GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:LNRASC264

Facility Name: GAINESVILLE EYE CENTER, LLC

County: Hall

Street Address: 2061 BEVERLY ROAD

City: GAINESVILLE

Zip: 30501

Mailing Address: 2061 BEVERLY ROAD

Mailing City: GAINESVILLE

Mailing Zip: 30501

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: Becky B. Burnett

Contact Title: Clinical Manager

Phone: 770-532-4444

Fax: 770-535-1852

E-mail: becky.brntt@gmail.com

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
	NA	

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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

Full Name	License Number
Stephen J. Farkas	AF8779021
Jack M. Chapman	BC8221296
Clayton G. Blehm	BB8056625

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	1,505	923

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	1	38	38

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	961	1,543
Total	**961**	**1,543**

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	442	716
Female	519	827
Total	**961**	**1,543**

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
66984	Extra Capsular cataract removal with intraocular lens implant	1,397	1,200.00
66821	Yag Laser	38	350.00
15823	Blepharoplasty	54	950.00
67924	Entropion	12	625.00
67916	Ectropion	13	625.00
665780	Pterygium Excision	22	925.00
66985	Secondary Implant of Intraocular Lens	2	1,200.00
677005	Vitrectomy	1	650.00
66170	Trabeculoplasty	4	800.00

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)*:

Single speciality, physician owned, office based ambulatory surgery center (Ophthalmology)

Services Provided:

CPT Code Description 15820 Revision, lower eyelid 15822 Revision, upper eyelid 15823 Revision, upper eyelid 65091 Revise eye 65093 Revise eye with implant 65101 Removal of eye 65103 Remove eye, insert implant 65105 Remove eye/attach implant 65235 Remove object from internal eye 65270 Repair of eye wound; conjunctiva 65272 Repair of eye wound; conjunctiva 65273 Repair of eye wound; conjunctiva 65275 Repair of eye wound; cornea 65280 Repair of eye wound; cornea/sclera 65285 Repair of eye wound; cornea/sclera 65290 Repair of eye socket wound 65400 Removal of cornea lesion 65410 Biopsy of cornea 65420 Remove/transfer pterygium 65426 Remove/transfer pterygium, w/graft CPT Code Description 65710 Corneal transplant 65730 Corneal transplant, penetrating 65750 Corneal transplant, aphakia 65755 Corneal transplant, pseudophakia 65772 Correction of astigmatism 65775 Correction of astigmatism 65800 Drainage of eye 65815 Drainage of eye 65865 Incise inner eye adhesions 65870 Incise inner eye adhesions

65875 Sever inner eye adhesions,posterior 65880 Incise inner eye adhesions 65900 Remove eye lesion 65920 Remove implant of eye 65930 Remove blood clot from eye 66020 Injection treatment of eye 66130 Remove eye lesion 66160 Glaucoma surgery 66170 Incision of eye for glaucoma 66172 Incision of eye 66180 Implant eye fluid shunt 66185 Revise eye fluid shunt 66250 Followup surgery of anterior eye 66500 Incision of iris 66600 Remove iris and lesion 66625 Removal of iris 66630 Removal of iris 66635 Removal of iris 66680 Repair iris & ciliary body 66682 Repair iris & ciliary body 66700 Destroy ciliary body, diathermy 66720 Destruction, ciliary body 66821 After cataract laser surgery 66825 Reposition intraocular lens 66840 Removal of lens material 66850 Removal of lens material 66920 Extraction of lens 66930 Extraction of lens 66940 Extraction of lens 66982 Cataract surgery, complex 66983 Cataract surg w/iol, 1 stage 66984 Cataract surg w/iol, 1 stage 66985 Insert lens prosthesis 66986 Exchange lens prosthesis 67005 Partial removal of eye fluid 67010 Partial removal of eye fluid 67015 Release of eye fluid CPT Code Description 67031 Laser surgery, eye strands 67141 Treatment of retina 67227 Treatment of retinal lesion 67311 Revise eye muscle 67312 Revise two eye muscles 67314 Revise eye muscle 67316 Revise two eye muscles 67318 Revise eye muscle(s) 67320 Revise eye muscle(s) add-on 67331 Eye surgery follow-up add-on 67332 Rerevise eye muscles add-on 67334 Revise eye muscle w/suture 67335 Eye suture during surgery 67340 Revise eye muscle add-on 67350 Biopsy eye muscle 67400 Explore/biopsy eye socket 67405 Explore/drain eye socket 67412 Explore/treat eye socket 67413 Explore/treat eye socket 67420 Explore/treat eye socket 67430 Explore/treat eye socket 67440 Explore/drain eye socket 67450 Explore/biopsy eye socket 67715 Incision of eyelid fold 67808 Remove eyelid lesion(s) 67835 Revise eyelashes 67880 Revision of eyelid 67882 Revision of eyelid 67900 Repair brow defect 67901 Repair eyelid defect 67902 Repair eyelid defect 67903 Repair eyelid defect 67904 Repair eyelid defect 67906 Repair eyelid defect 67908 Repair eyelid defect 67909 Revise eyelid defect 67911 Revise eyelid defect 67914 Repair eyelid defect 67916 Repair eyelid defect 67917 Repair eyelid defect 67921 Repair eyelid defect 67923 Repair eyelid defect 67924 Repair eyelid defect 67935 Repair eyelid wound 67950 Revision of eyelid 67961 Revision of eyelid CPT Code Description 67966 Revision of eyelid 67971 Reconstruction of eyelid 67973 Reconstruction of eyelid 67974 Reconstruction of eyelid 67975 Reconstruction of eyelid 68115 Remove eyelid lining lesion 68130 Remove eyelid lining lesion 68320 Revise/graft eyelid lining 68326 Revise/graft eyelid lining 68330 Revise eyelid lining 68335 Revise/graft eyelid lining 68340 Separate eyelid adhesions 68360 Revise eyelid lining 68362 Revise eyelid lining 68520 Removal of tear sac 68525 Biopsy of tear sac 68700 Repair tear ducts 68720 Create tear sac drain 68745 Create tear duct drain 68750 Create tear duct drain 68811 Probe nasolacrimal duct 68815 Probe nasolacrimal duct

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	851	1,386	1,458,160	1,090,319
Medicaid	0	0	0	0
PeachCare for Kids	0	0	0	0
Third Party	74	121	171,520	20,541
Self Pay	36	36	37,585	24,163
Other Payer	0	0	0	0
Total	**961**	**1,543**	**1,667,265**	**1,135,023**

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.

Donna Chadwick, Administrator

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	0
Medicare Contractual Adjustments	0
Medicaid Contractual Adjustments	0
Other Contractual Adjustments	0
Total Contractual Adjustments	**0**
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	**0**
Other Revenue	0
Total Net Revenue	**0**
Total Expenses	0
Adjusted Gross Revenue	**0**
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
Banks	77
Habersham	77
Hall	1157
Jackson	77
South Carolina	32
Union	46
White	77
Total	**1,543**

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)	1.00	0	0
Licensed Practical Nurses (LPNs)	0	0	0
Aides/Assistants	0	0	0
Allied Health Therapists	0	0	0

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	31-60 Days
Licensed Practical Nurse	NA
Aides/Assistants	NA
Allied Health Therapists	NA

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: Becky B Burnett

Date: 6/22/2009

Title: Clinical Manager

Comments: