PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

Suggested Format for

BED TRANSFER REQUEST APPLICATION

TITLE 55. HUMAN SERVICES
PART III. MEDICAL ASSISTANCE MANUAL
CHAPTER 1187. NURSING FACILITY SERVICES
SUBCHAPTER L. NURSING FACILITY PARTICIPATION REQUIREMENTS AND REVIEW PROCESS

Rev: 04-10-15

Pennsylvania Bed Transfer Request Application Instructions

The attached application form is formatted to assist applicants with compliance with the relevant regulations and to assure consistent and complete presentation of information from all applicants to allow for an efficient and timely review process.

Per 1187.173 - information included in this request is subject to public review.

General Instructions:

To clarify any question, refer to the regulation upon which it is based. A regulatory citation is provided at each question.

1. Pages should be single sided on 8 ½ x 11 paper
2. Pages should **not** be stapled together
3. Pages should be numbered
4. All lines in this application must be answered at a minimum by yes, no or N/A
5. No inserts, sleeves, or tabs should be used
6. Attachments should be clearly labeled in the upper right hand corner as Attachment A, Attachment B, etc.
7. Do not submit the application instructions along with your application
8. Submit questions related to completing the Bed Transfer Request Applications to RA-PartReview@pa.gov

A completed application includes:

1. A signed and dated application, where all of Sections A, B, and C have been completed in their entirety.
2. A Table of Contents that lists all included attachments.

Mailing Instructions:

Completed applications (one original and two copies) must be delivered or mailed to:

Department of Human Services
Office of Long-Term Living
Bureau of Finance
Division of Rate Setting and Auditing
Participation Review Unit
Forum Place, 6th Floor
P.O. Box 8025
Harrisburg, Pennsylvania 17105-8025

****INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE APPLICANT****

Pennsylvania Bed Transfer Request Application

Section A (to be completed by Applicant/Submitter)

Date of Application:		
Name of Applicant/Submitter:	Applicant/Submitter's Email Address:	
Name of Receiving Provider:	Physical Address of Receiving Provider:	County of Receiving Provider:
Contact Person:	Mailing Address:	
Telephone Number:	Fax Number:	
Contact's Email Address:		
Surrendering Provider(s):	Physical Address of Surrendering Provider(s):	County of Surrendering Provider(s):
Contact Person:	Mailing Address:	
Telephone Number:	Fax Number:	
Contact's Email Address:		
I affirm that the representations made and the information provided in this bed transfer request are true and correct to the best of my knowledge, information and belief. Signature of Applicant/Submitted Date		
I certify that the applicant is authorized to submit the bed transfer request on behalf of the legal entity and that the legal entity has reviewed and approves the contents of this bed transfer request. Signature of Owner/Legal Entity Date		
REMINDER: Please submit an original and two copies of the bed transfer request to the department.		

Section B (to be completed by applicant) (§ 1187.162 & § 1187.21)		
Question	Answer (Circle)	
1. Does the applicant seek the department's approval to increase the number of MA-certified beds in the receiving provider?	Yes	No
a. If yes, how many beds?	_____ beds	
2. Does the applicant represent that, if the department approves the request, at least the same number of MA-certified beds will be decertified and closed by the surrendering provider(s)?	Yes	No
a. If yes, how many beds?	_____ beds	
3. Is the receiving nursing facility certified as an MA provider?	Yes	No
4. Is the surrendering nursing facility certified as an MA provider?	Yes	No
5. If the receiving nursing facility has 60 or more beds, are they Medicare certified? § 1187.21(4)	Yes	No
6. Are the receiving and surrendering nursing facilities located in the same county? If no, complete question 7, otherwise go to Section C.	Yes	No
7. A. Is the driving distance between the receiving and surrendering nursing facilities no greater than 25 miles apart if both providers are in Metropolitan Service Area (MSA) Level A, or no greater than 50 miles in all other cases?	Yes	No
B. What is the driving distance between the receiving and the surrendering provider?	_____Miles	
Section C (to be completed by applicant		
I. Ownership Information - § 1187.172(a)(1)	Page #/Attach Reference	
A. Provide a list of names and addresses of each person who is any of the following: the applicant (including a description of the applicant's involvement in the proposed project), the legal entity or an owner of the subject facility and any related party to the project with a description of the related party's involvement in the proposed project. For each person identified specify:		
a) If the person is a spouse, parent, child or sibling of another person identified;		
b) Identify if, during the 3-year period preceding the bed request, the person is or was an owner of a nursing facility, whether or not located in the Commonwealth, and if so, list the name and address of each nursing facility. Please indicate if not applicable.		
*Please ensure information included in this request is consistent with information supplied to the Division of Program Operations and Management Provider Enrollment Section.		
II. Project Overview - § 1187.172(a)(2)	Page #/Attach Reference	
A. Provide an overview of the proposed project, including a description of the population and primary service area that are intended to be served.		
III. Financial Information - § 1187.172(a)(3)	Page #/Attach Reference	
A. Provide a feasibility or market study and financial projections prepared for the proposed project. Feasibility or market study will identify at a minimum the following:		
a) project costs;		

	b) sources of project funds;			
	c) projected revenue sources by payor type;			
	d) specific assumptions used and expected occupancy rates by payor type.			
B.	Provide a copy of any independent audited or reviewed financial statements of the subject facility for the <u>most recent complete year</u> prior to the fiscal year in which the bed request is filed. If financial statements are not available for the subject facility, the applicant shall provide independent audited or reviewed financial statements of the legal entity or parent corporation of the subject facility for the most recent year prior to the fiscal year in which the bed request was filed.			
C.	Provide the requested financial information as a part of the department's financial review of the subject facility:			
	a. Schedule of *Revenue* and *Nursing Facility Days* broken down by payor source (i.e., Private Pay, Medicare, Medicaid, and other 3rd Party), complete projected year 1 estimates only. Schedule 1 (attached) may be used for this purpose. If another format is used all information must be provided.			
	b. Anticipated costs identified on the *Computation and Allocation of Allowable Cost* for a period of 1 year, by payor source based on the new bed complement. Schedule C of the MA- 11 currently in use may be utilized for this process.			
	c. Estimates for construction and for major movable and minor movable property.			
IV.	<u>Compliance History</u> - § 1187.172(a)(4)	Answer (Circle)		
A.	For each person identified in the ownership information section of the bed transfer request application, specify whether or not any of the following applies, and, if so, <u>attach copies</u> of all documents relating to the applicable action, including notices, orders or sanction letters received from the Federal Centers for Medicare and Medicaid Services or any state Medicaid, survey or licensing agency.	Yes	No	N/A
	a) Was the person precluded from participating in Medicare or any state Medicaid program during the 3-year period preceding the bed transfer request?	Yes	No	N/A
	b) Was the person a party to or the owner of a party to a corporate integrity agreement with the department or the Federal government at any time during the 3-year period preceding the date of the bed transfer request?	Yes	No	N/A
	c) Did the person own, operate or manage a nursing facility, including the subject facility and, at any time during the 3-year period preceding the date of the bed transfer request where i through v applied? Include a detailed description if any of the following applied.	Yes	No	N/A
	i. The facility was precluded from participating in the Medicare Program or any State Medicaid Program;	Yes	No	N/A
	ii. The facility had its license to operate revoked or suspended;	Yes	No	N/A
	iii. The facility was subject to the imposition of	Yes	No	N/A

