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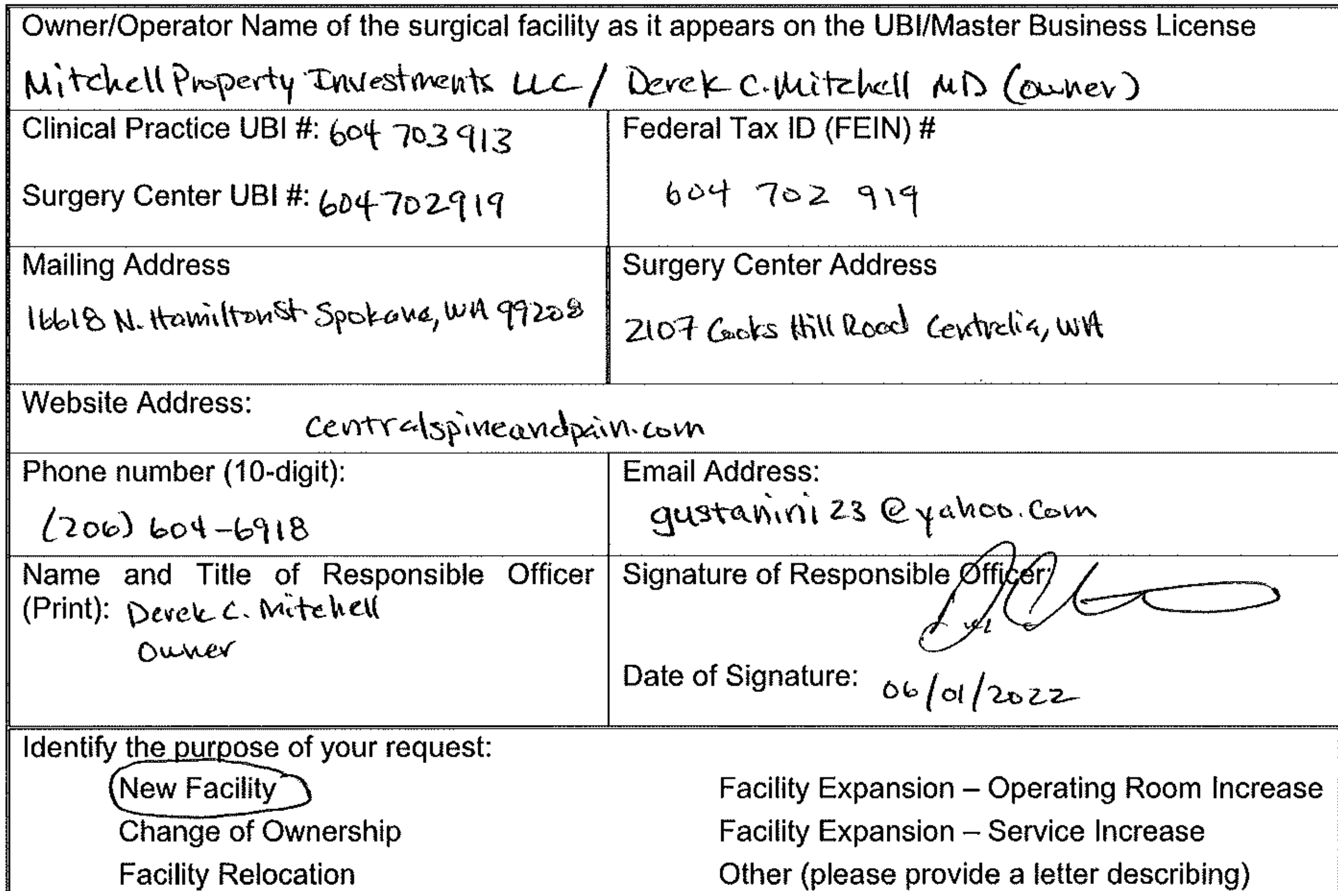
Certificate of Need
Determination of Reviewability
Ambulatory Surgical Facility and Ambulatory Surgery Center
(Do not use this form for any other type of ASC/F project)

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	
Mitchell Property Investments LLC / Derek C. Mitchell MD (owner)	
Clinical Practice UBI #: 604 703 913 Surgery Center UBI #: 604702919	Federal Tax ID (FEIN) # 604 702 919
Mailing Address 16618 N. Hamilton St. Spokane, WA 99208	Surgery Center Address 2107 Cooks Hill Road Centralia, WA
Website Address: centralspineandpain.com	
Phone number (10-digit): (206) 604-6918	Email Address: gustanini23@yahoo.com
Name and Title of Responsible Officer (Print): Derek C. Mitchell Owner	Signature of Responsible Officer: [signature] Date of Signature: 06/01/2022

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

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

Yes No

NA 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	

NA 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:	
Number of new operating and procedure rooms:	1
Total:	1

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

Clinical and Surgical Services

NA 6. Check all surgical procedures currently performed in the facility.

Ear, Nose, & Throat
Plastic Surgery
Orthopedics
Ophthalmology
Gynecology
Gastroenterology
Podiatry
Pain Management
Oral Surgery
Maxillo facial
General Surgery
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: ______**	**Projected first full year of operation after the proposed changes** **Year: 2024**
Total revenue for clinical services		500,000
Total revenue for surgical services		300,000
Total revenue		800,000

This site's patient visits	**Most recent full year of operation** **Year: ______**	**Projected first full year of operation after the proposed changes** **Year: 2024**
Total clinical patient visits		3,840
Total surgical patient visits		1,920
Total patient visits		5,760

Certificate of Need Proposed Exemption Narrative

I, Derek Mitchell MD, am seeking an exemption from Certificate of Need for the establishment of an ambulatory surgery center (ASC) related to my solo practice.

I, Derek Mitchell MD, am currently practicing in a private clinic in Spokane, of which I am not an owner. Central Spine and Pain, LLC is a solo clinical practice owned by me but not yet in operation. It is a legal corporation registered with Washington State. My intention is to construct a building to serve as a private clinic for Central Spine and Pain LLC with an attached Ambulatory Surgical Center at 2107 Cooks Hill Road in Centralia, WA in Lewis County.

The proposed ASC would be operated in the private facilities of Central Spine and Pain, LLC. The ASC would be operated under a separate legal entity-Mitchell Property Investments LLC. Mitchell Property Investments LLC will be registered with the IRS to do business as Central Spine and Pain Ambulatory Surgery. Mitchell Property Investments LLC is owned by Derek and Amanda Mitchell MD.

Privileges to utilize the ASC will be limited to physicians within the group of Central Spine and Pain LLC. Privileges will thus be limited to myself, Derek Mitchell MD. No other groups, individuals, companies will be permitted to utilize the ASC. Future owners may have access to the ASC.

Procedures to be performed at the ASC include those typical of Pain Medicine. These include but are not limited to epidural steroid injections, radiofrequency neuroablations, joint, tendon, muscle injections, peripheral nerve blocks, spinal cord stimulation trials and implants, neurotoxin therapy (Botox) and regenerative medicine.

No management agreement for the ASC is proposed.

Thank you for your consideration,

Derek C Mitchell MD
Mitchell Property Investments LLC
206-604-6918
16618 N Hamilton St Spokane, WA 99208