

ARKANSAS BLUE CROSS AND BLUE SHIELD, INC.  
Statistical Questionnaire  
(Bed Complement Form)

ROOMS:	NUMBER OF BEDS	PROPOSED DAILY ROOM RATE
PRIVATE (1 Bed)	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____

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SEMI-PRIVATE (2 To 4 Beds)	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____

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WARD (5 Or More Beds)	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____

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INTENSIVE CARE UNIT BEDS	_____	\$ _____
CORONARY CARE UNIT BEDS	_____	\$ _____

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NURSERY ICN NURSERY	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____
	_____	\$ _____

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TOTAL NUMBER OF BEDS APPROVED BY ARKANSAS STATE HEALTH DEPARTMENT \_\_\_\_\_

\_\_\_\_\_  
 Administrator's Signature

\_\_\_\_\_  
 Name of Hospital

\_\_\_\_\_  
 Effective Date