		civil monetary penalties, sanctions or remedies for resident's rights violations;			
	iv.	The facility was subject to the imposition of remedies based on the failure to meet applicable Medicare and Medicaid Program participation requirements, and the facility's deficiencies were graded as immediate jeopardy (graded by the Centers for Medicare and Medicaid Services as 'J', 'K', or 'L') of health and safety to the facility's residents; and/or	Yes	No	N/A
	v.	The facility was designated a special focus facility by the Federal Centers for Medicare and Medicaid Services, indicating a poor performing facility.	Yes	No	N/A
V.	Criteria for the approval of bed transfer requests - § 1187.175(a)		Answer (Circle)		
	A.	Do you attest that this application contains the information required under § 1187.172(a) (relating to contents and submission of bed requests)?	Yes	No	
	B.	Provide a narrative that describes how the receiving provider will agree to achieve and maintain an MA day-one admission rate that is equal to or greater than the surrendering provider's MA day-one admission rate or another MA day-one admission rate as may be agreed to by the department.	Page #/Attach Reference		
	C.	Provide a narrative that describes how change in the bed complements of the receiving and surrendering providers will result in maintaining or improving access to medically necessary nursing facility services for MA recipients.	Page #/Attach Reference		
	D.	To the best of your knowledge, will either provider receive an increase in reimbursement as a result of a change in its peer group if the bed transfer request is approved? If yes, describe in detail. You may view the information at: http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/longtermcarecasemixinformation/peergroups/index.htm.	Yes	No	If yes, Page #/Attach Reference
	E.	Will the proposed bed transfer result in a change in peer group assignments under this chapter for the surrendering or receiving provider? If yes, provide a description of the negative effect the change will have on the MA Program, on MA recipients or on other facilities which are members of the affected peer group. You may view the information at: http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/longtermcarecasemixinformation/peergroups/index.htm.	Yes	No	If yes, Page #/Attach Reference

	F. Will the approval of this bed transfer request result in increased costs to the MA Program? If yes, provide a detailed description.	Yes	No	If yes, Page #/Attach Reference
	G. Attach a signed and dated letter from both the surrendering provider and the receiving provider confirming that both the surrendering provider and the receiving provider agree that the new or additional beds at the receiving provider will be licensed, MA-certified and available for immediate occupancy before the surrendering provider decertifies and closes a bed.	Page #/Attach Reference		
	H. How will the proposed project affect the department's goal to rebalance the publicly-funded long-term living system to create a fuller array of service options for MA recipients?	Page #/Attach Reference		
	I. Provide a detailed description of any alternatives to the transfer of beds, such as an increase in home and community-based services that would be less costly, more efficient or more appropriate in assuring that long-term living care and services will be provided under the MA Program in a manner consistent with applicable Federal and State law.	Page #/Attach Reference		
	J. Does the applicant fully understand that the approval of a bed transfer request is not a determination that additional MA-certified beds are needed to maintain or improve MA recipients' access to medically necessary services in the primary service area or county in which the receiving provider is located?	Yes		No
VI.	Optional Information - § 1187.172(b)	Page #/Attach Reference		
	A. In addition to the required contents, include any information you feel is relevant to or supports your bed transfer request.			
VII.	Timelines for completion of approved projects - § 1187.177	Answer (Circle)		
	A. If the department approves this project, will it be completed in sufficient time so that the beds may be licensed, certified and available for occupancy within 3 years from the date of the department's decision, or by another date as may be agreed to by the department?	Yes		No
	a) What has the receiving facility identified as the timeline for completion of the proposed project?	Page #/Attach Reference		
	b) Provide a timeline for completion of the proposed project. Include outline details and phases.	Page #/Attach Reference		
	B. If approved, do you agree to make documentation available upon the department's written request at any time and for so long as the nursing facility is an MA provider, as may be necessary to demonstrate compliance with the terms of the approved bed transfer request?	Yes		No

Reminder:

This application should serve as a checklist for the applicant prior to submission to the department.

Schedule 1

Bed Exception Request

Revenue and Nursing Facility Days

Subject Facility Name: _____

Description	Project Year 1
Year Ending Date	
Medicaid Resident Days	
Medicare Resident Days	
Private Pay Resident Days	
Other Third Party Resident Days	
Total Resident Days	
Average Medicaid Rate	
Average Medicare Rate	
Average Private Pay Rate	
Average Other Third Party Rate	
Medicaid Revenue	
Medicare Revenue	
Private Pay Revenue	
Other Third Party Revenue	
Other Operating Revenue	
Ancillary Services Revenue	
Contractual Adjustment	
Total Operating Revenue	
Non-Operating Revenue	
TOTAL Revenue	
Average CMI for MA Residents	