INFORMATION RELATING TO COMPLETION OF THE "REQUEST FOR BED CHANGE" FORM (#-81500A)

BACKGROUND:

In a May 2000 State Operation Manual (SOM) revision, the Kansas Department of Health and Environment (KDHE) was advised by the Centers for Medicare & Medicaid Services (CMS) of a change that takes place immediately regarding bed change requests from providers in Medicare/Medicaid facilities.

Medicare/Medicaid participating facilities may elect to **change the number of beds** that are certified to participate in the Medicare or Medicaid program up to **two times per cost reporting year** in accordance with the requirements set out in the May 2000 SOM, Revision 16. In other words an institution or institutional complex may only change the bed size of its SNF and/or its NF once on the first day of the beginning of its cost reporting year and again on the first of a single cost reporting quarter within that same cost reporting year in order to effect a change. **At no time** can the KDHE **approve two decreases** in the bed size of an institution within the same cost reporting year.

REQUIREMENTS:

Institutions or institutional complexes seeking a change in the number or location of Medicare and/or Medicaid certified beds must use the attached Request for Bed Change form to accomplish the following:

- ❑ **submit a written request** to the Kansas Department of Health and Environment (KDHE) for the change 45 days before:
  - the first day of its cost reporting year to effect a change on the first day of its cost reporting year **or**;
  - the first day of a single cost reporting quarter within the same cost reporting year at which time it seeks to change its bed size to effect a change on the first day of the designated cost reporting quarter; **and**
- ❑ **submit floor plans** identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for KDHE to determine that the proposed change is in fact, in conformance with the rules for the participation or distinct part certification, which ever applies; **and**
- ❑ include a **reference to the cost reporting year** of the institution or institutional complex.

KDHE will review providers request and notify them in writing of our determination regarding the request, including the effective date of the change in bed size and the bed locations, prior to the start of the cost reporting year or the cost reporting quarter, whichever applies. Please direct your inquiries and requests you may have regarding bed changes to Tamara Wilkerson, Certification Coordinator at 785-296-1263.

KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
BUREAU OF CHILD CARE AND HEALTH FACILITIES

REQUEST for BED CHANGE

Facility_____ Fed Provider #_____ State ID #_____

Address_____City_____ Zip_____ Phone (_____) _____

I Check box (s) that best describe requested action:

☐ This is an increase of Medicare certified beds from _____ to _____, or
☐ This is a decrease of Medicare certified beds from _____ to _____,
☐ This is a change in location of Medicare certified beds (Attached is a separate sheet that describes change)
and/or
☐ This is a request to increase the licensed bed capacity from _____ to_____, or
☐ This is a request to decrease the licensed bed capacity from _____ to _____.

II Indicate facility type or section of facility in which the change is being requested:

☐ Nursing facility ☐ Assisted Living Facility
☐ Residential Health Care Facility ☐ Homes Plus
☐ Adult Day Care ☐ Boarding Care ☐ ICF/MR

III Indicate Medicare cost reporting year_____ and/or
Medicaid cost reporting year_____ (as appropriate).

☐ Not applicable since this is a licensed category that has no cost report year.

IV Changes in Medicare & Medicaid certified beds only will require the facility to submit floor plans identifying all areas of the facility with current certified bed configuration & the proposed certified bed configuration. You will need to identify the room number(s) and number of beds for each room.

V Indicate Intermediary (for Medicare participating facilities only):

☐ Blue Cross of Kansas ☐ Mutual of Omaha ☐ Other _____

VI If the change request indicated in Section I results in a change in the number of licensed beds, there will be a charge of $50 plus $15 per resident for each bed increase or decrease (KAR 28-39-145a(j). Indicate amount enclosed $_____. (check, money order, or Discover card accepted)

VII If the change request indicated in Section I would result in a change in the use of a required room or area, then completion of the "Request For Change In Use of Required Room" form is required. (KAR 28-39-145a(i))

_____ _____ _____
Printed Name Title Signature (date: mm/dd/yy)

Submit form to: **Kansas Department of Health & Environment**
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1365

PRINT RESET

AGENCY USE ONLY - DO NOT WRITE BELOW THIS LINE

☐ _____ _____ _____
(Certification Approval) **(Licensure Approval)** **(date)**

☐ _____ _____ _____
(Certification Dis-approval) **(Licensure Dis-approval)** **(date)**