STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In re: EASTSIDE MEDICAL GROUP CERTIFICATE OF NEED TO ESTABLISH AN AMBULATORY SURGICAL FACILITY IN ISSAQUAH, SWEDISH HEALTH SERVICES, a Washington nonprofit corporation, Petitioner.	Master Case No. M2012-102 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER ON REMAND

APPEARANCES:

Petitioner Swedish Health Services (Swedish), by
Perkins Coie, LLP, per
Brian W. Grimm, Attorney at Law

Petitioner Eastside Medical Group (Eastside), by
Freimund Jackson Tardif & Benedict Garratt, PLLC, per
Jeff Freimund, Attorney at Law

Department of Health Certificate of Need Program (Program), by
Office of the Attorney General, per
Richard McCartan, Assistant Attorney General

PRESIDING OFFICER: John F. Kuntz, Review Judge

A hearing was held in this matter on November 27-28, 2012. The issue at hearing was whether Eastside's application to establish a two-operating room ambulatory surgical facility should be granted.

Because the calculation of the operating room supply was disputed by the parties (a requirement for the correct calculation of need), the matter is remanded to the

Program with instructions for recalculation of the WAC 246-310-270(9) need methodology.

ISSUES

(1) Whether need exists for Eastside's proposed two-operating room ambulatory surgical facility under the need methodology in WAC 246-310-270(9):

(2) Even if need does not exist in the planning area, whether there are extraordinary circumstances to warrant the approval of Eastside's Certificate of Need (CN) application?

SUMMARY OF PROCEEDINGS

At the hearing, the Program presented the testimony of Janis Sigman, Certificate of Need (CN) Program Manager. Swedish presented testimony of Chuck Salmon, Chief Executive, Swedish/Issaquah Medical Group; and Frank Fox, Ph.D., CN Consultant. Eastside presented testimony of Dr. Kalle Kang; and Jody Carona, Eastside's Consultant.

The Presiding Officer admitted the following exhibits at hearing:

Program exhibits

P-1: The 434-page Administrative Record complied by the Program related to Eastside's CN application; and

P-2: Revised ASC Need Methodology calculation of Janis Sigman, dated November 19, 2012.

Swedish exhibits

S-1: Application Record;

S-2: Curriculum vitae of Frank Fox, Ph.D.;

S-4: Certificate of Need Program's evaluation of Swedish's application to establish an ambulatory surgical facility in East King County planning area, April 17, 2008; and

S-5: Calculations of East King County planning area operating room need calculated by Frank Fox, Ph.D.

Eastside exhibits

E-1: The Administrative Record;

E-2: Snoqualmie Valley Hospital's website (Exhibit 5 to the deposition of Janis Sigman);

E-3: The exhibit included with the Janis Sigman deposition (specifically Exhibit 6); and

E-4: Need calculation of Jody Carona.

The parties submitted post-hearing briefs in lieu of closing arguments. The opening brief cutoff date was December 21, 2012. The closing brief cutoff date was January 11, 2013. *See* Prehearing Order No. 2; *see also* RCW 34.05.461(7). The hearing record was closed January 11, 2013.

PROCEDURAL HISTORY

On August 23, 2011, Eastside applied for a CN to establish a two-operating room ambulatory surgery center in Issaquah, Washington.

On January 25, 2012, the Program approved Eastside's application with conditions (providing charity care in compliance with policies; limiting Eastside's facility to two operating rooms; providing an executed copy of a Patient Transfer Agreement for the Program's review and approval prior to commencing services). Eastside notified the Program in writing that it would comply with the conditions on February 7, 2012. The

Program issued CN #1462 to Eastside on February 10, 2012.

On February 16, 2012, Swedish filed an Application for Adjudicative Proceeding with the Adjudicative Service Unit to contest the Program's award of CN #1462. The hearing on the Application for Adjudicative Proceeding was conducted on November 27-28, 2012.

I. FINDINGS OF FACT

1.1 A CN is a non-exclusive license for health care providers seeking to establish a new health care facility. The definition of health care facility includes an ambulatory surgical facility. An ambulatory surgical facility consists of a minimum of two operating rooms available for outpatient surgery. The term operating room is not specifically defined in the CN statutes or regulations. It can be defined as a room in which a surgery (invasive medical procedures that utilize a knife, laser, heat, freezing, or chemicals to remove, correct, or facilitate the diagnosis or cure of a disease or injury) is performed on a patient. *See* RCW 70.230.010(7).

1.2 Surgery can be performed on an inpatient or outpatient basis. In outpatient surgery, the operation will be performed on a patient and the patient will be released in less than 24 hours. If the patient is required to remain under medical care for longer than 24 hours, the surgery is considered as inpatient surgery. Inpatient operating rooms can be used to perform outpatient surgery. When need exists for additional operating rooms in a planning area, WAC 246-310-270(5) specifies that a preference shall be given for dedicated outpatient operating rooms.

1.3 To determine if there is a need for operating rooms in a planning area[1] (here, East King County), WAC 246-310-270(9) provides the method for calculating the need. The need methodology calculation consists of three steps: (1) determining the existing capacity of operating rooms in the planning area; (2) anticipating the number of surgeries in the planning area three years into the future; and (3) determining whether the existing operating room capacity is sufficient to accommodate the projected number of future surgeries. The lower the existing capacity (supply) in step 1 and/or the greater the projected demand in step 2, the more likely there will be need in step 3. The need calculation assumes that the population in the planning area will increase; this assumption of population growth was used by the parties in their respective need methodology calculations.

1.4 To complete the future need calculations (the anticipated number surgeries), the methodology requires the calculation of a number known as the "use rate" (the number of surgeries per every 1,000 individuals of the population within the planning area). The use rate is calculated by dividing the total number of surgeries performed in the base year by the total population of the planning area and multiplying that number by 1,000. For example: in its evaluation, the Program calculated a use rate of 141.726/1,000. When completing the WAC 246-310-270(9) need evaluation with that use rate, the Program computes that there is a 20.88 operating room shortage of

[1] *See* WAC 246-310-270(3). A planning area is a county or a portion of a county; when it is a portion of a county, it is defined by zip codes. *See* Application Record (AR) 20 and 389.

dedicated outpatient operating rooms in the East King County planning area in 2013. The Program concluded that need existed and granted Eastside's CN application. *See* AR 332

1.5 On its face, the WAC 246-310-270(9) methodology calculation appears to be a straightforward process for the applicant. That is, the applicant simply inserts the appropriate number of existing operating rooms in the planning area (here, East King County) and the anticipated number of surgeries to determine whether need exists by the third year. However, the parties in the present case dispute: (1) what constitutes the correct number of existing operating rooms in East King County for the relative time period; and (2) which procedures must be used in calculating the anticipated number of surgeries in the planning area (for example, should endoscopy procedures count as surgeries for step 2 in Paragraph 13 above). *See* Swedish Post-Hearing Brief, page 6.[2]

1.6 The confusion in the need methodology calculation arises from several factors, which include:

A. Information regarding the number of operating rooms is obtained by submitting surveys to the facilities in the planning area. *See* AR 354 to 385. The facility providing the operating room information may report a different number of operating rooms from year to year. The facility may not report the number of allotted operating rooms (the number it has under the facility's CN); rather it may report how many operating rooms it is using in a given year.

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[2] A copy of page 6 is incorporated as part of the Remand Order for reference.

B. The facility may also change the number of operating rooms depending on how the room is currently being used. For example, a facility may choose to designate an available operating room as a special purpose room or a hybrid room (a room where a facility can perform surgery, interventional radiology or cardiac catheterization procedures.) The need methodology calculation permits the exclusion of special purpose operating rooms (such as open heart surgery rooms) from the capacity figure. *See* WAC 246-310-270(9)(a)(iv).

C. A facility with both outpatient and inpatient operating rooms (here, Overlake Hospital) may choose to designate its inpatient operation rooms as "dedicated operating rooms" which are unavailable to outpatient surgery. In this circumstance, the removal of 15 operating rooms from the total number of available operating rooms changes the need methodology calculation.

D. A facility may obtain a CN to operate an ambulatory surgical facility in a planning area but choose to utilize another of its facilities in the planning area to conduct surgeries (for example, Swedish has an approved three operating room CN facility that was approved for use. However the facility was not yet built at the time of Eastside applied for its CN).

1.7 A comparison of the factors in Paragraph 1.6 above shows that the parties are not in agreement on all of the issues, as the parties' revised need methodology calculations show. The parties do agree on the East King County planning area population in 2015 (558,789); they agree on little else. The Program's revised need methodology calculations (revised in preparation for the hearing) found a use rate of

112.715/1000 and a need for 24.54 operating rooms by 2015.[3] *See* Exhibit P-2. Eastside's revised calculation found a use rate of 156.93/1,000 and a need for 32.36 operating rooms by 2015. *See* Exhibit E-4. Swedish's second revised need methodology calculations found a use rate of 125.89 use rate and a surplus of 10.83 operating rooms in the planning area. *See* Exhibit S-5.

1.8 The confusion in the present case arises, at least in part, from the Washington Supreme Court's ruling in *Overlake Hospital Association v. Department of Health*, 170 Wn.2d 43 (2010) (*Overlake*). In the *Overlake* case, Swedish applied for an ambulatory surgical facility CN. In performing the WAC 246-310-270(9) methodology, the Program excluded exempt operating rooms[4] from the existing supply of operating rooms but included the number of surgeries performed at the exempt facilities in determining future need. The Program consistently used this approach (excluding exempt operation rooms from supply but including surgeries in determining need). Overlake challenged the Program's approach, arguing: (1) exclude both the exempt operating rooms and the exempt surgeries in the calculations; OR (2) include both the exempt operating rooms and the exempt surgeries in the calculations.

1.9 In the *Overlake* decision, the Washington Supreme Court ruled that the Department of Health should resolve any ambiguity in WAC 246-310-270(9) by ensuring

[3] CN applications uses a "snapshot in time", or a snapshot of facts around the time the application is filed. *See Univ. of Washington Med. Ctr. v. Dept of Health*, 164 Wn.2d 95, 103 (2008). At hearing, parties may submit updated calculations to provide the most accurate picture regarding the applications.

[4] The definition of "ambulatory surgical facilities" excludes a facility in the office of a private physician, whether for individual or group practice, if the privilege of using the facility is not extended to physicians outside the individual or group practice. *See* WAC 246-310-011(5).

the CN statute provided accessible health services. *Overlake*, 170 Wn.2d at 55. The Court stated the "paramount concern is to ensure that the regulation is interpreted consistently with the underlying legislative policy of the statute [RCW 70.38.015(1)]." *Id.* Based on this ruling, the Court determined that the Program's approach of *excluding* exempt operating rooms from the capacity but *including* the number surgeries from the exempt facilities in the need calculations was the proper approach to ensure accessible health services.

1.10 How does the Supreme Court's analysis in the *Overlake* decision affect the calculations in present matter? The question relates to the interpretation of WAC 246-310-270(9)(a)(iv). That subsection states in relevant part:

> When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating need in an area. Exclude cystoscopic[5] and other special purpose rooms (e.g. open heart surgery) and delivery rooms.

The above language creates some ambiguity in the approach used by the parties in this matter. The ambiguity includes:

A. Similar to the Washington Supreme Court's holding in *Overlake*, Eastside argues that endoscopic rooms (a special purpose room) should be excluded on the existing capacity side of the computation but the endoscopic procedures should be included in the future need calculation. The Program and Swedish argue both the endoscopic rooms and the endoscopic surgeries should

[5] A "cystoscope" is an instrument for interior examination of bladder and ureter. A "cystoscopy" is the examination of the bladder with a cystoscope. *See* Taber's Cyclopedic Medical Dictionary, 21st Edition (2009), page 570.

be excluded in a manner similar to dedicated emergency operating rooms in WAC 246-310-270(9)(a)(iv). The Program's past practice is to exclude endoscopic surgeries from future need calculations.

