GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2010 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC069

Facility Name: Clayton Cataract and Laser Surgery Center

County: Clayton

Street Address: 1000 Corporate Center Drive Suite 180

City: Morrow

Zip: 30260

Mailing Address: 1000 Corporate Center Drive Suite 180

Mailing City: Morrow

Mailing Zip: 30260

2. Report Period

Report Data for the full twelve month period, January 1, 2010 - December 31, 2010 (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: Julia McClendon, RN

Contact Title: Director of Surgical Services

Phone: 770-968-8888

Fax: 770-692-1235

E-mail: claytonsurgcenter@bellsouth.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
Joon Y. Kim, MD, PC,d/b/a Clayton Cataract and Las	For Profit	5-9-2008

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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

Full Name	License Number
Joon Y. Kim, MD	026318

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 Community Health pursuant to Rule 111-8-4-.01.

Room Type	Number of Rooms	Number of Procedures	Number of Patients
Operating Procedure Rooms	1	2,602	2,602

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?

0

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	74	74
Black/African American	843	843
Hispanic/Latino	23	23
Pacific Islander/Hawaiian	0	0
White	1,438	1,438
Multi-Racial	6	6
Unknown	217	217
Total	**2,602**	**2,602**

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	1,052	1,052
Female	1,550	1,550
Total	**2,602**	**2,602**

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
66821	YAG Capsulotomy	344	884.00
15823	Yag Iridotomy	35	1,103.00
65855	Trabeculoplasty	32	1,453.00
66984	Cataract Surgery	1,987	3,400.00
66982	Complex Cataract Surgery	53	4,104.00
65780	Ocular Surface Reconstruction	7	6,000.00
65815	Paracentesis of Anterior Chamber of Eye	2	6,000.00
65436	Removal of Corneal Epithelium With Agent	2	826.00
66250	Revision or Repair of Operative Wound of Anterior Seg	2	2,000.00
67031	Severing of Vitreous Strands, Adhesions, Sheets	2	1,500.00

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 Healthcare Facility Regulation Division or Office of Regulatory Services permit)*:

Ophthalmology

Services Provided:

ophthalmology

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	1,767	1,767	3,745,983	1,464,516
Medicaid	48	48	256,500	38,333
PeachCare for Kids	0	0	0	0
Third Party	679	679	3,309,442	642,266
Self Pay	79	79	319,850	121,750
Other Payer	29	29	160,500	22,115
Total	**2,602**	**2,602**	**7,792,275**	**2,288,980**

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	23	23
Charity	6	6
Total	**29**	**29**

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 2010. ☑

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

05-09-2008

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.

Julia McClendon, RN

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 2010 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	7,792,275
Medicare Contractual Adjustments	2,281,467
Medicaid Contractual Adjustments	218,167
Other Contractual Adjustments	2,651,976
Total Contractual Adjustments	**5,151,610**
Bad Debt	198,100
Indigent Care Gross Charges	160,500
Indigent Care Compensation	14,515
Uncompensated Indigent Care (Net)	**145,985**
Charity Care Gross Charges	7,600
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**7,600**
Other Free Care	0
Total Net Patient Revenue	**2,288,980**
Other Revenue	0
Total Net Revenue	**2,288,980**
Total Expenses	1,366,776
Adjusted Gross Revenue	**5,094,541**
Total Uncompensated I/C Care	**153,585**
Percent Uncompensated Indigent/Charity Care	**3.01%**

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
Bibb	3
Bryan	1
Butts	17
Carroll	4
Cherokee	4
Clayton	716
Cobb	7
Coweta	104
Crawford	1
DeKalb	25
Douglas	2
Fayette	97
Fulton	168
Gwinnett	3
Henry	1006
Houston	1
Jasper	13
Lamar	59
Meriwether	20
Morgan	5
Pike	56
Spalding	225
Upson	65
Total	**2,602**

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 12-31-2010.

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)	1.00	0.00	0.00
Aides/Assistants	1.00	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	NA
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: Gloria English, Administrator

Date: 5/7/2013

Title: Medical Director and CEO

Comments: