9,116	1,230
R-15	Palmer Memorial	Fayette	West Union	CITY	22	0	0	8	78.3	6,290	1,088
R-15	Mercy	Fayette	Oelwein	CH	55	0	0	12	80.6	16,186	2,060
R-15	Community Memorial	Bremer	Sumner	NPA	37	0	0	8	56.6	7,639	851
I-4	People's Hospital	Buchanan	Independence	CITY	38	0	15	10	62.8	12,152	2,166
I-4	St. Joseph's Mercy	Bremer	Waverly	CH	0	0	46	10	59.1	8,579	1,053
I-4	Allen Memorial	B. Hawk	Waterloo	NPA	83	130	0	24	78.1	60,691	9,318
I-4	Schoitz Memorial	B. Hawk	Waterloo	NPA	212	0	0	26	70.4	54,461	7,834
I-4	St. Francis	B. Hawk	Waterloo	CH	0	124	0	26	76.0	34,380	5,416
I-4	Sartori Memorial	B. Hawk	Cedar Falls	CITY	24	36	0	10	81.5	17,849	2,512
	Region "E" Waterloo -- Subtotals				533	362	105	166	xxxx	256,317	37,643

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SUITABILITY REPORT ON General HOSPITAL BEDS AND OR FACILITIES "F" REGION Dubuque

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-7	Veterans' Memorial	Allamakee	Waukon	CITY	46	0	0	8	58.6	7,486	1,059 (1
R-7	Postville Community	Allamakee	Postville	CITY	Closed 12/31/60			NA	NA	4,629	594
R-7	Community Memorial	Allamakee	Postville	CITY	32	0	0	8	Project Iowa-85		(2
R-7	McGregor Community	Clayton	McGregor	NPA	0	0	15	3	52.5	2,873	297
R-7	Elkader Community	Clayton	Elkader	NPA	20	0	0	6	Under Construction		
R-7	Riverview	Clayton	Guttenberg	IND	Closed o/a 1 Jan. '61				NA	2,456	242
R-7	Guttenberg Municipal	Clayton	Guttenberg	CITY	38	0	0	8	Project Iowa-84		(3
R-25	Jackson County Public	Jackson	Maquoketa	CO	60	0	0	10	NR	(18,000)	3,000
I-5	Finley	Dubuque	Dubuque	NPA	29	28	56	18	61.1	25,186	3,695
I-5	St. Joseph Mercy	Dubuque	Dubuque	CH	200	150	58	35	43.0	64,023	6,343
I-5	Xavier	Dubuque	Dubuque	CH	100	0	0	16	95.3	34,789	5,797
I-5	Bellevue	Jackson	Bellevue	NPA	0	0	19	6	65.2	4,552	728
	Region "F" Dubuque -- Subtotals				525	178	148	118	xxxx	163,994	21,755

(1) Project Iowa-83. Occupancy: 26 beds/200 days; 46 beds/165 days

(2) Opened 1 January 1961

(3) Opened 1 January 1961

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

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINETS	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-17	Delaware County Memorial	Delaware	Manchester	CO	66	0	0	8	55.1	13,279	2,497
R-24	John McDonald	Jones	Monticello	NPA	53	0	0	8	87.6	9,593	1,583 (1)
R-24	Mercy Irregular Facility	Jones	Anamosa	CH	0	0	23	9	78.7	6,609	1,091
R-31	Marengo Memorial	Iowa	Marengo	CITY	28	4	0	6	59.5	6,949	1,238
I-7	Virginia Gay	Benton	Vinton	CITY	36	0	0	10	66.0	8,676	1,279
I-7	Mercy	Linn	Cedar Rapids	CH	103	146	90	32	56.4	69,737	9,956
I-7	St. Luke's Methodist	Linn	Cedar Rapids	CH	414	0	0	46	70.3	106,273	15,862
	Region "G" Cedar Rapids -- Subtotals				700	150	113	119		221,116	33,506

(1) Project Iowa-86. Occupancy based on daily average of 30 available beds

SUITABILITY REPORT ON General HOSPITAL BEDS AND OR FACILITIES "H" REGION Davenport

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
I-8	Jane Lamb Memorial	Clinton	Clinton	NPA	40	49	0	16	89.8	29,157	4,757
I-8	St. Joseph Mercy	Clinton	Clinton	CH	0	55	27	20	85.8	25,680	3,481
I-8	DeWitt Community	Clinton	DeWitt	NPA	32	0	0	8	63.1	7,366	993
I-10	Muscatine General	Muscatine	Muscatine	CO	139	0	0	16	51.1	25,933	4,283
I-10	Bellevue	Muscatine	Muscatine	IND	Closed 12/9/60			NA	NA	10,759	478
I-10	Mercy	Scott	Davenport	CH	224	0	0	56	64.7	52,900	6,723
I-10	St. Luke's	Scott	Davenport	CH	52	90	0	22	96.9	50,200	6,890
I-10	Davenport Osteopathic	Scott	Davenport	NPA	68	0	0	10	51.4	12,746	2,032
I-10	Convalescent	Scott	Davenport	CO	0	35	0	---	55.2	7,053	122
	Region "H" Davenport -- Subtotals				555	229	27	148	xxxx	221,794	29,759

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SUITABILITY REPORT ON General HOSPITAL BEDS AND OR FACILITIES "I" REGION Burlington

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-45	Irregular Facility								NR	(7,000)	(500)
R-45	Sacred Heart	Lee	Ft. Madison	CH	61	60	0	24	75.8	33,471	4,320
R-45	Graham	Lee	Keokuk	NPA	0	76	18	5	86.7	29,763	3,837
R-45	St. Joseph	Lee	Keokuk	CH	55	26	0	16	110.7	17,317	2,350 (1)
I-12	Henry County Memorial	Henry	Mt. Pleasant	CO	56	0	0	8	NR	(12,600)	(1,815)
I-12	Burlington	D. Moines	Burlington	CH	204	2	0	16	92.0	47,119	6,180 (2)
I-12	Mercy	D. Moines	Burlington	CH	19	106	0	16	88.0	36,946	4,365
	Region "I" Burlington -- Subtotals				395	270	18	85	xxxx	184,216	23,367

(1) Project Iowa-91. Occupancy based on 43 existing beds

(2) Project Iowa-94GR. Occupancy based on 110 beds

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

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			No. of Bassinet	% Occup.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-35	Washington County	Washingtn.	Washington	CO	0	54	0	10	49.3	9,719	1,318
B-1	Mercy	Johnson	Iowa City	CH	190	0	0	34	74.8	51,839	7,400 (1
B-1	University Hospitals	Johnson	Iowa City	STATE	0	219	0	54	67.7	54,150	6,371
B-1	Irregular Facilities									2,941	896
	(1) Project Iowa-107. Nurse Residence Only										
	Region "J" Iowa City -- Subtotals				190	273	0	98	xxxx	118,649	15,985

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SUITABILITY REPORT ON General HOSPITAL BEDS AND OR FACILITIES "K" REGION Ottumwa

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-34	Mahaska County	Mahaska	Oskaloosa	CO	0	60	0	15	73.4	16,081	2,811
R-34	Mercy	Mahaska	Oskaloosa	PART	Closed End of 1960				66.1	8,445	1,373
R-34	Keokuk County	Keokuk	Sigourney	CO	34	0	0	10	49.1	6,098	927
R-39	Jefferson County	Jefferson	Fairfield	CO	25	0	21	8	98.3	16,499	2,579
R-43	St. Joseph Mercy	Appanoose	Centerville	CH	82	0	0	10	54.0	16,171	2,568
R-44	Davis County	Davis	Bloomfield	CO	71	0	0	12	75.8	19,641	2,332
R-44	Van Buren County Memorial	VanBuren	Keosauqua	CO	23	0	0	7	82.7	6,942	1,535
I-11	Ottumwa	Wapello	Ottumwa	NPA	139	0	0	28	73.9	37,484	5,375
I-11	St. Joseph	Wapello	Ottumwa	CH	139	0	0	24	100.2	36,583	3,608 (1)
I-11	Monroe County	Monroe	Albia	CO	37	0	0	8	65.5	8,843	1,453
	Region "K" Ottumwa -- Subtotals				550	60	21	129	xxxx	172,787	24,561

(1) Project Iowa-78. Occupancy based on 100 existing beds

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

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINETS	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-22	Boone County	Boone	Boone	CO	100	0	0	16	67.4	24,604	3,345
R-23	Story County	Story	Nevada	CO	50	0	0	10	58.7	10,703	1,308
R-23	Story City Memorial	Story	Story City	CITY	16	0	0	4	85.1	4,969	764
R-23	Mary Greeley Memorial	Story	Ames	CITY	81	96	0	20	99.0	24,566	4,157 (1
	Irregular Facility									2,226	663
R-29	Guthrie County	Guthrie	Guthrie Ctr.	CO	38	0	0	8	49.6	6,881	906
R-30	Mary Francis Skiff Mem.	Jasper	Newton	CITY	94	0	0	10	63.8	21,899	3,535
R-30	Grinnell Community	Poweshiek	Grinnell	NPA	0	41	0	15	65.5	9,806	1,307
R-30	St. Francis	Poweshiek	Grinnell	CH	0	37	0	8	80.9	10,927	1,195
R-32	Adair County Memorial	Adair	Greenfield	CO	29	0	0	8	57.2	6,053	923
R-32	Madison County Memorial	Madison	Winterset	CO	39	0	0	8	59.8	8,513	1,077
R-33	Collins Memorial	Marion	Knoxville	IND	30	0	0	6	85.7	9,389	1,776
R-33	Pella Community	Marion	Pella	NPA	34	0	0	8	Project Iowa-87.		
R-37	Greater Community	Union	Creston	CO	0	0	50	10	76.3	13,930	2,402
R-38	Yocom	Lucas	Chariton	IND	0	0	21	7	80.7	6,185	618
R-38	Lucas County Memorial	Lucas	Chariton	CO	35	0	0	10	Project Iowa-82		
R-41	Ringgold County	Ringgold	Mt. Ayr	CO	30	0	0	8	52.9	5,789	1,115

(1) Project Iowa-89. Occupancy based on 68 existing beds

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

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF NURSES	% OCCUP.	NURSE DATA	
		COUNTY	TOWN							PATIENT-DAYS	NURSING
R-42	Decatur County	Decatur	Leon	CO	0	30	0	5	70.0	7,667	1,410
R-47	Clarke County Public	Clarke	Osceola	CO	32	0	0	8	77.2	11,680	1,704
R-48	Wayne County	Wayne	Corydon	CO	34	0	0	8	68.0	8,441	791
I-6	Mercy	Marshall	Marshalltown	CH	29	62	0	10	66.6	19,445	2,264 (1)
I-6	Evangelical	Marshall	Marshalltown	CH	0	132	8	20	62.8	32,062	4,432
B-2	Dallas County	Dallas	Perry	CO	38	0	0	10	77.9	10,802	1,495
B-2	Clinic	Dallas	Dexter	PART	14	0	0	5	153.7	7,856	738
B-2	Broadlawns Polk County	Polk	Des Moines	CO	0	147	14	24	70.1	41,712	5,184
B-2	Iowa Lutheran	Polk	Des Moines	CH	90	135	0	25	90.6	74,438	9,521 (2)
B-2	Iowa Methodist & Blank Mem.	Polk	Des Moines	CH	343	0	0	25	94.9	118,758	15,952 (3)
B-2	Mercy	Polk	Des Moines	CH	310	0	50	40	69.1	90,727	13,017 (4)
B-2	Wilden Osteopathic	Polk	Des Moines	CORP	35	0	11	8	57.3	9,620	2,062
B-2	Still Osteopathic	Polk	Des Moines	CORP	0	75	0	16	60.0	16,415	2,043
B-2	Des Moines General	Polk	Des Moines	CORP	70	0	33	10	58.8	22,099	3,379
B-2	Redfield Hospital & Clinic	Dallas	Redfield	IND	8	0	0	3	105.7	3,087	272
B-2	Doctors' Hospital	Polk	Des Moines	CORP	103	0	0	16	Under	Construction	
	Region "L" Des Moines -- Subtotals				1,682	755	187	389	xxxx	641,249	89,355

(1) Project Iowa-95. Occupancy based on 80 existing beds
(2) Project Iowa-99. Nurse Residence Addition only
(3) Project Iowa-100. Nurse Residence Addition only
(4) Project Iowa-66. All beds not available throughout year

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DIVISION OF HOSPITAL SERVICES

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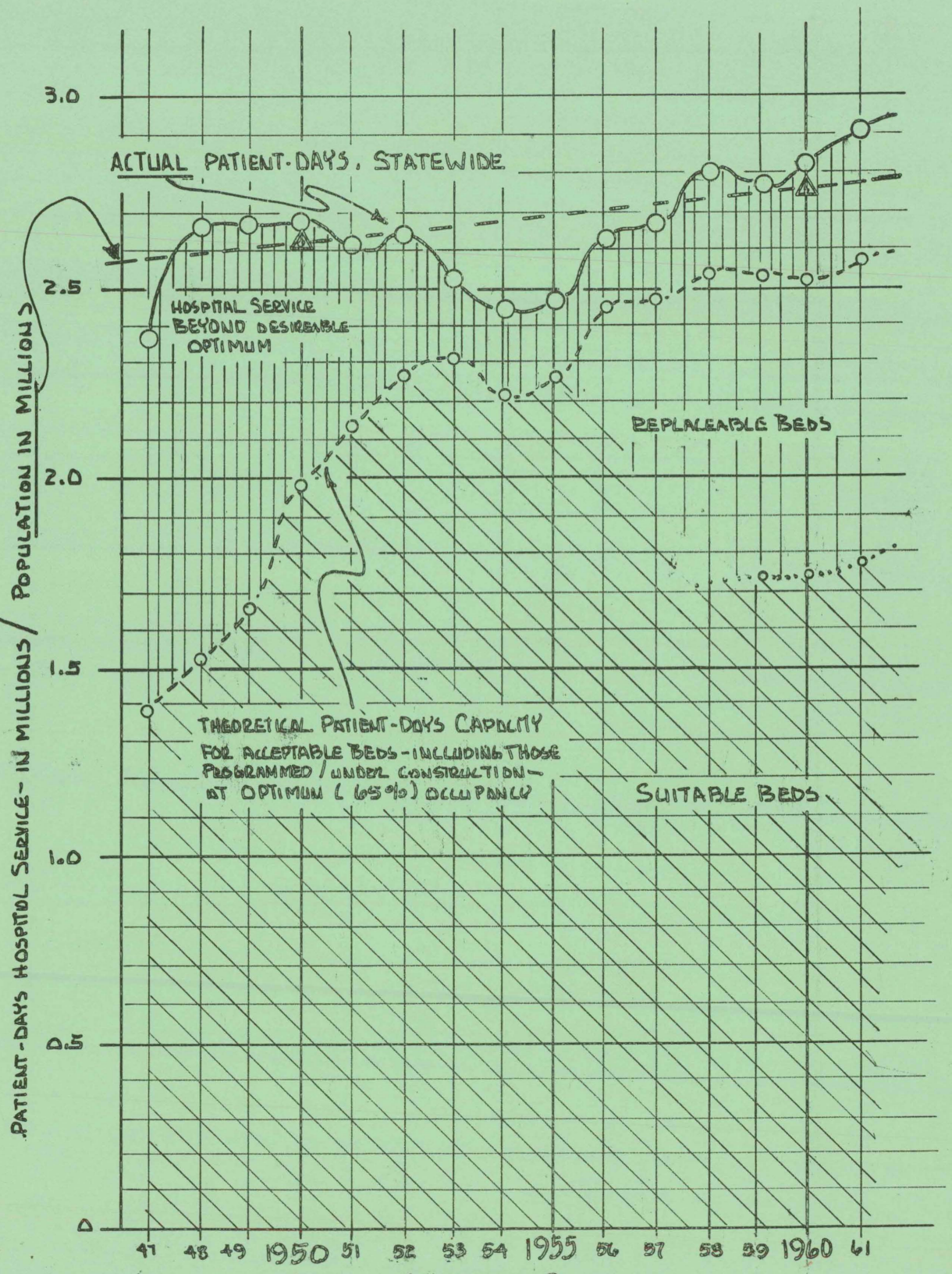
SUITABILITY REPORT ON General HOSPITAL BEDS AND OR FACILITIES "M" REGION Council Bluffs

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
R-19	Crawford County Memorial	Crawford	Denison	CO	50	0	0	10	59.9	10,933	1,791
R-20	St. Anthony	Carroll	Carroll	CH	0	14	102	20	61.8	42,340	4,234
R-20	Manning General	Carroll	Manning	IND	0	15	0	6	58.8	3,219	414
R-26	Community Memorial	Harrison	Mo. Valley	NPA	30	0	0	8	85.9	9,402	1,165
R-27	Myrtue Memorial	Shelby	Harlan	CO	47	0	0	16	71.4	12,245	2,071
R-28	Atlantic Memorial	Cass	Atlantic	NPA	36	32	0	10	67.3	16,702	2,274
R-28	Audubon County Memorial	Audubon	Audubon	CO	30	0	0	8	44.8	4,902	951
R-36	Rosary	Adams	Corning	NPA	41	0	0	8	45.7	6,833	1,145
R-36	Murphy Memorial	Montgom.	Red Oak	CITY	43	0	0	10	62.2	9,766	1,349
R-40	Community Hospital, Inc.	Fremont	Hamburg	CITY	0	0	25	8	76.0	6,937	1,089
R-40	Clarinda Municipal	Page	Clarinda	CITY	55	0	0	8	68.9	9,980	1,602 (1
R-40	Hand Community	Page	Shenandoah	NPA	53	0	0	8	55.3	10,690	1,534
I-9	Jennie Edmundson Memorial	Pottawat.	Council Blfs.	NPA	154	60	0	16	71.8	42,723	6,523 (2
I-9	Mercy	Pottawat.	Council Blfs.	CH	14	0	206	24	78.7	47,471	6,802
	Irregular Facility									13,217	950
	Region "M" Council Bluffs -- Subtotals				553	121	333	120	xxxx	247,360	33,894
	GRANT TOTALS -- STATEWIDE				7,555	3,430	1,167	1,903	xxxx	2,920,718	405,010

(1) Project Iowa-106. Occupancy based on 40 existing beds

(2) Project Iowa-96. Occupancy based on 163 existing beds



COMPARISON - ACUTE GENERAL HOSPITALS - STATEWIDE
BED DEMAND VS AVAILABLE ACCEPTABLE BEDS
VS POPULATION GROWTH

IOWA DEPT OF HEALTH DIV OF HOSPITAL SERVICES

BED INCREASE DUE TO POPULATION INCREASE FACTOR

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

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

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

POPULATION TRENDS IN IOWA - BY COUNTY - 1950 THRU 1960
POPULATION INCREASE FACTOR - PROJECTED TO 1980

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

POPULATION TRENDS IN IOWA - BY COUNTY - 1950 THRU 1960
POPULATION INCREASE FACTOR - PROJECTED TO 1980

COUNTY	POPULATION		POPULATION CHANGE IN PERCENT	POPULATION INCREASE BEYOND STATE AVERAGE			
				PROJECTED TO 1980		NET BEDS	APPLICABLE REGION
	1960	1950		%	NUMBER		
Jefferson	15,818	15,696	0.8				
Johnson	53,663	45,756	17.3	+34.6	18,567	84	B-1
Jones	20,693	19,401	6.7	+13.4	2,773	7	R-24
Keokuk	15,492	16,797	- 7.8				
Kossuth	25,314	26,241	- 3.5				
Lee	44,207	43,102	2.6				
Linn	136,899	104,274	31.3	+62.6	85,699	340	1-7
Louisa	10,290	11,101	- 7.3				
Lucas	10,923	12,069	- 9.5				
Lyon	14,468	14,697	- 1.6				
Madison	12,295	13,131	- 6.4				
Mahaska	23,602	24,672	- 4.3				
Marion	25,886	25,930	- 0.2				
Marshall	37,984	35,611	6.7	+13.4	5,090	20	1-6
Mills	13,050	14,064	- 7.2				
Mitchell	14,043	13,945	0.7				
Monona	13,916	16,303	-14.6				
Monroe	10,463	11,814	-11.4				
Montgomery	14,467	15,685	- 7.8				
Muscatine	33,840	32,148	5.3	+10.6	3,587	14	1-10
O'Brien	18,840	18,970	- 0.7				
Osceola	10,064	10,181	- 1.1				
Page	21,023	23,921	-12.1				
Palo Alto	14,736	15,891	- 7.3				
Plymouth	23,906	23,252	2.8				
Pocahontas	14,234	15,496	- 8.1				
Polk	266,315	226,010	17.8	+35.6	94,898	427	B-2
Pottawattamie	83,102	69,682	19.3	+38.6	32,077	128	1-9
Poweshiek	19,300	19,344	- 0.2				
Ringgold	7,910	9,528	-17.0				
Sac	17,007	17,518	- 2.9				
Scott	119,067	100,698	18.2	+36.4	43,340	173	1-10
Shelby	15,825	15,942	- 0.7				
Sioux	26,375	26,381	---				
Story	49,327	44,294	11.4	+22.8	11,247	28	R-23
Tama	21,413	21,688	- 1.3				
Taylor	10,288	12,420	-17.2				
Union	13,712	15,651	-12.4				
Van Buren	9,778	11,007	-11.2				
Wapello	46,126	47,397	- 2.7				
Warren	20,829	17,758	17.3	+34.6	7,207	32	B-2
Washington	19,406	19,557	- 0.8				
Wayne	9,800	11,737	-16.5				
Webster	47,810	44,241	8.1	+16.2	7,745	31	1-3
Winnebago	13,099	13,450	- 2.6				
Winneshiek	21,651	21,639	0.1				
Woodbury	107,849	103,917	3.8				
Worth	10,259	11,068	- 7.3				
Wright	19,447	19,652	- 1.0				
IOWA --	2,757,537	2,621,073	+ 5.2			1,732	

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

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE ____ OF ____
REGION ____

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8		EXISTING SUITABLE / REPLACEABLE BEDS 9		TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
A	Sioux City	207,548		745	641+392/2	837	878	41	
B	Spencer	135,588	(4)	394	358+54/2	385	484	99	
C	Fort Dodge	170,295	(31)	542	536+233/2	652	656	4	
D	Mason City	169,809	(33)	515	317+353/2	494	564	70	
E	Waterloo	269,715	(235)	931	553+362/2	734	1,193	459	
F	Dubuque	138,746	(90)	469	525+178/2	614	614	0	
G	Cedar Rapids	227,996	(347)	825	700+150/2	775	1,192	417	
H	Davenport	218,845	(235)	875	555+229/2	670	1,110	440	
I	Burlington	109,957	(22)	373	395+270/2	530	530	0	
J	Iowa City	76,782	(84)	307	190+273/2	326	391	65	
K	Ottumwa	146,493	--	451	550+60/2	580	629	49	
L	Des Moines	621,788	(523)	2,269	1,682+755/2	2,059	2,920	861	
M	Council Bluffs	263,943	(128)	805	553+121/2	614	987	373	
Statewide - Grand Totals		2,757,535	(1,732)	9,501	7,555+3430/2	9,270	12,148	2,878	
	Pool Beds Held in Reserve						+ 1,318	+ 1,318	
	Adjusted Totals --						13,466	4,196	68.84

13. State Ratio (4.5)(2,757.535) = 12,409
14. Excess Beds-Orig. State Pool = +1,057
15. Total Beds Allowed 13,466

Replaceable Beds
Total Suitable Beds
Beds From Population Increase Factor

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 1 OF 14
"A" REGION Sioux City

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9		TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-1		28,562	71	93-8/2	89	89	0	100
	Orange City			27-8				
	Sioux Center			26-0				
	Rock Rapids			32-0				
R-8		22,997	57		82	82	0	100
	LeMars			68-0				
	Hawarden			14-0				
R-9		28,867	72	92-50/2	67	72	5	93.05
	Battle Creek			0-15				
	Cherokee			42-35				
R-18	Onawa	13,916	36	0-0	0	36	36	0.00
B-3		113,206	509	766-334/2	599	599	0	100
	Akron			21-0				
	Sioux City - Lutheran			72-66				
	Methodist			141-0				
	St. Jos. Mercy			156-145				
	St. Vincent's			42-98				
	Gordon Memorial			0-25				
	Subtotals -							
	Region "A" Sioux City	207,548	745	641+392/2	837	878	41	xxxx

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 2 OF 14
"B" REGION Spencer

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-2		30,846	77	32	77	45	41.56
	Sheldon			32-0			
	Sibley			0-0			
R-3		28,984	(4) 72	151	151	0	100
	Estherville			103-0			
	Spirit Lake			48-0			
R-10		38,196	95	112-12/2 106	106	106	100
	Sac City			32-0			
	Alta			19-0			
	Storm Lake			49-0			
	Sioux Rapids			0-12			
I-1		37,562	150	117-42/2 96	150	54	64.00
	Emmetsburg			0-18			
	Hartley			27-0			
	Spencer			48-24			
	Region "B" Spencer - Subtotals	135,588	(4) 394	358+54/2 385	484	99	xxxx

