STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In re:	)	
	)	
Certificate of Need Decision by	)	Docket No. 06-06-C-2003CN
DEPARTMENT OF HEALTH re:	)	
SWEDISH HEALTH SERVICES	)	FINDINGS OF FACT,
ISSAQUAH AMBULTORY SURGERY	)	CONCLUSIONS OF LAW
CENTER,	)	AND ORDER ON REMAND
	)	
OVERLAKE HOSPITAL MEDICAL	)	
CENTER, a Washington non-profit	)	
Corporation,	)	
	)	
Petitioners.	)	
_____	)	

APPEARANCES:

Petitioner, Overlake Hospital Medical Center (Overlake), by
Ogden Murphy Wallace P.L.L.C., per
Donald W. Black and Jeffrey D. Dunbar, Attorneys at Law

Intervenor, Swedish Health Services
dba Swedish Medical Center (Swedish), by
Dorsey & Whitney LLP, per
Peter S. Ehrlichman and Brian W. Grimm, Attorneys at Law

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

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

Overlake appeals the Program's decision granting a certificate of need to Swedish to establish an ambulatory surgery center in Issaquah, Washington. The Presiding Officer, on authority delegated to him by the Secretary of Health, convened a hearing on the appeal on September 7, 2007.

ISSUES

A. Whether the certificate of need application filed by Swedish met all of the necessary criteria set forth in chapters 70.38 RCW and 246-310 WAC?

B. Whether the Program correctly awarded the Swedish certificate of need application?

SUMMARY OF THE PROCEEDINGS

Randall Huyck testified during the Program's case in chief. Jody Carona testified during Overlake's case in chief. Swedish did not present any witness testimony.

Fourteen exhibits were offered for admission at hearing. The following ten exhibits were admitted at the hearing:

Exhibit 1: Swedish Health Services–Issaquah Ambulatory Surgical Center certificate of need application record;

Exhibit 2: Curriculum Vitae of Jody Carona;

Exhibit 3: Curriculum Vitae of Robert Edward "Scott" MacStravic, Ph.D.;

Exhibit 4: Withdrawn;

Exhibit 5: Not admitted;[1]

Exhibit 6: Not admitted;[2]

Exhibit 7: Past evaluations of the Program, past Health Law Judge decisions in certificate of need adjudications, and other court decisions in certificate of need cases. These evaluations and/or decisions include:

7A. Evaluation of the Certificate of Need Application Submitted by Virginia Mason Medical Center Proposing to Establish a Free-Standing Ambulatory Surgery Center in Federal Way;

[1] Exhibit 5 was not admitted at hearing, but is included as part of the offer of proof submitted by Overlake. *See* Hearing Transcript (TR) pages 20-21 and 23.
[2] Exhibit 6 was not admitted at hearing, but is included as part of the offer of proof submitted by Overlake. *See* TR pages 20-21 and 23.

7B. Evaluation of the Certificate of Need Application Submitted on Behalf of Multicare Health System Proposing to Establish an Ambulatory Surgery Center in the City of Gig Harbor Within Pierce County;

7C. Department of Health's Remand Findings for the Certificate of Need Application Submitted on Behalf of Ear, Nose, Throat and Plastic Surgery Associates, P.S., Proposing to Establish a Freestanding Ambulatory Surgical Center Located in Auburn, King County;

7D. Analysis of the Certificate of Need Application Submitted on Behalf of Puyallup Orthopedic Associates, LLC, Proposing to Establish a Free-standing Ambulatory Surgery Center in East Pierce County;

7E. The Department of Health's Findings for the Certificate of Need Application Submitted on Behalf of Northwest Nasal Sinus Center, Kirkland, Proposing to Establish a Free-Standing Ambulatory Surgery Center to be Known as Northwest Surgical Specialists (Certificate of Need No. 1250);

7F. Evaluation of the Certificate of Need Application Submitted by Proliance Surgeons, Inc., PS, Proposing to Establish an Ambulatory Surgery Center in Snohomish County; and

7G. Evaluation of the Certificate of Need Application Submitted by Proliance Surgeons, Inc., P.S., Proposing to Establish an Ambulatory Surgery Center in Kirkland.

