Washington State Department of Health

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 Kyle Huish, DDS PLLC	
Clinical Practice UBI #: 604 105 090 Surgery Center UBI #: 604 105 090	Federal Tax ID (FEIN) # 84-2690826
Mailing Address 10010 N. Division Street Spokane, WA 99218	Surgery Center Address 521 E. Holland Avenue Spokane, WA 99218
Website Address: www.dynamicdentalcare.com	
Phone number (10-digit): (509) 466-2587	Email Address: kyle.huish@gmail.com
Name and Title of Responsible Officer (Print): Kyle Huish, DDS, Member	Signature of Responsible Officer:  Date of Signature: 8/28/25

Identify the purpose of your request:

☒	New Facility	☐	Facility Expansion – Operating Room Increase
☐	Change of Ownership	☐	Facility Expansion – Service Increase
☐	Facility Relocation	☐	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:	0
Number of new operating and procedure rooms:	2
Total:	2

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) Dental Services

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: _____**	**Projected first full year of operation after the proposed changes** **Year: _____**
Total revenue for clinical services	0	$2,500,000.00
Total revenue for surgical services	0	$500,000.00
Total revenue	0	$3,000,000.00

This site's patient visits	**Most recent full year of operation** **Year: _____**	**Projected first full year of operation after the proposed changes** **Year: _____**
Total clinical patient visits	0	4,500
Total surgical patient visits	0	250
Total patient visits	0	4,750

The projected clinical and surgical patients visits and revenue are based on the past volumes at the practice.

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

EXHIBIT 1
KYLE HUISH, DDS PLLC - ANNUAL REPORT

WASHINGTON
Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 03/25/2025
Effective Date: 03/25/2025
UBI #: 604 105 090

Annual Report

BUSINESS INFORMATION

Business Name:
KYLE HUISH, DDS PLLC

UBI Number:
604 105 090

Business Type:
WA PROFESSIONAL LIMITED LIABILITY COMPANY

Business Status:
ACTIVE

Principal Office Street Address:
10010 N DIVISION ST, SPOKANE, WA, 99218-1305, UNITED STATES

Principal Office Mailing Address:
10010 N DIVISION ST, SPOKANE, WA, 99218-1305, UNITED STATES

Expiration Date:
03/31/2026

Jurisdiction:
UNITED STATES, WASHINGTON

Formation/Registration Date:
03/23/2017

Period of Duration:
PERPETUAL

Inactive Date:

Nature of Business:
GENERAL DENTAL

REGISTERED AGENT RCW 23.95.410

Registered Agent Name	Street Address	Mailing Address
RANDALL DANSKIN, PS	601 W 1ST AVE STE 800, SPOKANE, WA, 99201-3817, UNITED STATES	

PRINCIPAL OFFICE

Phone:

Email:
JTT@RANDALLDANSKIN.COM

Street Address:

10010 N DIVISION ST, SPOKANE, WA, 99218-1305, USA

Mailing Address:
10010 N DIVISION ST, SPOKANE, WA, 99218-1305, USA

GOVERNORS

Title	Type	Entity Name	First Name	Last Name
GOVERNOR	INDIVIDUAL		KYLE	HUISH

NATURE OF BUSINESS

- GENERAL DENTAL

EFFECTIVE DATE

Effective Date:
03/25/2025

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:
Email:
Address:

UPLOAD ADDITIONAL DOCUMENTS

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

AUTHORIZED PERSON

☐ I am an authorized person.

Person Type:
INDIVIDUAL

First Name:
J TODD

Last Name:
TAYLOR

Title:

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