**IOWA DEPARTMENT OF PUBLIC HEALTH**
**DIVISION OF EXECUTIVE STAFF**

CERTIFICATE OF NEED
REDUCTION OF BED CAPACITY
==========

1. Name of Facility _____

2. Address_____
Street City County Zip

3. Contact Person_____ (____)_____
Name Telephone

4. State how many beds, by type, (Iowa Administrative Code 641-202.1(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.

5. Attach an explanation 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.

B. Project future utilization and describe how the reduced number of beds will accommodate that utilization.

6. 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.

7. **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.*

588-1030 BEDDEL (04/95)