B. The Program and Eastside seek to exclude the two operating rooms at Children's Hospital in the existing capacity side of the need calculation but to include the surgeries performed in those operating rooms in the future need side of the calculations (the *Overlake* approach). Swedish argues that WAC 246-310-270(9)(a)(iii) states "[c]alculate the total annual capacity (in number of surgeries) of *all* dedicated outpatient operating rooms in the area." (Emphasis added). Unlike the Program and Eastside, Swedish argues that there is nothing in this regulatory language to allow the exclusion of pediatric operating rooms from supply. Swedish argues WAC 246-310-270(9)(a)(iii) requires that both the operating rooms and the surgeries (in a manner similar to dedicated emergency operating rooms) must be included in the need calculations.

C. The Program and Eastside each exclude the two operating rooms in Swedish's existing Lakeside ambulatory surgical center (ASC) in the capacity side. They would include the surgeries on the future need side, but the record does not show any surgeries being performed in this facility. In fact, the lack of current surgeries at the ASC is why the Program/Eastside each argues to exclude the two operating rooms. Swedish would include the two operating rooms in the capacity side of the need equation under WAC 246-310-270(9)(a)(iii). Swedish argues the facility *could* be used even

though it is not currently in use.

D. The Program and Eastside each seek to exclude the three operating rooms ASC authorized but not yet built by Swedish in its Issaquah, Washington facility. They would include any surgeries on the future need side, but the record does not show any surgeries being performed in this facility. As with the Lakeside ASC, the Program/Eastside would exclude these operating rooms because of non-use. Swedish would include the two operating rooms in the capacity side of the need equation.

E. The Program and Eastside each seek to exclude the two operating rooms in the Snoqualmie Valley ASC from the capacity side of the equation, again because there are no surgeries being performed there. Swedish argues the Snoqualmie Valley ASC is performing outpatient surgery. *See* TR 299, line 2 to TR 300, line 8.

F. Finally, there are four facilities (Overlake Surgery Center; Evergreen Surgery Center; Overlake Hospital; and Swedish Hospital) in which the parties cannot agree on what is the “correct” number of available operating rooms.

1.11 Following his analysis of the above information, and based on the testimony and exhibits presented at the hearing, the Presiding Officer finds:

A. As a starting point, the public access requirement in the Washington Supreme Court’s holding in *Overlake* applies. The application of the *Overlake* holding recognizes that some operating rooms are excluded from the

WAC 246-310-270(9)(a) existing capacity (supply) section of the need methodology calculation while the surgeries (procedures) are included in the future need analysis.

B. Endoscopy rooms and pain treatment procedure rooms are "special purpose rooms," as that term is identified in WAC 246-310-270(9)(a)(iv). Endoscopy and pain treatment procedure rooms are not built for or equipped for surgery. For that reason, those rooms should be excluded in the need methodology calculations.

C. Even though procedures from excluded operating rooms are normally included in the future need analysis, endoscopy procedures and pain treatment procedures should also be excluded from the WAC 246-310-270(9) need methodology calculations. These procedures are not "surgeries" as described in Paragraph 1.1 above. This approach is consistent with the Program's past practice regarding endoscopy and pain procedures.

D. Consistent with the holding in *Overlake*, the two operating rooms in Children's Hospital ASC should be excluded from the supply side of the need methodology calculations. This exclusion is based on the fact that the operating rooms are specifically built for children and cannot be used for adult surgeries. However, the surgeries performed in the Children's Hospital ASC should be included in the future need methodology calculations in WAC 246-310-270(9)(b).

E. The two operating rooms at the Lakeside ASC should be excluded from the supply side of the need methodology calculation. The evidence at

hearing shows that Swedish stopped using this facility in mid-2011 when the Swedish Issaquah Hospital opened for outpatient surgery.

F. The three operating rooms approved, but not yet built, at the Swedish ASC in Issaquah, Washington should be excluded from the supply side of the need methodology calculation. Normally, the Department considers approved but not built operating rooms in determining existing capacity under WAC 246-310-270(9)(a), if the approval and part or all of the construction is completed within the snapshot in time for the current CN application. However, these three operating rooms are currently in litigation (*see* Master Case No. M2012-1076) and the Issaquah ASC legal status is yet to be determined.[6] Given the undetermined status, the Presiding Officer excludes the three operating rooms from the existing capacity total under WAC 246-310-270(9)(a).

G. The two operating rooms at the Snoqualmie Valley Hospital should not be counted in the need methodology calculations under WAC 246-310-270(9). The hospital has ceased to maintain any operating rooms. Although there is some evidence of surgical procedures being performed at the facility up to 2011, there is no Comprehensive Hospital Abstract Reporting System (CHARS) data, which indicates surgeries being performed beyond that point. *See* TR 299-300.

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[6] This ruling is limited to the outcome of this proceeding. The current ruling should not in any way be considered in the resolution of Master Case No. M2012-1076.

H. The next question is what is the correct number of operating rooms for the need methodology calculation regarding the Overlake Hospital? Hospitals may have three types of operating rooms: (1) dedicated inpatient; (2) dedicated outpatient; or (3) "mixed use," which can be used for either inpatient or outpatient surgery. Why this is important? To determine what is the existing capacity in WAC 246-310-270(9)(a). More specifically, WAC 246-310-270(9)(a)(iii) calculates "the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area." WAC 246-310-270(9)(a)(iv) then calculates "the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for 24 dedicated emergency rooms." If the WAC 246-310-270(9)(a)(iii) language addresses outpatient operating rooms, then it is logical to read WAC 246-310-270(9)(a)(iv) language to speak to the "mixed-use" operating rooms.

I. Overlake reports that of its 19 operating rooms, four are dedicated outpatient operating rooms, and 15 are dedicated inpatient operating rooms.[7] Overlake argues, and the Program agreed in its need calculations, that the 15 inpatient operating rooms should be excluded from the

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[7] While recognizing that facilities must retain some flexibility its use of operating rooms, public policy dictates that the Department, and not the facility, is the ultimate authority to characterize whether an operating room is a mixed use room. Otherwise, there can be no consistency, predictability and transparency in calculating the need for operating rooms in a planning area for public access as required under the Court's *Overlake* holding.

WAC 246-310-270(9)(a)(iv) calculations. It is less important how a facility characterizes an operating room; rather it is important how the facility utilizes the operating room. Based on the evidence in the application record, Overlake's 15 operating rooms are more correctly characterized as "mixed use" rooms. For that reason, the 15 operating rooms must be included in the existing capacity calculations, along with the four dedicated outpatient operating rooms.

J. The parties have a similar dispute over the number of operating rooms at the Evergreen Surgery Center, namely whether that number is six operating rooms or eight. The record shows that Evergreen has reported both numbers. However, Evergreen did not respond to the Program's survey during the 2011 Eastside application process. The best available evidence is the 2009 Integrated Licensing and Regulatory System (ILRS) data, which shows the actual number of operating rooms at the Evergreen facility to be six. For that reason, six operating rooms should be used in the need methodology calculations under WAC 246-310-270(9)(a).

K. The parties also dispute how many operating rooms exist at the Overlake ASC. In 2009, Overlake ASC claimed five. In a January 2010 email, it claimed four (not counting two additional operating rooms being used for pain/colon procedures). In January 2011, it had four operating rooms (not counting three additional operating rooms being used for pain/colon procedures). Of the four being reported, Overlake ASC reported one was not being used on a regular basis; it was for this reason that the Program determined to use three

operating rooms in its earlier calculations. Even though the ASC reports that it is not using one of the operating rooms on a regular basis, the appropriate number of operating rooms for the need calculation methodology is four, given that the operating room is available.

