Washington State Department of Health

FOR DEPARTMENT USE ONLY
Date Stamp Here
Fee Received:_____
Check #: _____
Initials_____

NURSING HOME FULL FACILITY CLOSURE BED BANKING NOTICE

The following information will be used to evaluate the conformance of the project with all applicable review criteria contained in Revised Code of Washington (RCW) 70.38.115 and Washington Administrative Code (WAC) 246-310-396.

Full Facility Closure Bed banking notices must be submitted with a fee in accordance with WAC 246-310-990 and the completed invoice on page 2 of this form.

This notice is made for Full Facility Closure Bed Banking in accordance with provisions in RCW 70.38 and WAC 246-310-396, rules and regulations adopted by the Washington State Department of Health. I hereby certify that the statements made in this notice are correct to the best of my knowledge and belief.

SEA MAR COMMUNITY CARE CENTER
Name of the Nursing Home (facility)

SEA MAR SKILLED NURSING FACILITY
Name of the facility's Licensee

SANDRA MILES
Print Name of Person Making the Request

206-763-5210
Telephone Number

ADMINISTRATOR
Title of person making the request

EMPLOYEE OF LICENSEE
Relationship to licensee

I understand that any evasion or suppression of material facts, misrepresentation, false statements or misleading statements regarding any of the information contained in this notice shall be grounds for actions under the provisions of WAC 246-310-500 and forfeiture of the beds.

Sandra Miles
Signature of Licensee

1/12/2021
Date

Address:
1040 SOUTH HENDERSON
SEATTLE, WA 98108

Invoice for Submission of Full Facility Closure Bed Banking Notice

1. This form must be accompanied by a check payable to: ***The Department of Health*** for the review fee as identified below.

2. Complete the following prior to submission for review:

REVIEW FEE: $ 1,347.00 (Refer to fee schedule)

APPLICANT NAME: SEA MAR COMMUNITY CARE CENTER

DATE OF SUBMISSION: _____ CHECK NUMBER: _____

3. Mail **ORIGINAL,** signed notice and payment to:

Physical Address:

Department of Health
Certificate of Need Program
310 Israel Road SE
Tumwater, Washington 98501

To mail overnight, UPS or FedEx

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.38 AND WAC 246-310

FULL FACILITY CLOSURE BED BANKING

The following information is used to evaluate the conformance of the project with all applicable review criteria in Revised Code of Washington (RCW) 70.38.115 and Washington Administrative Code (WAC) 246-310-396.

Please note the following definition:

"Effective date of facility closure" means:

- The date on which the facility's license was relinquished, revoked or expired; or
- The date the last resident leaves the facility, whichever comes first.

Information Requirements:

1. Effective Date of the Facility's Closure: 1/9/2021 sm

2. Number of beds to be banked: 48

3. Is the existing licensee the building owner? Yes ____ No ✓ **(Yes, go to question 5)**
Building owner is an affiliate entity with licensee.

4. Does the building owner have a secured interest in the nursing home bed rights? Yes ____ No ✓
In the event the existing nursing home licensee is not the building owner, the licensee shall provide:

a) If the building owner has a secured interest in the bed rights, an **original** written statement signed by the building owner indicating the building owner's approval of the facility's closure,
OR

b) If the building owner does not have a secured interest in the bed rights, a copy of the notice sent to the building owner by the licensee informing the building owner of the planned facility closure.

5. If the party making this banking request is other than the licensee, provide documentation of the secured interest in the bed rights.

6. Name and address of Contact Person throughout the bed banking period:

SANDRA MILES, ADMINISTRATOR — Name

206-788-3230 — Telephone Number

Address :
1040 SOUTH HENDERSON
SEATTLE, WA 98108

Please note: If the beds being banked are licensed as part of an acute care hospital and used for transitional care (TCU), skilled nursing care (SNF), or nursing home care and recognized by the Certificate of Need program as nursing home beds, I understand that the use of these beds for any acute care services requires Certificate of Need review and approval under RCW 70.38.105(4) (e).

I understand that Certificate of need review shall be required for ANY party proposing to re-license the nursing home beds. Need shall be deemed met when the applicant is the licensee and who had operated the beds for at least one year immediately preceding the bed banking, and who is proposing to re-license the beds in the same planning area.