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA

"C" REGION Fort Dodge

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-4	Algona	25,314	63	61-0 61	63	2	96.83
R-11	Clarion Belmond	32,603	81	80 54-0 26-0	81	1	98.77
R-12	Webster City	20,032	50	46-32 ~~78-32/2~~ 62	62	0	100
R-21	Jefferson	14,379	36	57-0 57	57	0	100
I-3	Lake City Fort Dodge - St. Jos. Mercy Lutheran	77,967	(31) 312	~~493-201/2~~ 392 42-0 61-90 189-111	392	0	100
Region "C" Fort Dodge - Subtotals		170,295	(31) 542	536+233/2 652	655	3	xxxx

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 4 OF 14
"D" REGION Mason City

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-5	Osage Charles City	35,145	88	135-72/2 99 63-0 0-72	99	0	100
R-13	Eldora Iowa Falls Hampton	46,808	117	119-119/2 60 0-36 0-35 0-48	117	57	51.28
R-46	Britt Forest City Buffalo Center	27,703	69	74 32-0 25-0 17-0	74	0	100
I-2	Mason City Park Memorial St. Joseph Mercy	60,153	(33) 241	342-162/2 261 0-56 180-106	274	13	95.25
Region "D" Mason City - Subtotals		169,809	(33) 515	317+353/2 494	564	70	xxxx

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA

"E" REGION Waterloo

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-6		47,225	118	114-72/2 78	118	40	66.10
	Cresco			42-0			
	Decorah			0-20			
	New Hampton			0-52			
R-14	Grundy Center	14,132	35	40-0 40	40	0	100
R-15		36,827	92	114	114	0	100
	West Union			22-0			
	Oelwein			55-0			
	Sumner			37-0			
I-4		171,531	(235) 686	647-290/2 502	921	419	54.51
	Independence			38-0			
	Waverly			0-0			
	Cedar Falls			24-36			
	Waterloo - Allen Memorial			83-130			
	Schoitz Memorial			212-0			
	St. Francis			0-124			
Region "E"	Waterloo - Subtotals	269,715	(235) 931	553+362/2 734	1,193	459	xxxx

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES
ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 6 OF 14
"F" REGION Dubuque

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8		EXISTING SUITABLE / REPLACEABLE BEDS 9		TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-7		37,944		95		136	136	0	100
	Waukon				46-0				
	Postville				32-0				
	Elkader				20-0				
	Guttenberg				38-0				
R-25	Maquoketa	19,248	(12)	48	60-0	60	60	0	100
I-5		81,554	(78)	326	507-178/2	418	418	0	100
	Dubuque - Finley				29-28				
	St. Joseph Mercy				200-150				
	Xavier				100-0				
Region "F" Dubuque - Subtotals		138,746	(90)	469	525+178/2	614	614	0	xxxx

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA

"G" REGION Cedar Rapids

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-17	Manchester	18,483	46	66-0 66	66	0	100
R-24	Monticello Anamosa	20,693	(7) 52	53 53-0 0-0	59	6	89.83
R-31	Marengo	18,894	47	28-4 30	47	17	63.83
I-7	Vinton Cedar Rapids - Mercy St. Luke's Meth.	169,926	(340) 680	699-146/2 626 36-0 103-146 414-0	1,020	394	61.37
Region "G" Cedar Rapids - Subtotals		227,996	(347) 825	700+150/2 775	1,192	417	xxxx

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 8 OF 14
"H" REGION Davenport

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
I-8	DeWitt Clinton - Jane Lamb Mem. St. Joseph Mercy	55,060	(48) 220	176-104/2 124 32-0 40-49 0-55	268	144	46.27
I-10	Muscatine Davenport - Mercy St. Luke's Convalescent Osteopathic	163,785	(187) 655	608-125/2 546 139-0 224-0 52-90 0-35 68-0	842	296	64.85
Region "H" Davenport - Subtotals		218,845	(235) 875	555+229/2 670	1,110	440	xxxx

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES
ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 9 OF 14
"I" REGION Burlington

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY 13 / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-45	Fort Madison Keokuk - Graham St. Joseph	44,207	110	278-162/2 197 61-60 0-76 55-26	197	0	100
I-12	Mt. Pleasant Burlington - Burlington Mercy	65,750	(22) 263	387-108/2 333 56-0 204-2 19-106	333	0	100
Region "I" Burlington - Subtotals		109,957	(22) 373	395+270/2 530	530	0	xxxx

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES
ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 10 OF 14
"J" REGION Iowa City

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8		EXISTING SUITABLE / REPLACEABLE BEDS 9		TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-35	Washington	19,406		49	0-54	27	49	22	55.10
B-1	Iowa City - Mercy Univ. Hospitals	57,376	(84)	258	409-219/2 190-0 0-219	299	342	43	87.43
Region "J" Iowa City - Subtotals		76,782	(84)	307	190+273/2	326	391	65	xxxx

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 11 OF 14
"K" REGION Ottumwa

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY 19 / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9		TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-34	Sigourney Oskaloosa	39,094	98	94-60/2 34-0 0-60	64	98	34	65.31
R-39	Fairfield	15,818	40	25-0	25	40	15	62.50
R-43	Centerville	16,015	40	82-0	82	82	0	100
R-44	Bloomfield Keosauqua	18,977	47	71-0 23-0	94	94	0	100
I-11	Albia Ottumwa - Ottumwa St. Joseph	56,589	226	37-0 139-0 139-0	315	315	0	100
Region	"K" Ottumwa - Subtotals	146,493	451	550+60/2	580	629	49	xxxx

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 12 OF 14
"L" REGION Des Moines

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-22	Boone	28,037	70	100-0 100	100	0	100
R-23		49,327	(28) 123	243-96/2 195	195	0	100
	Nevada			50-0			
	Story City			16-0			
	Ames			81-96			
R-29	Guthrie Center	13,607	34	38-0 38	38	0	100
R-30		52,084	(16) 138	172-78/2 133	154	21	86.36
	Newton			94-0			
	Grinnell - Grinnell Comm.			0-41			
	St. Francis			0-37			
R-32		23,188	58	68	68	0	100
	Greenfield			29-0			
	Winterset			39-0			
R-33		25,886	65	64	65	1	98.46
	Knoxville			30-0			
	Pella			34-0			
R-37	Creston	13,712	34	0-0 0	34	34	0.0
R-38	Chariton	10,923	27	35-0 35	35	0	100
R-41	Mt. Ayr	7,910	20	30-0 30	30	0	100

Continued on following page --

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 13 OF 14
"L" REGION Des Moines (Cont.)

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY 13 / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9	TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-42	Leon	10,539	26	0-30 15	26	11	57.69
R-47	Osceola	8,222	20	32-0 32	32	0	100
R-48	Corydon	9,800	24	34-0 34	34	0	100
I-6	Marshalltown	57,288	(20) 229	223-194/2 126	249	123	50.60
	Mercy			29-62			
	Evangelical			0-132			
B-2		311,267	(459) 1,401	1,368-357/2 1,189	1,860	671	63.92
	Perry			38-0			
	Dexter			14-0			
	Redfield			8-0			
	Des Moines						
	Broadlawns			0-147			
	Iowa Lutheran			90-135			
	Iowa Methodist			343-0			
	Mercy			310-0			
	Wilden Osteopathic			35-0			
	Still Osteopathic			0-75			
	Des Moines General			70-0			
	Doctors'			103-0			
Region "L" Des Moines - Subtotals		621,788	(523) 2,269	1,682+755/2 2,059	2,920	861	xxxx

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

ACUTE GENERAL HOSPITAL SUMMARY

1 JULY 1961 IOWA
PAGE 14 OF 14
"M" REGION Council Bluffs

AREA 5	WHERE EXISTING / PROPOSED SUITABLE / REPLACEABLE FACILITY IS / WILL BE LOCATED 6	CIVILIAN POPULATION 1960 CENSUS 7	BED ALLOWANCE BASED ON AREA RATIO 8	EXISTING SUITABLE / REPLACEABLE BEDS 9		TOTAL BEDS ALLOWED BY P.L. 725 10	ADDITIONAL BEDS PROPOSED FOR CONSTRUCTION 11	% OF BED-NEED MET 12
R-19	Denison	18,569	46	50-0	50	50	0	100
R-20	Manning Carroll	23,431	59	29-29/2 0-15 0-14	15	59	44	25.42
R-26	Missouri Valley	17,600	44	30-0	30	44	14	68.18
R-27	Harlan	15,825	40	47-0	47	47	0	100
R-28	Atlantic Audubon	28,838	72	98-32/2 36-32 30-0	82	82	0	100
R-36	Corning Red Oak	21,935	55	41-0 43-0	84	84	0	100
R-40	Clarinda Shenandoah	41,593	104	55-0 53-0	108	108	0	100
I-9	Council Bluffs Jennie Edmundson Mercy	96,152	(128) 385	228-60/2 154-60 14-0	198	513	315	38.60
Region "M" Council Bluffs - Subtotals		263,943	(128) 805	553+121/2	614	987	373	xxxx
Statewide - Grand Totals --		2,757,535	1,732 9,501	7455+3430/2	9,170	12,148	2,978	68.10
Pool Beds in Reserve --						+ 1,318	+ 1,318	
Compensated Totals --						13,466	4,296	

13. State Ratio (4.5)(2,757.535) = 12,409
14. Excess Beds-Orig. State Plan = 1,057
15. Total Beds Allowed = 13,466

Replaceable Beds
Suitable Beds
Beds From Population Incr. Factor

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

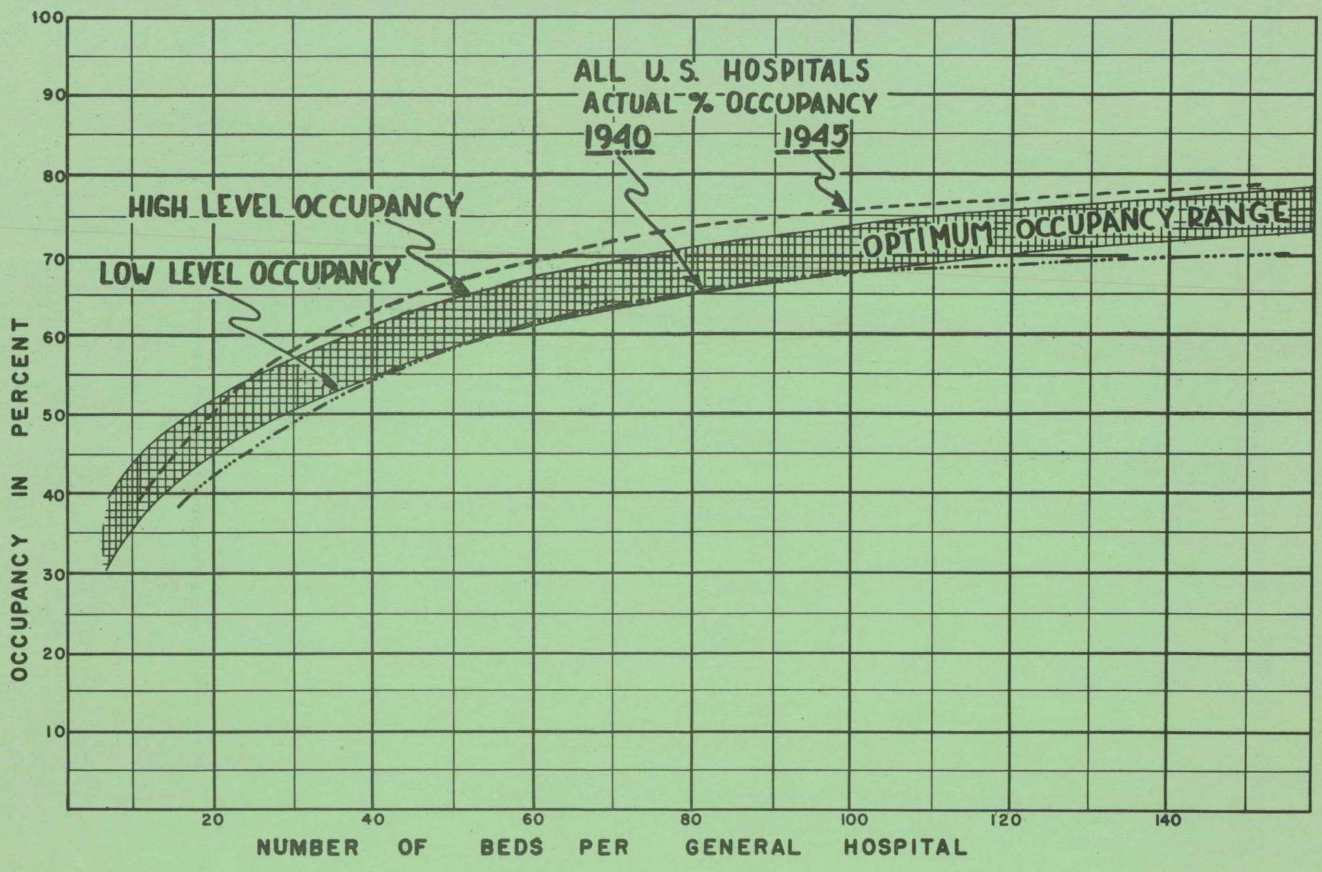
1 JULY 1961

RELATIVE PRIORITY - ACUTE GENERAL HOSPITALS - IOWA

AREA	CENTER	% OF NEED MET	PRIORITY FACTOR ANALYSIS		
			RURALITY	INCOME	GROSS FACTOR
R-18	Onawa	0	1.5017	1.1853	2.6870
R-37	Creston	0	0.8972	1.1750	2.0722
R-20	Carroll	25.42			
I-9	Council Bluffs	38.60			
R-2	Sibley	41.56			
I-8	Clinton	46.27			
I-6	Marshalltown	50.60			
R-13	Iowa Falls	51.28			
I-4	Waterloo	54.51			
R-35	Washington	55.10			
R-42	Leon	57.69			
I-2	Mason City	58.76			
I-7	Cedar Rapids	61.37			
R-39	Fairfield	62.50			
R-31	Marengo	63.83			
B-2	Des Moines	63.92			
I-1	Spencer	64.00			
I-10	Davenport	64.85			
R-34	Oskaloosa	65.31			
R-6	New Hampton	66.10			
R-26	Missouri Valley	68.18			
R-30	Newton	86.36			
B-1	Iowa City	87.43			
R-24	Anamosa	89.93			
R-9	Cherokee	93.05			
R-14	Algona	96.83			
R-33	Pella	98.46			
R-11	Humboldt	98.77			

ALL OTHER AREAS ARE 100% AS FOLLOWS:

B-3	Sioux City	R-22	Boone
I-3	Fort Dodge	R-23	Ames
I-11	Ottumwa	R-25	Maquoketa
I-5	Dubuque	R-27	Harlan
I-12	Burlington	R-28	Atlantic
R-1	Orange City	R-29	Guthrie Center
R-5	Charles City	R-32	Greenfield
R-7	Postville	R-36	Red Oak
R-8	LeMars	R-38	Chariton
R-10	Storm Lake	R-41	Mt. Ayr
R-3	Estherville	R-43	Centerville
R-12	Webster City	R-44	Bloomfield
R-14	Grundy Center	R-45	Keokuk
R-15	Oelwein	R-46	Britt
R-17	Manchester	R-47	Osceola
R-19	Denison	R-48	Corydon
R-21	Jefferson	R-40	Clarinda



DEFINITION AND INTERPRETATION OF GRAPH

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

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

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

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

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

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

DIVISION OF HOSPITAL SERVICES
IOWA STATE DEPT. OF HEALTH

PART II TUBERCULOSIS HOSPITALS

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

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

ANNUAL RESIDENT DEATH RATE - IOWA - CALENDAR YEARS

Year	Number
1940	421
1941	370
1942	395

Annual Average Death Rate - 374.8

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

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

Year	Number
1955	364
1956	311

Average Number - 339.5

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

Occupancy - Statewide - of all beds available was 86.8 per cent.

PATIENT LOAD - STATEWIDE - HAS BEEN AS FOLLOWS:

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

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.

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT ON Tuberculosis HOSPITAL BEDS AND OR FACILITIES

REGION Statewide

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			NO. OF BASSINET	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
	State Sanatorium	Johnson	Oakdale	STATE	64	285	0	294.1	85.4	108,832	370
	Broadlawns Polk County	Polk	Des Moines	COUNTY	0	0	12	31.4	83.8	4,893	156
	Sunnyslope Sanatorium	Wapello	Ottumwa	COUNTY	63	0	0	437.0	79.8	18,355	42
	Statewide Totals -------				127	285	12	xx	xx	132,080	568

PART III NERVOUS AND MENTAL HOSPITALS

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

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

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

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

This 13th Revision incorporates refinements which were proposed in the recommendations of the American Psychiatric Association in the above mentioned report. In addition to the specifics of the narrative, the numerical elements in terms of beds have been induced into the tabulations of this hospital plan.

To better indicate the theme and intent of "A Mental Health Program for Iowa," we have taken the liberty of extracting certain quotations from the narrative which go far to reflect the problems that exist in the state as a whole, as well as to convey the fundamentals and philosophy which are applicable to guide a sound corrective program of effort and monetary expenditure.

We offer the following synopsis and extracts:

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 has no real authority or responsibility. He is subject to the authority of the board, serves at their pleasure ---."

"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 2,600 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 felt, "While there has been some improvement, the number 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 2,400 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 provision 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 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 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 of 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 recreation 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.

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"(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 to 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) Outpatient 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 hospitals.

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

"(5) Local communities and agencies should set of 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 set forth its recommendations. Those which referred to facilities were 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."

The 58th General Assembly gave some discussion to the entire mental health problem and provided certain funds which would permit expanding the professional staffs at the state institutions. However, the pattern of reproducing obsolete layouts with new structures continues without regard for the upgrading target which was set forth in the program outlined in the earlier mentioned study.

The 1956 report of the Study Committee became available to the 57th General Assembly while in session. Some debate ensued but little action was taken on the premise that this broad subject was entitled to more study before setting a major course of action. However, the 58th and 59th General Assemblies produced no means for pursuing the Study Committee Recommendations beyond that pertaining to the University facilities which had the benefit of Federal grants and guidance. State programs are negligible.

In the meantime, those elements of the report pertinent to this State Plan have been induced to round out the total program. The summary and tabulation of specific beds is stated and the totals reflected in the table of priority for the Nervous and Mental category. It goes on to evaluate existing beds in terms of "suitable, replaceable and unsuitable."

The Governor's Study Committee on Care of the Aging reported to the 57th General Assembly on the findings which appeared in their preliminary surveying. Included in the report were elements regarding the aged as found in the state mental institutions. Generally, it was a favorable development when the State of Iowa faced the fact that the old and accepted order of procedure is more than questionable and gave specific data on the inequities. Excerpts:

1. "Patients 65 years and older comprise 32 per cent of entire case load..." in the state institutions.

2. Of all patients removed from state mental institutions, 50 per cent are discharged to the several channels and the remaining 50 per cent die within the institution.

3. "The patients in the older age groups, for the most part, have grown old in the institution. With early, intensive treatment, this trend should be prevented, particularly in the schizophrenic group. Early treatment-early recovery, is the trend in the schizophrenic group, the largest group in the institutions."

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4. Regarding discharged patients from state institutions, only those over 65 years of age are reported in terms of destination. Of these, 61 per cent are discharged to their home community and 0.6 per cent to the Veterans Administration. The remaining 38 per cent are DISCHARGED TO NURSING HOMES AND TO COUNTY HOMES, neither of which have a semblance of facilities or personnel capable of following through on a total treatment program for the mentally ill.

The lack of progress in the mental field within this state is not unique to Iowa. Many other states are in a comparable situation. However, this is hardly justification to ignore the fact that there are some states who are proceeding in an aggressive manner and are demonstrating the tremendous possibilities, dollar-wise, which can be realized when subterfuge is overridden and facts are approached aggressively. Because of the dominance of the retrograde states in the nation and because the problem nationally is becoming so very acute, an effort was made thru the Surgeon General, U. S. Public Health Service, to provide corrective guidance for the benefit of all. The Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities did pursue the subject through a committee made up of representative spokesmen from all phases, bodies and agencies related to the subject. The results of this committee's activity are published within the report titled "Planning of Facilities for Mental Health Services," as published by the U. S. Department of Health, Education and Welfare, and dated January 1961. The purpose of the study and report "is to offer a guide to states in developing adequate mental health facilities." Emphasis is given to the absolute necessity of each state developing a plan which is comprehensive and is coordinated with every other health planning program of the state including the community mental health services. While the report as a whole is a complete and detailed approach to this problem, we can do no more than reflect its highlights in this presentation. A summary of the recommendations resulting from this national study are not inconsistent with the basic principles which have been repeated annually in previous revisions of this State Plan. Briefly, this most current study's points include:

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

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

(3) This total state plan should be based upon a comprehensive survey of all existing facilities and services with realistic evaluation of their place in a total program, and from that determine the unmet need. This phase of the analysis should give proper consideration to proposed community mental health activities, existing services, state population patterns and movement, and logical service areas. Simultaneously, thoroughly evaluate existing legislation and administrative procedures preparatory to guiding such legislation as would be essential to permit

freedom of adjustment for the upgraded program. In turn, certain areas of need should be given a primary priority for execution to make early expenditures immediately responsive. This same body should be appropriately authorized to preclude splinter activities expending scarce resource locally unless expenditure does complement the total pattern being inaugurated.

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

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

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

In our instance, the Iowa mental institutions, while implying an intensive treatment program, provide no more than stringent budget will permit, namely a service dominated by marginal custodial care. The average length of stay continues to be in excess of two years per admission, as compared with an average of 39 patient days per admission in the non-profit and/or charitable intensive treatment units. The obvious penalty is in the humane factor which cannot be evaluated in dollars. Beyond this is the cold economic factor--and this can be reduced to comparative dollars and thus point up the fallacy of insufficient intensive treatment programming in our state institutions.

Upon adjournment of the 59th General Assembly, we find resultant legislation pertinent to mental health is less than progressive. The practice by the state institutions of transferring a broad category of mental patients from the state institutions, with their intensive treatment program limited by appropriation, to county homes offering, at best, marginal custodial care without treatment or psychiatric supervision, was applauded, thereby projecting this archaic pattern into Iowa's future. As a result, we have more mental patients in county homes without benefit of professional supervision than Iowa has in all other mental facilities. If the philosophy that things will not improve until they are bad enough has any merit, it would appear that Iowa is on the threshold of great things insofar as mental health is concerned.

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

Federal assistance will be available only to facilities which will present, upon application, a total program approvable in the light of current standards for intensive treatment units, and proof that the means for administering, staffing and financing the operational phase of such an undertaking exists.

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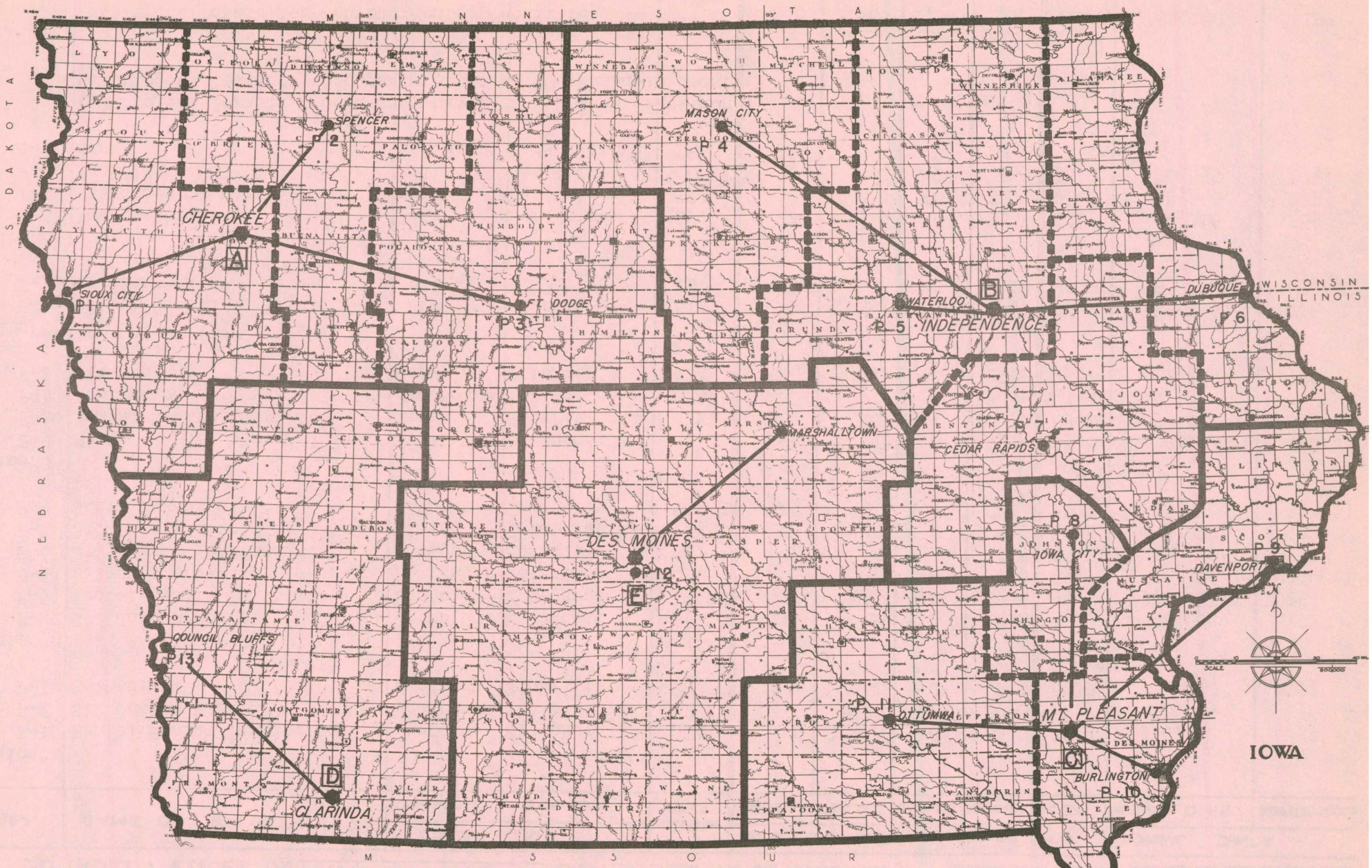
In no instance will program funds be made available for long-term domicilary facilities. Unless the proposal positively provides the means for a well-qualified staff to aggressively administer intensive treatment in accord with the best standards available today, the moneys will be diverted to other categories. The qualifications of each proposal will be indicated in a presentation by the sponsors. The application must be supplemented by the detailed program being planned for the proposed facility. This principal shall govern in the case of proposed replacement of structures which are presently declared unsuitable. Outright replacement would merely insure continuance of the grossly inadequate and uneconomical care which currently dominates the mental illness program in Iowa.

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

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

LOCATION OF FACILITY	EXISTING SUITABLE PLUS REPLACEABLE BEDS	PROPOSED BEDS AND SPECIFIC PURPOSE					TOTAL BEDS PROPOSED
		DISTURBED CHILDREN'S UNIT	CRIMINALLY "INSANE" UNIT	T. B. DISTURBED UNIT	TO REPLACE UNSUITABLE EXISTING FACILITIES	FOR UNMET BED-NEED EXISTING AND KNOWN	
Cherokee	1,272	50	0	0	0	0	1,322
Independ.	560	50	0	0	520	45	1,175
Mt. Pleasnt.	621	0	0	0	559	0	1,180
Clarinda	1,246	0	0	0	0	0	1,246
Des Moines	0	50	75	75	0	0	200
STATEWIDE--	3,699	150	75	75	1,079	45	5,123
Beds Indicated in Need Report	3,699	Total of Combined Beds to be Added 1,424					5,123

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

IOWA

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

IOWA STATE DEPT OF HEALTH
DIVISION OF HOSPITAL SERVICE

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT ON Nervous & Mental HOSPITAL BEDS AND OR FACILITIES

REGION Statewide

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			PAT DAYS PER ADM.	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
Region"A"											
P-1	Mental Health Institute	Cherokee	Cherokee	STATE	0	1,272	0	483.0	76.3	354,042	733
P-1	St. Joseph Mercy	Woodbury	Sioux City	CH.	0	30	12	29.8	65.3	10,009	336
P-1	Methodist	Woodbury	Sioux City	CH.	19	0	0	42.9	61.9	4,290	102
Region"B"											
P-4	St. Joseph Mercy	Cerro Gdo.	Mason City	CH.	0	16	0	18.6	35.2	2,054	151
P-5	Mental Health Institute	Buchanan	Independence	STATE	0	560	520	356.0	95.1	374,846	1,053
P-5	Allen Memorial	Blackhawk	Waterloo	CH.	32	0	0	18.0	79.7	6,376	354(1)
P-6	St. Joseph Sanitarium	Dubuque	Dubuque	CH.	0	0	230	50.5	46.1	38,730	767
P-7	St. Luke's Methodist	Linn	Cedar Rapids	CH.	31	0	0	9.0	46.8	5,299	592
P-8	State Psychopathic	Johnson	Iowa City	STATE	27	60	0	54.3	86.1	18,850	347(2)
Region"C"											
P-9	Mercy	Scott	Davenport	CH.	35	0	0	13.2	55.8	7,123	538
P-10	Mental Health Institute	Henry	Mt. Pleasant	STATE	240	381	587	584.0	89.1	393,013	673
P-10	Burlington	Des Moines	Burlington	NPA	22	0	0	Project Iowa-94GR			
P-11	Ottumwa	Wapello	Ottumwa	NPA	25	0	0	19.1	25.2	2,295	120
Region"D"											
P-13	Mental Health Institute	Page	Clarinda	STATE	0	1,246	0	483.1	76.9	349,743	724
P-13	St. Bernard's	Pottawat.	C. Bluffs	CH.	200	0	0	121.4	79.0	57,673	475
Region"E"											
P-12	Iowa Methodist	Polk	Des Moines	CH.	22	0	0	33.9	113.5	9,116	269
P-12	Hillcrest (Retreat)	Polk	Des Moines	NPA	0	0	50	51.1	78.2	14,266	279
P-12	Broadlawns Polk Co.	Polk	Des Moines	COUNTY	19	0	0	9.5	93.1	6,455	679
P-12	Mercy	Marshall	Marshalltown	CH.	22	0	0	Project Iowa-95			
	Statewide Totals for Nervous/Mental Facilities ---				694	3,565	1,399	xx	xx	1,654,180	8,192

(1) Project Iowa-81. Occupancy based on 250 days operation.
(2) Project Iowa-68. Occupancy based on 60 available beds.

RELATIVE NEED REPORT

IOWA

14TH REVISION IOWA HOSPITAL PLAN
NERVOUS AND MENTAL FACILITIES

1 JULY 1961

BASIC REGIONAL DATA			BED ANALYSIS				"O" % PRIORITY ANALYSIS		
AREA	POPULATION CENTER	POPULATION	EXISTING ACCEPT. BEDS	TO BE ADDED TREAT.	TO BE ADDED T'M'T'G	TO BE ADDED TOTAL	% NEED MET	RURALITY FACTOR	INCOME FACTOR	GROSS FACTOR
INTENSIVE TREATMENT FACILITIES										
P-2	Spencer	135,588	0	136	0	136	0	1.4433	0.9737	2.4170
P-3	Fort Dodge	170,295	0	170	0	170	0	1.3623	1.0012	2.3636
P-6	Dubuque	138,746	0	139	0	139	0	1.0769	1.0778	2.1547
P-12	Des Moines	621,788	63	559	580	1,202	5.24			
	Methodist	(22)								
	Broadlawns	(19)								
	Marshalltown	(22)								
P-4	Mason City	169,809	16	154	0	170	9.41			
P-7	Cedar Rapids	227,996	31	197	90	318	9.75			
P-8	Iowa City	76,782	87	(-10)	889	966	9.90			
P-5	Waterloo	269,715	32	238	0	270	11.85			
P-9	Davenport	218,845	35	184	10	229	15.28			
P-11	Ottumwa	146,493	25	121	0	146	17.12			
P-10	Burlington	109,957	22	88	0	110	20.00			
P-1	Sioux City	207,548	49	159	10	218	22.48			
	St. Jos. Mercy	(30)								
	Methodist	(19)								
P-13	Council Bluffs	263,943	200	64	20	284	70.42			
SUBTOTAL INTENSIVE TREATMENT			560	2199	1,599	4,358				
LONG-TERM MENTAL INSTITUTIONS										
"A"	Cherokee=	513,441	1272	50	0	1,322				
"B"	Independence	806,276	560	615	0	1,175				
"C"	Mt. Pleasant	552,087	621	559	0	1,180				
"D"	Clarinda	263,943	1246	0	0	1,246				
"E"	Des Moines	621,788	0	200	0	200				
SUBTOTAL LONG-TERM CARE UNITS			3699	1424	0	5,123				
PLANNING RESERVE FOR FUTURE CONTINGENCIES										
If/when state mental care is reorganized to provide qualified autonomous administration by a professional psychiatrist and with appropriate advisory guidance, refinement and adjustment will be made in the state hospital plan. These pool beds are reserved for future realistic assignment.										
SUBTOTAL CONTINGENCY				4007	300	4307				
GRAND TOTAL - STATEWIDE --		2,757,535	4259	7630	1899	13,788	30.89%			

No priority is provided in this group until state mental institutions are under a qualified autonomous director, assisted by an appropriate advisory body, and budgetary support is sufficient to assure a continuous intensive treatment program under competent and adequate staff in keeping with current standards of the American Psychiatric Association.

PART IV. PUBLIC HEALTH CENTERS

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

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

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

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

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

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

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

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

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

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

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

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

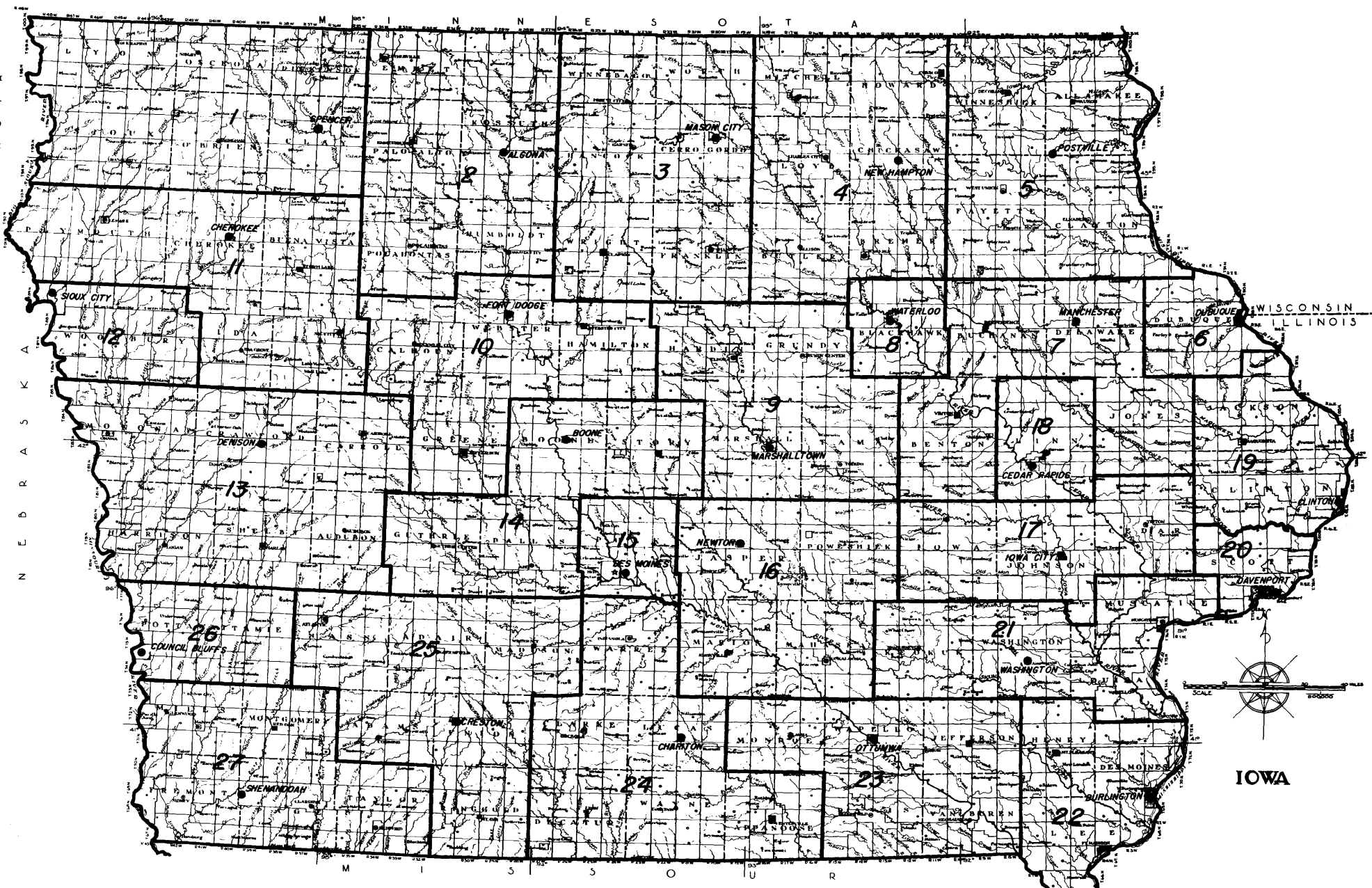
offered by a full-time health service will cause these counties to organize a full-time county health service first.

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

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

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

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



IOWA

PROPOSED PUBLIC HEALTH CENTERS

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

8

IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

PUBLIC HEALTH CENTERS REPORT

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS BY STATE RATIO IS 87

1 JULY 1961

IOWA

14TH REVISION

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

IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

1 JULY 1961

PUBLIC HEALTH CENTERS REPORT

IOWA

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS BY STATE RATIO IS 87

14TH REVISION

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

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IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

1 JULY 1961

IOWA

14TH REVISION

PUBLIC HEALTH CENTERS REPORT

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS BY STATE RATIO IS 87

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

IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

1 JULY 1961

PUBLIC HEALTH CENTERS REPORT

IOWA

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS BY STATE RATIO IS 87

14TH REVISION

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

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IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

1 JULY 1961

IOWA

14TH REVISION

PUBLIC HEALTH CENTERS REPORT

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS BY STATE RATIO IS 87

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

IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

1 JULY 1961

PUBLIC HEALTH CENTERS REPORT

IOWA

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS BY STATE RATIO IS 87

14TH REVISION

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

IOWA STATE DEPARTMENT OF HEALTH

DIVISION OF HOSPITAL SERVICES

1 JULY 1961

IOWA

14TH REVISION

PUBLIC HEALTH CENTERS REPORT

MAXIMUM NUMBER OF PUBLIC HEALTH CENTERS BY STATE RATIO IS 87

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

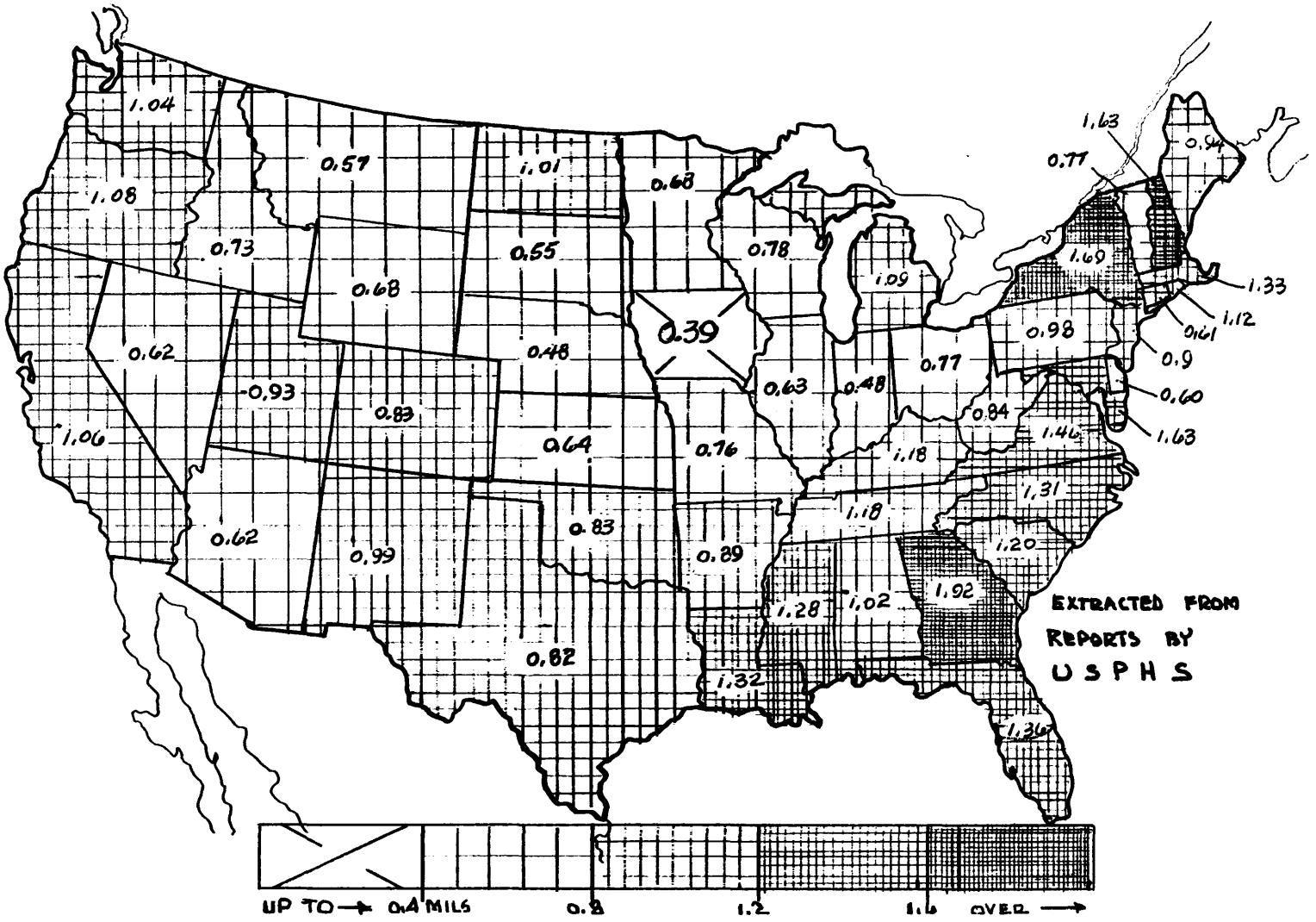
IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

RELATIVE NEED REPORT
PUBLIC HEALTH CENTERS
14th Revision

1. Page 1 of 1
2. Date July 1, 1961
3. State Iowa

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

MULTI-COUNTY UNITS		TAXABLE PROPERTY FACTOR	PER CAPITA INC. FACTOR	RURALITY FACTOR	PRIORITY FACTOR
NO.	LOCATION				
24	Centerville	1.1945	1.2612	1.4893	3.9450
5	Postville	1.0148	1.1593	1.6315	3.8056
14	Boone	1.0597	0.9620	1.7454	3.7671
25	Creston	0.9450	1.1376	1.5341	3.6167
4	New Hampton	0.9672	1.2139	1.3116	3.4927
13	Denison	0.8385	1.0599	1.5455	3.4439
1	Spencer	0.7754	0.9694	1.6376	3.3824
23	Ottumwa	1.3096	1.1118	0.9742	3.3956
7	Manchester	0.8858	1.1127	1.3299	3.3284
2	Algona	0.7528	0.9453	1.5513	3.2494
27	Shenandoah	0.8330	1.1393	1.2578	3.2301
16	Newton	1.0031	1.0541	1.1617	3.2189
21	Washington	0.9995	0.9752	1.2353	3.2110
11	Cherokee	0.7203	0.9372	1.4989	3.1564
17	Iowa City	1.0241	0.8995	1.1770	3.1006
9	Marshalltown	0.8013	0.9447	1.3511	3.0971
10	Fort Dodge	0.8202	0.9738	1.2210	3.0150
3	Mason City	0.8284	0.9308	1.2171	2.9763
19	Clinton	1.0728	0.9763	0.8457	2.8948
22	Burlington	--Existing Facility--			



GRAPHIC COMPARISON OF STATES FOR FISCAL 1959

EXPENDITURE FOR PUBLIC HEALTH

EXPRESSED IN MILLS OF AVERAGE PER CAPITA INDIVIDUAL INCOME

(IE- DOLLARS PER THOUSAND DOLLARS OF INDIVIDUAL INCOME)

IOWA STATE DEPT. OF HEALTH
DIV. OF HOSPITAL SERVICES

PART V. HOSPITALS FOR CHRONICALLY ILL AND IMPAIRED

In the course of hospital development in Iowa during the past 15 years, the impact of aging has been duly noted. It is a major topic in those circles interested in this phase of our society. The 1960 census shows Iowa as having the highest percentage of population over age 65 (11.9% of total population.) Quite probably the public concern is increasing and there has been much dissemination of information regarding possible answers to problems that are developing at both local and state levels. Unfortunately the term "gerontology," while discussing the problems of aging, has been interpreted by many as being synonomus with chronic illness and its reference to the degenerative diseases. Permit us to point out that the term "hospital" includes general, tuberculosis, mental, chronic disease, and shall be restricted to institutions providing community service for inpatient medical and/or surgical care of the sick or injured.

The definition for chronic disease hospital more specifically refers to a hospital for the treatment of chronic illness, including the degenerative diseases, and that such treatment and care is administered by, or under the direction of, persons licensed to practice medicine or surgery in the state. The term does not include facilities primarily for the care of mentally ill or tuberculosis patients, nursing homes and institutions, the primary purpose of which is mere domiciliary care.

As a result of the confusion which exists in the minds of certain people, considerable discussion and even planning has been misdirected toward community intent to provide an answer in the social sphere of housing for their aged residents. Only recently would it appear that community planning is finally identifying properly the difference between the facilities oriented medically as opposed to those oriented to social problems.

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. In addition, accident rates have caused some 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 of 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 other purposes 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

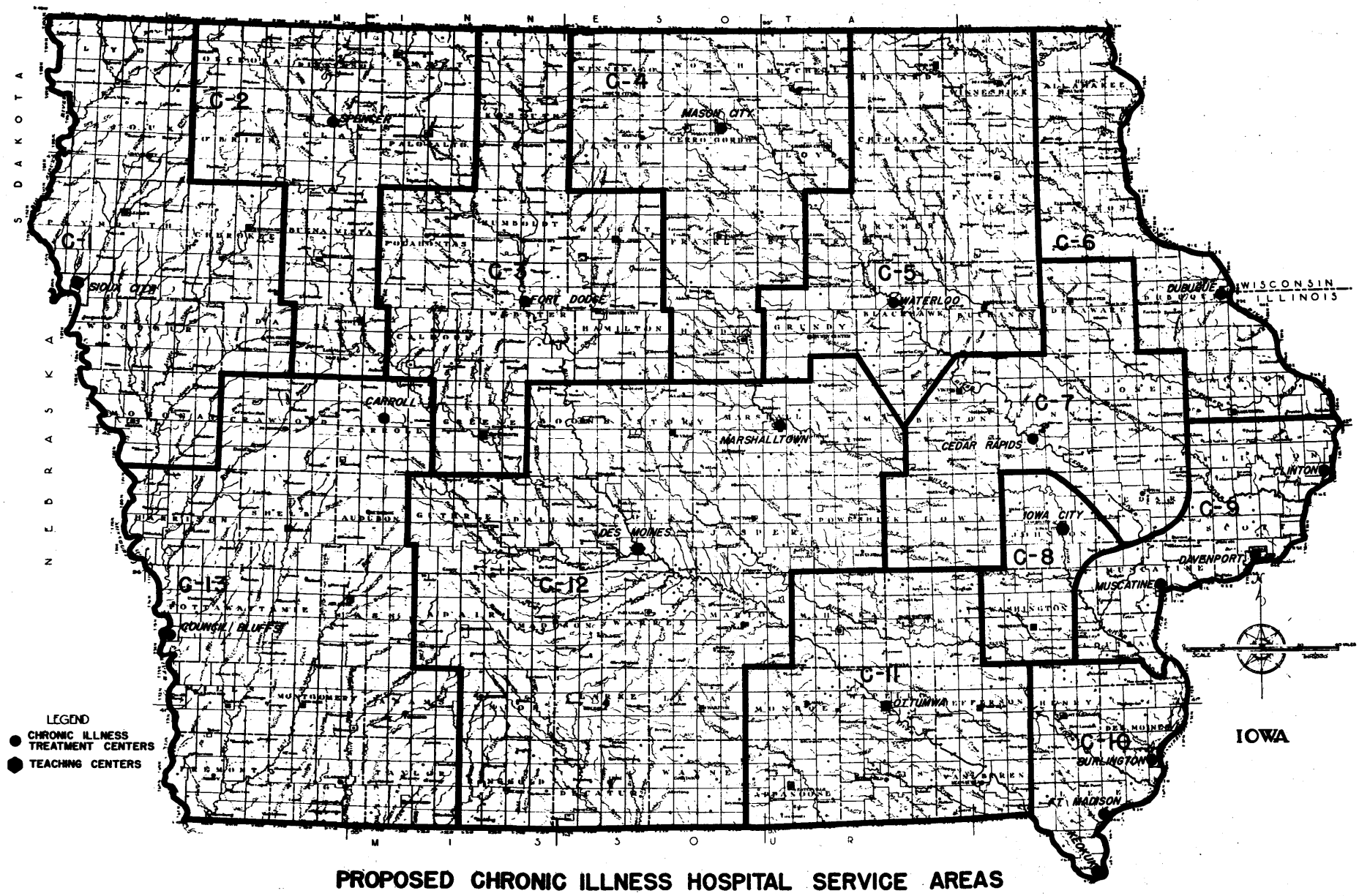
2. description of complete related services realistically contiguous to the primary activity, including logical and adequate therapy facilities.

3. availability of qualified professional staff

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

5. prospectus of resources for construction and 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 merits of the applicant's total presentation, as it sets forth physical facilities, adequacy of staff and personnel, and program of operation.



PROPOSED CHRONIC ILLNESS HOSPITAL SERVICE AREAS

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

1 JULY 1961 IOWA
PAGE 1 OF 1

SUITABILITY REPORT ON Chronic Illness HOSPITAL BEDS AND OR FACILITIES

REGION Statewide

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	BED CAPACITY			PAY-DAYS NO. OF PER ADM REQUEST	% OCCUP.	USAGE DATA	
		COUNTY	TOWN		SUITABLE	REPLAC.	UNSUIT.			PATIENT-DAYS	ADMISSIONS
C-1	St. Joseph Mercy	Woodbury	Sioux City	CH.	0	25	50	315.7	79.6	21,785	69
C-2	Community Memorial	O'Brien	Sheldon	NPA	40	0	0	Project Iowa-103			
C-2	Buena Vista County	B. Vista	Storm Lake	CO.	49	0	0	Project Iowa-110			
C-7	Virginia Gay	Benton	Vinton	CITY	48	0	0	Project Iowa-104			
C-8	University Hospitals	Johnson	Iowa City	STATE	0	738	0	12.2	83.6	225,077	18,467
C-8	U. Sch. f/Severely Handic.Ch.	Johnson	Iowa City	STATE	51	0	0	67.3	89.8	13,249	197(1)
C-8	Mercy	Johnson	Iowa City	CH.	43	0	0	31.1	31.1	5,690	183
C-9	Mercy	Scott	Davenport	CH.	86	0	0	85.8	68.4	21,466	2,502
C-10	St. Joseph	Lee	Keokuk	CH.	26	0	0	Project Iowa-91			
C-11	Ottumwa	Wapello	Ottumwa	NPA	46	0	0	70.2	45.9	7,723	110
C-12	Iowa Methodist	Polk	Des Moines	CH.	120	0	0	78.0	26.2	11,469	147(2)
	Statewide Totals --				509	763	50	xx	xx	300,769	21,675

(1) Program operates 295+ days per year
(2) Project Iowa-65GC. Partial operation during staff organization and personnel training period.

RELATIVE NEED REPORT
14TH REVISION- IOWA HOSPITAL PLAN
CHRONIC ILLNESS FACILITIES

IOWA
1 JULY 1961

BASIC REGIONAL DATA				BED ANALYSIS				"O" % PRIORITY ANALYSIS		
AREA	POPULATION CENTER	POPULATION	EXIST'G SUITABLE BEDS	TO BE ADDED TREAT.	TO BE ADDED T.C.H'S	PROPOSED TOTAL	% NEED MET	RURALITY FACTOR	INCOME FACTOR	GROSS FACTOR
C-3	Fort Dodge	170,295	0	170	---	170	0	1.0013	1.3623	2.3636
C-13	Council Bluffs	263,943	0	264	20	284	0	1.1055	1.2261	2.3322
C-4	Mason City	169,809	0	170	0	170	0	0.9981	1.2490	2.2471
C-6	Dubuque	138,746	0	139	0	139	0	1.0778	1.0769	2.1547
C-5	Waterloo	269,715	0	270	0	270	0	1.0225	0.9636	1.9861
C-12	Des Moines	621,788	120	502	580	1,202	9.98			
C-1	Sioux City	207,548	25	183	10	218	11.47			
C-7	Cedar Rapids	227,996	48	180	90	318	15.09			
C-10	Burlington	109,957	26	84	0	110	23.63			
C-11	Ottumwa	146,493	46	100	---	146	31.51			
C-9	Davenport	218,845	86	133	10	229	37.72			
C-2	Spencer	135,588	89	47	---	136	65.44			
C-8	Iowa City	76,782	832	34	106	972	85.59			
	Treatment OF 77		(43)							
	Teaching OF 895		(789)							
STATEWIDE TOTALS --		2,757,535	1,272	2,276	816	4,364	29.15			

SUMMARY OF COMPOSITE TOTAL OF LONG TERM NURSING BEDS - (CHRONIC PLUS NURSING HOME)

CATEGORIES OF AREA RATIOS	EXISTING BEDS WITHIN AREA RATIO	EXISTING BEDS BEYOND AREA RATIO	PROPOSED BEDS TO BE BUILT	TOTAL BEDS PROPOSED
Chronic Beds				
Treatment= 1/1000 Population	483	---	2,275	2,758
Teaching= 5/Post.Grad.Yr.Man	789	---	816	1,605
Nursing Home Beds				
3/1000 Population	2,563	170	5,712	8,445
Pool Beds				
Basic 1/1000 Pop. = 2,758				
Less Teaching - 1,605				
Less N.H. Beyond Ratio - 170				
Net Pool Beds Remaining 983	---	---	983	983
Statewide Summary of Long-Term Beds --	3,835	170	9,786	13,791

EXHIBIT D

MEDICAL FACILITIES

Previous paragraphs have discussed resources and needs in terms of hospital facilities, both acute general and specialized, as we find them today. 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 social institution which, 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, and care for the infirm was administered by the younger generations.

Because of transportation limitations, the demands on the doctor's services and time became excessive. He therefore 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. Today the state, generally speaking, has a reasonable pattern of hospital facilities, thus removing most care activities 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, with guidance from the best consultants available, provided means and funds for psychiatric treatment. Unfortunately for Iowa, the established responsibilities have been increasingly neglected and the 1870 goal has been aborted. The original outmoded pattern continues 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 fortunate, in terms of tuberculosis beds, for its total bed needs are met. 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 aging are major contributors 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 this problem by industry, all echelons of government, and by leaders of the various population groups. The National Government is gravely concerned with the aging population trends of the country as a whole. Iowa is faced with circumstances and trends which are even more critical than those of the nation as a whole.

A corrective plan must apply effort in several directions:

1. Inaugurate preventive steps which will maintain the able bodied to a maximum extent.

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

3. Reconsider (and probably extend) age of retirement permitting capable persons to continue working 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 develop their economic self-sufficiency to the maximum extent that their capabilities will permit.

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

In continuing to develop a program for facilities capable of providing the complete health program, it has been realized that the standard facilities must be complemented with added services. The original Hill-Burton Program was amended to stimulate development of such ancillary services in 1957. New categories of facilities were induced into the programming and included rehabilitation, diagnostic and treatment facilities and nursing home facilities. Simultaneously, a newer trend in hospital care has given increased emphasis to the philosophy of progressive care whereby gradation of patient services was broadened to realize effective grouping of patients in terms of nursing care needs.

The Iowa legislature did create permissive legislation enabling this state agency to participate in the broader Federal program. The categorical grants in the Federal program provide an artificial limitation which somewhat restricts the effectiveness of the funds. However, some worthy projects have resulted and are very illustrative of the possibilities of related health facilities elements in the Federal program.

The following pages set forth the inventory of needs in these several categories and the proposed new construction which can fulfill the needs of the state in a reasonable fashion to make these services available to all residents of the state.

To provide a program which pursues the above points, available facilities and personnel must be utilized with maximum efficiency and supplemented quite deliberately. Such a transition will take appreciable time for expedient patterns of the past have accumulated a tremendous reserve of chronic/aged persons in domiciliary-type facilities in the state.

In 1957, the 57th General Assembly was shocked into some activity when sixteen persons lost their lives in a fire which destroyed a domiciliary facility during the legislative session. Certain regulatory powers were created and standards were drawn up to inaugurate a program of correction. The 58th General Assembly (1959) tended to revert to the old pattern by attempting to delete a large segment of the domiciliary institutions from regulation and by failing to provide suitable budget. In general, there has been no great progress.

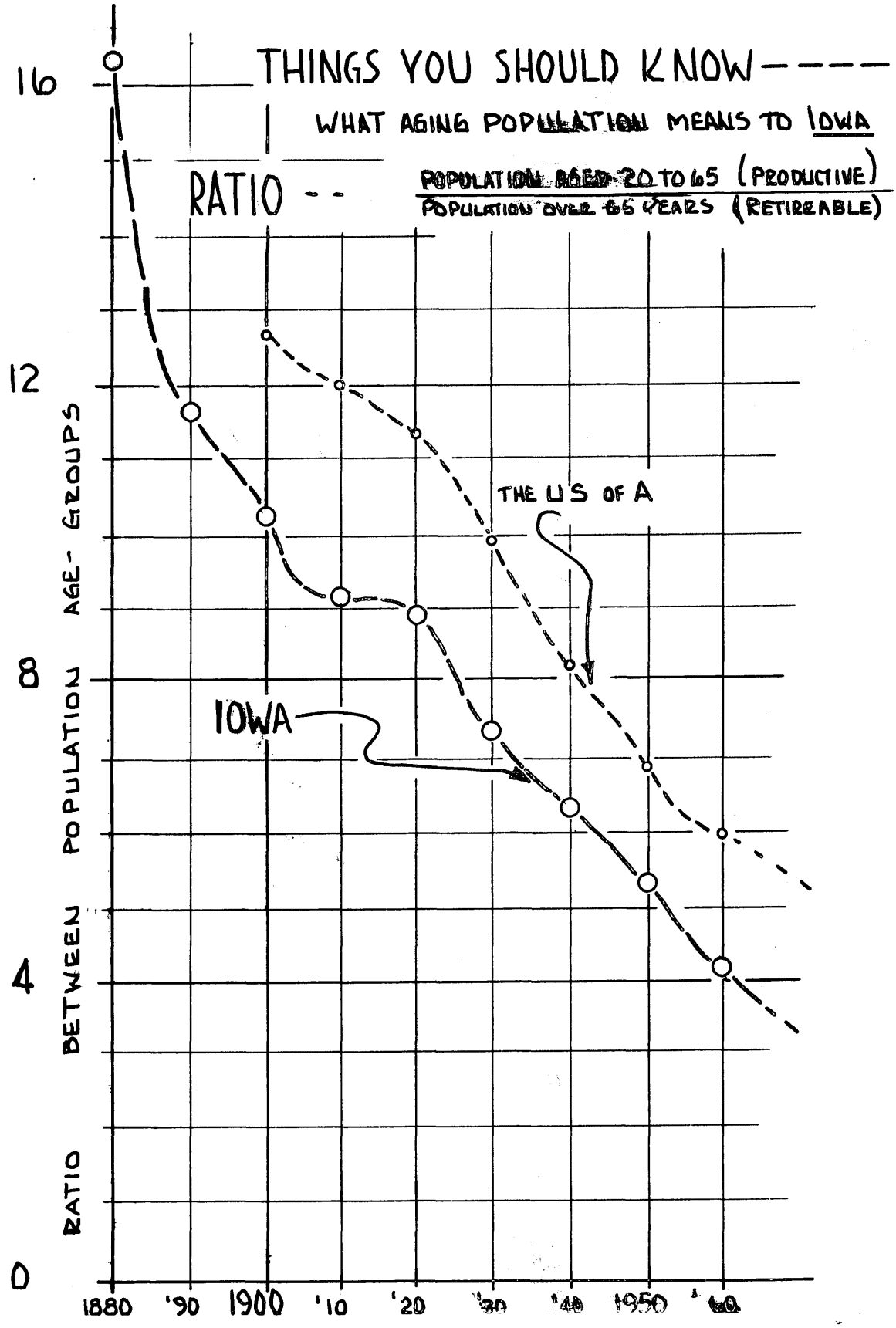
The Federal Grants Program has been the basic means of tempting the thinking of communities toward aggressive planning which will provide a balanced and complete program of patient care. Each of the services approaches a total answer which will serve the complete gamut of needs. Several smaller communities have provided nursing homes units attached to acute general hospitals. These prove most admirably that the infirm bedfast patient is not necessarily a hopeless terminal case. Many patients already have been treated and encouraged to a point where they are capable of administering to their needs and able to return to normal activities and living outside the nursing home.

At the other end of the line are the very complete hospitals who provide specialized treatment to the acutely ill, to the physically impaired, the mentally ill and the chronically ill. By coordinating these specialized services and an array of professional talents within a properly equipped facility, patients are diagnosed, treated intensively and retrained to the maximum of their limitations,

thus permitting them to return to normal activity appropriate for their circumstances .

The added facets beyond the acute general, the psychiatric, the tuberculosis and chronically ill facilities are incorporated in such a total program through Part "G" of the Hill-Burton Program. Categorical grants are available (in limited amounts) to provide adjunct services in the fields in rehabilitation, diagnostic and treatment facilities and nursing homes. A combination of all of these elements in proper proportion will provide an effective answer to meet the total need while utilizing existing resource and personnel at maximum economy. It is a direct corrective answer to the failure perpetuated by our past social performance which grew under the guise of economy but which actually created an overbearing burden.

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



GRAPHIC COMPARISON OF TRENDS IN AGE GROUPS AND POSSIBLE IMPACT ON RESPECTIVE ECONOMIES.

IOWA STATE DEPT OF HEALTH
BUREAU OF HOSPITAL SERVICES

PART VI NURSING HOMES

A 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 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."

The term "nursing home" is applied by the public to a great variety of establishments. Most of this confusion stems from the earliest definition (1947) in the Iowa Code. In 1959 the definition in the Iowa Statutes was upgraded but continues to be something less than the definition by the Federal Agency. As a result, the average concept of nursing home and the services to be expected from same is inferior to that intended by this program and will range from the establishment providing care comparable to general hospital service down through that which involves only slight supervision by professional personnel while the patient provides for virtually all of his needs.

In the smaller nursing homes this complete range of services quite probably will have to be available, thus realizing only little difference in operational costs. In the larger installations it will be possible to segment these service gradations into units, geared directly to a specific degree of nursing care, so that the saving in operational cost and personnel time can be passed on to the consumer/individual.

Beyond this point is still another classification of institution, the need for which is becoming increasingly apparent. The population group referred to as "Senior Citizens," "Golden Agers," the "Aged and Infirm," or the "Retired" primarily need and demand housing of a nature which will take care of everyday living and will include social activities, interests, stimulants, and services aimed directly at their needs. This falls within the statutory definition of "Custodial Home" which is defined in an earlier section of this plan. It is also that element for which the Federal Housing Administration is providing answers under the name of "Home for the Aged." These classifications should not be construed as being medical facilities but more properly described as another phase of public housing in our present pattern of society. It is more aptly referred to as a social need rather than a medical care need.

The point which should be constantly borne in mind, that the institution which provides housing for specialized groups dominated by the aged, is that these same institutions are extremely vulnerable to the attrition of human aging. While the residents are able bodied and quite self-sufficient when entering these homes, it is only realistic to foresee the percentage of "down time" for each resident increasing progressively so that in from two to five years their primary needs will be nursing home services.

Homes for the aged, custodial homes, and other comparable housing facilities are normally not readily adaptable to provide nursing home services. As a result there is a constant tendency to compromise nursing home standards when providing expedient nursing service in ill-conceived layouts and structural arrangements.

What was initially expedient will ultimately be commonplace and routine. The end result of this inevitable progression is the excessive expenditure of professional personnel time and the excessive drain of individual resources while the patient receives something less than the care his case requires.

The logical approach is that facilities which are designed to attract and accumulate older population groups be patterned in such a way that if and when the need arises, the structure can readily be modified to nursing units which are sized large enough for efficient operation, which will provide the means for room layouts capable of properly accommodating patients' needs and which can readily be upgraded in terms of plumbing and other considerations to provide appropriate utility services.

Another feature which is becoming increasingly evident is that the most effective nursing home service is that unit appended to an acute general hospital and thus functions with maximum correlation to hospital services. By having many services common to the two elements, savings can be appreciable and the quality of medical and nursing supervision improved while meeting the patient's needs. Costs which can thus be prorated over a greater number of beds include food service, laundry, boiler plant operation, staff and administrative services. The end result will provide a broader range of service facilities to more efficiently meet the patient's total needs.

The evolution of the "nursing home" as defined by Iowa law goes back a number of years. Initially, a quasi-institution 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 and nursing homes to receive non-violent mental patients who had been released by State Mental Institutions after five years of residence if they were declared "incurable." The homes provide no treatment that might permit improvement. County administrations are quite willing to utilize their county homes for housing returnees for the monetary allowance granted. The unit cost to the county is slightly less, while the patient receives no semblance of treatment.

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 survey activity in the area of nursing homes for this revision it is increasingly evident that there are many establishments other than licensed nursing homes which imply merely domiciliary accommodations but who actually accommodate and attract persons more reasonably classed as patients requiring skilled nursing care. Failure to better classify this "gray zone" is

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attributable to several things:

1. The State Agency's staff, being limited, is unable to fulfill all of the duties assigned by the legislature without a budget more realistically in keeping with the workload.

2. Present statutes, being an accumulation of enactments by many legislative sessions of the past, provide only limited regulatory authority and ill-defined intent.

3. Reluctance of certain interests precludes correction of the statutory inadequacies and discourages aggressive legislative action which could correct many deficiencies.

In spite of this, there is sound reason to believe that there exists a tremendous area outside the zone of licensing activities which represents an appreciable need for nursing home facilities. An effort was made to give recognition to this ill-defined patient load in the Inventory of Nursing Home Facilities. The end product convinces us that a minimum of 20,000 beds are needed at this precise moment and the optimum need would be something greater than 20,000 beds.

In late 1958, the Governor's Study Committee on "Care of the Aged" (State of Iowa) did submit their preliminary report of findings. The study was never intended to be a complete and precise investigation but rather a rapid, over-all measure of facilities, demand, needs, and shortcomings in areas related to the older age group of our population. For your information we are quoting a series of gems of information revealed by this study group which are indicative of their over-all findings. They are as follows:

"FACTS ABOUT OUR AGING POPULATION
YOU SHOULD KNOW"

1. There are 623 licensed nursing homes in Iowa.
2. There are 11,404 beds in these licensed nursing homes.
3. There are 140 licensed custodial homes in Iowa. (Incomplete)
4. There are 2,713 beds in licensed custodial homes in Iowa. (Incomplete)
5. There are no census figures for the number of persons living in nursing homes, but their number is estimated at 19,715.
6. That the total population in all Iowa state mental institutes for July 1, 1956 was 4,182.
7. That 32 per cent of all first admissions to mental institutes in Iowa were 65 years of age.
8. That Iowa seems to have the second highest rate of first admissions to mental institutions, of persons over 65 years of age, of any state in the nation.
9. That the number of persons in state mental institutes over 65 years of age, in the 1956-57 period was 32 per cent of the total population.
10. That the cause of first admission to mental institutes is 30 per cent for senility, 41 per cent for arteriosclerosis of persons over 65 years of age.
11. That on July 1, 1956 33 per cent of all patients in mental hospitals were 65 years of age or older.
12. That 55 per cent of all patients over 65 years of age dying at mental institutes are hospitalized one year or less.
13. That no separate statistics are kept in Iowa of the cause of death of patients in nursing homes.
14. Three counties, Ringgold, Harrison and Madison have leased their county homes to private nursing home operators.

15. That in 62 counties the social welfare director is also county overseer of the poor.
16. That counties are not required by law to make a report to the state of funds spent by them for poor relief.
17. That population trends indicate by 1967 that 11.6 per cent of the Iowa population will be past 65 years of age.
18. That in 1950 there were eight counties which had a population in which 14 per cent or more of the people were past 65 years of age, and that in one county 16 per cent of the people were past 65 years of age.
19. That the number of persons receiving old age assistance in Iowa in October, 1958 was 36,628.
20. That the average old age assistance grant in Iowa in October, 1958 was $67.55.
21. That some Iowa counties are supplementing old age assistance grants because the cost of nursing home care is greater than the grant.
22. That most nursing homes in Iowa are of wooden construction and were originally built for homes.
23. That the maximum grant of the social welfare department for nursing care for old age recipients is $112.50.
24. That the cost per month of care of persons in Iowa institutions in 1957 is as follows: Soldiers' Home $153.26; Cherokee $139.04*; Clarinda $119.27*; Mt. Pleasant $125.12*; Independence $163.68*; Toledo $118.23*; Davenport $117.08*; Glenwood $84.07*; Woodward $96.74*; Eldora $187.83; Anamosa $123.57; Ft. Madison $98.97; Rockwell City $256.44; Mitchellville $232.86.

* As of September 30, 1958

While the report submitted by the Study Committee is somewhat voluminous we are including the Summary of Recommendations which were the conclusion of that body:

"SUMMARY OF RECOMMENDATIONS"

1. That there be created workshops on an area basis to provide training for nursing home operators and their employees.

2. That there be enacted a Joint Resolution by the Legislature declaring a moratorium on the use of state, county or municipal tax funds for the purpose of building new state hospitals and mental institutions, the building of any new county homes or the building of hospital wings devoted to the care of the aged in city or county hospitals for a period of three years.

3. The creation by an executive order of the Governor of an interdepartmental agency consisting of representatives of agencies of different departments of state government dealing with the aged.

4. The establishment of a program for the gathering of statistics relating to the operation of nursing homes and other problems relating to the aged in the Division of Vital Statistics in the State Department of Health and the enactment of legislation if necessary, requiring such reports.

5. A program aimed at the elimination of conflicts, the overlapping and the inequities in the Iowa law and in its administration by state and local agencies.

6. Study followed by legislation to achieve uniform standards by counties in the supplementation of old age assistance grants from county poor funds.

7. A study followed by action to create a program whereby relatives may legally supplement old age assistance grants in excess of the standard set by the state, without penalty to the recipient.

8. The elimination of the county poor fund and the creation of a joing county and state fund to provide for the relief of needy persons.

9. A study of the advisability of a state matching grant and a state revolving fund to build nursing homes, either by local units of government or by private individuals.

10. That the Social Welfare Department establish a program whereby patients released from state mental institutions or senile patients received by them, are not intermingled with patients of normal mental capacities.

11. That legislation be enacted after the 1961 President's Conference, providing for the erection of a substantial number of medium sized publicly supported nursing homes for the care of patients released from the state mental hospitals who still require a sheltered type of living, and for the care of senile persons who cannot successfully and happily live in a normal society because of the eccentricities resulting from age, but whose condition does not warrant their being committed as insane persons; these homes to serve as half-way houses for persons going or coming from normal society to state hospitals; with the purpose that state mental hospitals may become true hospitals as distinguished from custodial institutions.

12. Legislation providing for the supervision and protection of funds held by private retirement programs created by employers or employees.

13. Legislation defining the status of non-profit nursing homes so far as tax exemption is concerned at both the state and federal level.

14. In view of inflation, legislation should be enacted increasing the amount of liquid assets which an old age recipient may hold in reserve from $300.00 to at least $500.00.

15. The Extension Service should be asked to explore the possibility of extending service in the field of arts and crafts to elderly people.

16. Libraries should develop a program in connection with churches or service clubs for the delivery and collection of reading material to shut-in persons.

17. The establishment of an educational program through the Department of Education and the Extension Service to teach older people and children and the public generally, the necessity for special diets, safety programs and the creation by churches, fraternal orders and service clubs of local programs aimed at preventing isolation and lonesomeness which result in health problems for older people.

18. A Joint Resolution by the 1959 Legislature providing for a citizens' committee and to formulate recommendations for the President's conference in 1961.

19. Provide the Health Department funds for staff to inspect nursing homes.

20. Legislation authorizing counties or municipalities to build and operate nursing homes.

21. To make provision, either in the Division of Vital Statistics or in the Division of Hospitals and Homes, for a continuing study of the cost and care of nursing homes.

22. The Social Welfare Department to consider and establish an experimental program which would encourage voluntary cooperative existence by recipients of old age assistance and to encourage them to share house accommodations and costs.

23. To encourage old age recipients whose health permits to accept a greater amount of employment without penalty.

The above-mentioned report was placed in the hands of each member of the legislature during the first week of the legislative session, Spring 1959, 58th General Assembly.

In spite of considerable interest from organizations and public spirited groups, no legislative enactment was realized in keeping with the Governor's Study Committee Recommendations.

Since 1957 when the statutes of Iowa were modified to create a realistic definition for nursing homes, this State Agency did develop rules and regulations for nursing homes and custodial homes in terms of licensing requirements. Because this involved upgrading of standards from those previously existing for nursing homes, considerable time was involved in moving forward. It should be understood that at this point the transition is not complete. Considerable progress has been realized in spite of staff limitations and budget inadequacies.

The nursing home construction 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 has been realized in this field with this limited resource is that several representative establishments were stimulated and created to illustrate the tremendous possibilities of the nursing home in meeting the demands of the state.

The most obvious point of application is creating nursing homes in conjunction with existing hospitals in rural areas. These institutions 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, can 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 had hardly 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.

The above philosophy was first set forth in the 10th Revision, Iowa Hospital Plan dated 1 July 1957. Currently ten nursing home projects have started within the grants-in-aid program under the hospital facilities section. There are still other nursing home projects with the assistance of funding through the Federal Housing Administration. Private enterprise has also started several projects, utilizing commercial loan agencies in their financial structure. These provide a tremendous range of refinement in services. For the most part, those outside the grants program elude the true intent of the nursing home as we have described it in earlier paragraphs. Those nursing homes within the grants program which are in operation are admirably proving the point that has been made. Facilities directly related to hospital services demonstrate the merit and value of well qualified medical and nursing super-

vision in that patients are restored to near normal self-sufficiency and those qualified are returned to their normal manner of living and their usual activities. However, the work, statewide, that has been accomplished up to this point is relatively insignificant and does nothing more than show the possibilities in this total area. The field, generally speaking, is virtually untouched and there is little possibility of overextending in nursing home construction in the foreseeable future.

The possibilities outlined above have been recognized and resultant interest was reflected in action by the 59th General Assembly (1961). Permissive legislation now authorizes county, city and publicly owned memorial hospitals to issue bonds and finance construction of nursing home units adjunct to their hospital facilities. Approximately 20 publicly owned hospitals have already indicated interest and intent to broaden their service facilities to incorporate worthy nursing home units. Quite probably there are others who, unknown to this agency, are also pursuing their possibilities in the light of this very recent authorization.

Relative priority among the service areas of the state is reflected in the following pages titled "The Relative Need Report for Nursing Homes." Criteria for determining relative priority is based on population data and the unmet bed need. Because two-thirds of the state's service areas have no suitable or replaceable facilities (0.0% need met), the zero areas were further evaluated in terms of their per capita income and degree of rurality. The most rural community with the lowest per capita income is given the greatest perference in receiving grants-in-aid.

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 who will sponsor or motivate nursing home construction within the communities.

As has been stated previously, the goal of this entire program is to realize maximum utilization of the individual's resource toward acquiring appropriate treatment, rehabilitation, and his returning to a productive position in his community. The position of the nursing home is to provide that required skilled nursing care to the long-term convalescent, thus extending the individual's resources to a maximum in realizing his ultimate re-establishment as a productive citizen.

In evaluating the nursing homes in the inventory of the state, criteria have been utilized as rules of thumb. The replaceable units are in three general groups:

1. The proprietary licensed nursing home, which complies with normal statutory requirements, is housed in a fire resistant structure and might qualify as a true nursing home if admission procedures, degree of skilled nursing care and/or medical supervision are established/upgraded to conform with the standards of the Federal Register. The structures themselves may be readily adaptable and acceptable for true nursing home purposes.

2. The licensed nursing homes operated by charitable or nonprofit organizations housed in fire resistant structures which conform with the nursing home needs. If the admission procedures, care policies, degree of skilled nursing care and/or medical supervision are upgraded, these also might be classed as nursing homes as defined.

3. The county home housed in a fire resistant structure if the structure can be readily modified for nursing home purposes. Too frequently the location is away from responsible and appropriate hospital service. In some instances the structures could be further partitioned to provide appropriate patient rooms properly related to nursing services. However, these establishments too frequently lack appropriate medical supervision and skilled nursing care, their services are barely sufficient to meet domiciliary care needs, and there is no semblance of treatment facilities.

In the light of the above circumstances replacement, upgrading, expansion and/or relocation are definitely in order for those units classified as replaceable within the inventory before the care and treatment offered by these facilities are sufficient to be considered adequate in rendering approvable community service.

In addition to the points described in other parts of this Plan which are necessary to support an application for Federal grants, the following specific points are elements for consideration in the case of nursing homes. A concise and detailed narrative program shall clearly state all facets of the eventual operation. The program shall give positive assurance of the precise staff which will be made available with outlined job descriptions for the registered nurses positions on the staff. There shall be firm statements indicating the competence and adequacy of the medical staff which will support the nursing home activity and which will assure appropriate medical supervision. The narrative program shall describe quite distinctly all professional personnel assignments which will be made. This shall be correlated with the description of the diagnostic procedures and realistically adequate facilities which will be available to the operation. The same applies in describing the medical rehabilitation services which will become a part of the nursing home operation. To clarify the community service aspect of the proposal, there shall be a complete description of the admitting standards which will become the governing rule as well as the principles and standards which will govern the discharge of patients. To support the administrative phase of operation, specific points shall be made in describing the plans for developing medical history at admission and the continuance of the patients' medical records. Application Part I and the narrative description shall be supported by the bylaws appropriately drawn up in keeping with their corporate requirements which will guide the manner of governing the nursing home unit.

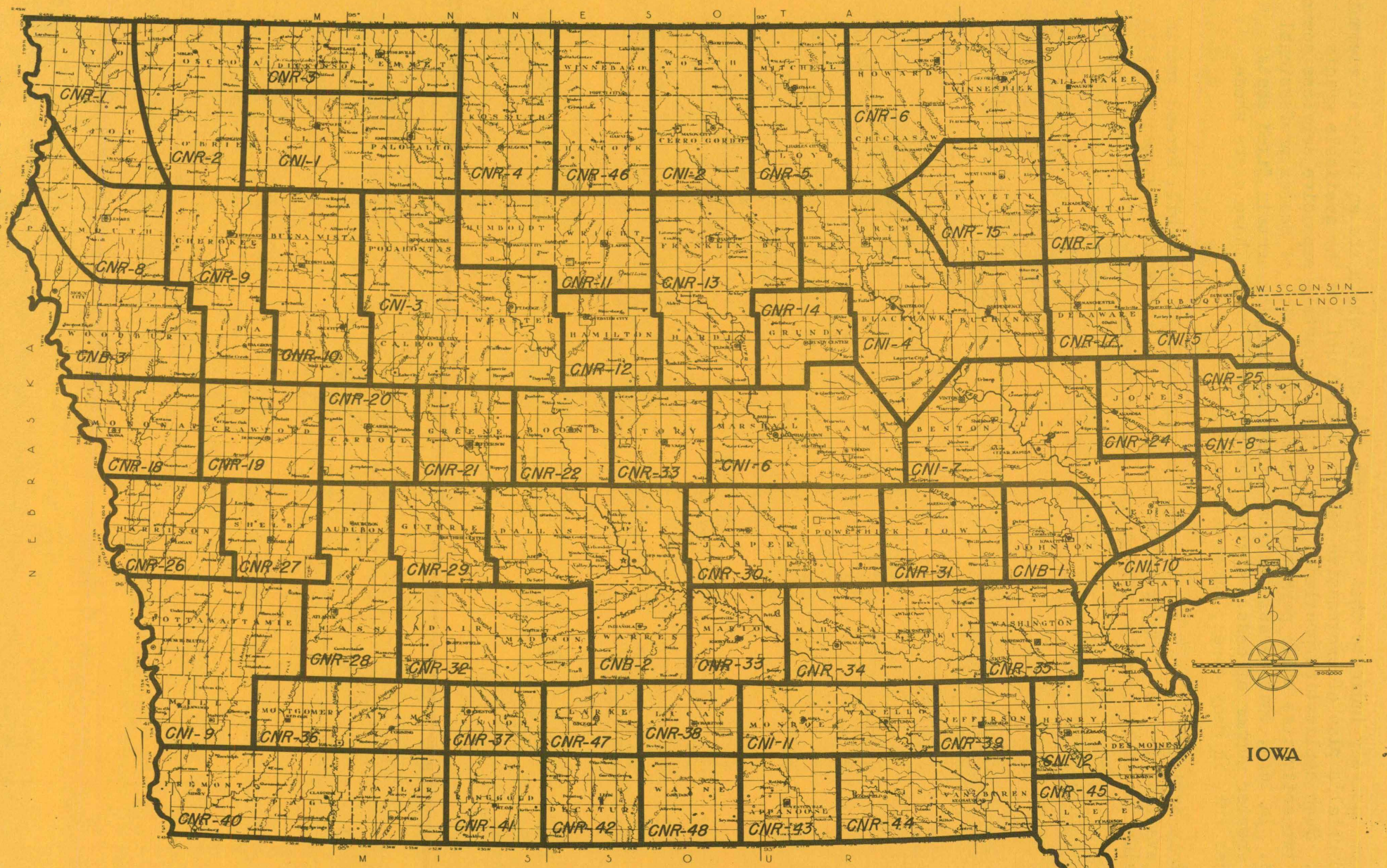
In other words, the narrative program for a nursing home application shall be sufficiently detailed and distinct to preclude questions of the Advisory Council, thus permitting that body to accurately evaluate the relative merit of all approvable nursing home applications and fairly determine those qualified for consideration in the allotment of the limited categorical moneys available to Iowa.

This same narrative program can go far in guiding the designer during the schematic stages. It should not be construed to be superfluous in the over-all development of a well-organized and realistic nursing home program.

Because the grants moneys available for the category of long-term nursing beds is relatively limited and far less than the demand within the state, the Plan is hereby qualified to stipulate that maximum consideration will be given to applications proposing projects planned integrally with a hospital operation. In so doing, hospital services, extended administrative control and standards, existing policies, bylaws, grade of care and the competent personnel and staff of the existing hospital will guide the long-term care operation toward the most appropriate nursing care. Observations and experience during these past five

years conclusively indicate that long-term care units which are an integral element of a hospital's plan of progressive care will best utilize the available grants moneys. Such application precludes duplication of certain expensive services common to the two activities while permitting maximum utilization of scarce professional talents. In turn, considerable economy exists in applying certain fixed costs over a greater number of beds. Savings can be passed on to those users whose resources are, in many cases, already over extended.

It is anticipated that the demands for nursing home funds will exceed grants moneys available. The priority table will govern the preference between areas in the evaluation of approvable nursing home applications.



PROPOSED AREAS FOR NURSING HOMES

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES (SUMMARY - STATEWIDE)

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

REGION STATEWIDE

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
Region A	Sioux City				212	300	405		165	0	89	
Region B	Spencer				44	69	352		37	0	71	
Region C	Fort Dodge				63	96	353		389	0	67	
Region D	Mason City				0	306	574		34	20	250	
Region E	Waterloo				72	54	716		22	20	282	
Region F	Dubuque				135	98	260		15	0	345	
Region G	Cedar Rapids				85	20	436		134	0	221	
Region H	Davenport				166	79	619		0	228	220	
Region I	Burlington				286	14	315		22	0	112	
Region J	Iowa City				0	25	186		65	0	75	
Region K	Ottumwa				0	0	462		0	0	199	
Region L	Des Moines				240	121	1,854		242	339	1,046	
Region M	Council Bluffs				208	40	824		125	0	227	
STATEWIDE	TOTAL (Licensed - over 10 beds)				1,511	1,222	7,356		1,250	607	3,005	
	39 Licensed Nursing Homes - under 10 beds (Avg. 6.7 beds/home)											
	161 Licensed Custodial Homes - under 10 beds (Avg. 5.0 beds/home								0	0	797	
	Plus (Estimated)											
	Unlicensed establishments probably existing and housing patients				0	0	1,500		0	0	2,500	
	County homes excluded from regulations but which properly should be incorporated in this tabulation				0	0	3,200		0	0	2,300	
STATEWIDE	GRAND TOTALS				1,511	1,222	12,316		1,250	607	8,602	
Subtotals	- for state - by category						15,049				10,459	

(1) Specific occupancy data not available. Spot checks made periodically indicates overall net annual occupancy above 95%

(2) Above data exclusive of long-term care reflected in other sections but includes facilities under contract/construction.

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"A" REGION Sioux City (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-1	Restmore Nursing Home	Lyon	Rock Rapids	PROP.	--	45	--		--	--	--	
NR-1	Winters Custodial Home	Lyon	Rock Rapids	PROP.	--	--	--		0	0	14	
NR-1	Sioux Center Comm. Hospital	Sioux	Sioux Center	NPA	31	0	0		--	--	--	
NR-1	Orange City Municipal Hosp.	Sioux	Orange City	CITY	0	18	0		--	--	--	
NR-8	Panska Nursing Home	Sioux	Hawarden	PROP.	--	--	42		--	--	--	
NR-8	Brentwood Nursing Home	Plymouth	LeMars	PROP.	47	0	0		--	--	--	
NR-8	Plymouth County Home	Plymouth	LeMars	COUNTY	--	--	--		60	0	0	
NR-9	Gregg Nursing Home	Cherokee	Cherokee	PROP.	0	0	18		--	--	--	
NR-9	Hilltop House	Cherokee	Cherokee	PROP.	29	0	0		--	--	--	
NR-9	Mann Nursing Home	Cherokee	Cherokee	PROP.	0	0	12		--	--	--	
NR-9	Marcus Nursing Home	Cherokee	Marcus	PROP.	0	0	16		--	--	--	
NR-9	Dill Custodial Home	Cherokee	Marcus	PROP.	--	--	--		0	0	11	
NR-9	Good Samaritan Nursing Home	Ida	Holstein	PROP.	0	0	25		--	--	--	
NR-18	Bennett Nursing Home	Monona	Turin	PROP.	0	0	14		--	--	--	
NR-18	Moss Nursing Home	Monona	Onawa	PROP.	0	0	11		--	--	--	
NR-18	Onawa Home for the Aged	Monona	Onawa	PROP.	40	0	0		--	--	--	
NR-18	Raymond Nursing Home	Monona	Onawa	PROP.	0	0	13		--	--	--	
NR-18	Estina Rest Home	Monona	Mapleton	PROP.	--	--	--		0	0	10	
NB-3	Anderson Nursing Home	Woodbury	Sioux City	PROP.	0	0	15		--	--	--	
NB-3	Cherry Lawn Nursing Home	Woodbury	Sioux City	PROP.	0	0	17		--	--	--	
NB-3	Court Street Home	Woodbury	Sioux City	PROP.	--	--	--		0	0	14	
NB-3	Cummings Nursing Home	Woodbury	Sioux City	PROP.	0	62	25		--	--	--	
NB-3	Elaine Nursing Home	Woodbury	Sioux City	PROP.	0	74	0		--	--	--	
NB-3	Falline Nursing Home	Woodbury	Sioux City	PROP.	0	0	17		--	--	--	
NB-3	Ingleside Nursing Home	Woodbury	Sioux City	PROP.	0	83	0		--	--	--	
NB-3	Julia's Nursing Home	Woodbury	Sioux City	PROP.	0	0	12		--	--	--	
NB-3	Leeds Nursing Home	Woodbury	Sioux City	PROP.	0	0	67		--	--	--	
NB-3	Maplewood Nursing Home	Woodbury	Sioux City	PROP.	0	0	19		--	--	--	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"A" REGION Sioux City (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NB-3	Restview Nursing Home	Woodbury	Sioux City	PROP.	0	0	20		--	--	--	
NB-3	Samaritan Home of Sioux City	Woodbury	Sioux City	NPA	--	--	--		0	0	20	
NB-3	Sanford's Nursing Home	Woodbury	Sioux City	PROP.	0	18	0		--	--	--	
NB-3	Thoene Nursing Home	Woodbury	Sioux City	PROP.	0	0	11		--	--	--	
NB-3	Sloan Nursing Home	Woodbury	Sioux City	PROP.	0	0	51		--	--	--	
NB-3	Westwood Nursing Home	Woodbury	Sioux City	PROP.	65	0	0		--	--	--	
NB-3	Vi's Custodial Home	Woodbury	Sioux City	PROP.	--	--	--		0	0	20	
NB-3	Sunrise Manor	Woodbury	Sioux City	NPA	--	--	--		105	0	0	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"B" REGION Spencer

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-2	Verdoorn Nursing Home	Osceola	Ashton	PROP.	0	0	34		--	--	--	
NR-2	McGranahan Custodial Home	Osceola	Ocheyedan	PROP.	--	--	--		0	0	12	
NR-2	Anchorage Nursing Home	O'Brien	Sheldon	PROP.	0	0	17		--	--	--	
NR-2	Cooper's Nursing Home	O'Brien	Sutherland	PROP.	0	0	19		--	--	--	
NR-2	Millie's Nursing Home	O'Brien	Sutherland	PROP.	0	0	14		--	--	--	
NR-2	Myrl's Nursing Home	O'Brien	Primghar	PROP.	0	0	20		--	--	--	
NR-3	Milford Nursing Home	Dickinson	Milford	PROP.	0	0	11		--	--	--	
NR-3	Balmer Nursing Home	Emmet	Estherville	PROP.	0	0	29		--	--	--	
NR-3	Estherville Good Samaritan	Emmet	Estherville	NPC.	44	0	0		--	--	--	
NR-3	Lauritsen Nursing Home	Emmet	Estherville	PROP.	0	0	14		--	--	--	
NR-10	Christine's Nursing Home	B. Vista	Alta	PROP.	0	0	19		--	--	--	
NR-10	Methodist Manor	B. Vista	Storm Lake	NPA	0	30	0		37	0	0	
NR-10	Morgan Nursing Home	B. Vista	Storm Lake	PROP.	0	0	20		--	--	--	
NR-10	Convalescent Nursing Home	Sac	Lake View	PROP.	0	0	11		--	--	--	
NR-10	Irish Home	Sac	Lake View	PROP.	--	--	--		0	0	18	
NR-10	Eastlawn Nursing Home	Sac	Odebolt	PROP.	0	0	18		--	--	--	
NR-10	Schaller Nursing Home	Sac	Schaller	PROP.	0	19	0		--	--	--	
NR-10	Hilltop Nursing Home	Sac	Sac City	PROP.	0	0	11		--	--	--	
NR-10	Tryon Nursing Home	Sac	Sac City	PROP.	0	0	14		--	--	--	
NR-10	Tryon Nursing Home	Sac	Sac City	PROP.	0	0	14		--	--	--	
NI-1	Carrie's Custodial Home	Clay	Spencer	PROP.	--	--	--		0	0	13	
NI-1	Delaney Nursing Home	Clay	Spencer	PROP.	0	0	37		--	--	--	
NI-1	Purintun Nursing Home	Clay	Everly	PROP.	0	0	12		--	--	--	
NI-1	McCroskey Nursing Home	O'Brien	Hartley	PROP.	0	0	14		--	--	--	
NI-1	Wagner Nursing Home	O'Brien	Hartley	PROP.	0	0	10		--	--	--	
NI-1	Emmetsburg Custodial Home	Palo Alto	Emmetsburg	PROP.	--	--	--		0	0	14	
NI-1	Haywood Nursing Home	Palo Alto	Emmetsburg	PROP.	0	20	0		--	--	--	
NI-1	Lakeview Nursing Home	Palo Alto	Emmetsburg	PROP.	0	0	14		--	--	--	
NI-1	Currie's Rest Home	Palo Alto	Emmetsburg	PROP.	--	--	--		0	0	14	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"C" REGION Fort Dodge

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-4	Good Samaritan Nursing Home	Kossuth	Algona	NPC	0	0	40		--	--	--	
NR-4	Wilfair Rest Haven	Kossuth	Burt	PROP.	--	--	--		0	0	13	
NR-11	Houston Nursing Home	Humboldt	Humboldt	PROP.	0	0	17		--	--	--	
NR-11	Sisson Nursing Home	Humboldt	Humboldt	PROP.	19	0	30		--	--	--	
NR-11	Torgerson Nursing Home	Humboldt	Humboldt	PROP.	0	0	15		--	--	--	
NR-11	Frank Finn Custodial Home	Wright	Belmond	PROP.	--	--	--		0	0	10	
NR-11	Minor Custodial Home	Wright	Eagle Grove	PROP.	--	--	--		0	0	10	
NR-12	Delt Nursing Home	Hamilton	Webster City	PROP.	0	0	12		--	--	--	
NR-12	Jewell Rest Home	Hamilton	Jewell	PROP.	0	0	18		--	--	--	
NR-12	Hillcrest Home	Hamilton	Webster City	PROP.	--	--	--		0	0	14	
NI-3	Pocahontas County Home	Pocahontas	Pocahontas	COUNTY	--	--	--		0	0	20	
NI-3	Good Samaritan Home	Pocahontas	Pocahontas	NPC	28	0	0		--	--	--	
NI-3	Good Samaritan Home	Pocahontas	Laurens	NPC	0	0	21		--	--	--	
NI-3	Good Samaritan Home	Calhoun	Manson	PROP.	0	0	20		--	--	--	
NI-3	Henry Nursing Home	Calhoun	Rockwell City	PROP.	0	0	14		--	--	--	
NI-3	Rose Nursing Home	Calhoun	Rockwell City	PROP.	0	0	12		--	--	--	
NI-3	Brown & Schaffer Nursing H.	Calhoun	Lake City	PROP.	0	0	10		--	--	--	
NI-3	Midway Nursing Home	Calhoun	Lake City	PROP.	0	0	20		--	--	--	
NI-3	Waters Nursing Home	Calhoun	Lake City	PROP.	0	0	18		--	--	--	
NI-3	Ellen's Nursing Home	Webster	Fort Dodge	PROP.	16	0	24		--	--	--	
NI-3	Friendship Haven	Webster	Fort Dodge	NPA	0	96	0		389	0	0	
NI-3	Johnson Nursing Home	Webster	Fort Dodge	PROP.	0	0	49		--	--	--	
NI-3	Sherman Nursing Home	Webster	Fort Dodge	PROP.	0	0	13		--	--	--	
NI-3	Margaret's Nursing Home	Webster	Fort Dodge	PROP.	0	0	20		--	--	--	

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DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"D" REGION Mason City

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-5	Falk Nursing Home	Mitchell	Stacyville	PROP.	0	0	13		--	--	--	
NR-5	Osage Nursing Home	Mitchell	Osage	PROP.	0	45	0		--	--	--	
NR-5	Welcome Haven Rest Home	Floyd	Charles City	PROP.	--	--	--		0	0	15	
NR-5	Salsbury Baptist Home	Floyd	Charles City	NPA	--	--	--		34	0	0	
NR-5	Sunnydale Convalescent Home	Floyd	Charles City	PROP.	--	--	--		0	0	18	
NR-5	Charles City Nursing Home	Floyd	Charles City	PROP.	0	0	18		--	--	--	
NR-5	Chatauqua Nursing Home	Floyd	Charles City	PROP.	0	41	0		--	--	--	
NR-5	DeBuhr Nursing Home	Floyd	Charles City	PROP.	0	0	16		--	--	--	
NR-5	Nora Springs Nursing Home	Floyd	Nora Springs	PROP.	0	0	46		--	--	--	
NR-5	Good Samaritan Farm	Floyd	Rockford	NPA	--	--	--		0	0	21	
NR-5	Rockford Convalescent Home	Floyd	Rockford	PROP.	0	0	26		--	--	--	
NR-5	Harris Convalescent Home	Floyd	Marble Rock	PROP.	--	--	--		0	0	12	
NR-13	Christiansen Nursing Home	Franklin	Sheffield	PROP.	0	0	19		--	--	--	
NR-13	Ahrens Nursing Home	Franklin	Hampton	PROP.	0	0	20		--	--	--	
NR-13	Thies Rest Home	Franklin	Hampton	PROP.	--	--	--		0	0	13	
NR-13	Lutheran Nursing Home	Franklin	Hampton	NPA	0	0	27		--	--	--	
NR-13	Idle Hour Nursing Home	Hardin	Alden	PROP.	0	0	14		--	--	--	
NR-13	Bonnie's Nursing Home	Hardin	Eldora	PROP.	0	0	12		--	--	--	
NR-13	Lawless Nursing Home	Hardin	Eldora	PROP.	0	0	18		--	--	--	
NR-13	Long's Nursing Home	Hardin	Iowa Falls	PROP.	0	0	20		--	--	--	
NR-13	Deal's Custodial Home	Hardin	Iowa Falls	PROP.	--	--	--		0	0	13	
NR-13	Clark Nursing Home	Butler	Greene	PROP.	0	0	19		--	--	--	
NR-13	Edna's Nursing Home	Butler	Allison	PROP.	0	0	11		--	--	--	
NR-13	Reiner's Nursing Home	Butler	Dumont	PROP.	0	0	20		--	--	--	
NR-13	Burke Custodial Home	Hardin	Union	PROP.	--	--	--		0	0	16	
NR-13	Presbyterian Home	Hardin	Ackley	NPA	--	--	--		0	20	20	
NI-2	L & M Custodial Home	C. Gordo	Clear Lake	PROP.	--	--	--		0	0	12	
NI-2	Lake Rest Nursing Home	C. Gordo	Clear Lake	PROP.	0	0	25		--	--	--	
NI-2	Bethany Nursing Home	C. Gordo	Clear Lake	PROP.	0	0	19		--	--	--	
NI-2	Schiff Rest Home	C. Gordo	Mason City	PROP.	--	--	--		0	0	15	
NI-2	I.O.O.F. Nursing Home	C. Gordo	Mason City	NPA	0	0	75		0	0	95	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"E" REGION Mason City (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	AVAILAB.	AV. DAILY CENSUS	SUITABLE	REPAIR.	AVAILABLE.	AV. DAILY CENSUS
NI-2	Good Samaritan Nursing Home	C. Gordo	Mason City	NPA	0	220	0		--	--	--	
NI-2	Norris Nursing Home	C. Gordo	Mason City	PROP.	0	0	20		--	--	--	
NI-2	Rest Haven Nursing Home	C. Gordo	Mason City	PROP.	0	0	30		--	--	--	
NI-2	South Side Nursing Home	C. Gordo	Mason City	PROP.	0	0	19		--	--	--	
NI-2	Wass Nursing Home	C. Gordo	Mason City	PROP.	0	0	20		--	--	--	
NI-2	Rockwell Nursing Home	C. Gordo	Rockwell	PROP.	0	0	33		--	--	--	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"E" REGION Waterloo

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-6	Birtwistle Nursing Home	Howard	Cresco	PROP.	0	0	19		--	--	--	
NR-6	Good Samaritan Nursing Home	Howard	Cresco	NPC	0	0	26		--	--	--	
NR-6	Hyberger Nursing Home	Howard	Cresco	PROP.	0	0	20		--	--	--	
NR-6	Reutlinger Nursing Home	Howard	Cresco	PROP.	0	0	20		--	--	--	
NR-6	Evans Rest Home	Howard	Elma	PROP.	--	--	--		0	0	10	
NR-6	Aase Haugen Nursing Home	Winneshk.	Decorah	NPA	0	0	60		--	--	--	
NR-6	Fritze Nursing Home	Chickasaw	Nashua	PROP.	0	0	31		0	0	16	
NR-6	Kruse Nursing Home	Chickasaw	New Hampton	PROP.	0	0	10		--	--	--	
NR-6	Golden Age Nursing Home	Chickasaw	New Hampton	COUNTY	0	0	16		--	--	--	
NR-6	Hines Rest Home	Chickasaw	New Hampton	PROP.	--	--	--		0	0	10	
NR-15	Bakke's Rest Home	Fayette	Oelwein	PROP.	0	0	20		--	--	--	
NR-15	Manning Nursing Home	Fayette	Oelwein	PROP.	0	0	14		--	--	--	
NR-15	Driscoll Custodial Home	Fayette	Oelwein	PROP.	--	--	--		0	0	15	
NR-15	Riley Rest Home	Chickasaw	Fredericksburg	PROP.	--	--	--		0	0	10	
NR-15	Good Samaritan Nursing Home	Fayette	West Union	PROP.	0	0	38		--	--	--	
NI-4	Ahrens Nursing Home	Butler	Clarksville	PROP.	0	0	14		--	--	--	
NI-4	Osweiler Nursing Home	Butler	Shell Rock	PROP.	0	0	18		--	--	--	
NI-4	Waverly Convalescent Home	Bremer	Waverly	PROP.	0	0	34		--	--	--	
NI-4	Bartels Nursing Home	Bremer	Waverly	PROP.	0	0	19		0	0	16	
NI-4	Bantz Home for the Aged	Buchanan	Brandon	PROP.	--	--	--		0	0	10	
NI-4	Happy Valley Nursing Home	Buchanan	Independence	PROP.	0	0	10		--	--	--	
NI-4	Helen's Haven Rest Home	Buchanan	Independence	PROP.	0	0	10		--	--	--	
NI-4	L M N Home for the Aged	Buchanan	Hazleton	PROP.	0	0	17		--	--	--	
NI-4	Hendren Nursing Home	Buchanan	Hazleton	PROP.	0	0	10		--	--	--	
NI-4	Walton Nursing Home	Buchanan	Independence	PROP.	0	0	10		--	--	--	
NI-4	Sunnycrest	Tama	Dysart	PROP.	0	32	0		--	--	--	
NI-4	G & G Nursing Home	Tama	Dysart	PROP.	0	0	20		--	--	--	
NI-4	Lawn City Nursing Home	Blackhawk	Cedar Falls	PROP.	0	0	44		--	--	--	
NI-4	Ploeger Rest Home	Blackhawk	Cedar Falls	PROP.	--	--	--		0	0	14	
NI-4	Western Nursing Home	Blackhawk	Cedar Falls	PROP.	0	0	10		0	0	155	
NI-4	Boorom's	Blackhawk	Cedar Falls	PROP.	0	0	16		--	--	--	
NI-4	Cedar Falls Lutheran Home	Blackhawk	Cedar Falls	NPA	0	22	0		22	20	0	

IOWA STATE DEPARTMENT OF HEALTH
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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES "E" REGION Waterloo (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REHAB.	SUBSTD	AV. DAILY CENSUS	SUITABLE	REHAB.	SUBSTD.	AV. DAILY CENSUS
NI-4	Bonorden's	Blackhawk	Waterloo	PROP.	0	0	12		--	--	--	
NI-4	E. Barton Convalescent Home	Blackhawk	Waterloo	PROP.	0	0	25		--	--	--	
NI-4	East First Street Nursing H.	Blackhawk	Waterloo	PROP.	0	0	19		--	--	--	
NI-4	McCready's	Blackhawk	Waterloo	PROP.	0	0	15		--	--	--	
NI-4	Edith's Nursing Home	Blackhawk	Waterloo	PROP.	0	0	19		--	--	--	
NI-4	Wood Lawn Convalescent Home	Blackhawk	Waterloo	PROP.	0	0	120		--	--	--	
NI-4	Allen Memorial Hospital	Blackhawk	Waterloo	NPA	72	0	0		--	--	--	
NI-4	Ramus Convalescent Home	Blackhawk	LaPorte City	PROP.	--	--	--		0	0	15	
NI-4	Williams Rest Home	Blackhawk	LaPorte City	PROP.	--	--	--		0	0	11	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"F" REGION Dubuque

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPLAC.	UNSUIT	AV. DAILY CENSUS	SUITABLE	REPLAC.	UNSUIT.	AV. DAILY CENSUS
NR-7	Laffan Nursing Home	Allamakee	Waukon	PROP.	0	0	10		--	--	--	
NR-7	Good Samaritan Nursing Home	Allamakee	Waukon	NPA	32	0	23		--	--	--	
NR-7	Moser Nursing Home	Clayton	Strwbry. Pt.	PROP.	0	0	12		--	--	--	
NR-7	Lutheran Home for the Aged	Clayton	Strwbry. Pt.	NPA	--	--	--		15	0	17	
NR-7	The Samaritan	Clayton	Elkader	PROP.	0	0	17		--	--	--	
NR-25	Flagel Custodial Home	Jackson	Maquoketa	PROP.	--	--	--		0	0	20	
NR-25	Armstrong Nursing Home	Jackson	Maquoketa	PROP.	0	0	19		--	--	--	
NR-25	Gilmore Nursing Home	Jackson	Maquoketa	PROP.	0	0	19		--	--	--	
NR-25	Rorah Nursing Home	Jackson	Maquoketa	PROP.	0	0	10		--	--	--	
NR-25	Manning Nursing Home	Jackson	Maquoketa	PROP.	0	0	20		--	--	--	
NI-5	Dubuque County Home	Dubuque	Dubuque	COUNTY	0	98	0		--	--	--	
NI-5	Frommelt-Schaefers Conv. H.	Dubuque	Dubuque	PROP.	0	0	50		--	--	--	
NI-5	Lady of Lourdes	Dubuque	Dubuque	PROP.	0	0	150		--	--	--	
NI-5	Holy Family Hall	Dubuque	Dubuque	NPA	103	0	0		--	--	--	
NI-5	St. Anthony's	Dubuque	Dubuque	NPA	--	--	--		0	0	150	
NI-5	Bethany Nursing Home	Dubuque	Dubuque	PROP.	0	0	30		0	0	24	
NI-5	Martin Luther Home	Dubuque	Dubuque	NPA	--	--	--		0	0	12	
NI-5	McCauley's Rest Home	Dubuque	Dubuque	PROP.	--	--	--		0	0	18	
NI-5	St. Francis Home for Aged	Dubuque	Dubuque	NPA	--	--	--		0	0	104	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"G" REGION Cedar Rapids

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-17	Fairview Nursing Home	Delaware	Manchester	PROP.	0	0	19		--	--	--	
NR-17	Bolin Rest Home	Delaware	Manchester	PROP.	--	--	--		0	0	16	
NR-17	Oneida Nursing Home	Delaware	Manchester	PROP.	0	0	20		--	--	--	
NR-17	Bush Custodial Home	Delaware	Manchester	PROP.	--	--	--		0	0	14	
NR-17	Snodgrass Nursing Home	Delaware	Manchester	PROP.	0	0	14		--	--	--	
NR-17	Rippon Custodial Home	Delaware	Manchester	PROP.	--	--	--		0	0	13	
NR-24	Oxford Junction Rest Home	Jones	Oxford Junct.	PROP.	--	--	--		0	0	14	
NR-24	Straub Rest Home	Jones	Monticello	PROP.	--	--	--		0	0	16	
NR-24	Brandt Nursing Home	Jones	Wyoming	PROP.	0	0	17		--	--	--	
NR-24	Anamosa Custodial Home	Jones	Anamosa	PROP.	--	--	--		0	0	17	
NR-24	Kleineck Rest Home	Jones	Onslow	PROP.	--	--	--		0	0	14	
NR-31	Watts Nursing Home	Iowa	Marengo	PROP.	0	0	16		--	--	--	
NR-31	Popham Custodial Home	Iowa	North English	PROP.	--	--	--		0	0	10	
NR-31	Yearian Nursing Home	Iowa	Williamsburg	PROP.	0	20	0		--	--	--	
NI-7	Lutheran Home for the Aged	Benton	Vinton	NPA	0	0	24		0	0	29	
NI-7	Vinton Nursing Home	Benton	Vinton	PROP.	0	0	20		--	--	--	
NI-7	Utopia Nursing Home	Cedar	Tipton	PROP.	0	0	20		--	--	--	
NI-7	Tipton Custodial Home	Cedar	Tipton	PROP.	--	--	--		0	0	10	
NI-7	Springville Nursing Home	Linn	Springville	PROP.	0	0	14		--	--	--	
NI-7	Benion Nursing Home	Linn	Center Point	PROP.	0	0	20		--	--	--	
NI-7	Mount Vernon Rest Home	Linn	Mt. Vernon	PROP.	0	0	20		--	--	--	
NI-7	Martinson Nursing Home	Linn	Marion	PROP.	0	0	15		--	--	--	
NI-7	Evergreen Custodial Home	Linn	Marion	PROP.	--	--	--		0	0	18	
NI-7	Maple Lawn Home for the Aged	Linn	Marion	PROP.	0	0	20		0	0	12	
NI-7	Boldt Nursing H. (1st N.W.)	Linn	Cedar Rapids	PROP.	0	0	12		--	--	--	
NI-7	Boldt Nursing H. (1st S.W.)	Linn	Cedar Rapids	PROP.	0	0	17		--	--	--	
NI-7	Good Samaritan Custodial H.	Linn	Cedar Rapids	PROP.	--	--	--		0	0	18	
NI-7	Cains Nursing Home	Linn	Cedar Rapids	PROP.	0	0	19		--	--	--	
NI-7	Cedar Rapids Nursing Home	Linn	Cedar Rapids	PROP.	0	0	20		--	--	--	
NI-7	Greene Square Nursing Home	Linn	Cedar Rapids	PROP.	0	0	40		--	--	--	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"G" REGION Cedar Rapids (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPLAC.	UNSUIT	AV. DAILY CENSUS	SUITABLE	REPLAC.	UNSUIT.	AV. DAILY CENSUS
NI-7	Happy Nursing Home	Linn	Cedar Rapids	PROP.	0	0	20		--	--	--	
NI-7	Irene's Nursing Home	Linn	Cedar Rapids	PROP.	0	0	19		--	--	--	
NI-7	Megan Nursing Home	Linn	Cedar Rapids	PROP.	0	0	16		--	--	--	
NI-7	Shain Nursing Home	Linn	Cedar Rapids	PROP.	0	0	14		--	--	--	
NI-7	Wood Nursing Home	Linn	Cedar Rapids	PROP.	0	0	20		--	--	--	
NI-7	Halmar	Linn	Cedar Rapids	NPA	30	0	0		--	--	--	
NI-7	Meth-Wick Manor	Linn	Cedar Rapids	NPA	55	0	0		134	0	0	
NI-7	Snodgrass Custodial Home	Linn	Coggan	PROP.	--	--	--		0	0	20	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"H" REGION Davenport

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NI-8	Calamus Nursing Home	Clinton	Calamus	PROP.	0	0	11		--	--	--	
NI-8	Gest Nursing Home	Clinton	Grand Mound	PROP.	0	0	14		--	--	--	
NI-8	Lohr Moor Nursing Home	Clinton	Lohr Moor	PROP.	0	0	14		--	--	--	
NI-8	Clinton Nursing Home	Clinton	Clinton	PROP.	0	0	20		--	--	--	
NI-8	Mt. Alverno Home for Aged	Clinton	Clinton	CHAR.	0	0	53		--	--	--	
NI-8	Sarah Harding Home for Aged	Clinton	Clinton	NPA	--	--	--		0	0	18	
NI-10	Poage Nursing Home	Louisa	Wapello	PROP.	0	0	20		--	--	--	
NI-10	Restopia	Louisa	Columbus Jct.	PROP.	0	0	34		--	--	--	
NI-10	Hawker Nursing Home	Muscatine	West Liberty	PROP.	0	0	18		--	--	--	
NI-10	Hershey Convalescent	Muscatine	Muscatine	CITY	0	0	62		--	--	--	
NI-10	Riverview Heights Nursing H.	Muscatine	Muscatine	PROP.	0	30	45		--	--	--	
NI-10	Grigg Nursing Home	Muscatine	Muscatine	PROP.	0	0	16		--	--	--	
NI-10	Jones Nursing Home	Muscatine	Muscatine	PROP.	0	0	17		--	--	--	
NI-10	Julia Elizabeth Home	Muscatine	Muscatine	NPA	--	--	--		0	0	10	
NI-10	Lippelgoes Nursing Home	Muscatine	Muscatine	PROP.	0	0	17		--	--	--	
NI-10	Haven of Rest	Muscatine	Muscatine	PROP.	--	--	--		0	0	10	
NI-10	Lutheran Home	Muscatine	Muscatine	PROP.	0	0	14		0	0	33	
NI-10	Wilton Nursing Home	Muscatine	Wilton Jct.	PROP.	32	0	0		--	--	--	
NI-10	Blue Grass Nursing Home	Scott	Blue Grass	PROP.	0	0	15		--	--	--	
NI-10	Masonic Sanatorium	Scott	Bettendorf	NPA	0	0	50		--	--	--	
NI-10	Grandview Home	Scott	Bettendorf	PROP.	--	--	--		0	0	14	
NI-10	Golden Age Rest Home	Scott	Davenport	PROP.	0	0	14		--	--	--	
NI-10	Davenport Nursing Home	Scott	Davenport	PROP.	0	49	0		--	--	--	
NI-10	Iowa Nursing Home	Scott	Davenport	PROP.	0	0	17		--	--	--	
NI-10	Fejervary Nursing Home	Scott	Davenport	NPA	0	0	32		--	--	--	
NI-10	Kahl Memorial Home for Aged	Scott	Davenport	CHAR.	134	0	0		0	0	29	
NI-10	Hillcrest Nursing Home	Scott	Davenport	PROP.	0	0	20		--	--	--	
NI-10	Kirkwood Convalescent Home	Scott	Davenport	PROP.	0	0	20		--	--	--	
NI-10	Royal Neighbor Home	Scott	Davenport	NPA	0	0	8		0	0	56	
NI-10	Lantz Nursing Home	Scott	Davenport	PROP.	0	0	19		--	--	--	
NI-10	Marian's Rest Home	Scott	Davenport	PROP.	--	--	--		0	0	17	
NI-10	Marquette Nursing Home	Scott	Davenport	PROP.	0	0	30		--	--	--	
NI-10	Scott County Home	Scott	Davenport	COUNTY	--	--	--		0	128	0	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES "H" REGION Davenport (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		EXISTING	REPAIR.	AUGMENT	AV. DAILY CENSUS	EXISTING	REPAIR.	AUGMENT.	AV. DAILY CENSUS
NI-10	Morning Star Nursing Home	Scott	Davenport	PROP.	0	0	20		--	--	--	
NI-10	Noles Nursing Home	Scott	Davenport	PROP.	0	0	19		--	--	--	
NI-10	Sunnyside Rest Home	Scott	Davenport	PROP.	--	--	--		0	0	20	
NI-10	Earls Rest Home	Scott	Davenport	PROP.	--	--	--		0	0	13	
NI-10	Pine Knoll Home	Scott	Davenport	COUNTY	--	--	--		0	100	0	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"I" REGION Burlington

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REHAB.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REHAB.	UNSUIT.	AV. DAILY CENSUS
NR-45	Metz Nursing Home	Lee	Donnellson	PROP.	0	0	32		--	--	--	
NR-45	Hospitality House	Lee	Ft. Madison	PROP.	0	0	20		--	--	--	
NR-45	Hocker Nursing Home	Lee	Keokuk	PROP.	0	0	20		--	--	--	
NR-45	Luke Custodial Home	Lee	Keokuk	PROP.	--	--	--		0	0	20	
NR-45	Clark Nursing Home	Lee	Keokuk	PROP.	0	0	31		--	--	--	
NI-12	Harmony Home	Des Moines	Mediapolis	PROP.	0	0	20		--	--	--	
NI-12	Burlington Custodial Home	Des Moines	Mediapolis	PROP.	--	--	--		0	0	20	
NI-12	North Hill Nursing Home	Des Moines	Burlington	PROP.	0	0	20		--	--	--	
NI-12	King's Daughters Home	Des Moines	Burlington	NPA	--	--	--		0	0	13	
NI-12	Shady Nook Nursing Home	Des Moines	Burlington	PROP.	0	0	18		--	--	--	
NI-12	Ritter Home for the Aged	Des Moines	Burlington	PROP.	--	--	--		0	0	10	
NI-12	St. Francis Cont. Care Ctr.	Des Moines	Burlington	CH.	126	0	0		--	--	--	
NI-12	Klein Memorial	Des Moines	Burlington	NPA	160	0	0		--	--	--	
NI-12	Mennonite Retirement Home	Henry	Wayland	NPA	0	14	0		22	0	0	
NI-12	Beauchamp Nursing Home	Henry	Winfield	PROP.	0	0	20		--	--	--	
NI-12	DeVol Nursing Home	Henry	Mt. Pleasant	PROP.	0	0	16		--	--	--	
NI-12	Kennedy Nursing Home	Henry	Mt. Pleasant	PROP.	0	0	20		--	--	--	
NI-12	Mills Nursing Home	Henry	Mt. Pleasant	PROP.	0	0	10		--	--	--	
NI-12	Millspaugh Nursing Home	Henry	Mt. Pleasant	PROP.	0	0	16		--	--	--	
NI-12	Rest Haven Nursing Home	Henry	Mt. Pleasant	PROP.	0	0	58		--	--	--	
NI-12	Holland Rest Home	Henry	Mt. Pleasant	PROP.	--	--	--		0	0	16	
NI-12	Wehrle Custodial Home	Henry	Mt. Pleasant	PROP.	--	--	--		0	0	19	
NI-12	Shelton's Nursing Home	Henry	New London	PROP.	0	0	14		--	--	--	
NI-12	Bugg Rest Home	Henry	New London	PROP.	--	--	--		0	0	14	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"J" REGION Iowa City

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-35	Pleasant View Home	Washington	Kalona	NPA	0	25	0		29	0	0	
NR-35	Shenk Nursing Home	Washington	Wellman	PROP.	0	0	42		--	--	--	
NR-35	The Pines	Washington	Washington	PROP.	0	0	20		--	--	--	
NR-35	Sunny Haven	Washington	Washington	PROP.	0	0	20		--	--	--	
NR-35	United Presbyterian Home	Washington	Washington	NPA	0	0	10		0	0	45	
NR-35	Home Assn. of Washington	Washington	Washington	NPA	--	--	--		36	0	0	
NB-1	Happy Haven Nursing Home	Johnson	Lone Tree	PROP.	0	0	20		--	--	--	
NB-1	Clausen Nursing Home	Johnson	Iowa City	PROP.	0	0	34		--	--	--	
NB-1	Gibson Custodial Home	Johnson	Iowa City	PROP.	--	--	--		0	0	10	
NB-1	Lindley Nursing Home	Johnson	Iowa City	PROP.	0	0	20		--	--	--	
NB-1	Smith Custodial Home	Johnson	Iowa City	PROP.	--	--	--		0	0	10	
NB-1	Rest Haven	Johnson	Iowa City	PROP.	0	0	20		--	--	--	
NB-1	Cookson Memorial Home	Cedar	West Branch	PROP.	--	--	--		0	0	10	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"K" REGION Ottumwa

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	REPLAC.	AV. DAILY CENSUS	SUITABLE	REPAIR.	REPLAC.	AV. DAILY CENSUS
NR-34	Faye Reed Rest Home	Keokuk	Ollie	PROP.	--	--	--		0	0	10	
NR-34	Bales Nursing Home	Keokuk	Sigourney	PROP.	0	0	20		--	--	--	
NR-34	Kensler Custodial Home	Keokuk	Sigourney	PROP.	--	--	--		0	0	16	
NR-34	Rest Haven Home	Keokuk	Sigourney	PROP.	--	--	--		0	0	18	
NR-34	Twilight Rest Home	Keokuk	Keota	PROP.	--	--	--		0	0	18	
NR-34	Inman Nursing Home	Mahaska	Univ. Park	PROP.	0	0	10		--	--	--	
NR-34	Ray Nursing Home	Mahaska	Oskaloosa	PROP.	0	0	11		--	--	--	
NR-34	Hillcrest Custodial Home	Mahaska	Oskaloosa	PROP.	--	--	--		0	0	15	
NR-34	Rest Haven Nursing Home	Mahaska	Oskaloosa	PROP.	0	0	12		--	--	--	
NR-34	Stringfellow Rest Home	Mahaska	Oskaloosa	PROP.	--	--	--		0	0	10	
NR-34	Tower Park	Mahaska	Oskaloosa	PROP.	0	0	43		--	--	--	
NR-39	Briggs & Eskew Nursing Home	Jefferson	Fairfield	PROP.	0	0	16		--	--	--	
NR-39	Bethany Home	Jefferson	Fairfield	NPA	--	--	--		0	0	16	
NR-39	Nelson Nursing Home	Jefferson	Fairfield	PROP.	0	0	36		--	--	--	
NR-43	Golden Age Nursing Home	Appanoose	Centerville	PROP.	0	0	60		--	--	--	
NR-43	Guinn Custodial Home	Appanoose	Centerville	PROP.	--	--	--		0	0	11	
NR-43	Luse Nursing Home	Appanoose	Centerville	PROP.	0	0	20		--	--	--	
NR-43	Williams Rest Home	Appanoose	Cincinnati	PROP.	--	--	--		0	0	10	
NR-44	Hainline Custodial Home	VanBuren	Bonaparte	PROP.	--	--	--		0	0	18	
NR-44	Moore Nursing Home	VanBuren	Stockport	PROP.	0	0	19		--	--	--	
NR-44	Davis Custodial Home	VanBuren	Keosauqua	PROP.	--	--	--		0	0	14	
NR-44	Farmington Rest Home	VanBuren	Farmington	PROP.	--	--	--		0	0	20	
NI-11	Shahan Nursing Home	Wapello	Eddyville	PROP.	0	0	10		--	--	--	
NI-11	Kirk's Rest Home	Wapello	Agency	PROP.	--	--	--		0	0	13	
NI-11	Elsie's Nursing Home	Wapello	Ottumwa	PROP.	0	0	17		--	--	--	
NI-11	Happy Home	Wapello	Ottumwa	PROP.	0	0	10		--	--	--	
NI-11	Solt Nursing Home	Wapello	Ottumwa	PROP.	0	0	18		--	--	--	
NI-11	Morgan's Ideal Rest Home	Wapello	Ottumwa	PROP.	0	0	18		--	--	--	
NI-11	Wilma's Nursing Home	Wapello	Ottumwa	PROP.	0	0	17		--	--	--	
NI-11	Good Samaritan Home	Wapello	Ottumwa	NPA	0	0	85		--	--	--	
NI-11	Rest Haven Home	Wapello	Ottumwa	PROP.	0	0	25		--	--	--	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"K" REGION Ottumwa (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	CONSUMPT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	CONSUMPT.	AV. DAILY CENSUS
NI-11	Sweatt Nursing Home	Wapello	Ottumwa	PROP.	0	0	15		--	--	--	
NI-11	Alma's Custodial Home	Wapello	Ottumwa	PROP.	--	--	--		0	0	10	

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"L" REGION Des Moines

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-22	Iowa Lutheran Home for Aged	Boone	Madrid	NPA	50	0	0		95	0	0	
NR-22	Eastern Star	Boone	Boone	NPA	0	50	0		24	68	0	
NR-22	DuGun Custodial Home	Boone	Boone	PROP.	--	--	--		0	0	20	
NR-22	Evangelical Free Church Home	Boone	Boone	NPA	0	0	10		0	0	38	
NR-22	Dolly Meis Nursing Home	Boone	Boone	PROP.	0	0	20		--	--	--	
NR-22	Kathie's Rest Home	Story	Nevada	PROP.	--	--	--		0	0	19	
NR-22	Ames Nursing Home	Story	Ames	PROP.	0	0	20		--	--	--	
NR-23	Leola's Guest Home	Story	Nevada	PROP.	0	0	14		--	--	--	
NR-23	Borton's Rest Home	Story	Nevada	PROP.	--	--	--		0	0	14	
NR-23	Story City Old People's Home	Story	Story City	NPA	0	0	16		0	0	70	
NR-23	Gilmore Home	Story	Nevada	PROP.	--	--	--		0	0	18	
NR-23	Golden Inn	Story	Zearing	PROP.	--	--	--		0	0	10	
NR-29	Walter's Nursing Home	Guthrie	Panora	PROP.	0	0	16		--	--	--	
NR-30	Goeke Nursing Home	Poweshiek	Montezuma	PROP.	0	0	12		--	--	--	
NR-30	Happy Hours	Poweshiek	Grinnell	PROP.	0	0	14		--	--	--	
NR-30	Lone Elm Nursing Home	Poweshiek	Grinnell	PROP.	0	0	30		--	--	--	
NR-30	Gardner Nursing Home	Jasper	Colfax	PROP.	0	0	19		--	--	--	
NR-30	Hillside Rest Home	Jasper	Colfax	PROP.	--	--	--		0	0	14	
NR-30	Shaw Rest Haven Nursing Home	Jasper	Newton	PROP.	0	0	38		--	--	--	
NR-30	Nelson's Manor	Jasper	Newton	PROP.	0	26	0		--	--	--	
NR-30	Roush Custodial Home	Jasper	Newton	PROP.	--	--	--		0	0	18	
NR-32	Adair Nursing Home	Adair	Adair	PROP.	0	0	13		--	--	--	
NR-32	Acker Nursing Home	Adair	Greenfield	PROP.	0	0	10		--	--	--	
NR-32	Greenfield Rest Home	Adair	Greenfield	PROP.	0	0	20		--	--	--	
NR-32	Strables Nursing Home	Madison	St. Charles	PROP.	0	0	14		--	--	--	
NR-32	Horton Nursing Home	Madison	Winterset	PROP.	0	0	68		0	0	26	
NR-32	Fair Haven's Rest Home	Madison	Winterset	PROP.	--	--	--		0	0	12	
NR-32	Peterson Nursing Home	Madison	Winterset	PROP.	0	0	18		--	--	--	
NR-33	Pella Rest Home	Marion	Pella	PROP.	--	--	--		0	0	13	
NR-33	Pella Community Hospital	Marion	Pella	NPA	30	0	0		--	--	--	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

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SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"L" REGION Des Moines (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-33	DeJong Nursing Home	Marion	Knoxville	PROP.	0	0	35		--	--	--	
NR-33	Farrell Custodial Home	Marion	Knoxville	PROP.	--	--	--		0	0	19	
NR-33	Pettinger Custodial Home	Marion	Knoxville	PROP.	--	--	--		0	0	15	
NR-37	Eblen Nursing Home	Union	Afton	PROP.	0	0	13		--	--	--	
NR-37	Cochran Nursing Home	Union	Creston	PROP.	0	0	15		--	--	--	
NR-37	Holmes Nursing Home	Union	Creston	PROP.	0	0	10		--	--	--	
NR-37	Green Nursing Home	Union	Creston	PROP.	0	0	14		--	--	--	
NR-37	McCarthy Nursing Home	Union	Creston	PROP.	0	0	10		--	--	--	
NR-37	Huntington Nursing Home	Union	Creston	PROP.	0	0	12		--	--	--	
NR-37	Union County Home	Union	Creston	COUNTY	--	--	--		0	0	26	
NR-37	Oswald Nursing Home	Union	Creston	PROP.	0	0	19		--	--	--	
NR-38	O'Donnell Nursing Home	Lucas	Russell	PROP.	0	0	19		--	--	--	
NR-38	Gardner Rest Home	Lucas	Chariton	PROP.	0	0	12		--	--	--	
NR-38	Baker Nursing Home	Lucas	Chariton	PROP.	0	0	39		--	--	--	
NR-41	Horton Nursing Home	Ringgold	Mt. Ayr	PROP.	0	0	38		--	--	--	
NR-42	Frost Nursing Home	Decatur	Leon	PROP.	0	0	45		--	--	--	
NR-42	Tripp Nursing Home	Decatur	Leon	PROP.	0	0	33		--	--	--	
NR-47	Cass Street Guest Home	Clarke	Osceola	PROP.	0	0	14		--	--	--	
NR-47	Osceola Nursing Home	Clarke	Osceola	PROP.	0	0	19		--	--	--	
NR-47	Harken Nursing Home	Clarke	Osceola	PROP.	0	0	10		--	--	--	
NR-47	Fillmore Custodial Home	Clarke	Osceola	PROP.	--	--	--		0	0	10	
NI-6	Hines Rest Home	Tama	Toledo	PROP.	--	--	--		0	0	12	
NI-6	Kriegel Custodial Home	Tama	Tama	PROP.	--	--	--		0	0	19	
NI-6	Toledo Convalescent Home	Tama	Toledo	PROP.	--	--	--		0	0	14	
NI-6	Tama Convalescent Home	Tama	Tama	PROP.	0	0	30		--	--	--	
NI-6	Zigler Nursing Home	Tama	Tama	PROP.	0	0	18		--	--	--	
NI-6	Traer Custodial Home	Tama	Traer	PROP.	0	0	27		--	--	--	
NI-6	Bryant Nursing Home	Marshall	State Center	PROP.	0	0	12		--	--	--	
NI-6	Pleasant View Nursing Home	Marshall	State Center	PROP.	0	0	14		--	--	--	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

1 JULY 1961 IOWA

SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"L" REGION Des Moines (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPLAC.	ADDLNT	AV. DAILY CENSUS	SUITABLE	REPLAC.	ADDLNT.	AV. DAILY CENSUS
NI-6	Clemens Nursing Home	Marshall	Marshalltown	PROP.	0	0	15		--	--	--	
NI-6	Sherman Nursing Home	Marshall	Marshalltown	PROP.	0	0	18		--	--	--	
NI-6	Iowa Soldiers' Home	Marshall	Marshalltown	STATE	0	0	185		0	150	386	
NI-6	Henderson Rest Home	Marshall	Marshalltown	PROP.	--	--	--		0	0	10	
NI-6	Kuper's Nursing Home	Marshall	Marshalltown	PROP.	0	0	16		--	--	--	
NI-6	McCarthy Rest Home	Marshall	Marshalltown	PROP.	--	--	--		0	0	14	
NI-6	Shady Lawn Nursing Home	Marshall	Marshalltown	PROP.	0	0	20		--	--	--	
NB-2	Garwood Nursing Home	Dallas	Dexter	PROP.	0	0	19		--	--	--	
NB-2	Garwood Custodial Home	Dallas	Dexter	PROP.	--	--	--		0	0	17	
NB-2	Hartwig Nursing Home	Dallas	Perry	PROP.	0	0	18		--	--	--	
NB-2	Lutheran Home for the Aged	Dallas	Perry	NPA	0	0	27		0	0	14	
NB-2	Terrill Custodial Home	Dallas	Perry	PROP.	--	--	--		0	0	10	
NB-2	Rowley Masonic Home	Dallas	Perry	NPA	--	--	--		20	0	0	
NB-2	Indianola Custodial Home	Warren	Indianola	PROP.	--	--	--		0	0	15	
NB-2	Burton Nursing Home	Warren	Indianola	PROP.	0	0	46		--	--	--	
NB-2	Goodwin Nursing Home	Warren	Indianola	PROP.	0	0	12		--	--	--	
NB-2	McKasson Nursing Home	Warren	Indianola	PROP.	0	0	18		--	--	--	
NB-2	Boughton Guest Home	Warren	Indianola	PROP.	--	--	--		0	0	14	
NB-2	Porter Nursing Home	Warren	Indianola	PROP.	0	0	11		--	--	--	
NB-2	Chambers Rest Home	Warren	Indianola	PROP.	--	--	--		0	0	17	
NB-2	Collins Nursing Home	Polk	Mitchellville	PROP.	0	0	12		--	--	--	
NB-2	Elizabeth's Nursing Home	Polk	Altoona	PROP.	0	0	20		--	--	--	
NB-2	Stuart Nursing Home	Polk	Altoona	PROP.	0	0	15		--	--	--	
NB-2	Bishop Drumm Home	Polk	Des Moines	CH.	28	0	0		0	121	0	
NB-2	Brown Nursing Home	Polk	Des Moines	PROP.	0	0	25		--	--	--	
NB-2	Danish Old People's Home	Polk	Des Moines	NPA	0	0	10		0	0	34	
NB-2	Elm Crest Nursing Home	Polk	Des Moines	PROP.	0	0	41		--	--	--	
NB-2	Grayson Nursing Home	Polk	Des Moines	PROP.	0	0	45		--	--	--	
NB-2	Hamilton Nursing Home	Polk	Des Moines	PROP.	0	0	14		--	--	--	
NB-2	Higgins Nursing Home	Polk	Des Moines	PROP.	0	0	19		--	--	--	
NB-2	Highland Park Nursing Home	Polk	Des Moines	PROP.	0	0	20		--	--	--	
NB-2	Home for Sightless Women	Polk	Des Moines	STATE	0	0	12		--	--	--	
NB-2	Home for the Aged	Polk	Des Moines	NPA	0	0	10		--	--	--	
NB-2	Hutchinson Nursing Home	Polk	Des Moines	PROP.	0	0	32		--	--	--	
NB-2	Hutchinson Annex	Polk	Des Moines	PROP.	--	--	--		0	0	15	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

1 JULY 1961 IOWA

SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"L" REGION Des Moines (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NB-2	Iowa Jewish Home	Polk	Des Moines	NPA	40	0	29		--	--	--	
NB-2	Johnson Nursing Home	Polk	Des Moines	PROP.	0	0	44		--	--	--	
NB-2	Link Nursing Home	Polk	Des Moines	PROP.	0	0	20		--	--	--	
NB-2	New Haven Nursing Home	Polk	Des Moines	PROP.	0	0	19		--	--	--	
NB-2	Mingus Nursing Home	Polk	Des Moines	PROP.	0	0	12		--	--	--	
NB-2	Restview Custodial Home	Polk	Des Moines	PROP.	40	0	25		0	0	19	
NB-2	New Haven Nursing Home	Polk	Des Moines	PROP.	0	0	60		--	--	--	
NB-2	Thompson Nursing Home	Polk	Des Moines	PROP.	0	0	16		--	--	--	
NB-2	Oaks Nursing Home	Polk	Des Moines	PROP.	0	0	28		--	--	--	
NB-2	Warford Restorium	Polk	W. Des Moines	PROP.	0	0	48		--	--	--	
NB-2	Ramsey Memorial Home	Polk	Des Moines	NPA	0	35	0		--	--	--	
NB-2	Wesley Acres	Polk	Des Moines	CH.	10	10	0		103	0	0	
NB-2	Wickwire Nursing Home	Polk	Des Moines	PROP.	0	0	15		--	--	--	
NB-2	Woodland Nursing Home	Polk	Des Moines	PROP.	0	0	48		--	--	--	
NB-2	Alamo	Polk	Des Moines	PROP.	--	--	--		0	0	15	
NB-2	Benedict Home	Polk	Des Moines	PROP.	--	--	--		0	0	16	
NB-2	Collins Custodial Home	Polk	Des Moines	PROP.	--	--	--		0	0	13	
NB-2	Houghton-Nelson Rest Home	Polk	Des Moines	PROP.	--	--	--		0	0	12	
NB-2	Killiam Rest Home	Polk	Des Moines	PROP.	--	--	--		0	0	12	
NB-2	Peterson Custodial Home	Polk	Des Moines	PROP.	--	--	--		0	0	10	
NB-2	Williams Custodial Home	Polk	Des Moines	PROP.	--	--	--		0	0	16	
NB-2	New Haven Nursing Home	Polk	Des Moines	PROP.	42	0	0		--	--	--	

IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

1 JULY 1961 IOWA

SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"M" REGION Council Bluffs

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	UNSUIT.	AV. DAILY CENSUS
NR-19	Saunders Nursing Home	Crawford	Denison	PROP.	0	0	37		--	--	--	
NR-20	Coon Rapids Nursing Home	Carroll	Coon Rapids	PROP.	0	0	10		--	--	--	
NR-20	Albright Nursing Home	Carroll	Coon Rapids	PROP.	0	0	16		--	--	--	
NR-20	Carroll Nursing Home	Carroll	Carroll	PROP.	0	0	11		--	--	--	
NR-20	Spieker Nursing Home	Carroll	Carroll	PROP.	0	0	10		--	--	--	
NR-20	Perry Nursing Home	Carroll	Carroll	PROP.	0	0	20		--	--	--	
NR-20	Henrietta Holstein Nursing H.	Carroll	Carroll	PROP.	0	0	15		--	--	--	
NR-20	Eckhoff Custodial Home	Carroll	Carroll	PROP.	0	0	14		--	--	--	
NR-26	Dougherty Custodial Home	Harrison	Mo. Valley	PROP.	--	--	--		0	0	10	
NR-26	Horton Nursing Home	Harrison	Logan	PROP.	0	0	50		--	--	--	
NR-26	Gillette Home for the Aged	Harrison	Mo. Valley	PROP.	--	--	--		0	0	11	
NR-26	Rose Vista Nursing Home	Harrison	Woodbine	PROP.	56	0	0		--	--	--	
NR-27	Baptist Memorial Home	Shelby	Harlan	NPA	26	0	0		48	0	0	
NR-27	Salem Lutheran Home	Shelby	Elk Horn	NPA	0	16	0		0	0	121	
NR-28	Friendship Home	Audubon	Audubon	NPA	10	0	0		77	0	0	
NR-28	Potter Nursing Home	Cass	Anita	PROP.	0	0	16		--	--	--	
NR-28	Neighbors Nursing Home	Cass	Griswold	PROP.	0	0	20		--	--	--	
NR-28	Dotson Rest Home	Cass	Griswold	PROP.	--	--	--		0	0	12	
NR-28	Berry Nursing Home	Cass	Atlantic	PROP.	0	0	20		--	--	--	
NR-28	Garnsey Rest Home	Cass	Atlantic	PROP.	--	--	--		0	0	10	
NR-28	Dennis Nursing Home	Cass	Atlantic	PROP.	0	0	20		--	--	--	
NR-28	Shady Lawn Rest Home	Cass	Atlantic	PROP.	--	--	--		0	0	18	
NR-28	Miller Nursing Home	Cass	Atlantic	PROP.	0	0	12		--	--	--	
NR-36	Shady Lawn Nursing Home	Montgmry.	Villisca	PROP.	0	0	17		--	--	--	
NR-36	Villisca Nursing Home	Montgmry.	Villisca	PROP.	0	0	17		--	--	--	
NR-36	Cottage Rest Home	Montgmry.	Red Oak	PROP.	0	0	20		--	--	--	
NR-36	Marshall Manor Nursing Home	Montgmry.	Red Oak	PROP.	0	0	20		--	--	--	
NR-36	Marshall Domain	Montgmry.	Red Oak	PROP.	0	0	16		--	--	--	
NR-36	Murphy Memorial Hospital	Montgmry.	Red Oak	NPA	40	0	0		--	--	--	

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IOWA STATE DEPARTMENT OF HEALTH
DIVISION OF HOSPITAL SERVICES

1 JULY 1961 IOWA
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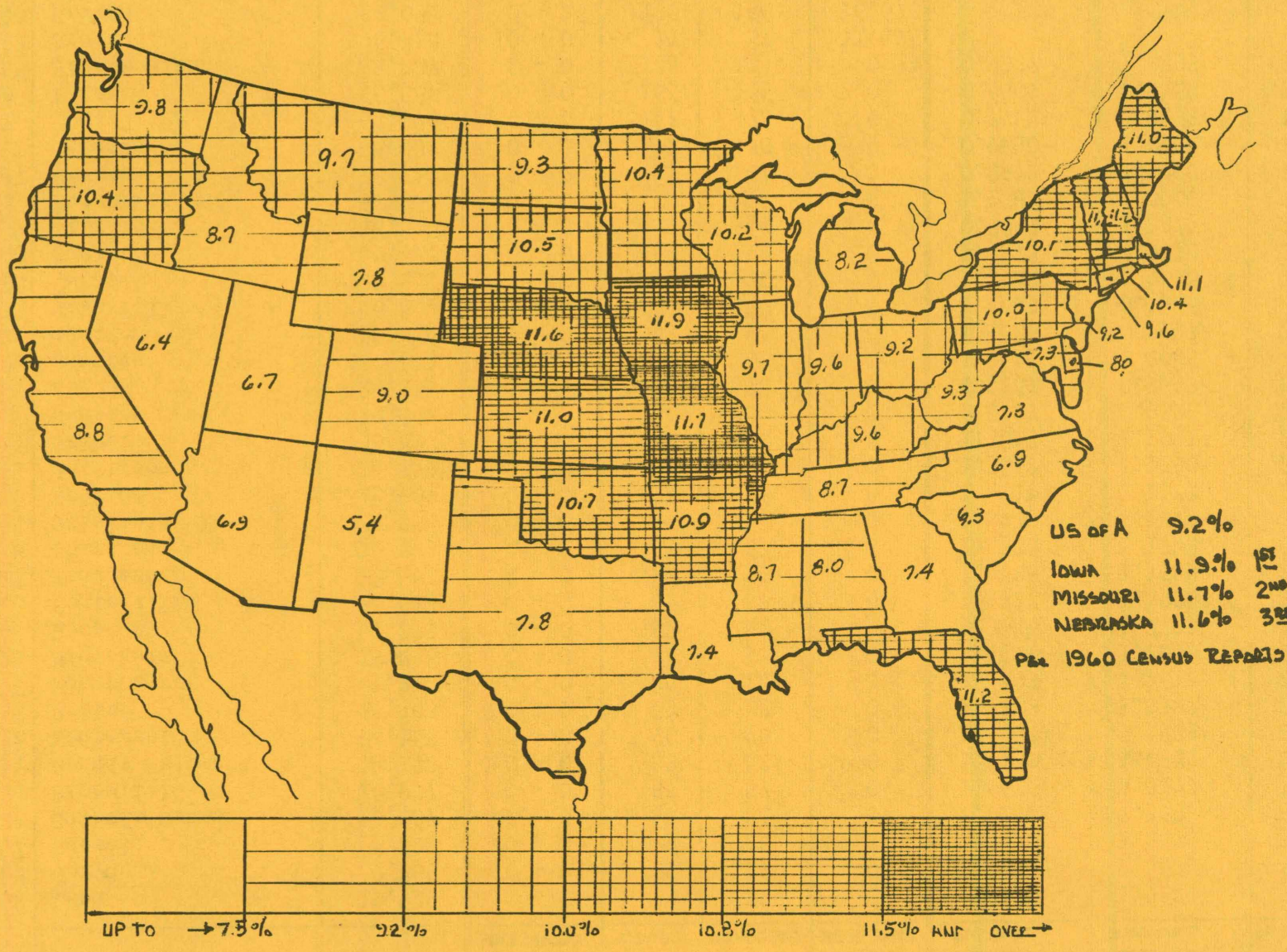
SUITABILITY REPORT FOR NURSING HOMES AND CUSTODIAL HOMES

"M" REGION Council Bluffs (cont.)

AREA	NAME OF FACILITY	LOCATION		OWNERSHIP	NURSING HOME BEDS				CUSTODIAL HOME BEDS			
		COUNTY	CITY		SUITABLE	REPAIR.	ADDIT.	AV. DAILY CENSUS	SUITABLE	REPAIR.	ADDIT.	AV. DAILY CENSUS
NR-40	Melton Nursing Home	Fremont	Hamburg	PROP.	0	0	20		--	--	--	
NR-40	Good Samaritan Rest Home	Fremont	Tabor	NPA	0	0	48		0	0	20	
NR-40	Simmons Nursing Home	Page	Shenandoah	PROP.	0	0	19		--	--	--	
NR-40	Clarinda Rest Home	Page	Clarinda	PROP.	0	0	14		--	--	--	
NR-40	Gillespie's Nursing Home	Page	Clarinda	PROP.	0	0	20		--	--	--	
NR-40	West Portal Nursing Home	Page	Clarinda	PROP.	0	0	20		--	--	--	
NR-40	Williams Nursing Home	Page	Clarinda	PROP.	0	0	20		--	--	--	
NR-40	Young Nursing Home	Page	Clarinda	PROP.	0	0	50		--	--	--	
NR-40	Hand Memorial Hospital	Page	Shenandoah	NPA	28	0	0		--	--	--	
NR-40	Lenox Nursing Home	Taylor	Lenox	PROP.	0	0	16		--	--	--	
NR-40	Armstrong Rest Home	Taylor	Bedford	PROP.	0	0	19		--	--	--	
NR-40	Court Street Rest Home	Taylor	Bedford	PROP.	0	0	17		--	--	--	
NR-40	Clearview Nursing Home	Taylor	Clearfield	PROP.	0	24	0		--	--	--	
NI-9	Horton Nursing Home	Mills	Glenwood	PROP.	0	0	44		--	--	--	
NI-9	Nishna Cottage Nursing Home	Mills	Malvern	PROP.	0	0	35		--	--	--	
NI-9	Avoca Rest Home	Pottawat.	Council Blfs.	PROP.	0	0	15		--	--	--	
NI-9	Gilmore Rest Home	Pottawat.	Council Blfs.	PROP.	0	0	27		--	--	--	
NI-9	Hillcrest Home	Pottawat.	Council Blfs.	PROP.	0	0	20		--	--	--	
NI-9	Jackson Convalescent Home	Pottawat.	Council Blfs.	PROP.	0	0	19		--	--	--	
NI-9	Young Rest Home	Pottawat.	Council Blfs.	CORP.	0	0	60		--	--	--	
NI-9	Avoca Nursing Home	Pottawat.	Avoca	PROP.	48	0	0		--	--	--	
NI-9	Faddis Rest Home	Pottawat.	Avoca	PROP.	--	--	--		0	0	10	
NI-9	Watsons Guest Retreat	Pottawat.	Council Blfs.	PROP.	--	--	--		0	0	15	



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

IOWA STATE DEPT. OF HEALTH
DIV. OF HOSPITAL SERVICES

IOWA STATE DEPT OF HEALTH
DIV. OF HOSPITAL SERVICES

NURSING HOME SUMMARY AND RELATIVE NEED REPORT (14th REVISION)

1 JULY 1961

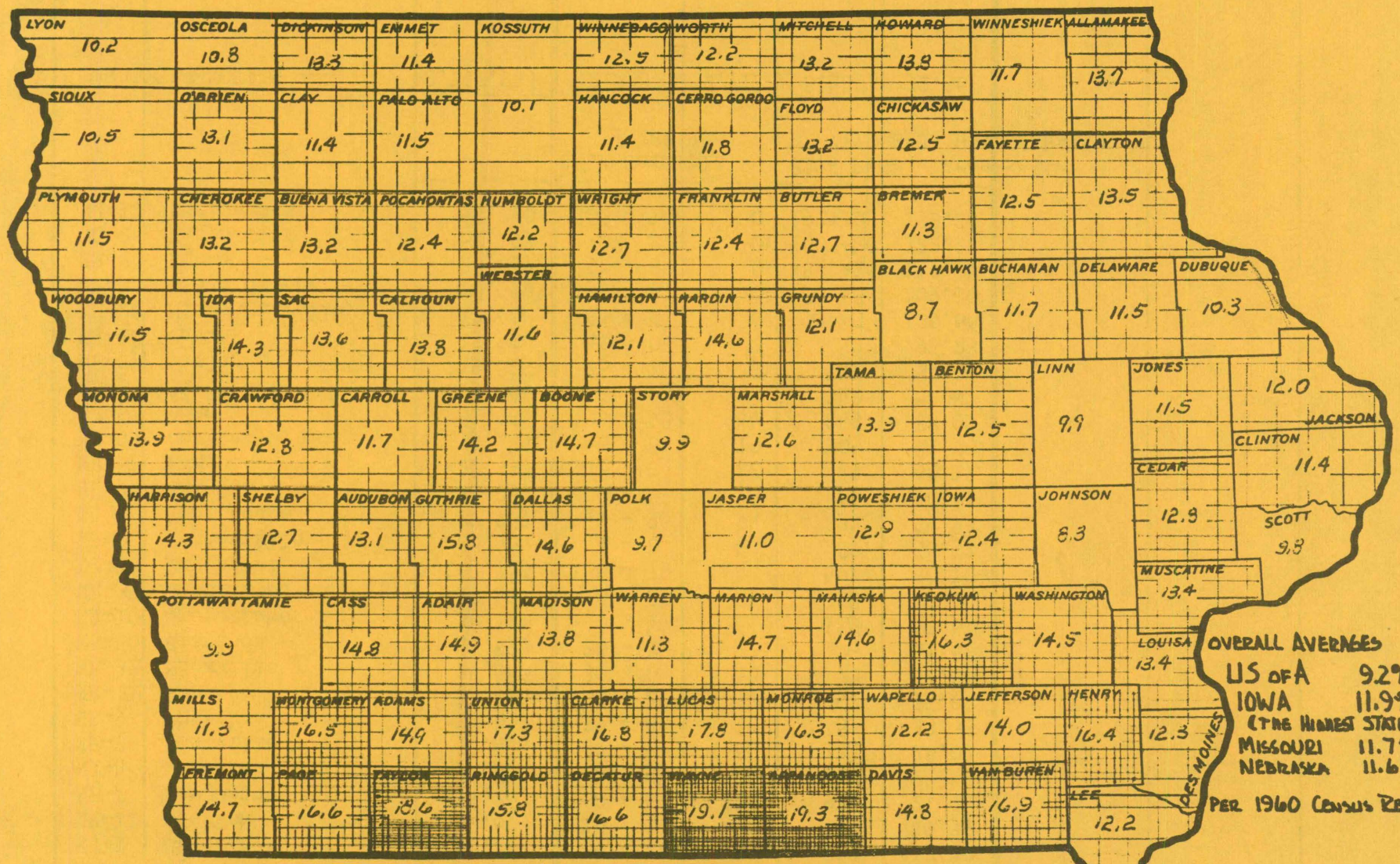
BASIC AREA DATA			BED INVENTORY OR SUMMARY				PRIORITY ANALYSIS		
SYMBOL	AREA CENTER	POPULATION	EXISTING SUM. BEDS	TO BE ADDED	TOTAL PROPOSED	% OF NEED MET	RURALITY FACTOR	INCOME FACTOR	GROSS PRIORITY FACTOR
NR-42	Leon	10,539	0 - 0	32	32	0	1.9130	1.4679	3.3809
NR-48	Corydon	9,800	0 - 0	29	29	0	1.9081	1.4674	3.3755
NR-47	Osceola	8,222	0 - 0	25	25	0	1.9030	1.4670	3.3700
NR-29	Guthrie Center	13,607	0 - 0	41	41	0	1.9130	1.3652	3.2782
NR-44	Bloomfield	18,977	0 - 0	57	57	0	1.6676	1.3779	3.0455
NR-14	Grundy Center	14,132	0 - 0	42	42	0	1.9130	1.0284	2.9414
NR-32	Winterset	23,188	0 - 0	70	70	0	1.6448	1.2523	2.8971
NR-46	Britt	27,703	0 - 0	83	83	0	1.7272	1.0327	2.7599
NR-41	Mount Ayr	7,910	0 - 0	24	24	0	1.4893	1.2612	2.7505
NR-25	Maquoketa	19,248	0 - 0	58	58	0	1.4711	1.2630	2.7341
NR-6	Decorah	47,225	0 - 0	142	142	0	1.3844	1.2793	2.6637
NR-43	Centerville	16,015	0 - 0	48	48	0	1.1727	1.4900	2.6627
NR-17	Manchester	18,483	0 - 0	55	55	0	1.4826	1.1549	2.6375
NR-38	Chariton	10,923	0 - 0	33	33	0	1.4378	1.1743	2.6121
NR-34	Oskaloosa	39,094	0 - 0	117	117	0	1.4020	1.1929	2.5949
NR-19	Denison	18,569	0 - 0	56	56	0	1.4711	1.1183	2.5894
NR-21	Jefferson	14,379	0 - 0	43	43	0	1.3812	1.1380	2.5192
NR-15	Oelwein	36,827	0 - 0	110	110	0	1.3812	1.1091	2.4903
NR-12	Webster City	20,032	0 - 0	60	60	0	1.5227	0.9525	2.4752
NR-4	Algona	25,314	0 - 0	76	76	0	1.5189	0.9519	2.4708
NR-24	Anamosa	20,693	0 - 0	62	62	0	1.2435	1.2045	2.4480
NR-2	Sheldon	30,846	0 - 0	93	93	0	1.4826	0.9543	2.4369
NR-13	Iowa Falls	46,803	0 - 0	140	140	0	1.4093	0.9966	2.4059
NR-20	Carroll	23,431	0 - 0	70	70	0	1.3965	0.9618	2.3583
NR-23	Ames	49,327	0 - 0	148	148	0	1.3478	0.9570	2.3048
NR-39	Fairfield	15,818	0 - 0	47	47	0	0.8895	1.2377	2.1272
NI-6	Marshalltown	57,288	0 - 0	172	172	0	1.1241	1.0000	2.1241
NR-37	Creston	13,712	0 - 0	41	41	0	0.8972	1.1750	2.0722
NI-11	Ottumwa	56,589	0 - 0	170	170	0	0.9640	1.0108	1.9748
NB-1	Iowa City	57,376	0 - 0	172	172	0	0.7748	0.9452	1.7200
NI-8	Clinton	55,060	0 - 0	165	165	0	0.6409	0.9488	1.5897
NR-45	Fort Madison	44,207	0 - 0	133	133	0	0.5337	1.0495	1.5832
NR-28	Audubon	28,838	10 - 0	77	87	11.49			
NR-30	Newton	52,084	0 - 26	130	156	16.67			
NI-9	Council Bluffs	96,152	48 - 0	240	288	16.67			
NI-7	Cedar Rapids	169,926	85 - 0	425	510	16.67			

NURSING HOME SUMMARY AND RELATIVE NEED REPORT (14th REVISION)

1 JULY 1961

BASIC AREA DATA			BED INVENTORY OR SUMMARY				PRIORITY ANALYSIS		
SYMBOL	AREA CENTER	POPULATION	EXISTING & SUIT. BEDS	TO BE ADDED	TOTAL PROPOSED	% OF NEED MET	RURALITY FACTOR	INCOME FACTOR	GROSS PRIORITY FACTOR
NI-1	Spencer	37,562	0 - 20	93	113	17.70			
NR-11	Clarion	32,603	19 - 0	79	98	19.39			
NB-2	Des Moines	311,267	160 - 45	729	934	21.95			
NI-4	Waterloo	171,531	72 - 54	389	515	24.47			
NR-7	Postville	37,944	32 - 0	82	114	28.07			
NR-9	Cherokee	28,867	29 - 0	58	87	33.33			
NR-31	Marengo	18,894	0 - 20	37	57	35.09			
NR-33	Knoxville	25,886	30 - 0	48	78	38.46			
NR-40	Clarinda	41,593	28 - 24	73	125	41.60			
NR-10	Storm Lake	38,196	0 - 49	66	115	42.61			
NR-35	Washington	19,406	0 - 25	33	58	43.10			
NI-10	Davenport	163,785	166 - 79	246	491	50.10			
NR-3	Estherville	28,984	44 - 0	43	87	50.57			
NI-3	Fort Dodge	77,967	44 - 96	94	234	59.83			
NR-36	Red Oak	21,935	40 - 0	26	66	60.61			
NR-8	LeMars	22,997	47 - 0	22	69	68.12			
NR-5	Charles City	35,145	0 - 86	19	105	81.90			
NI-5	Dubuque	81,554	103 - 98	44	245	82.04			
NB-3	Sioux City	113,206	65 - 237	38	340	88.82			
NR-27	Harlan	15,825	26 - 16	5	47	89.36			
NR-18	Onawa	13,916	40 - 0	2	42	95.23			
NR-26	Missouri Valley	17,600	56 - 0	0	53 +3	105.66			
NR-1	Sioux Center	28,592	31 - 63	0	86 +8	109.30			
NR-22	Boone	28,037	50 - 50	0	84 +16	119.04			
NI-2	Mason City	60,153	0 - 220	0	180 +40	122.22			
NI-12	Burlington	65,750	286 - 14	0	197+103	152.28			
			1511 Suitable /1222 Repl.		8275 Beds - Area Ratio /170 Beds Beyond Ratio				
STATEWIDE TOTALS ---		2,757,535	2,733	5,712	8,445	32.36			

135


LYON 10.2
OSCEOLA 10.8
DICKINSON 13.3
EMMET 11.4
KOSSUTH
WINNEBAGO 12.5
WORTH 12.2
MITCHELL 13.2
HOWARD 13.8
WINNESHIEK 11.7
ALLAMAKEE 13.7
SIOUX 10.5
O'BRIEN 13.1
CLAY 11.4
PALO ALTO 11.5
10.1
HANCOCK 11.4
CERRO GORDO 11.8
FLOYD 13.2
CHICKASAW 12.5
FAYETTE 12.5
CLAYTON 13.5
PLYMOUTH 11.5
CHEROKEE 13.2
BUENA VISTA 13.2
POCAHONTAS 12.4
HUMBOLDT 12.2
WRIGHT 12.7
FRANKLIN 12.4
BUTLER 12.7
BREMER 11.3
BLACK HAWK 8.7
BUCHANAN 11.7
DELAWARE 11.5
DUBUQUE 10.3
WEBSTER 11.6
WOODBURY 11.5
IDA 14.3
SAC 13.6
CALHOUN 13.8
HAMILTON 12.1
HARDIN 14.6
GRUNDY 12.1
MONONA 13.9
CRAWFORD 12.8
CARROLL 11.7
GREENE 14.2
BOONE 14.7
STORY 9.9
MARSHALL 12.6
TAMA 13.9
BENTON 12.5
LINN 9.9
JONES 11.5
JACKSON 12.0
CLINTON 11.4
CEDAR 12.9
SCOTT 9.8
HARRISON 14.3
SHELBY 12.7
AUDUBON 13.1
GUTHRIE 15.8
DALLAS 14.6
POLK 9.1
JASPER 11.0
POWESHIEK 12.9
IOWA 12.4
JOHNSON 8.3
MUSCATINE 13.4
POTTAWATTAMIE 9.9
CASS 14.8
ADAIR 14.9
MADISON 13.8
WARREN 11.3
MARION 14.7
MAHASKA 14.6
KEOKUK 16.3
WASHINGTON 14.5
LOUISA 13.4
MILLS 11.3
MONTGOMERY 16.5
ADAMS 14.9
UNION 17.3
CLARKE 16.8
LUCAS 17.8
MONROE 16.3
WAPELLO 12.2
JEFFERSON 14.0
HENRY 16.4
12.3
DES MOINES
FREMONT 14.7
PAGE 16.6
TAYLOR 18.6
RINGGOLD 15.8
DECATUR 16.6
WAYNE 19.1
APPANOOSE 19.3
DAVIS 14.8
VAN BUREN 16.9
LEE 12.2
OVERALL AVERAGES
US OF A 9.2%
IOWA 11.9%
(THE HIGHEST STATE)
MISSOURI 11.7%
NEBRASKA 11.6%
PER 1960 CENSUS REPORTS
GRAPHIC COMPARISON - IOWA COUNTIES - % OF TOTAL POPULATION OVER 65 YEARS OLD
TO → 10.1% 11.1% 12.1% 14.0% 16.0% 18.0% OVER →
IOWA STATE DEPT. OF HEALTH
DIV. OF HOSPITAL SERVICES

PART VII. DIAGNOSTIC AND TREATMENT CENTERS

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

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

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

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

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

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

Based upon the inventory, the following conclusions were drawn:

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

2. The geographic distribution of the various facilities generally

follows the concentration of population, and, at the same time, the services are disseminated throughout the entire State so as to be quite readily available to all of the people of the State. To further demonstrate this fact, the map shows the geographic distribution of the offices of 2,634 practicing medical doctors, 478 doctors of osteopathy, 1,648 dentists and 171 hospitals.

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

4. Current study indicates a need for additional diagnostic and treatment services in 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 highest relative priority.

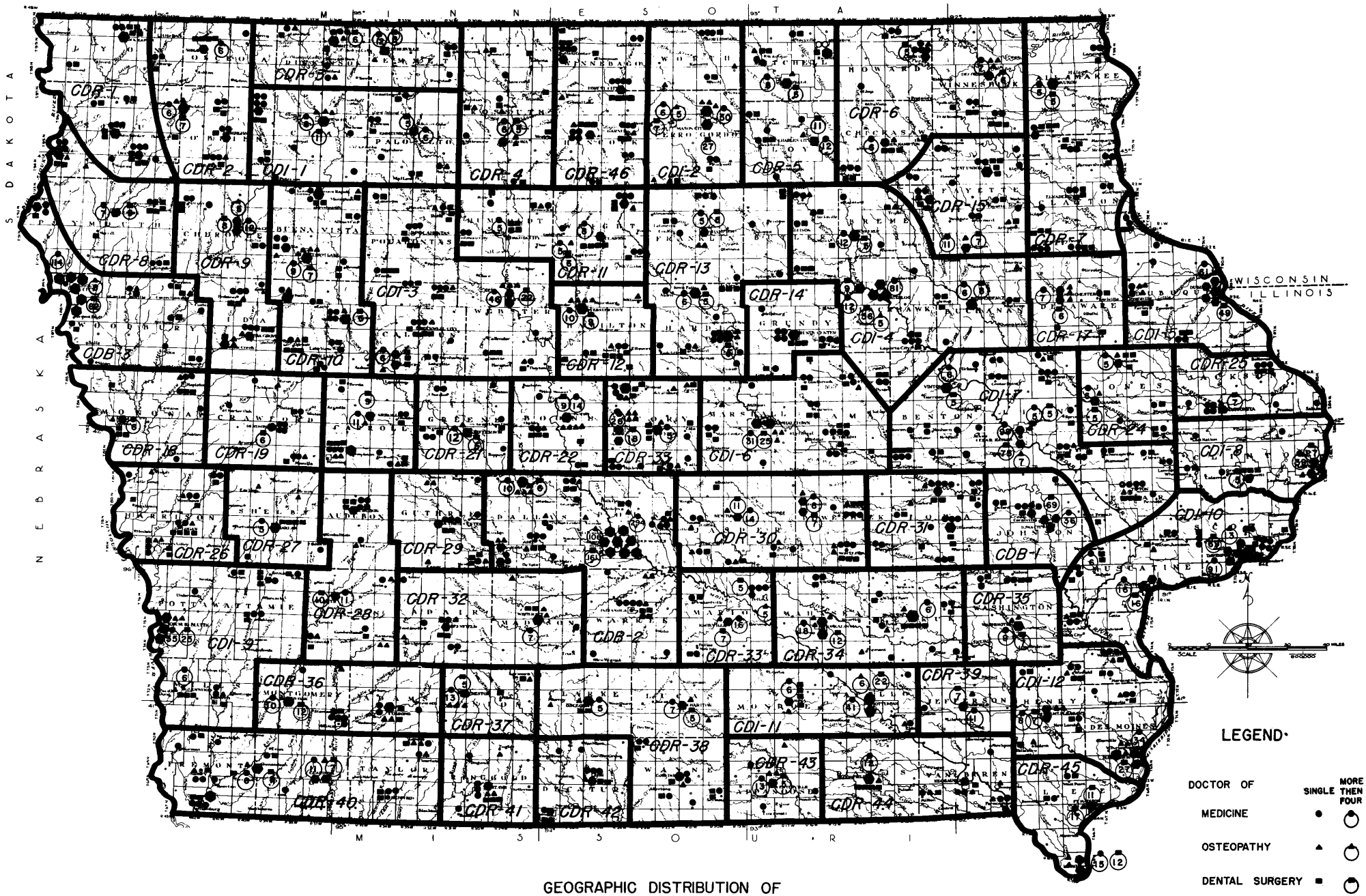
(b) The dental clinic at the State University of Iowa serves as a diagnostic and treatment center for unusual and complex dental conditions, as well as a training center for dentists. The number of dentists that can be trained is limited by the size of the clinic. In order to make this dental service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

(c) 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 Des Moines. It is therefore proposed that an outpatient facility be established in Iowa City to serve the need referred to by the Governor's Study Committee. The unit is assigned the third highest priority.

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

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

IOWA STATE DEPT. OF HEALTH
DIVISION OF HOSPITAL SERVICES

01

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

1 JULY 1961
14TH REVISION - IOWA PLAN

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

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

(B) Refer to pages 99 thru 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 preceding pages.

PART VIII. REHABILITATION CENTERS

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

(1) REHABILITATION FACILITY "A facility providing community service which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of 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 plan of services in which the disabled individual is viewed as a whole. When members of the team contribute to the diagnosis and treatment of illness, their contributions must be coordinated under medical responsibility. These integrated services may be provided in a facility to care for many types of disabilities or a single type of disability."

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

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

Services available to the State in this field are extremely inadequate, when measured in terms of total need. This generalization became quite evident when basic survey data was reviewed. While a number of organizations have attempted to serve the needs of the disabled, very few are able to provide the essential elements in the four aread 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 to the close association of field personnel in the Division of Vocational Rehabilitation with the varied efforts put forth by charity and non-profit organizations. The interpretation placed upon the basic data shall not be construed as criticism of those organizations who are active in rehabilitation. More realistically, it represents the public reluctance to recognize the needs in this field and illustrates the impact this failing is having on tax dollars. When the public realizes how many individuals, without sufficient resource and dependent on political subdivisions for care, could be re-established as producers and taxpayers, we may witness 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 it impossible to overbuild if duplication is avoided.

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

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

IOWA STATE DEPARTMENT OF HEALTH (HOSPITAL SERVICES)
INVENTORY OF REHABILITATION FACILITIES

NAME OF FACILITY	LOCATION	CLASSIFICATION (CODE)	OWNERSHIP OR CONTROL	AV. DAILY CASELOAD: INPATIENT	AV. DAILY CASELOAD: OUTPATIENT	NO. OF PERSONS SERVED ANNUALLY	AGE GROUPS SERVED: UNDER 16	AGE GROUPS SERVED: OVER 16	DISABILITY GROUPS SERVED: DEAF	DISABILITY GROUPS SERVED: BLIND	DISABILITY GROUPS SERVED: T.B.	DISABILITY GROUPS SERVED: CARDIAC	DISABILITY GROUPS SERVED: ORTHOPEDIC	DISABILITY GROUPS SERVED: NEUROLOGICAL	DISABILITY GROUPS SERVED: OTHER	SERVICES: MEDICAL	SERVICES: PSYCHOPATHIC	SERVICES: SOCIAL	SERVICES: VOCATIONAL
Ia. Voc. Rehab. Center	Des Moines	S	STATE	20	40	178		X	X		X	X	X	X		ABCDEFGHLM	N	OPQR	STUV
Ia. Soc. for Crippled Children & Adults	Des Moines	S	NPA		18	220	X	X	X	X		X	X	X		ABCDEFHM	N	OPQR	STUVWY
Iowa Methodist Hospital	Des Moines	S	CH	80	120	(730)	X	X	X	X		X	X	X	X	Complete	N	OPQR	STUV
University Hospitals	Iowa City	S	STATE	25		278	X	X	X	X		X	X	X	X	ABCDEFGHJ KLM	N	OPQR	STV
Em. Dist. Childrens Unit	Iowa City	S	STATE	48	12	480							X	X		ABCDEGHI JKLM	N	OPQR	STUV
Iowa Braille & Sight Saving School	Vinton	U	STATE	172		172	X	X		X						ABDFGHJKLM	N	OPQR	STVWZ
(Decorah Rehab. Center)	Decorah	S	NPA	(Under Construct.)			X	X					X		X	ABCDJKLM		R	S
Oakdale Sanatorium	Oakdale	S	STATE	80		180	X	X			X					ABDJILM	N	OPQR	STUVW
United Cerebral Palsy C.	Cedar Rpds.	S	NPA		28	60	X	X						X		ABCDELM	N	OPR	S
St. Luke's Meth. Hsp.	Cedar Rpds.	S	CH	NR	NR	NR	X	X	X	X		X	X	X	X	AM	N	OPQR	STUV
Linn Co. Soc. for Crippled Children	Cedar Rpds.	S	NPA			60	X	X					X			ABCLM		R	ST
Burlington Hospital	Burlington	S	NPA	(Under Construct.)			X	X			X	X	X	X	X	Complete	N	OPQR	STUV
Sunnyslope Sanatorium	Ottumwa	S	CO	63		63	X	X			X					ABDJLM		OPQR	STVW
Iowa School for Deaf	C. Bluffs	S	STATE	350		350	X	X	X							ABEFGHIKLM	N	OPQR	STUVWY
Siouxland Rehab. Ctr.	Sioux City	S	NPA	0	40	680	X	X	X	X		X	X			ACDEFGHJLM	N	OPQR	STUV

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

2. CODE FOR COLUMNS 21 THRU 24

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

PSYCHO.
N-Evaluation

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

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

IOWA STATE DEPARTMENT OF HEALTH

Division of Hospital Services

1. Page 1 of 1
2. Date July 1, 1961
3. State Iowa

REHABILITATION FACILITIES SUMMARY

4. Population	5. Total Facilities allowed by the state ratio
2,757,537	(9) (6 disabilities) - 57 Disability Services

6. Additional Facilities Proposed - 44 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.	
Iowa City Davenport Waterloo	Facilities will vary in keeping with available talent, resources, and demonstrated community support. Preference will be given to multiple disability units and the program proposed. Evaluation will be based on degree of service attainable with the approvable proposal.

DETERMINATION OF RELATIVE NEED

Priority of Categories

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

Priority of Hospital Categories (Public Law 725)

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

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

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

CATEGORY	EXISTING "ACCEPT." BEDS	PROPOSED TO BE ADDED	TOTAL BEDS PROPOSED	% NEED MET
Chronic	1,272	3,092	4,364	29.15
Mental	4,259	9,529	13,788	30.89
General	9,170	4,296	13,466	68.10
Tuberculosis	407	0	407	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 state allotment may be made available for public health centers within a given state.

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

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

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

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

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

Priority of Related Health Facility Categories (Public Law 482)

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

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

The funds for chronic illness hospitals will be guided by the priority table set forth in Part V. Funds established for convalescent nursing homes will be granted in keeping with priority table in Part VI. Greatest unmet need is the primary consideration. In areas with no need met, greatest rurality and lowest per capita income give preference. Both diagnostic centers and rehabilitation centers are 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.

Intent of Project Sponsors

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

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

Service Area Priority

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

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:

$$\frac{\text{Area Rural Population}}{\text{Area Rural Population}} = \text{Per Cent Area Rural Population}$$

State Rural Population / State Rural Population = Per Cent State Rural Population

Area % Rural Population / State % Rural Population = Rurality Factor

Per Capita Income Factor:

State Average Per Capita Income / Area Average Per Capita Income = Per Capita Income Factor

Population Density Factor:

Area Total Population / Area Total Square Miles = Area Average Density

State Total Population / State Total Square Miles = State Average Density

Area Average Density / State Average Density = Population Density Factor

Population Increase Factor:

(100) 1960 Area Population / 1950 Area Population = % Area Population Increase + 100

(100) 1960 State Population / 1950 State Population = % State Population Increase + 100

% Area Population Increase + 100 / % State Population Increase + 100 = Population Increase Factor

Per Capita Taxable Property Factor:

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

Area Taxable Property Value / Area Population = Per Capita Taxable Property Value

State Total Taxable Property Value / State Total Population = State Per Capita Taxable Property Value

State Per Capita Taxable Prop. Value / Area Per Capita Taxable Prop. Value = Per Capita Taxable Property Value Factor

Replaceable Bed Priority Factor:

Number of Replaceable Beds / Suitable Beds Plus Replaceable Beds = Replaceable Bed Factor

Source of Basic Factor Data:

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

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

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

EXHIBIT F

METHOD OF ADMINISTRATION

Publication of the State Plan

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

2. After approval of the 14th Revision of the State Plan by the Iowa Advisory Council for Hospitals and Related Health Facilities, the Iowa State Department of Health did take steps to insure publication of a general description of the State Plan in the Des Moines Sunday Register on 10 April 1961. In addition, societies, organizations, and associations were urged to cooperate in bringing the essential portions and provisions of the State Plan to the attention of interested and affected parties, persons, organizations and associations in their respective communities.

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

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

Federal Share Determination

In accordance with the amended Hospital Survey and Construction Act (Section 631 (k) (2); Public Law 725, Public Law 380, and Public Law 482, the "Federal Share" as defined in the above-mentioned Acts has been determined as 33 1/3 per centum for all projects proposed to be constructed under these Acts in the State of Iowa during the fiscal year commencing July 1, 1961, except for rehabilitation. In keeping with the Health Grants Manual, paragraph 23-2 10-B-2 (b); Participation in rehabilitation projects under Part "G" shall be at the rate of 50% of the total project cost as set forth by approved application.

Non-Discrimination Statement

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

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

Project Construction Schedule

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

Changes in Area Priority

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

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

Factors Determining Project Construction Schedule

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

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

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

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

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

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

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

7. The Project Construction Schedule pertinent to allotment under

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

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

The Project Construction Schedules will be 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/or other assurances.

Project Applications

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

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

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

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

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

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

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

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

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

   d. Name of architect or engineer retained.

   e. A 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. Upon receipt of a letter of intent from the owners, appropriate Part I forms will be supplied to the prospective sponsors for guidance in the preparation of certain supporting documentation. Items to be included in triplicate in an approvable application are:

   a. Part I of Application.

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

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

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

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

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

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

h. The owner and architect shall be prepared to give conclusive evidence that the project will proceed directly through planning and be placed on the market for bidding and contracting before 2 April 1962. Failure by the owners/architect to provide evidence of suitable progress in keeping with the assurance given the Advisory Council at the time Part I was approved will be grounds for reviewing the application. Such failure will warrant reconsideration and re-assignment of funds to a project prepared to proceed directly to contract in keeping with the intent of the program and plan.

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

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

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

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

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

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

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

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

(1) Giving evidence of adequate funds.

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

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

c. Voluntary withdrawal from program.

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

Transfer of Funds to Adjacent States

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

Standards of Construction and Equipment

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

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

Inspection and Certification by the State Department of Health

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

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

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

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

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

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

Certification for Payments

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

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

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

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

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

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

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

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

Accounting System and Records, Construction Allotments

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

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

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

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

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

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

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

Annual Revisions of the Over-All Hospital Construction Program

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

Personnel Standards

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

Conflict of Interest

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

EXHIBIT G

MINIMUM STANDARDS FOR MAINTENANCE AND OPERATION

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

EXHIBIT H

FAIR HEARING PROCEDURE

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

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

entitled to a hearing on any one of the following:

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

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

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

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

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

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Time Kept. The period of loan is two weeks; older books may be once renewed. New books and Journals are not renewable.

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.