



CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

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Governor

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Mark D. Birdwhistell  
Secretary

Shawn M. Crouch  
Commissioner

October 02, 2007

**TO: Nursing Facility (12) Providers  
Provider Letter A-229**

**RE: Bed Reserve Census**

Dear *KyHealth Choices* Provider:

In conjunction with setting the Bed Reserve rate for your facility, effective with the 2007 third quarter census, the Census Cover Sheet and supporting documentation should be sent directly to Myers and Stauffer LC rather than to the Department for Medicaid Services. The information may be submitted by mail or fax to:

Bed Reserve Census  
Myers and Stauffer, LC  
104 Progress Drive  
Frankfort, KY 40601  
502-695-3068 Fax

Myers and Stauffer LC must receive the census form and documentation by the 15<sup>th</sup> of the month following the end of each quarter. If the 15<sup>th</sup> is not a business day, the census must be received by the following business day. Any census or documentation received after the due date will not be accepted even if post marked by the 15<sup>th</sup>. You may want to consider making submissions using certified mail with a return receipt requested to provide proof of delivery.

Enclosed is a copy of the census cover sheet. Please note this form has been slightly modified.

If you have any questions regarding this letter, please call Lynette S. Gurney, Division of Long Term Care and Community Alternatives, at 502-564-5707, Monday through Friday, 8:00 a.m. until 4:30 p.m. eastern-time.

Sincerely,

Shawn M. Crouch  
Commissioner

Xc: Nursing Facility (12) Provider Letter Number A-229

SMC/CB/amd00339



**CENSUS COVER SHEET**

DATES OF QUARTERLY CENSUS: \_\_\_\_/\_\_\_\_/\_\_\_\_ thru \_\_\_\_/\_\_\_\_/\_\_\_\_

\*FACILITY NAME: \_\_\_\_\_

\*(This information must also be on the census)

MEDICAID PROVIDER NUMBER: \_\_\_\_\_

NATIONAL PROVIDER NUMBER: \_\_\_\_\_

Instructions – When computing total bed days used and available, include all NF beds, including bed reserve, regardless of payer source. (Do not include personal care beds.)

(1) Total bed days used (month 1) = \_\_\_\_\_

(2) Total bed days used (month 2) = \_\_\_\_\_

(3) Total bed days used (month 3) = \_\_\_\_\_

(4) Total bed days used for quarter = \_\_\_\_\_

**(Add lines 1, 2 and 3 to compute this total)**

(5) Total available bed days for NF = \_\_\_\_\_

**(# of beds multiplied by days in the quarter)**

(6) Percentage occupancy used for quarter = \_\_\_\_\_. \_\_\_\_\_. \_\_\_\_\_. \_\_\_\_\_. (2 decimal places)

**(Line 4 divided by Line 5)**

(7) Is the % in line 6 equal to 95% or higher? (Yes/No) \_\_\_\_\_

**Yes:**

Number of beds = \_\_\_\_\_

Have the number of beds changed since last quarter? (Yes/No) \_\_\_\_\_

If yes, effective date of change = \_\_\_\_/\_\_\_\_/\_\_\_\_

**No: Do nothing.** You will automatically be paid 50% of your per diem rate for bed reserve.

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature/Title of Facility Staff

\_\_\_\_\_  
Contact Phone Number

\_\_\_\_\_  
Printed Name of Facility Staff

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**Attach this form to the Quarterly Census**