Washington State Department of Health

DOR 19-12

Certificate of Need Application
Determination of Reviewability Ambulatory Surgery Center/Facility
(Do not use this form for any other type of ASC/F project)

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

The Department of Health (department) will use this application to determine whether my ambulatory surgical center requires a Certificate of Need under state law and rules. Criteria and consideration used to make the required determinations are Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310. I certify that the statements in the application are correct to the best of my knowledge and belief. I understand that any misrepresentation, misleading statements, evasion, or suppression of material fact in this application may be used to take actions identified in (WAC) 246-310-500.

My signature authorizes the department to verify any responses provided. The department will use such information as appropriate to further program purposes. The department may disclose this information when requested by a third party to the extent allowed by law.

Owner/Operator Name of the surgical facility as it appears on the UBI/Master Business License April Holdings PLLC		
UBI # 604 190 737	Federal Tax ID (FEIN) # 82-3465183	
Mailing Address 1420 5th Avenue Suite 3400		
City Seattle	County King	Zip Code 98101
Name and Title of Responsible Officer (Print): James Ridgway Owner	Signature of Responsible Officer: Date of Signature: 12/17/18	
Phone number (10-digit): 206.434.1989	Fax number (10-digit): Pending	
Email Address: jridgwaymd@gmail.com	Website Address: https://www.drjamesridgway.com/	

Identify the purpose of this application:

- [x] New Facility
- [ ] Change of Ownership
- [ ] Facility Relocation
- [ ] Facility Expansion – Operating Room Increase
- [ ] Facility Expansion – Service Increase
- [ ] Other (please provide a letter describing)

Washington State Department of Health

Ambulatory Surgery Center/Facility Certificate of Need Determination of Reviewability Application Packet

Contents:

Submission Instructions:
Provide one paper copy of the application. If you wish to provide an additional copy in an electronic format, please provide on a CD or thumb drive.

To be accepted, the application must include:
- A completed and signed Certificate of Need application, including the face sheet
- A check or money order for the review fee of **$1,925** payable to **Department of Health.**
- Mail or deliver the application and review fee to:

Mailing Address:

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

Other Than By Mail:

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

Contact Us:
Certificate of Need Program Office 360-236-2955

Definitions

The Certificate of Need (CN) Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

A physician's office with a room for performing only office-based procedures is not subject to CN review, unless physicians outside the practice use the room. A facility is subject to CN review **if it is used primarily for surgical procedures**. For example, if the majority of a facility's business hours are dedicated to surgical procedures, then it likely is subject to CN review. A physician's clinical office that closes one day a week to operate as a Medicare-certified ambulatory surgical center might not be subject to CN review because the facility **as a whole** is used primarily to provide clinical services. The fact that a facility has an ambulatory surgical facility license does not determine whether a Certificate of Need is required. Nonetheless, if a facility is required to have a license because **it is used primarily for surgical procedures**, then it is likely subject to CN review for the same reason. For more information, please see the department's interpretation of WAC 246-310-010(5) 18-01 Interpretive Statement.

RCW 70.38.105 requires new healthcare facilities to obtain a Certificate of Need.

RCW 70.38.025(6) defines healthcare facilities to include ambulatory surgical facilities.

"Ambulatory surgical facility" or "**ASF**" means any free-standing entity, including an ambulatory surgery center that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization. This term does not include a facility in the offices of private physicians or dentists, whether for individual or group practice, if the privilege of using the facility is not extended to physicians or dentists outside the individual or group practice. (WAC 246-310-010(5))

"Ambulatory surgical center" or "**ASC**" is also a term for a facility that provides ambulatory surgical procedures. The Centers for Medicare and Medicaid use this term for billing purposes. CN review is not required for an ambulatory surgical center unless it also fits the definition of an ambulatory surgical facility in WAC 246-310-010(5).

"Person" means an individual, a trust or estate, a partnership, any public or private corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district. (WAC 246-310-010(42))

Application Instructions

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- **Do not** bind or 3-hole punch the application.
- Make the narrative information complete and to the point.
- If any sections are not large enough to contain your response, please attach additional pages as necessary. Ensure that any attached pages are clearly labeled with the applicable question or section.

- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement, and
  d. includes all exhibits that are referenced in the agreement.

Do not skip any questions in this application. If you believe a question is not applicable to your project, provide rationale as to why it is not applicable.

Surgical Facility Owner/Operator Information

1. Organization. Check the type of business organization and attach a copy of business formation documents.

☐	Limited Partnership	☒	Limited Liability Company
☐	Partnership	☐	Limited Liability Partnership
☐	Professional Services Corporation	☐	Sole Proprietor
☐	Independent Practice Association (IPA)	☐	Other (describe)

2. Members/partners/shareholders. Identify persons with an ownership interest in the surgical facility and their respective ownership percentage. If more than one owner, provide a copy of the legal document establishing the ownership interests.

Name	Percent Ownership
James Ridgway MD	100%

3. Will the surgical facility be operated under a management agreement?

☐ Yes ☒ No

If yes, attach a copy of the management agreement.

4. Identify any entity other than the surgical facility owner/operator that has a financial interest in the operation of the surgical facility. This includes, but is not limited to, timeshare agreements and cooperative agreements with administrative service providers.

~~None~~

Provide a copy of the agreement. (N/A)

Clinical Practice Owner/Operator Information

5. Type of Practice. Check the type of practice.

☒ Solo practice

☐ Group practice (provide a copy of the group practice agreement)

☐ Independent Practice Association (IPA)

☐ Other (describe)

6. Is the owner/operator the same for both the ASF and clinical practice?

☒ Yes – **move on to question 7** ☐ No

If no, complete the following information for the **Clinical Practice.**

Owner/Operator Name of the clinical practice as it appears on the UBI/Master Business License		
UBI #	Federal Tax ID (FEIN) #	
Mailing Address		
City	State	Zip Code

Identify persons with an ownership interest in the clinical practice and their respective ownership percentage. If more than one owner, provide a copy of the legal document establishing the ownership interests.

Name	Percent Ownership

Facility Information

7. Physical Address (check one). Include any information necessary to locate the site of the clinical practice and surgical facility such as suite or building number. Attach additional pages as necessary.

☐ The physical address of the site is the same as the Applicant's mailing address.

☒ The physical address of the facility is:

Suite 900 1231 116th Avenue NE, Bellevue, Washington

☐ The clinical practice has more than one practice site. The additional addresses are below. Attach additional pages as necessary.

8. Although you are not required to apply for an ASF license before a CN determination is issued, have you applied for a license?

☐ Yes ☒ No

If no, do you intend to apply for an ambulatory surgical facility license?

☐ Yes ☒ No

9. Number of Operating Rooms
Identify the number of operating rooms 1
Note: for Certificate of Need purposes, procedure rooms are considered operating rooms.

Floor Plan: Attach a floor plan, to scale, clearly indicating the clinical spaces, surgery center, and operating rooms.

Clinical and Surgical Services

. Clinical Services. Describe the clinical services provided at this site.

Rhinoplasty, blepharoplasty, facelift, necklift, midface lift, brow lift, cancer reconstruction, otoplasty, facial implants, laser resurfacing, dermabrasion, liposuction, and autologous fat grafting

11. Surgical Services. We perform only office-based procedures in the facility.

☐ Yes ☒ No

12. Surgical Procedures. Check all surgical procedures performed in the facility.

☒	Ear, Nose, & Throat	☐	Gynecology	☐	Oral Surgery
☒	Plastic Surgery	☐	Gastroenterology	☐	Maxillo facial
☐	Orthopedics	☐	Podiatry	☐	General Surgery
☐	Ophthalmology	☐	Pain Management	☐	Urology

☐ Other (describe)

13. Will you be charging a facility fee related to Medicare reimbursement?

☐ Yes ☒ No

☐ Some, but not all procedures are subject to a facility fee.
Describe the procedures subject to a facility fee:

14. **Scheduling Interval**. Identify the days and times you schedule the facility for clinical services and surgical procedures. If you schedule clinical services and surgical services on an interval other than daily, such as a weekly or monthly, please describe the interval, specifying the number of hours and the interval that the facility is used for clinical practices and surgical procedures.	
Clinical Practice Day(s) and time(s):	☐ Sun: from_____am/pm to_____am/pm ☐ Mon: from 8_____am/pm to 5_____am/pm ☐ Tue: from 8_____am/pm to 5_____am/pm ☐ Wed: from 8_____am/pm to 5_____am/pm ☐ Thur: from 8_____am/pm to 5_____am/pm ☐ Fri: from 8_____am/pm to 5_____am/pm ☐ Sat: from_____am/pm to_____am/pm
Surgical Procedures Day(s) and time(s):	☐ Sun: from_____am/pm to_____am/pm ☐ Mon: from_____am/pm to_____am/pm ☐ Tue: from_____am/pm to_____am/pm ☐ Wed: from 8_____am/pm to 5_____am/pm ☐ Thur: from 8_____am/pm to 5_____am/pm ☐ Fri: from_____am/pm to_____am/pm ☐ Sat: from_____am/pm to_____am/pm

Physicians Using the Surgical Facility

15. **Owner Physicians.** Identify the physicians with an ownership interest in the clinical practice that will be using the surgical facility. Attach additional pages as necessary	
Name	Credential #
James Ridgway MD	

16. **Employee Physicians.** Identify physicians who are employees of the clinical practice that will be using the surgical facility. Attach additional pages as necessary.		
Name	Credential #	% of time employed by applicant's practice
None		

For each employee physician that is not 100% employed by the applicant's practice, please attach a written statement with the following information:

- Identify the physician
- If the physician is employed by other practices, identify the name of other practices;
- Identify the percentage of time the physician is employed by the other practices.

17. Are there physicians who will be using the surgical facility who are not included in the response to question #15 or #16 above?

☐ Yes ☒ No

If yes, please attach a written statement with the following information:

- Provide the name and credential # of the physician
- Identify the name of physician's other practice sites
- Identify the percent of time the physician conducts business at the other practice sites
- Provide a description of services provided at the other practice sites.
- Fully describe the business relationship under which the physician will be using the surgical facility.

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

WAC Reference	Title/Topic
246-310-010	Certificate of Need Program —Definitions
246-310-010	Interpretive Statement CN 01-18 – Interpretation of WAC 246-310-010(5), definition of Ambulatory Surgical Facility
246-310-270	Certificate of Need Program —Ambulatory Surgery