Exhibit 8: Withdrawn;

Exhibit 9: Findings of Fact, Conclusions of Law and Final Order on Remand, In Re: Swedish Health Services Bellevue ASC, Docket No. 03-06-C-2001CN (the Bellevue ASC decision);

Exhibit 10: Copy of "Changing Patterns of Surgical Care in the United States, 1980-1995," Health Care Financing Review, Fall 1999, Volume 21, Number 1;

Exhibit 11: Two Copies of SHS Issaquah Ambulatory Surgery Center Operating Room Need Methodology;[3]

Exhibit 12: Copy of July 21, 2005 Screening Questions 40, 41, 42, and 43;

Exhibit 13: Five Certificate of Need Program Ambulatory Surgery Center Survey forms:

13A: Virginia Mason Issaquah, date stamped received by the Certificate of Need Program on July 31, 2002;

13B: Sammamish Center for Facial Plastic Surgery, date stamped received by the Certificate of Need Program on July 5, 2002.

13C: Pacific Cataract & Laser Institute, date stamped received by the Certificate of Need Program on July 8, 2002;

13D: Overlake Ambulatory Surgery Center, date stamped received by the Certificate of Need Program on July 11, 2002; and

13E: Eastside Podiatry ASC, date stamped received by the Certificate of Need Program on July 5, 2002.[4]

Exhibit 14: Two Proliance Issaquah OR Need Methodology calculation worksheets:

14A: Methodology calculation using 2009 Service Area Population of 532,996 and performed with a use rate of 82/1000;[5] and

14B: Methodology calculation using 2009 Service Area Population of 546,288 and performed with a use rate of 82/1000.[6]

[3] The second page, marked 3C, performed the methodology calculations using 82/1000, even though the use rate shown is 102/1000. *See* TR 53, line 18-23.
[4] The document was originally date stamped received by Facilities and Services Licensing on July 3, 2002.
[5] The heading of the methodology calculation sheet indicates a use rate of 102/1000. Ms. Carona testified that she substituted a use rate of 82/1000 in the actual calculation. *See* TR 121, line 14 through TR 122, line 18.
[6] The heading of the methodology calculation sheet indicates a use rate of 102/1000. Ms. Carona testified that she substituted a use rate of 82/1000 in the actual calculation. *See* TR 121, line 14 through TR 122, line 18.

The parties requested permission to submit written briefs in lieu of closing argument. The request was granted, and the parties were required to submit opening briefs by October 5, 2007, and reply briefs by October 12, 2007. A short extension of the submission of the reply brief was granted, and the date continued to October 16, 2007.

Based on the evidence submitted in this matter, the Presiding Officer enters the following:

I. FINDINGS OF FACT

1.1 On August 3, 2005, Swedish applied for a certificate of need to establish a free-standing ambulatory surgical facility in Issaquah, King County, Washington.[7] Swedish's Issaquah facility would be located in the East King County secondary health services planning area (the planning area). As the Swedish application was filed within four months of another ambulatory surgical facility application in the same planning area, the Program determined the two applications should undergo review on a common timetable.[8] In the case of a review involving two potentially competing projects, the Program's evaluation makes recommendations regarding whether both, neither or one of the individual applicants should be issued a certificate of need.[9]

[7] An "ambulatory surgical facility" means any free-standing entity, including an ambulatory surgery center, that operates primarily to perform surgical procedures for patients not requiring hospitalization. WAC 246-310-010(5). The terms ambulatory surgical facility and ambulatory surgery center are often used interchangeably.
[8] AR 415. The second applicant, Proliance Surgeons, Inc., applied to establish an ambulatory surgical facility, known as Issaquah Surgery Center, on April 1, 2005.
[9] AR 415.

1.2 On May 12, 2006, the Program found the Swedish application met, or was consistent with, all of the ambulatory surgical facility criteria, and conditionally approved the Swedish application. On June 7, 2006, Overlake appealed the Program's decision.

1.3 An ambulatory surgical facility consists of two or more operating rooms.[10] That is, the facility consists of two or more rooms where surgery is performed on an inpatient or outpatient basis.[11] Inpatient surgery is when a person's surgery requires board and room in a health care facility (that is, a hospital) on a continuous, 24-hour a day basis.[12]

1.4 An applicant seeking to establish an ambulatory surgical facility uses a mathematical formula or methodology to determine whether additional inpatient and outpatient operating rooms are needed in a planning area.[13] The first step in the methodology requires an applicant to determine what is the capacity of the existing operating rooms in the planning area. Existing capacity is determined by taking one operating room in a hospital, and one operating room dedicated to ambulatory surgery, and assuming the annual capacity in minutes for each type of operating room.[14] The applicant then calculates the total annual capacity of all dedicated outpatient operating rooms in the area.

1.5 When calculating or determining the capacity of existing operating rooms in a secondary health services planning area, the applicant must include the surgical

[10] WAC 246-310-270(6).
[11] "Surgery" means that "branch of medicine dealing with the manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases." Taber's Cyclopedic Medical Dictionary (14th Edition, 1981), at page 1395.
[12] *See* WAC 246-310-010(5) and WAC 246-310-010(33).
[13] *See* WAC 246-310-270(9). An example of the calculation can be found in Exhibit 11.
[14] *See* WAC 246-310-270(9)(a).

volume or number of surgeries that have been performed in both ambulatory surgery centers (that is, surgical centers that are exempt from the certificate of need requirement) and ambulatory surgical facilities (that is, surgical facilities that are required to obtain a certificate of need). The goal is to capture the total volume or total number of inpatient and outpatient surgeries that have been performed in the planning area.

1.6 The second step requires an applicant to determine whether there is need for additional capacity in the same secondary health service planning area in the future (the future being defined as the third year of operation of the facility, or three years after the applicant anticipates starting the operation of its facility). This projected number is 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.[15] To determine if additional capacity is required (that is, determine whether need exists for additional surgical capacity), the applicant calculates a figure know as a "use rate." The term "use rate" is not specifically defined in chapter 70.38 RCW or chapter 246-310 WAC, but is commonly understood to represent the projection of the number of the inpatient and outpatient surgeries within the applicant's planning area for the target year (i.e., the third year of operation).[16] The use rate is expressed as a percentage of the surgeries required per 1000 individuals of the given population (for example, 100 surgeries for every 1000 individuals in the population, or 100/1000).

[15] *See* WAC 246-310-270(9)(b).
[16] *See* WAC 246-310-270(9)(b)(i).

1.7 When calculating the future need for ambulatory surgical facilities, an applicant excludes from that count, the number of operating rooms from the ambulatory surgery centers (exempt facilities). Unlike the capture of all facility capacity in determining current capacity, the calculation of future need of capacity only reflects or captures the capacity of non-exempt facilities. The reasoning for this approach is an individual may need surgery in the future, but may not qualify to obtain that surgery in an exempt facility.

1.8 In its application Swedish identified a use rate of 119.34/1000 to calculate whether need existed. Swedish obtained this information from the latest (1996) Center for Disease Control and Prevention/National Center for Health Statistics survey of ambulatory surgery in the United States.[17] So the Swedish use rate was based on national statistical data, not on data obtained for the East King County health planning area.

1.9 To review an ambulatory surgical facility certificate of need application, the Program typically obtains surgical information by forwarding surveys to the facilities in the health planning area. Following this standard practice, the Program submitted surveys to the 28 ambulatory surgical facility providers in the East King County planning area in late 2005. The Program intended to use the information obtained through its survey results to calculate what the appropriate use rate was in the planning area, and to confirm or reject the approach taken by Swedish. Of the 28 providers within the

[17] Hall, Margaret Jean and Lawrence, Linda, "Ambulatory Surgery in the United States, 1996," form the publication Advance Data, Number 3000, August 12, 1998 (Vital and Health Statistics of the Center for Disease Control and Prevention/National Center for Health Statistics). AR 79-94.

planning area to whom surveys were sent, only nine providers submitted survey results to the Program.

1.10 The Program determined that the information obtained from nine provider surveys was insufficient to determine the correct use rate for the planning area. The Program took the survey result information it received from the nine providers, supplemented it with survey information received from seven of the remaining 18 non-responsive providers, which the Program received from surveys obtained in a different recent certificate of need application in the same planning area, and calculating the use rate using the 16 providers (the nine original provider surveys and the supplemental seven provider surveys).[18] Using the information from the 16 providers, the Program calculated the use rate to be 80.38/1000. This use rate was based on approximately 57 percent of the available providers in the planning area. Given that the 80.38/1000 use rate reflected slightly more than 50 percent of the facilities in the health planning area, the Program determined that use rate under-reported the actual need. For that reason the Program chose not to utilize the 80.38/1000 use rate as a part of its analysis.

1.11 Facilities in a health planning area are expected to complete, but not required to complete, the surveys regarding the surgical capacity in their respective facilities. Therefore, the capacity calculations in any given application are affected by the number of facilities that submit a reply to the survey request.

[18] Evergreen Orthopedic Surgery Center, June 21, 2005. *See* AR 422, footnote 3.

1.12 Rather than adopting the 119.34/1000 use rate provided by Swedish, or the 80.38/1000 use rate calculated on the survey data, the Program substituted a use rate of 102/1000, which was obtained from another national study.[19] The Program determined this 102/1000 use rate was more accurate than the data submitted by Swedish. While the Program agreed with Swedish that need existed, the Program disagreed with the use rate adopted by Swedish in support of its application.

1.13 The Program adopted the 102/1000 use rate, in part, because it had utilized the use rate in other recent certificate of need decisions. While the Program adopted the 102/1000 use rate in other recent certificate of need decisions, it did not do so consistently.[20] The Program's decision to use the 102/1000 use rate figure was determined, in large part, to the number of survey responses it received in any given application.

1.14 There is currently no statutory provision in chapter 70.38 RCW, or regulatory provision in chapter 246-310 WAC, which compels or requires that the providers in a given planning area respond to the Program's survey request. Additionally, there is no statutory or regulatory provision that specifies that the Program obtain a given percentage or number of surveys responses before it can determine what constitutes a valid use rate.

[19] Kozak, Lola Jean, Ph.D., McCarthy, Eileen and Pokras, Robert M.S., "Changing patterns of Surgical Care in the United States, 1980-1995." Healthcare Financing Review, Volume 21, No. 1 (Fall 1999). AR 422; *See also* Exhibit 10.

[20] Compare and contrast Exhibits 7F and 7G to Exhibit 7A. In one case before this Presiding Officer, the Program argued against an applicant being allowed to use the same 102/1000 national use rate it propose to utilize here. *See* In Re Overlake Hospital Medical Center, Docket No. 03-06-C-2001CN.

1.15 Swedish did not submit or calculate a use rate based on the projected number of inpatient and outpatient surgeries performed within the hospital planning area. Rather, Swedish calculated need by including a use rate obtained from a national survey.

1.16 In its analysis of the Swedish application, the Program did not adopt or calculate a use rate base on the projected number of inpatient and outpatient surgeries performed within the hospital planning area. Rather the Program calculated need using a use rate obtained from a national survey.

II. CONCLUSIONS OF LAW

2.1 The certificate of need program is regulated pursuant to chapters 70.38 RCW and 246-310 WAC. The development of health services and resources should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation. RCW 70.38.015(2). Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need. WAC 246-310-270(4).

2.2 In all licensing application cases, the burden shall be on the applicant to establish that the application meets all applicable criteria. WAC 246-10-606.[21] Those criteria are set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, WAC 246-310-240 and WAC 246-310-270. *See* WAC 246-310-270(1); *see also*

[21] Certificate of need proceedings are governed by the Administrative Procedure Act (chapter 34.05 RCW), chapter 246-310 WAC and chapter 246-04 WAC. WAC 246-310-610. The relevant sections in chapter 246-08 WAC were replaced in 1993 by chapter 246-10 WAC. WAC 246-10-101.

WAC 246-310-200. The Program then decides whether to grant or deny a certificate of need application. The Program's written decision must contain sufficient information to support the Program's decision to grant or deny the application. *See* WAC 246-310-200(2)(a); *see also In re*: *Auburn Regional Medical Center*, Docket No. 01-05-C-1052CN (February 20, 2003). Evidence is admissible in certificate of need hearings if it is the kind of evidence on which reasonably prudent persons are accustomed to rely on in the conduct of their affairs. RCW 34.05.452(1) and WAC 246-10-606.

2.3 In general, a certificate of need hearing does not supplant the certificate of need application review process. Rather, the hearing assures that the procedural and substantive rights of the parties have been observed, and the factual record supports the Program's decision and analysis. *In re Ear, Nose, Throat*, Docket No. 00-09-C-1037CN (April 17, 2001) (Prehearing Order No. 6).[22]

2.4 Consist with the requirements of WAC 246-10-606, Swedish applied for a certificate of need to establish an ambulatory surgical facility. Swedish submitted an application to show that it had met all of the necessary licensing criteria. This included meeting the need requirement by adopting a use rate obtained from a national study. The Program granted Swedish's certificate of need application, finding that Swedish met all of the necessary criteria. Instead of accepting the national study use rate adopted by Swedish, the Program substituted a use rate from another national study to show that

[22] In *Davita v. Department of Health*, 137 Wn. App. 174, 184 (2007), the Division Two Court of Appeals held that the Presiding Officer is both the adjudicative officer and the final decision maker. Consistent with the Secretary of Health's September 27, 2007 Memorandum, evidence that did not exist at the time the Certificate of Need Program made its decision should not be admitted at the adjudicative proceeding.

need for additional ambulatory surgical facility operating rooms. So both Swedish and the Program found need existed, but relied upon different use rates to support that proposition. Calculating future need with either use rate would support a finding of need for additional ambulatory surgical facility operating rooms.

2.5 The language relating to how a use rate is calculated is set forth in WAC 246-310-270(9)(b)(i). That section states:

> 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.

WAC 246-310-270(9)(b)(i) (emphasis added).

2.6 Rules of statutory construction apply to administrative rules and regulations, particularly where they are adopted pursuant to legislative authority. *See State v. Burke*, 92 Wn.2d 474, 478 (1979). Where the meaning of a provision is plain on its face, the court must give effect to that plain meaning as an expression of legislative intent. *City of Olympia v. Drebick*, 156 Wn.2d 289, 295 (2006) (citing *Department of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2 1, 9-10 (2002). The plain language of WAC 246-310-270(9)(b)(i) requires both: (1) that the projected number of inpatient and outpatient surgeries be performed within the hospital planning area for the third year of operation; and (2) that this (that is, the projected number of inpatient and outpatient surgeries) shall be based on the current number of surgeries adjusted for forecasted growth in the population served. In other words, the plain language of the regulation specifies that the use rate must be based on surgeries performed within the

hospital planning area and not based on statewide or national studies. The Program analyst admitted as much at the hearing.[23]

2.7 However, the Program argues that it can refer to national studies, based on language contained in WAC 246-310-200(2)(b)(v) and (vi). The regulation provides:

> (2) Criteria contained in this section *and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240* shall be used by the department in making the required determinations.
>
> (a) In the use of criteria for making the required determinations, the department shall consider:
> (i) The consistency of the proposed project with service or facility standards contained in this chapter;
> (ii) *In the event the standards contained in this chapter do not address in sufficient detail for a required determination the services or facilities for health services proposed, the department may consider standards not in conflict with those standards in accordance with subsection (2)(b) of this section*; and
> (iii) The relationship of the proposed project to the long-range plan (if any) of the person proposing the project.
>
> (b) The department may consider any of the following in its use of criteria for making the required determinations:
> (i) Nationally recognized standards from professional organizations;
> (ii) Standards developed by professional organizations in Washington state;
> (iii) Federal Medicare and Medicaid certification requirements;
> (vi) State licensing requirements;
> (v) *Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to a propose undertaking; and*
> (vi) *The written findings and recommendations of individuals, groups, or organizations with recognized expertise related to a proposed undertaking, with*

[23] TR page 44, lines 2-8.

> *whom the department consults during the review of the application*.

WAC 246-310-200(2) (emphasis added).

