



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

**2012 Freestanding Ambulatory Surgery Center Survey**

**Part A : General Information**

**1. Identification**

**UID:ASC044**

**Facility Name:** Atlanta Center for Reconstructive Foot and Ankle Surgery

**County:** Fulton

**Street Address:** 218 Sandy Springs Place

**City:** Atlanta

**Zip:** 30328-3812

**Mailing Address:** 218 Sandy Springs Place NE

**Mailing City:** Atlanta

**Mailing Zip:** 30328-3812

**2. Report Period**

Report Data for the full twelve month period, January 1, 2012 - December 31, 2012 (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:** Portia Walker

**Contact Title:** Director of Surgical Services

**Phone:** 404-257-0611

**Fax:** 404-446-1953

**E-mail:** pwalker@vpcenters.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
Atlanta Center for Reconstructive Foot & Ankle Sur	For Profit	02/01/2007

#### 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
NA	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
Bednarz, Michael	POD001030
Banks, Alan	POD000545
Brody, Evan	POD000937
Butlin, Winfield	POD000322
Camasta, Craig	POD000676
Carter, Steve	POD000747
Cutsuries, Anthony	POD000739
Filiatrault, Annette	POD000966

Greenbaum, Mark	POD000611
Harley, Brian	POD001016
Helfman, David	POD000643
John, Mathew	POD000926
Julien, Perry	POD000582
Lazerson, Allen	POD000496
Light, Mark	POD000630
McGlamry, Michael	POD000680
Monday, Lawanna	POD001038
Peebles, Charles	POD000796
Pierre, Felecia	POD000853
Pitts, Darryl	POD000877
Price, Jennifer	POD000991
Raphael, Allen	POD001050
Ruch, John	POD000407
Richman, Steve	POD000500
Schancupp, Joe	POD000506
Sharif, Mohammad	POD000944
Ulett, Dane	POD000960
Bednarz, Michael	POD001030
Banks, Alan	POD000545
Brody, Evan	POD000937
Butlin, Winfield	POD000322
Camasta, Craig	POD000676
Carter, Steve	POD000747
Cutsuries, Anthony	POD000739
Filiatrault, Annette	POD000966
Greenbaum, Mark	POD000611
Harley, Brian	POD001016
Helfman, David	POD000643
John, Mathew	POD000926
Julien, Perry	POD000582
Lazerson, Allen	POD000496
Light, Mark	POD000630
McGlamry, Michael	POD000680
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Peebles, Charles	POD000796
Pierre, Felecia	POD000853
Pitts, Darryl	POD000877
Price, Jennifer	POD000991
Raphael, Allen	POD001050
Ruch, John	POD000407
Richman, Steve	POD000500
Schancupp, Joe	POD000506

Sharif, Mohammad	POD000944
Ulett, Dane	POD000960
Todd, Tobi	POD000972
Tuck, Stuart	POD000590
Warner, Andrew	POD000781
Weiskopf, Steve	POD000889
Zarett, Jon	POD004748

## 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	2	2,534	1,322

### **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	4	10
Asian	14	20
Black/African American	408	832
Hispanic/Latino	33	54
Pacific Islander/Hawaiian	0	0
White	857	1,601
Multi-Racial	0	0
Unknown	6	17
<b>Total</b>	<b>1,322</b>	<b>2,534</b>

#### **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	312	495
Female	1,010	2,039
<b>Total</b>	<b>1,322</b>	<b>2,534</b>

### **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
28285		640	6,781.00
28296		355	12,235.00
28270		121	4,322.00
28080		85	8,233.00
20680		76	6,266.00
28289		73	11,234.00
28060		62	9,083.00
28232		53	4,653.00
28292		51	8,683.00
28122		47	6,604.00

#### **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):**

Podiatry

**Services Provided:**

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	227	499	3,581,334	331,686
Medicaid	47	76	665,455	27,074
PeachCare for Kids	0	0	0	0
Third Party	896	1,693	13,574,324	1,010,619
Self Pay	23	22	308,934	19,936
Other Payer	129	274	2,124,175	1,038,860
<b>Total</b>	<b>1,322</b>	<b>2,564</b>	<b>20,254,222</b>	<b>2,428,175</b>

### 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	9	17
Charity	2	3
<b>Total</b>	<b>11</b>	<b>20</b>

## 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 2012. ☐

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 2012 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	20,254,222
Medicare Contractual Adjustments	3,254,294
Medicaid Contractual Adjustments	635,492
Other Contractual Adjustments	13,306,533
<b>Total Contractual Adjustments</b>	<b>17,196,319</b>
Bad Debt	58,476
Indigent Care Gross Charges	184,490
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>184,490</b>
Charity Care Gross Charges	404,447
Charity Care Compensation	17,685
<b>Uncompensated Charity Care (Net)</b>	<b>386,762</b>
Other Free Care	0
<b>Total Net Patient Revenue</b>	<b>2,428,175</b>
Other Revenue	0
<b>Total Net Revenue</b>	<b>2,428,175</b>
Total Expenses	0
<b>Adjusted Gross Revenue</b>	<b>16,305,960</b>
<b>Total Uncompensated I/C Care</b>	<b>571,252</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>3.50%</b>



## 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.  
Accreditation of Association for Podiatric Surgical Facilities

## 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	3
Bartow	3
Bibb	3
Butts	1
Carroll	7
Cherokee	104
Clayton	30
Cobb	202
Dawson	2
DeKalb	196
Douglas	38
Fannin	12
Fayette	2
Forsyth	11
Franklin	2
Fulton	286
Greene	1
Gwinnett	251
Hall	4
Haralson	2
Henry	15
Jackson	8
Jasper	4
Lumpkin	1
Morgan	4
Newton	25
Other- Out of State	30
Paulding	21
Pickens	3
Pierce	1
Putnam	3
Rockdale	18
Spalding	1
Towns	6
Troup	1
Union	14
Walton	7
<b>Total</b>	<b>1,322</b>

## 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 12-31-2012.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	4.00	0.00	2.00
Licensed Practical Nurses (LPNs)	0.00	0.00	0.00
Aides/Assistants	0.00	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	61-90 Days
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: Portia Walker

Date: 8/30/2013

Title: Director of Surgical Services

Comments: