



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2008 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC066

Facility Name: Albany Endoscopy Center

County: Dougherty

Street Address: 1009 North Monroe Street

City: Albany

Zip: 31701

Mailing Address: 1009 North Monroe Street

Mailing City: Albany

Mailing Zip: 31701

2. Report Period

Report Data for the full twelve month period, January 1, 2008 - December 31, 2008 (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: Lucile Lott

Contact Title: Administrator

Phone: 229-438-8685

Fax: 229-435-7007

E-mail: lulott@ppmh.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the name of the legal entities which own/operate the facility if applicable or the name of the physician(s) in ownership of the center. 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
Not Applicable	NA	

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

G. Physician Owner(s) (List all if owned jointly)

Full Name	License Number
Gandhiji Yalamanchili	025312
Ira Knepp	034002
Michael Szpak	034256
Marsha Pierdinock	036846
Vithal Kusuma	021536
Matthew Grundfast	052944

Part D : Ambulatory Surgery Rooms, Procedures and Patients

1A. Rooms, Procedures and Patients in CON-Authorized or Licensed 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	2	4,899	4,767

1B. Other Nonoperating/Procedure Rooms

If applicable, 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	0	0	0
Minor Procedure Rooms	0	0	0
Other Procedure Rooms	0	0	0

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?

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3. Ambulatory 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	1	1
Asian	41	41
Black/African American	1,668	1,715
Hispanic/Latino	47	47
Pacific Islander/Hawaiian	0	0
White	2,908	2,988
Multi-Racial	0	0
Unknown	102	107
Total	4,767	4,899

4. Ambulatory 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	2,050	2,107
Female	2,717	2,792
Total	4,767	4,899

Part E : Ambulatory Surgical Procedures, Licensed Specialty and Services

1. Top Ten 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
43249	EGD with Dilation	8	1,212.00
45380	Colonoscopy with Biopsy	1,944	1,212.00
45385	Colonoscopy with Snare	843	1,212.00
43239	EGD with Biopsy	1,291	1,212.00
45378	Colonoscopy	913	1,212.00
GO121	Screening Colonoscopy	222	1,212.00
43450	Maloney Dilation	221	906.00
43235	EGD	46	906.00
88305	Level IV Surgical Path	1,125	130.00
88312	Special Stains	317	60.00

2. Licensed Specialty and Services Provided

Report the licensed specialty of the ambulatory surgery center and the services provided.

Specialty(ies)(As indicated on the Office of Regulatory Services permit):

Ambulatory Surgical Treatment Center

Services Provided:

GI Endoscopic Procedures

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

1. Utilization by Payer Source

Please report the number of patients and procedures, Gross Patient Revenue, and Net Patient Revenue during the report period according to Payer Source. 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	1,792	1,843	2,560,019	729,044
Medicaid	448	454	34,201	29,301
PeachCare for Kids	0	0	0	0
Third Party	2,858	2,935	4,182,875	3,102,997
Self Pay	122	122	148,830	11,247
Other Payer	177	182	253,170	76,148
Total	5,397	5,536	7,179,095	3,948,737

2. Indigent/Charity Care

Provide the number of ambulatory surgery patients and procedures for patients who were income tested as indigent or charity care cases. Refer to the definitions of indigent and charity care in the instructions.

Category	Number of Patients	Number of Procedures
Indigent	111	111
Charity	0	0
Total	111	111

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 2008.

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

03/01/2008

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.

Dr. Gandhiji Yalamanchili, CEO

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 2008 calendar year. Please note that Total Uncompensated Indigent and Charity Care Charges (automatically calculated by the web form) should not exceed Gross Indigent and Charity Care Charges.

Revenue or Expense	Amount
Gross Patient Revenue	7,179,095
Medicare Contractual Adjustments	1,830,975
Medicaid Contractual Adjustments	4,900
Other Contractual Adjustments	1,071,665
Total Contractual Adjustments	2,907,540
Bad Debt	108,294
Indigent Care Gross Charges	134,532
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	134,532
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	0
Other Free Care	79,992
Total Net Patient Revenue	3,948,737
Other Revenue	4,041
Total Net Revenue	3,952,778
Total Expenses	1,412,835
Adjusted Gross Revenue	5,238,967
Total Uncompensated I/C Care	134,532
Percent Uncompensated Indigent/Charity Care	2.57%

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) Joint Commission for Accreditation of Healthcare Organizations (JCAHO)?
- D) Accreditation Association for Ambulatory Health Care (AAAHC)?
- E) Accreditation Association for Ambulatory Health Care (AAAHC)?
- F) 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 Patient Origin

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

County	Patients
Baker	38
Barrow	1
Ben Hill	2
Berrien	1
Brooks	1
Calhoun	96
Cherokee	1
Clay	28
Coffee	1
Colquitt	52
Cook	2
Crisp	168
Decatur	11
DeKalb	1
Dooly	54
Dougherty	2306
Early	86
Grady	4
Greene	1
Houston	3
Irwin	2
Jasper	1
Lee	625
Lowndes	2
Macon	14
Marion	5
Miller	36
Mitchell	227
Other- Out of State	8
Peach	1
Pulaski	1
Quitman	4
Randolph	82
Richmond	1
Schley	19
Seminole	10
Stewart	3
Sumter	298
Telfair	1

Terrell	264
Thomas	8
Tift	13
Turner	17
Walton	1
Ware	1
Webster	18
Wilcox	17
Worth	231
Total	4,767

Part J : Ambulatory Surgery Center Workforce Information

1. Budgeted FTE

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2008.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	6.00	0.00	0.00
Licensed Practical Nurses (LPNs)	1.00	0.00	0.00
Aides/Assistants	2.00	1.00	0.00
Allied Health Therapists	0.00	0.00	0.00

2. Filling Vacancies

Please enter the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Registered Nurse	Not Applicable
Licensed Practical Nurse	Not Applicable
Aides/Assistants	30 Days or Less
Allied Health Therapists	Not Applicable

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. The signature can be completed only AFTER all survey data has been finalized. 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 further 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: Gandhiji Yalamanchili

Date: 6/29/2009

Title: CEO

Comments: