GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2009 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC006

Facility Name: Perimeter Surgery Center of Atlanta

County: Fulton

Street Address: Bldg F, Suite 6100 1140 Hammond Drive

City: Atlanta

Zip: 30328-5338

Mailing Address: Building F, Suite 6100 1140 Hammond Drive

Mailing City: Atlanta

Mailing Zip: 30328-5338

2. Report Period

Report Data for the full twelve month period, January 1, 2009 - December 31, 2009 (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: DEBORAH BROWN

Contact Title: ADMINISTRATOR

Phone: 770-551-9944

Fax: 770-551-8826

E-mail: DEBORAH.BROWN@SCASURGERY.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
PERIMETER SURGERY CENTER OF ATLANTA	For Profit	7-1-2007

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SURGICAL CARE AFFILIATES	For Profit	7-1-2007

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
DEBORAH BROWN	Not Applicable	4-1-2006

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SURGICAL CARE AFFILIATES	For Profit	7-1-2007

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SURGICAL CARE AFFILIATES	For Profit	7-1-2007

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SURGICAL CARE AFFILIATES	For Profit	7-1-2007

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

Full Name	License Number

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	6	4,836	4,836

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	9	9
Asian	122	122
Black/African American	1,213	1,213
Hispanic/Latino	92	92
Pacific Islander/Hawaiian	0	0
White	2,230	2,230
Multi-Racial	1,170	1,170
Unknown	0	0
Total	**4,836**	**4,836**

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	1,875	1,875
Female	2,961	2,961
Total	**4,836**	**4,836**

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
45378	DIAGNOSTIC COLONOSCOPY	919	3,819.00
45380	COLONOSCOPY & BIOPSY	780	3,819.00
45385	LESIONAL REMOVAL COLONOPSCOPY	461	3,819.00
43239	UPPER GI ENDOSCOPY BIOPSY	302	3,819.00
19325	ENLARGE BREAST WITH IMPLANT	171	796.00
43770	LAP BAND	124	29,998.00
30520	REPAIR NASAL SEPTUM	111	4,514.00
64483	INJ FORAMEN EPIDURAL L/S	109	1,612.00
31255	REMOVE ETHMOID SINUS	105	4,921.00
45384	LESION REMOVE COLONOSCOPY	89	3,819.00

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)*:

MULTISPECIALTY

Services Provided:

OUTPATIENT SURGERY

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	347	347	2,868,125	320,562
Medicaid	0	0	0	0
PeachCare for Kids	0	0	0	0
Third Party	3,795	3,795	25,972,217	7,115,401
Self Pay	520	520	1,256,250	1,256,250
Other Payer	174	174	221,776	101,888
Total	**4,836**	**4,836**	**30,318,368**	**8,794,101**

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 2009. ☐

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 2009 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	30,318,368
Medicare Contractual Adjustments	2,500,124
Medicaid Contractual Adjustments	0
Other Contractual Adjustments	18,781,311
Total Contractual Adjustments	**21,281,435**
Bad Debt	242,832
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	**8,794,101**
Other Revenue	0
Total Net Revenue	**8,794,101**
Total Expenses	2,452,516
Adjusted Gross Revenue	**27,575,412**
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
Barrow	29
Bartow	49
Bibb	23
Brooks	4
Calhoun	26
Chattahoochee	14
Cherokee	383
Clarke	309
Cobb	1382
Columbia	2
Coweta	83
Crisp	1
Dade	16
DeKalb	1528
Dodge	2
Douglas	113
Elbert	1
Fayette	8
Floyd	32
Forsyth	364
Franklin	1
Fulton	2534
Gilmer	15
Glascock	3
Gwinnett	1126
Habersham	7
Hall	86
Haralson	8
Hart	6
Henry	271
Houston	17
Jackson	33
Jasper	2
Lamar	13
Lowndes	2
Lumpkin	15
Monroe	4
Morgan	13
Murray	3

Muscogee	11
Newton	78
Oconee	10
Paulding	67
Pickens	31
Pike	18
Polk	1
Putnam	24
Rabun	3
Rockdale	95
Spalding	17
Stephens	3
Turner	13
Twiggs	6
Walton	45
Wilcox	14
Total	**8,964**

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 12-31-2009.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	12	0	0
Licensed Practical Nurses (LPNs)	1	0	0
Aides/Assistants	8.5	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	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: DEBORAH BROWN

Date: 3/12/2010

Title: ADMINISTRATOR

Comments: