

BREAKDOWN OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS									
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NAME OF FACILITY: _____	TOWN: _____	PROVIDER NUMBER: _____
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If change in beds or room numbers
the effective date of the change: _____

[illegible]

INSTRUCTIONS: Complete and mail to appropriate Regional Office of the Division of Health Service Regulation, NC Department of Human & Human Services.

Total the beds for the different classifications (Medicare, Medicaid, etc.) at the bottom of the continuation sheet. The administrator must sign and date the form on the back since copies of these forms are sent to the appropriate certifying agency(ies) for reimbursement purposes.

*Identify type of beds (Nursing or Adult Care Home) Page 1

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NAME OF FACILITY: _____	TOWN: _____	PROVIDER NUMBER: _____
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	If change in beds or room numbers the effective date of the change: _____
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[illegible]

TOTAL

Medicare/Medicaid = _____ (Beds)

Medicare Only = _____ (Beds)

Medicaid Only = _____ (Beds)

Licensed Only = _____ (Beds)

FOR YOUR INFORMATION: Adult Care Home beds cannot be certified in Medicare nor Medicaid

***Identify type of beds (Nursing or Adult Care Home)**

Administrator's Signature: _____

Date: _____

