GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:LNRASC030

Facility Name: E.N.T. SURG CTR OF CENTRAL GA

County: Houston

Street Address: 1719 Russell Parkway,Bldg 300

City: WARNER ROBINS

Zip: 31088

Mailing Address: 1719 Russell Parkway,Bldg 300

Mailing City: WARNER ROBINS

Mailing Zip: 31088

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: Wendy Laseter

Contact Title: ASC Administrator

Phone: 478-923-0106 ext 130

Fax: 478-922-5211

E-mail: wendyk526@cox.net

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
E.N.T Surgical Center of Central Georgia, Inc	For Profit	September 1994

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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

Full Name	License Number
A. Daniel Toland, D.O., F.A.C.S	GA22901

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	1	2,027	852

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?

1

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	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Unknown	852	2,027
Total	**852**	**2,027**

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	430	1,087
Female	422	940
Total	**852**	**2,027**

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
69436	Tympanostomy w/tube insertion	400	4,500.00
69205	Removal Foreign Body from External Auditory Canal w/ General anesth	162	2,050.00
42825	Tonsillectomy under age 12	146	4,350.00
69631	Tympanoplasty without mastiodectomy	120	2,100.00
42830	Ademoindectomy under age 12	104	4,100.00
31255	Nasal Sinus Endoscopy w/Ethmoidectomy total anterior and posterior	89	2,000.00
31267	Nasal Sinus Endoscopy w/ maxillary antrostomy w/ removal of tissue fr	86	2,000.00
31237	Nasal sinus endoscopy with biopsy, polypectomy or debridement	54	1,300.00
21335	Open treatment of nasal fracture w/ concomitant open treatment of frac	57	6,000.00
30520	Septoplasty or submucous resection with or without cartilage scoring, c	35	5,400.00

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)*:

Otorhinolaryngology; Head and Neck Surgery; Facial Plastic and Reconstructive Surgery

Services Provided:

Myringotomy Myringotomy with tube insertion Tube/Foreign Body Removals Tympanoplasty Tympanomastoidectomy Stapedectomy Ossicular Reconstruction Mastoidectomy Tympanotomy Excision Cholesteatomas Excision Congenital Vestige (head & neck) I&D Hematoma (head and neck) Foreign Body Removal Control of Epitaxis Nasopharyngoscopy Septoplasty Sinus Surgery Reduction of Nasal fracture (open) Reduction of Nasal fracture (closed) Nasal Reduction Polypectomy Adenoidectomy Submucosal Resection of Turbinates I&D Septal Hematoma Sinus Debridement Reduction of Orbital Fracture Reduction of Zygomatic Arch Fracture Esophagoscopy Bronchoscopy Laryngoscopy Gastroscopy Esophagoduodenoscopy Videostroboscopy Tonsillectomy Polypectomy Uvulopalatopharyngoplasty Nasopharyngoscopy I&D Peritonsillar Abscess Lip Augmentation Liposuction (Head and Neck) Fat Transfers Exc. Lesions (benign and

malignant Reconstructive soft tissue defects Repair open lacerations Split Thickness Grafts Pedicle Grafts Composite Grafts Free Tissue Transfers Complex Repairs Adjacent Tissue Transfers Free Grafts Cheek Augmentation Scar Revision Keloid Removal Control of Tonsillar Hemorrhage Lip Surgery Tongue Surgery Hemiglossectomy Rannula Epulis Jaw Resection (minor) Release of Ankyloglossia Frenulectomies Z-plasty X-Y plasty Extract/Implant Teeth Alveoloplasty Arch Bar Removal Reduction Mandible Fracure Neck Surgery Tracheoesophageal puncture for Reconstruction Tracheostomy Parotidectomy Submandibular Gland Surgery I&D Thyroid/Neck masses Ultrasound of Thyroid/Neck masses Exc. Thyroglossal Duct Cysts Exc. Branchial Cleft cysts Labioplasty Sialolithotomy Sialodochoplasty Blepharoplasties Browpexy Forehead Left (endoscopic & coronal) Facelift Necklift Otoplasty Rhinoplasty CO2 Laser Resurfacing Demabrasion Chemical Peel (i.e. Phenol) Chin reduction Chin Augmentation Lip Reduction

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	86	206	437,718	15,922
Medicaid	27	102	336,311	27,275
PeachCare for Kids	19	49	133,233	8,034
Third Party	829	1,649	4,553,185	870,551
Self Pay	16	21	33,500	33,500
Other Payer	0	0	0	0
Total	**977**	**2,027**	**5,493,947**	**955,282**

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	0	0
Charity	0	0
Total	**0**	**0**

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.

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 2008 calendar year. Please not 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	5,493,947
Medicare Contractual Adjustments	421,796
Medicaid Contractual Adjustments	434,235
Other Contractual Adjustments	3,682,634
Total Contractual Adjustments	**4,538,665**
Bad Debt	0
Indigent Care Gross Charges	0
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**0**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**955,282**
Other Revenue	6,235
Total Net Revenue	**961,517**
Total Expenses	930,765
Adjusted Gross Revenue	**4,644,151**
Total Uncompensated I/C Care	**0**
Percent Uncompensated Indigent/Charity Care	**0.00%**

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
Baldwin	2
Bibb	50
Cook	1
Crawford	5
Crisp	10
Dodge	6
Dooly	5
Houston	669
Jones	1
Lamar	1
Laurens	5
Macon	7
Monroe	2
Other- Out of State	2
Pulaski	56
Rockdale	1
Schley	9
Sumter	1
Taylor	7
Telfair	2
Toombs	2
Towns	1
Twiggs	2
Walker	1
Wilcox	3
Wilkinson	1
Total	**852**

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)	2.00	0.00	0.00
Licensed Practical Nurses (LPNs)	0.00	0.00	0.00
Aides/Assistants	5.00	0.00	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	Not Applicable
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: A. Daniel Toland

Date: 7/31/2009

Title: Medical Director

Comments: