STUDEBAKER | NAULT

EMILY R. STUDEBAKER, ESQ.
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July 7, 2022

VIA EMAIL AND U.S. MAIL

Department of Health
Certificate of Need Program
111 Israel Road S.E.
Tumwater, Washington 98501

Sent via e-mail: eric.hernandez@DOH.WA.GOV

Re: Olympia Orthopaedic Associates, P.L.L.C.

Dear Mr. Hernandez:

Our office represents Olympia Orthopaedic Associates, P.L.L.C. ("Olympia Orthopaedic Associates"). Pursuant to WAC 246-310-050, Olympia Orthopaedic Associates is requesting from the Washington State Department of Health (the "Department") a formal determination of the applicability of the certificate of need review requirements at chapter 70.38 RCW to a procedure room located at 3901 Capital Mall Drive S.W., Olympia, WA 98502. While the procedure room is already built out, it currently is not being used for "surgical services" as defined in RCW 70.230.010(7). Olympia Orthopaedic Associates intends to use the room for procedures that may constitute surgery, and it understands a certificate of need exemption is needed to do so. For purposes of the information on primary purpose included in the enclosed application, the certificate of need approved ambulatory surgical facility in which Olympia Olympia Orthopaedic Associates physicians hold an interest has been excluded.

Please find enclosed a "Certificate of Need Application, Determination of Reviewability Ambulatory Surgery Center/Facility" form completed by Olympia Orthopaedic Associates regarding its procedure rooms. A check has been sent for the review fee in the amount of $1,925 payable to the Department via USPS, and the tracking number is 7021 2720 0001 4147 6859.

Please advise us at your earliest convenience whether this application is deemed complete. If the Department requires additional information for this application, please promptly advise.

Thank you in advance for your consideration. We look forward to working with you on this matter.

Regards,

STUDEBAKER NAULT, PLLC

Emily R. Studebaker

Enclosure
cc: Jessica Forsman, VP of Business Development
Olympia Orthopaedic Associates, P.L.L.C.

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

Contents:

Submission Instructions:

- One electronic copy of your application, including any applicable attachments – no paper copy is required.
- A check or money order for the review fee of $1,925 payable to Department of Health.

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

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 or FSLCON@doh.wa.gov.

Definitions

The Certificate of Need (CN) Program will use the information you provide 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.

"Primary purpose" is defined as the majority of income or patient visits for the site,* inclusive of all clinical services provided at the site, are derived from the specialty or multi-specialty surgical services. Department of Health website, frequently asked questions, informed by the licensing rules definition for ambulatory surgical facility.

*The site subject to a determination of reviewability is limited to a specific, physical address where an entity under single ownership provides or will provide specialty or multispecialty surgical services. A site whose "primary purpose" is specialty or multispecialty surgical services is required to obtain a certificate of need.

"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).

"Ambulatory surgical facility" or "**ASF**" as defined by licensing rules, and relied on by the CN Program for consistency, means any distinct entity that operates for the primary purpose of providing specialty or multispecialty outpatient surgical services in which patients are admitted to and discharged from the facility within twenty-four hours and do not require inpatient hospitalization, whether or not the facility is certified under Title XVIII of the federal Social Security Act. An ambulatory surgical facility includes one or more surgical suites that are adjacent to and within the same building as, but not in, the office of a practitioner in an individual or group practice, if the primary purpose of the one or more surgical suites is to provide specialty or multispecialty outpatient surgical services, irrespective of the types of anesthesia administered in the one or more surgical suites. An ambulatory surgical facility that is adjacent to and within the same building as the office of a practitioner in an individual or group practice may include a surgical suite that shares a reception area, restroom, waiting room, or wall with the office of the practitioner in an individual or group practice. WAC 246-330-010(5)

"Change of ownership" as defined by licensing rules, and relied on by the CN Program, is defined as (a) A sole proprietor who transfers all or part of the ambulatory surgical facility's ownership to another person or persons; (b) The addition, removal, or

substitution of a person as a general, managing, or controlling partner in an ambulatory surgical facility owned by a partnership where the tax identification number of that ownership changes; or (c) A corporation that transfers all or part of the corporate stock which represents the ambulatory surgical facility's ownership to another person where the tax identification number of that ownership changes. WAC 246-330-010(8)

"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)

Instructions

General Instructions:

- Include a table of contents for 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 form are in draft format, a draft is acceptable only 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.
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

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

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

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

The Department of Health (department) will use this form to determine whether my ambulatory surgical center or facility 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 submissions 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 **Olympia Orthopaedic Associates, PLLC**	
Clinical Practice UBI #: **601-617-151** Surgery Center UBI #: **601-617-151**	Federal Tax ID (FEIN) # **91-1674528**
Mailing Address **PO Box 368** **Olympia, WA 98507-0368**	Surgery Center Address **3901 Capital Mall Drive SW** **Olympia, WA 98502**
Website Address: **http://www.olyortho.com**	
Phone number (10-digit): **360-570-3465**	Email Address: **jforsman@olyortho.com**
Name and Title of Responsible Officer (Print): **Jessica Forsman** **VP, Business Development**	Signature of Responsible Officer: Jessica Forsman Date of Signature: 07/06/22
Identify the purpose of your request: ☐ New Facility ☐ Change of Ownership ☐ Facility Relocation	☐ Facility Expansion – Operating Room Increase ☐ Facility Expansion – Service Increase ☒ Other (please provide a letter describing)

Existing Facility Status

Complete for all applications concerning existing facilities

1. The CN Program previously determined the facility was not subject to CN Review (if yes, attach DOR letter)

   ☐ Yes ☒ No

2. If this request is for a change in ownership provide the following information:

Current facility's name	
Current facility's address	
Current facility's license number	ASF.FS.
Current facility's Certificate of Need status	☐ Exempt DOR# _____
	☐ Approved CN# _____
Anticipated change of ownership month and year	

3. If this request is for the relocation of an existing facility, provide the following information:

Current facility's address	
Anticipated relocation month and year	

Facility Information

4. Although you are not required to apply for an ASF license before a CN determination is issued, have you or do you intend to, apply for a license?*

   ☐ Yes, intend to apply ☒ No
   ☐ Yes, here is the facility's license #ASF.FS. _____

   *Your answer to this question will allow the CN program to effectively coordinate the licensure process with other DOH offices.

5.

Number of existing operating and procedure rooms:	**1**
Number of new operating and procedure rooms:	**0**
Total:	**1**

For Certificate of Need purposes operating and procedure rooms are one in the same.

Clinical and Surgical Services

6. Check all surgical procedures currently 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)

☐ This is a new facility, no surgical procedures are currently performed

Check all new surgical procedures proposed to be 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)				

Primary Purpose of the Facility

7. The Certificate of Need Program must understand how a facility operates in order to determine the facility's primary purpose. Typically, governance documents can aid the department in this understanding. These could be in the form of operating agreements, shareholder agreements, or corporate governing documents. Provide any documentation that could aid in this understanding.

8. A facility that receives more than 50% of their income or 50% of their visits from surgeries is subject to CN requirements. In order to determine if your project is subject to CN review, please provide the current (existing facility) and proposed (new facility) percentages of income and visits for clinical and surgical services. Include all assumptions used to determine the percentages provided.

This site's revenue	**Most recent full year of operation** **Year:** 2021	**Projected first full year of operation after the proposed changes** **Year:** 2023
Total revenue for clinical services	$19,627,494	$20,016,834
Total revenue for surgical services	$0	$0
Total revenue	$19,627,494	$20,016,834

This site's patient visits	**Most recent full year of operation** **Year:** 2021	**Projected first full year of operation after the proposed changes** **Year:** 2023
Total clinical patient visits	141,638	141,638
Total surgical patient visits	4,653	4,797
Total patient visits	146,291	146,435

These numbers are based on the following assumptions:

We reviewed our historical revenue and visits for the most recent full year of operations at the site. We then added the anticipated revenue and patient visits expected after the proposed changes, assuming that 10% of eligible cases from Olympia Orthopaedic Associates' other practice locations will shift to the procedure room in year one. We do not anticipate charging facility fees for the procedures performed in these procedure rooms and thus projected revenue for surgical services associated with the procedure rooms is $0. Surgery is expected to represent 3.3% of the total patient visits and 0% of the total revenue for this site.

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

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

Licensing Resources:
Ambulatory Surgical Facilities Laws, RCW 70.230
Ambulatory Surgical Facilities Rules, WAC 246-330
Ambulatory Surgical Facilities Program Web Page

Construction Review Services Resources:
Construction Review Services Program Web Page
Phone: (360) 236-2944
Email: CRS@doh.wa.gov

APPENDIX A

CERTIFICATE OF FORMATION

APP

STATE of WASHINGTON SECRETARY of STATE

I, Ralph Munro, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF FORMATION

to

OLYMPIA ORTHOPEDIC ASSOCIATES PROFESSIONAL
LIMITED LIABILITY COMPANY

a Washington Professional Limited Liability Company was/were filed for record in this office on the date indicated below.

