PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

Suggested Format for

BED 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

Pennsylvania Bed 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 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 Request Application

Section A (to be completed by Applicant/Submitter)

<table>
<tr><td colspan="3">Date of Application:</td></tr>
<tr><td>Name of Applicant/Submitter:</td><td colspan="2">Applicant/Submitter's Email Address:</td></tr>
<tr><td>Name of Provider:</td><td>Physical or Proposed Address of Provider (building location):</td><td>County of Physical or Proposed Address of Provider (building location):</td></tr>
<tr><td>Contact Person:</td><td colspan="2">Mailing Address:</td></tr>
<tr><td>Telephone Number:</td><td colspan="2">Fax Number:</td></tr>
<tr><td colspan="3">Contact's Email Address:</td></tr>
<tr><td colspan="3">I affirm that the representations made and the information provided in this bed request are true and correct to the best of my knowledge, information and belief.

Signature of Applicant/Submitter Date</td></tr>
<tr><td colspan="3">I certify that the applicant is authorized to submit the bed request on behalf of the legal entity and that the legal entity has reviewed and approves the contents of this bed request.

Signature of Owner/Legal Entity Date</td></tr>
<tr><td colspan="3">REMINDER: Please submit an original and two copies of the bed request to the department.</td></tr>
</table>

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 a subject facility that is a current provider?	Yes	No
a. If yes, how many beds?	_____ beds	
2. Does the applicant seek the department's approval to increase the number of MA certified beds in the MA Program by enrolling a subject facility as a new provider?	Yes	No
a. If yes, how many beds?	_____ beds	

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 most recent complete year 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. Compliance History - § 1187.172(a)(4)		Answer (Circle)		
A. For each person identified in the ownership information section of the bed request application, specify whether or not any of the following applies, and, if so, attach copies 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 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 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 request where i thru v below 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 civil monetary penalties, sanctions or remedies for resident's rights violations;		Yes	No	N/A
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 requests - § 1187.176	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)? If yes, please explain.	Yes, Page #/Attach Reference	No
B. Are the additional MA-certified nursing facility beds needed in the primary service area or the county in which the subject facility is located to maintain or improve MA recipients' access to medically necessary nursing facility services ? If yes, please explain.	Yes, Page #/Attach Reference	No
C. Is the existing MA-certified bed capacity in the primary service area or the county in which the subject facility is or will be located insufficient to assure that MA recipients have access to medically necessary nursing facility services?	Yes, Page #/Attach Reference	No
D. Are there systemic barriers that prevent MA recipients from accessing the existing MA-certified bed capacity in the primary service area or the county in which the subject facility is or will be located?	Yes, Page #/Attach Reference	No
E. Is the applicant proposing to admit and serve MA recipients who require specialized medical services in the subject facility?	Yes, Page #/Attach Reference	No
F. Do MA recipients have access to the specialized medical services in the existing MA-certified bed capacity in the primary service area or the county in which the subject facility is or will be located?	Yes, Page #/Attach Reference	No
G. Does the legal entity agree to admit and serve MA day-one recipients?	Yes	No
H. Will the subject facility maintain an MA occupancy rate that equals or exceeds the average MA occupancy rate of MA nursing facilities in the county in which the subject facility is or will be located?	Yes	No
I. In the case of a subject facility that is proposing to offer specialized medical services, do MA recipients have access to these services in the PSA or county?	Yes	No
a) If yes, provide the applicant's proposed MA occupancy rate?	_____%	
J. Will the construction and operation of the new or additional beds be economically and financially feasible without the receipt of MA fixed property capital component payments? *(The new or additional beds will not be entitled to MA capital component payments for fixed property).*	Yes	No
K. Is the overall average annual occupancy rate of providers in the primary service area and county in which the subject facility is or will be located at 95% or less?	Yes	No
L. Is the average MA occupancy rate of providers in the primary service area and county in which the subject facility is or will be located above the Statewide average rates or within one percentage point below the Statewide rates? You may view the information at: http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/.	Yes	No

	M. Is the average MA day-one admission rate of providers in the primary service area and county in which the subject facility is or will be located above the Statewide average rates or within one percentage point below the Statewide rates? You may view the information at: http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/.	Yes	No
	N. Would approval of the request negatively affect the department's goal to rebalance the Commonwealth's publically funded long-term living system to create a fuller array of service options for MA recipients?	Yes, Page #/Attach Reference	No
	O. Are there alternatives to the bed request 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?	Yes, Page #/Attach Reference	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 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) If no, enter the requested project completion date?	_____	
	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 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	