2.8 The statutory language of WAC 246-310-200(2) specifically applies to that section (that is, WAC 246-310-200), WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240. The WAC 246-310-200(2) language contains no specific reference to WAC 246-310-270. Courts do not engage in statutory interpretation of a statute that is not ambiguous, and if a statute is plain and unambiguous, its meaning must be derived from the wording of the statute itself. *State v. Keller*, 143 Wn.2d 267 (2001). A court will not add words or clauses to an unambiguous statute when the legislature has chosen not to include that language. *State v. Delgado*, 149 Wn.2d 723, 729 (2003). As WAC 246-310-270 was not included in the clear and unambiguous language of WAC 246-310-200(2), it follows that the subsections set forth in WAC 246-310-200(2)(b)(v) and (vi) cannot be used to qualify or establish the WAC 246-310-270(9) criteria.

2.9 Even if, for the sake of argument, the language contained in WAC 246-310-200(2) was ambiguous (i.e., that the language of WAC 246-310-200(2)(a)(ii) can be read to assist in the interpretation of WAC 246-310-270), the clear language of WAC 246-310-200(2)(a)(ii) provides that it would *only* apply in the event the standards contained in chapter 246-310 WAC do not address in sufficient detail what is required for a determination of the proposed health services or facilities. The language in WAC 246-310-270(9)(b)(i) clearly does specify what is required in sufficient detail: the applicant must project the number of inpatient and outpatient surgeries performed

within the hospital planning area. There is no ambiguity here. The primary goal of statutory interpretation is to ascertain and give effect to the legislature's intent and purpose. *Labor & Industries v. Gongyin*, 154 Wn.2d 38, 44 (2005). This is done by considering the statute as a whole, giving effect to all that the legislature has said, and using related statutes to help identify the legislative intent embodied in the provision in question. *Labor & Industries v. Gongyin*, 154 Wn.2d 44-45 (citing *Department of Ecology v. Campbell & Gwinn LLC*, 146 Wn.2d 1 (2002). The fact that the Program had difficulty in obtaining survey information, does not equate to whether WAC 246-310-270(9) sets forth what is required in sufficient detail.

2.10 Swedish did not submit an application containing a use rate consistent with the requirement of WAC 246-310-270(9)(b)(i). In reviewing the application, the Program did not review the Swedish application using a use rate consistent with the requirement set forth in WAC 246-310-270(9)(b)(i). For that reason, neither use rate can be used to determine whether additional need exists in the East King County planning area. The fact that the Program has recently used the 102/1000 use rate in other applications is not controlling here.

2.11 Therefore, the appropriate remedy in this case is to remand the proceeding back to the Certificate of Need Program for further processing using an appropriate use rate for calculating need. The appropriate use rate shall be based on information based on the East King County secondary health services planning area, and not on national use rate data.

2.12 Given that it is unclear that need exists, the Presiding Office need not address whether: (1) the Swedish application meets the criteria in WAC 246-310-220 through WAC 246-310-240; and (2) the Program selectively utilized data to determine the average inpatient and outpatient surgical minutes based on information contained in secondary health services planning area survey, even though it did not utilize the information obtained for purposes of determining the appropriate use rate.

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED:

3.1 The Swedish application to establish an ambulatory surgical facility in East King County is REMANDED to the Certificate of Need Program for further evaluation, consistent with use rate information based on the East King County secondary health service planning area criteria, from the appropriate time period. Nothing in this remand order precludes the Program from requiring or remanding the application to Swedish to provide supplemental application information consistent with this ruling.

3.2 The Certificate of Need Program shall complete its evaluation and submit its updated evaluation within 120 days of the date of service of this Order.

Dated this _19__ day of December, 2007.

_____/s/_____
JOHN F. KUNTZ, Health Law 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**:**
DONALD W. BLACK, JEFFREY D. DUNBAR, PETER S. EHRLICHMAN, BRIAN W. GRIMM, ATTORNEYS AT LAW AND RICHARD A. MCCARTAN, AAG by mailing a copy properly addressed with postage prepaid.

DATED AT OLYMPIA, WASHINGTON THIS _____ DAY OF DECEMBER, 2007.

_____
Adjudicative Service Unit

cc: **JANIS SIGMAN**