BREAKDOWN OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS

NAME OF FACILITY: _____ TOWN: _____ PROVIDER NUMBER: _____

If change in beds or room numbers the effective date of the change: _____

CHECK ONLY ONE							CHECK ONLY ONE					
Room Number	**# of Beds within Room**	**Medicare Medicaid**	**Medicaid Only**	**Medicare Only**	***Licensed Only**		**Room Number**	**# of Beds within Room**	**Medicare Medicaid**	**Medicaid Only**	**Medicare Only**	***Licensed Only**

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)**

DHSR-Form 4504 (03/09) - Formerly 4103

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TOTAL

Medicare/Medicaid = _____ (Beds) Medicaid Only = _____ (Beds)

Medicare 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: _____