SCHEDULE 4

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All Applicants with Current Licensed Beds

UTILIZATION OF EXISTING BEDS

	DATES	LICENSED BEDS		PATIENT DAYS		PERCENT UTILIZATION	
		NURSING HOME	OTHER	NURSING HOME	OTHER	NURSING HOME	OTHER
3RD PRIOR YEAR							
(12-month period)	_____	_____	_____	_____	_____	_____	_____
2ND PRIOR YEAR							
1st Quarter	_____	_____	_____	_____	_____	_____	_____
2nd Quarter	_____	_____	_____	_____	_____	_____	_____
3rd Quarter	_____	_____	_____	_____	_____	_____	_____
4th Quarter	_____	_____	_____	_____	_____	_____	_____
	TOTAL	_____	_____	_____	_____	_____	_____
MOST RECENT YEAR							
1st Quarter	_____	_____	_____	_____	_____	_____	_____
2nd Quarter	_____	_____	_____	_____	_____	_____	_____
3rd Quarter	_____	_____	_____	_____	_____	_____	_____
4th Quarter	_____	_____	_____	_____	_____	_____	_____
	TOTAL	_____	_____	_____	_____	_____	_____

Indicate the type of licensed beds shown in the "Other" category above: _____

PLEASE SHOW UTILIZATION FOR THE **TOTAL** OF LICENSED BEDS AT YOUR FACILITY

And

IF THE PROJECT WILL INCREASE A BED TYPE THAT ALREADY EXISTS AT YOUR FACILITY (for example, an increase in the number of nursing home beds) INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS UTILIZATION **ONLY** FOR THE SERVICE THAT WILL BE EXPANDED