



2011 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC009

Facility Name: Spivey Station Surgery Center

County: Clayton

Street Address: Suite 100 7813 Spivey Station Boulevard

City: Jonesboro

Zip: 30236

Mailing Address: 7813 Spivey Station Boulevard Suite 100

Mailing City: Jonesboro

Mailing Zip: 30236

2. Report Period

Report Data for the full twelve month period, January 1, 2011 - December 31, 2011 (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: Vangie Dennis

Contact Title: Administrator

Phone: 770-268-6047

Fax: 770-268-6001

E-mail: vdennis@spiveystationssurgerycenter.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
Southlake Ambulatory Surgery Center, LLLP	For Profit	1/18/2000

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
Southern Regional Ambulatory Surgery, Inc	Not for Profit	1/18/2000

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Southern Regional Ambulatory Surgery, Inc	NA	1/18/2000

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

Full Name	License Number
Darrell J. Carmen	039749
Stephen Cohen	038448
Jon P. Finley	043936
Howard K. Herman	036777
Rajiv D. Pandya	033254
Shevin D. Pollydore	045588
Gregory C. Taylor	POD000640
Shikha Sirvastava	038973

Srinivasa Gorjala	043378
Barry Zisholtz	030698
Gregory Lee	61599
Jeffery Kunkes	021535
Young H. An	052050
Monohar Nallathambi	029356

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	3	5,212	2,143

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	1	67	67
Minor Procedure Rooms	3	2,474	1,763
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	13	35
Asian	83	254
Black/African American	1,873	2,873
Hispanic/Latino	96	329
Pacific Islander/Hawaiian	0	0
White	1,802	3,890
Multi-Racial	106	372
Unknown	0	0
Total	3,973	7,753

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	1,858	3,678
Female	2,115	4,075
Total	3,973	7,753

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	Cataract	868	943.00
69436	Ear Tubes BMT	508	666.00
77003	Fluoroscopy	437	0.00
30140	Turbinates	396	983.00
09420	Pediatric Dental	194	448.00
64493	Facet Injections	271	294.00
64483	Epidural Steroid Injection	738	294.00
64484	Epidural Steroid Injection-Transforaminal	191	153.00
29881	Meniscectomy	185	1,175.00
62310	Cervical Epidural Steroid Injection	184	294.00

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):

License Specialty-Multi-Specialty Surgery Center

Services Provided:

Orthopedics Ophthalmology ENT/Otolaryngology GI Pain Pediatric Dental Gyn General Urology Podiatry Bariatrics

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	899	1,350	4,249,512	944,646
Medicaid	643	959	2,280,938	592,784
PeachCare for Kids	0	0	0	0
Third Party	2,372	5,293	11,013,307	3,523,455
Self Pay	40	79	98,330	67,045
Other Payer	19	72	170,106	150,877
Total	3,973	7,753	17,812,193	5,278,807

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	80	101
Charity	2	3
Total	82	104

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 2011.

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

01/01/2005

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.

Vangie Dennis

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 2011 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	17,812,193
Medicare Contractual Adjustments	3,198,093
Medicaid Contractual Adjustments	1,970,012
Other Contractual Adjustments	6,660,513
Total Contractual Adjustments	11,828,618
Bad Debt	268,763
Indigent Care Gross Charges	432,184
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	432,184
Charity Care Gross Charges	3,821
Charity Care Compensation	0
Uncompensated Charity Care (Net)	3,821
Other Free Care	0
Total Net Patient Revenue	5,278,807
Other Revenue	0
Total Net Revenue	5,278,807
Total Expenses	5,194,346
Adjusted Gross Revenue	12,375,325
Total Uncompensated I/C Care	436,005
Percent Uncompensated Indigent/Charity Care	3.52%

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.
CMS

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
Butts	131
Clayton	884
Coweta	110
DeKalb	107
Fayette	460
Fulton	434
Henry	1218
Newton	96
Pike	97
Rockdale	123
Spalding	217
Troup	45
Upson	51
Total	3,973

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 12-31-2011.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	8	0	0
Licensed Practical Nurses (LPNs)	0	0	0
Aides/Assistants	6	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	Not Applicable
Aides/Assistants	31-60 Days
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: Vangie Dennis BSN, RN, CNOR, CMLSO

Date: 3/7/2012

Title: Administrative Director

Comments: