



2007 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:

Facility Name:

County:

Street Address:

City:

Zip:

Mailing Address:

Mailing City:

Mailing Zip:

2. Report Period

Report Data for the full twelve month period, January 1, 2007 - December 31, 2007 (365 days).

Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year.

If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name:

Contact Title:

Phone:

Fax:

E-mail:

Part C : Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

Part D : Ambulatory Surgery Rooms, Procedures and Patients

1A. Rooms, Procedures and Patients in CON-Authorized Operating Procedure Rooms

An operating procedure room is a procedure room or area of the ambulatory surgical treatment center in which surgical procedures are performed and that is licensed as a procedure room by the Department of Human Resources pursuant to Rule 290-5-33-01(u).

Room Type	Number of Rooms	Number of Procedures	Number of Patients
Operating Procedure Rooms			

1B. Other Nonoperating/Procedure Rooms

Provide rooms, procedures and patients for other rooms at your facility where procedures are performed, but that are not licensed as operating rooms.

Room Type	Number of Rooms	Number of Procedures	Number of Patients
Endoscopy Procedure Rooms			
Minor Procedure Rooms			
Other Procedure Rooms			

2. Ambulatory Surgery Patients Admitted to Hospital

How many patients if any, were admitted to a hospital before completion of or immediately following ambulatory surgery?

3. Ambulatory Surgery Patients by Race/Ethnicity

Report the number of unduplicated patients who received ambulatory surgery by race/ethnicity category and provide the total number of ambulatory surgical procedures by race/ethnicity.

Race/Ethnicity	Number of Patients	Number of Procedures
American Indian/Alaska Native		
Asian		
Black/African American		
Hispanic/Latino		
Pacific Islander/Hawaiian		
White		
Multi-Racial		
Total		

4. Ambulatory Surgery Patients by Gender

Report the number of patients by gender served during the report period along with the total number of procedures by gender.

Gender	Number of Patients	Number of Procedures
Male		
Female		
Total		

Part E : Top Ten Ambulatory Surgical Procedures

Of the total procedures reported in Part D, provide the top ten procedures (volume-wise) performed within your facility by CPT Code, Procedure Name, Number of Procedures and Average Charge for Procedure.

CPT Code	Procedure Name	Number of Procedures	Average Charge

Part F : Utilization & Revenue by Payer Source for Ambulatory Surgery Services

1. Please report the number of patients and procedures, Gross Patient Revenue, and Net Patient Revenue during the report period according to Payer Source. Please report Peachcare for Kids as Third-Party. Please note that the Total Gross and Net Revenue columns should balance to Gross and Net Revenue reported in Part G.

Payer Source	Patients	Procedures	Gross Revenue	Net Revenue
Medicare				
Medicaid				
Third Party				
Self Pay				
Other Payer				
Total				

2. Provide the number of ambulatory surgery patients and procedures for patients who were income tested as indigent or charity care cases.

Category	Number of Patients	Number of Procedures
Indigent		
Charity		
Total		

Part G : Financial Summary and Indigent and Charity Care Information

1. Indigent and/or Charity Care Policy

Check the box to the right if the agency had a formal written policy or written policies concerning the provision of indigent and/or charity care during 2007.

If you indicated yes above, please indicate the effective date of the policy or policies.

2. Person Responsible

Please indicate the name and title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.

3. Charity Care Provision

Check the box if the policy or policies included provision for the care that is defined as charity.

4. Financial Table

Please complete the following financial table for the 2007 calendar year. Please note that Total Uncompensated Indigent and Charity Care Charges (automatically calculated by the database) should not exceed Gross Indigent and Charity Care Charges.

Revenue or Expense	Amount
Gross Patient Revenue	
Medicare Contractual Adjustments	
Medicaid Contractual Adjustments	
Other Contractual Adjustments	
Total Contractual Adjustments	
Bad Debt	
Indigent Care Gross Charges	
Indigent Care Compensation	
Uncompensated Indigent Care (Net)	
Charity Care Gross Charges	
Charity Care Compensation	
Uncompensated Charity Care (Net)	
Other Free Care	
Total Net Patient Revenue	
Other Revenue	
Total Net Revenue	
Total Expenses	
Adjusted Gross Revenue	
Total Uncompensated I/C Care	
Percent Uncompensated Indigent/Charity Care	

Part H : Accreditation

Indicate below if your ambulatory surgery center is accredited and if so indicate for each agency as applicable.

a) American Association of Ambulatory Care?

b) American Association for Accreditation of Plastic Surgery Facilities?

c) Other?

Specify other organizations that accredit your facility in the space below.

Part I : Patient Origin of Ambulatory Surgery Patients in the Surgical Center

1. Please report the county of origin for the patients treated in the surgical center.

County	Patients
Alabama	
Appling	
Atkinson	
Bacon	
Baker	
Baldwin	
Banks	
Barrow	
Bartow	
Ben Hill	
Berrien	
Bibb	
Bleckley	
Brantley	
Brooks	
Bryan	
Bulloch	
Burke	
Butts	
Calhoun	
Camden	
Candler	
Carroll	
Catoosa	

Charlton	
Chatham	
Chattahoochee	
Chattooga	
Cherokee	
Clarke	
Clay	
Clayton	
Clinch	
Cobb	
Coffee	
Colquitt	
Columbia	
Cook	
Coweta	
Crawford	
Crisp	
Dade	
Dawson	
Decatur	
DeKalb	
Dodge	
Dooly	
Dougherty	
Douglas	
Early	
Echols	
Effingham	
Elbert	
Emanuel	
Evans	
Fannin	
Fayette	
Florida	
Floyd	
Forsyth	
Franklin	
Fulton	
Gilmer	
Glascok	
Glynn	
Gordon	
Grady	
Greene	

Gwinnett	
Habersham	
Hall	
Hancock	
Haralson	
Harris	
Hart	
Heard	
Henry	
Houston	
Irwin	
Jackson	
Jasper	
Jeff Davis	
Jefferson	
Jenkins	
Johnson	
Jones	
Lamar	
Lanier	
Laurens	
Lee	
Liberty	
Lincoln	
Long	
Lowndes	
Lumpkin	
Macon	
Madison	
Marion	
McDuffie	
McIntosh	
Meriwether	
Miller	
Mitchell	
Monroe	
Montgomery	
Morgan	
Murray	
Muscogee	
Newton	
North Carolina	
Oconee	
Oglethorpe	

Other-Out of State	
Paulding	
Peach	
Pickens	
Pierce	
Pike	
Polk	
Pulaski	
Putnam	
Quitman	
Rabun	
Randolph	
Richmond	
Rockdale	
Schley	
Screven	
Seminole	
South Carolina	
Spalding	
Stephens	
Stewart	
Sumter	
Talbot	
Taliaferro	
Tattnall	
Taylor	
Telfair	
Tennessee	
Terrell	
Thomas	
Tift	
Toombs	
Towns	
Treutlen	
Troup	
Turner	
Twiggs	
Union	
Upson	
Walker	
Walton	
Ware	
Warren	
Washington	

Wayne	
Webster	
Wheeler	
White	
Whitfield	
Wilcox	
Wilkes	
Wilkinson	
Worth	
Total Patients	

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement or inaccurate data, nor omits requested material, information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature:

Title:

Date:

Comments: