DATE OF REQUEST (this request must be received by AHCA 45 days before first day bed change begins - Exceptions: bed location changes [30 day advance notification required] and dual certification of whole facility – see HCFA All States Letter 22-00)

DATE BED CHANGE WILL BEGIN (must begin on the first day of a cost report quarter/year: Exceptions: bed location changes and dual certification of whole facility - see HCFA All States Letter 22-00 for exceptions)

NAME OF FACILITY

STREET ADDRESS

CITY, ZIP

PHONE FAX

FISCAL INTERMEDIARY

MAILING ADDRESS

CITY/STATE/ZIP

MEDICARE PROVIDER NUMBER

TOTAL NUMBER OF BEDS IN FACILITY

CURRENT NUMBER OF BEDS

<table>
<thead>
<tr>
<th>A. TITLE 18 (MEDICARE ONLY) DO NOT INCLUDE MEDICAID BEDS IN THIS COLUMN</th>
<th>B. DUALLY CERTIFIED 18/19 (MEDICARE AND MEDICAID BEDS COMBINED)</th>
<th>C. TITLE 19 (MEDICAID ONLY) DO NOT INCLUDE MEDICARE BEDS IN THIS COLUMN</th>
<th>D. PRIVATE OR OTHER PAY OR SOURCE (neither Medicare nor Medicaid)</th>
<th>TOTAL NUMBER OF BEDS IN FACILITY: MUST EQUAL A+B+C+D</th>
</tr>
</thead>
</table>

REQUESTED CHANGE

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</tr>
</thead>
</table>

FOR OFFICE USE ONLY

BED CHANGE APPROVED YES NO

NUMBER OF CHANGES REQUESTED

SIGNATURE

Revised, March 2018