



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Certificate of Need Program
111 Israel Road Southeast – MS 4-7852
Olympia, Washington 98504

September 1, 2016

CERTIFIED MAIL # 7008 1830 0002 8022 0830

Kelly Callahan, President
Careage
4411 Point Fosdick Drive, #203
Gig Harbor, Washington 98335

RE: Determination of Reviewability #17-03

Dear Mr. Callahan:

We have completed review of the Replacement Authorization application submitted by Mission Healthcare at Bellevue, JV proposing partial replacement of Mission Healthcare at Bellevue as allowed under Revised Code of Washington 70.38 and Washington Administrative Code 246-310. The application is consistent with the applicable criteria of the Certificate of Need Program, provided Mission Healthcare at Bellevue, JV agrees to the following in its entirety.

Project Description:

This Replacement Authorization approves the replacement of 60 of the 129 licensed beds at Mission Healthcare at Bellevue to a new site in Renton. The table below shows the number of licensed beds at each site after project completion.

New Replacement Facility [No name yet]	
Address	# of Licensed Beds
17420 – 106 th Place Southeast Renton, Washington 98055	60

Mission Healthcare at Bellevue	
Address	# of Licensed Beds
2424 – 156 th Avenue Northeast Bellevue, Washington 98007	69

The estimated cost of the project is \$20,690,000.

Conditions:

1. Approval of the project description as stated above. Mission Healthcare at Bellevue, JV further agrees that any change to the project as described in the project description is a new project that requires a new Replacement Authorization.
2. Mission Healthcare at Bellevue will continue to participate in both the Medicare and Medicaid programs.
3. The new replacement nursing home will participate in both the Medicare and Medicaid programs.

You have two options, either accept or reject the above in its entirety. If you accept the above in its entirety, your application will be approved and a Replacement Authorization will be sent to you. If you reject any provision of the above, you must identify that provision, and your application will be denied because approval would not be consistent with applicable Certificate of Need review criteria. Please notify the Department of Health within 20 days of the date of this letter whether you accept the above in its entirety. Your written response should be sent to the Certificate of Need Program, at one of the following addresses.

Mailing Address:
Department of Health
Certificate of Need Program
Mail Stop 47852
Olympia, WA 98504-7852

Physical Address:
Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, WA 98501

If you have any questions, or would like to arrange for a meeting to discuss our decision, please contact me at (360) 236-2955.

Sincerely,

for 

Janis R. Sigman, Manger
Certificate of Need Program
Community Health Systems