U B I Number: 601 617 151

Date: March 28, 1995
Given under my hand and the seal of the State of Washington, at Olympia, the State Capitol.

Ralph Munro

Ralph Munro, Secretary of State

2-508612-5

SSF 6-A

1995 3154 7407 0434-0436

601-617-1

FILED
STATE OF WASHINGTON
MAR 2 8 1995
RALPH MUNRO
SECRETARY OF STATE

CERTIFICATE OF FORMATION
OLYMPIA ORTHOPEDIC ASSOCIATES PROFESSIONAL LIMITED LIABILITY COMPANY

Pursuant to Title 25 of the Revised Code of Washington, the undersigned does hereby submit this Certificate of Formation for the purpose of a limited liability company.

1. The name of the limited liability company is: OLYMPIA ORTHOPEDIC ASSOCIATES PROFESSIONAL LIMITED LIABILITY COMPANY.

2. The latest date on which the limited liability company is to dissolve is: April 1, 2045.

3. The name of the initial registered agent is: STEPHEN J. BEAN.

4. The initial registered office, which address is identical to the business office of the registered agent in Washington is: 320 North Columbia, Olympia, Washington 98501.

4A. (Optional) The post office box address, located in the same city as the Washington registered office address, which may be used for mailing purposes only, is: P.O. Box 2317, Olympia, Washington 98507.

CONSENT TO APPOINTMENT AS REGISTERED AGENT

I, STEPHEN J. BEAN, hereby consent to serve as Registered Agent in the state of Washington for the above named limited liability company. I understand that as agent for the limited liability company, it will be my responsibility to accept Service of Process on behalf of the limited liability company; to forward license renewals and other mail to the limited liability company; and to immediately notify the Secretary of State in the event of my resignation or of any changes in the Registered Office address.

3-17-95 STEPHEN J. BEAN

5. The address of the principal place of business of the limited liability company is: 3525 Ensign Road NE, Suite E, Olympia, Washington 98506.

6. Management of the limited liability company is not vested in one or more managers. It is member-managed.

Val: 03/28/1995 - 38356
$245.00 on 03/28/1995
Check - 03/28/1995 - 7673

1995 3154 7407 0435

7. The name and address of each person executing this certificate is:

Name	Address
LOUIS A. ROSER, M.D., INC., P.S.	3525 Ensign Road NE, Suite E, Olympia, WA 98506
KENNETH L. PARTLOW III, M.D., INC., P.S.	3525 Ensign Road NE, Suite E, Olympia, WA 98506
JEROME P. ZECHMANN, M.D.	3525 Ensign Road NE, Suite E, Olympia, WA 98506
P. BRODIE WOOD, M.D.	3525 Ensign Road NE, Suite E, Olympia, WA 98506

8. These Articles will be effective upon filing.

DATED: 3-28, 1995.

LOUIS A. ROSER, M.D., INC., P.S.

KENNETH L. PARTLOW III, M.D., INC., P.S.

JEROME L. ZECHMANN, M.D.

P. BRODIE WOOD, M.D.

APPENDIX B

ANNUAL REPORT

WASHINGTON
Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 01/24/2022
Effective Date: 01/24/2022
UBI #: 601 617 151

Annual Report

BUSINESS INFORMATION

Business Name:
OLYMPIA ORTHOPAEDIC ASSOCIATES, P.L.L.C.

UBI Number:
601 617 151

Business Type:
WA PROFESSIONAL LIMITED LIABILITY COMPANY

Business Status:
ACTIVE

Principal Office Street Address:
3909 9TH AVE SW, OLYMPIA, WA, 98502-5134, UNITED STATES

Principal Office Mailing Address:
PO BOX 368, OLYMPIA, WA, 98507-0368, UNITED STATES

Expiration Date:
03/31/2023

Jurisdiction:
UNITED STATES, WASHINGTON

Formation/Registration Date:
03/28/1995

Period of Duration:
PERPETUAL

Inactive Date:

Nature of Business:
HEALTH CARE, SOCIAL ASSISTANCE & SERVICE ORGANIZATION

REGISTERED AGENT CONSENT

To change your Registered Agent, please delete the current Registered Agent below.
Registered Agent Consent (Check One):

☐ I am the Registered Agent. Use my Contact Information.