L. Finally, Swedish Hospital at Issaquah reports it has 14 operating rooms: two are used for endoscopy and two for cardiac catheterization[8] procedures; and ten are mixed-use operating rooms. At the hearing, Swedish Executive Office Chuck Salmon testified that only ten of the operating rooms are equipped, with six for general surgery, and two each for endoscopy and catheterization. Despite the fact that Swedish Hospital is currently not using four of the mixed operating rooms, the application record and hearing record do not reflect that the four operating rooms could not be equipped and used for general surgery. For that reason, the correct number of operating rooms for the need methodology calculations is ten.[9]

II. CONCLUSIONS OF LAW

Evidence in Certificate of Need Decisions.

2.1 The Department of Health is authorized and directed to implement the CN Program. RCW 70.38.105(1). The applicant must show its

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[8] Catheterization rooms, like endoscopy rooms, are designed differently than regular operating rooms. *See* TR 67.

[9] There is a reason to treat these operating rooms differently than the operating rooms excluded for the Lakeside and Issaquah ASC. The evidence in the record indicates the Swedish Hospital operating rooms *will* be used, rather than those that *might* (but likely will not) be used in the ASC facilities.

application meets all of the applicable criteria. WAC 246-10-606(2). The standard of proof in CN matters is a preponderance of the evidence. *See* WAC 246-10-606. Admissible evidence in CN hearings is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1).

2.2 The Presiding Officer (on delegated authority from the Secretary of Health) is the agency's fact-finder and final decision maker. *DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007). The Presiding Officer considers the Program's written analysis in reaching his decision but is not required to defer to the Program analyst's decision or expertise. *DaVita*, 137 Wn. App. at 182-183. The Presiding Officer engages in a de novo review of the record because the Presiding Officer is the final decision maker. *See University of Washington Medical Center v. Department of Health*, 164 Wn.2d 95, 103 (2008) (citing to the *DaVita* decision).

2.3 In acting as the Department's final decision maker, the Presiding Officer reviews the application record. The Presiding Officer also reviews the hearing transcript and the closing briefs submitted by the parties in lieu of closing argument, as authorized under RCW 34.05.461(7). The Presiding Officer's analysis examines the "snapshot in time" anticipated in the application, which is defined as the facts around the time the application is filed. *See University of Washington Medical Center v. Department of Health*, 164 Wn.2d 95, 103 (2008).

Certificate of Need Criteria

2.4 Pursuant to WAC 246-310-200(1), a determination whether to grant a CN application depends on whether the proposed project:

A. Is needed;
B. will foster containment of the costs of health care;
C. is financially feasible; and
D. will meet the criteria for structure and process of care identified in WAC 246-310-230.

In the present matter, the parties have stipulated that if need exists, then the other criteria (financial feasibility; structure and process of care; and cost containment) will be met.[10]

Operating Room Methodology

2.5 WAC 246-310-270(9) states:

Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for

[10] *See* Stipulation and Agreed Order Regarding Three Certificate of Need Criteria, dated October 31, 2013.

twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this

subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

2.6 Because of the disparity in need methodology calculations, the Presiding Officer concluded it was necessary to determining the number of operating rooms for the supply side of the WAC 246-310-270(9)(a). Having decided what the correct number is, the Presiding Officer remands the matter to the Program to complete the need methodology calculations with that number of operating rooms.

III. ORDER

Based on the foregoing Procedural History, Findings of Fact, and Conclusions of Law, the matter is REMANDED to the Program to calculate the ambulatory surgical need methodology consistent with the above decision. The Program's calculation should be completed by **April 30, 2013**.

Dated this ___27_ day of March, 2013.

________________/s/_______________
JOHN F. KUNTZ, Review Judge
Presiding Officer

DECLARATION OF SERVICE BY MAIL
I declare that today I served a copy of this document upon the following parties of record**:**
BRIAN W. GRIMM AND JEFF FREIMUND, ATTORNEYS AT LAW AND RICHARD MCCARTAN, AAG by mailing a copy properly addressed with postage prepaid.

DATED AT OLYMPIA, WASHINGTON THIS _____ DAY OF MARCH, 2013.

____
Adjudicative Service Unit

cc: **JANIS SIGMAN**

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