

IOWA DEPARTMENT OF PUBLIC HEALTH

**CERTIFICATE OF NEED
REDUCTION OF BED CAPACITY**

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1. Name of Facility _____

2. Address _____
Street City County Zip

3. Contact Person _____ (_____) _____
Name Telephone

Email _____

4. Date of reduction _____

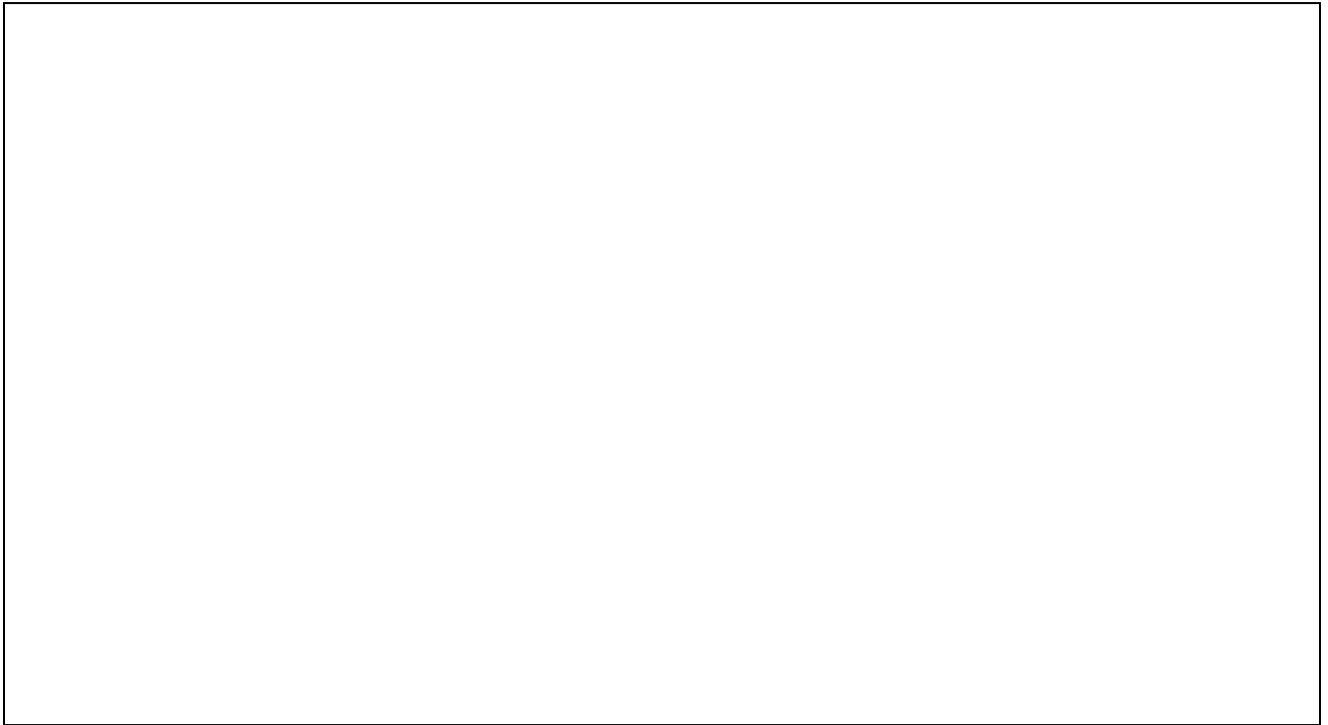
5. Current number of beds _____

6. State how many beds, by type, (641 Iowa Administrative Code 202.1(3)b) will be reduced. In the case of a health care facility, the new bed total must be consistent with the number of licensed beds at the facility. In the case of a hospital, the number of beds must be consistent with bed totals reported to the Department of Inspections and Appeals for purposes of licensure and certification. The new bed total must be reported on the hospital's next annual report to the Department of Public Health. Section 135.63(2)g, Iowa Code.

7. Explain why the beds can be eliminated without creating a hardship for the facility or the individuals served.

- A. Describe your current bed inventory by category and provide occupancy percentages by category for the past year. Use additional pages as necessary.

- B. Project future utilization and describe how the reduced number of beds will accommodate that utilization. Use additional pages as necessary. (See response text box on the next page.)



8. Explain any other advantages or disadvantages to your patients, residents or institution which may result following the reduction of beds, e.g. more flexible scheduling of staff, different reimbursement basis, use of space for other revenue producing functions. Use additional pages as necessary. (See response text box on the next page.)

9. **AUTHORIZATION:** Signatures of Administrator and Chairperson of the Board of Directors.

Administrator

Board Chairperson

Date

If this form is not completed and submitted at least thirty days before the reduction, the facility is subject to review as a new or changed institutional health service under section 135.61(18)d and subject to sanctions under section 135.73.