# *Agency for Health Care Administration*

**Name & Address of Facility: _____**
**_____**
**_____**

**Medicare Provider Number: _____ Facility's Fiscal Year End Date: _____**

# Existing Room Configuration

**[Place an "X" in the box indicating 18 (Medicare), 18/19 (dually certified), or 19 (Medicaid)]**

| Room Number | | # Beds in Room | | 18 Only (L37) | | 18/19 (L38) | | 19 Only (L39) | | Private Pay | | | | |
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| ***TOTAL*** | | | | | | | | | | | | | | |

# *Agency for Health Care Administration*

**Name & Address of Facility: _____**
**_____**
**_____**

**Medicare Provider Number: _____ Facility's Fiscal Year End Date: _____**

# Proposed Room Configuration

**[Place an "X" in the box indicating 18 (Medicare), 18/19 (dually certified), or 19 (Medicaid)]**

| Room Number | | # Beds in Room | | 18 Only (L37) | | 18/19 (L38) | | 19 Only (L39) | | Private Pay | | | | |
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| ***TOTAL*** | | | | | | | | | | | | | | |

(Please check if appropriate) ___These changes will not necessitate movement of a resident or residents.