☑ I am not the Registered Agent. I declare under penalty of perjury that the WA Professional Limited Liability Company has in its records a signed document containing the consent of the person or business named as registered agent to serve in that capacity. I understand the WA Professional Limited Liability Company must keep the signed consent document in its records, and must produce the document on request.

RCW 23.95.415 requires that all businesses in Washington State have a Registered Agent.
Some of this information is prepopulated from information previously provided. Please make changes as necessary to provide accurate information.

REGISTERED AGENT RCW 23.95.410

Registered Agent Name	Street Address	Mailing Address
BEN SHAH	3909 9TH AVE SW, OLYMPIA, WA, 98502-5134, USA	PO BOX 368, OLYMPIA, WA, 98507-0000, USA

PRINCIPAL OFFICE

Phone:
3604555144

Email:
MFLEMM@OLYORTHO.COM

Street Address:
3909 9TH AVE SW, OLYMPIA, WA, 98502-5134, USA

Mailing Address:
PO BOX 368, OLYMPIA, WA, 98507-0368, USA

GOVERNORS

Title	Type	Entity Name	First Name	Last Name
GOVERNOR	INDIVIDUAL		GREGORY	BYRD
GOVERNOR	INDIVIDUAL		CLYDE	CARPENTER
GOVERNOR	INDIVIDUAL		THOMAS	HELPENSTELL
GOVERNOR	INDIVIDUAL		ANDREW	MANISTA
GOVERNOR	INDIVIDUAL		P BRODIE	WOOD
GOVERNOR	INDIVIDUAL		ZACHARY	ABBOTT
GOVERNOR	INDIVIDUAL		L ANTHONY	AGTARAP
GOVERNOR	INDIVIDUAL		WILLIAM	PETERSON
GOVERNOR	INDIVIDUAL		TRENT	MCKAY
GOVERNOR	INDIVIDUAL		RYAN	HALPIN
GOVERNOR	INDIVIDUAL		JEROME	ZECHMANN
GOVERNOR	INDIVIDUAL		TIMOTHY	DUMONTIER
GOVERNOR	INDIVIDUAL		DOUGLAS	TAYLOR
GOVERNOR	INDIVIDUAL		BRADLEY	CHRIST
GOVERNOR	INDIVIDUAL		MILAN	MOORE
GOVERNOR	INDIVIDUAL		ADAM	GRAVER
GOVERNOR	INDIVIDUAL		RICHARD	LAMOUR

NATURE OF BUSINESS

HEALTH CARE, SOCIAL ASSISTANCE & SERVICE ORGANIZATION

EFFECTIVE DATE

Effective Date:
01/24/2022

CONTROLLING INTEREST

1. Does this entity own (hold title) real property in Washington, such as land or buildings, including leasehold improvements?
NO
2. In the **past 12 months**, has there been a transfer of at least 16-2/3 percent of the ownership, stock, or other financial interest in the entity?
NO
a. If "Yes", in the **past 36 months**, has there been a transfer of controlling interest (50 percent or greater) of the ownership, stock, or other financial interest in the entity?
NO
3. If you answered "Yes" to question 2a, has a controlling interest transfer return been filed with the Department of Revenue?
NO

You **must** submit a Controlling Interest Transfer Return form if you answered “yes” to questions 1 **and** 2a.

Failure to report a Controlling Interest Transfer is subject to penalty provisions of RCW 82.45.220.

For more information on **Controlling Interest**, visit www.dor.wa.gov/REET.

RETURN ADDRESS FOR THIS FILING

Attention:
SAMANTHA NEUMANN
Email:
SNEUMANN@OLYORTHO.COM
Address:
PO BOX 368, OLYMPIA, WA, 98507-0368, USA

UPLOAD ADDITIONAL DOCUMENTS

Do you have additional documents to upload? **No**

EMAIL OPT-IN

☐ By checking this box, I hereby opt into receiving all notifications from the Secretary of State for this entity via email only. I acknowledge that I will no longer receive paper notifications.

AUTHORIZED PERSON

☑ I am an authorized person.

Person Type:
INDIVIDUAL

First Name:
SAMANTHA

Last Name:

NEUMANN

Title:

STAFF ACCOUNTANT

☑ This document is hereby executed under penalty of law and is to the best of my knowledge, true and correct.