LICENSED BED SUMMARY

Provider Name:

Kentucky Medicaid Provider Number:
(If known)

Federal Tax ID Number:

1.	Acute (include swing)	_____
2.	ICU	_____
3.	CCU	_____
4.	TCU	_____
5.	Burn ICU	_____
6.	Surgical ICU	_____
7.	Psych	_____
8.	Rehab	_____
9.	Nursery	_____
10.	Neonatal	_____
11.	Chemical Dependency	_____
12.	Nursing (type, i.e. SNF, LTC, NF, etc.)	_____
13.	Intermediate Care	_____
14.	Nursery Bassinets	_____
15.	Other (Please explain)	_____
	TOTAL BEDS	_____

Signature: _____
Title

Date Signed: _____ Phone: _____