Georgia Department of Community Health

2013 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC061

Facility Name: North Georgia Foot & Ankle Surgery Center

County: Catoosa

Street Address: 146 Smitherman Road

City: Ringgold

Zip: 30736-7372

Mailing Address: 146 Smitherman Road

Mailing City: Ringgold

Mailing Zip: 30736-7372

2. Report Period

Report Data for the full twelve month period, January 1, 2013 - December 31, 2013 (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: 770-384-0284

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
North Georgia Foot & Ankle Surgery Center, LLC	For Profit	7/1/2006

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
	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
Bello, Clair	POD001010
Camasta, Craig	POD000676
Helfman, David	POD000643
Kraus, Ira	POD000658
Land, John	POD000679
Schulman, Barry	POD000970
Strickler, Jon	POD000799
Soloman, Aaron	POD000914

Wiles, Michael	POD001113

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	964	367

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	0	0
Asian	1	11
Black/African American	35	99
Hispanic/Latino	16	42
Pacific Islander/Hawaiian	0	0
White	315	812
Multi-Racial	0	0
Unknown	0	0
Total	**367**	**964**

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	90	197
Female	277	767
Total	**367**	**964**

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	Arthrodesis	137	6,274.00
64450	Injection Nerve	90	2,133.00
28270	Capsulotomy	54	4,410.00
28296	Austin Bunion Correction	46	12,202.00
28308	Osteotomy	35	7,237.00
20680	Removal of Implant; Deep	24	5,349.00
28080	Excision of Neuroma	21	8,100.00
28264	Capsilotomy Mid Tarsel	21	5,062.00
28299	Double Osteotomy	18	13,033.00
64445	Injection Sciatic Nerve	61	2,003.00

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:

Surgical Services

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	156	378	2,741,646	168,137
Medicaid	33	54	459,899	28,891
PeachCare for Kids	0	0	0	0
Third Party	157	480	2,873,559	304,661
Self Pay	10	16	127,926	10,472
Other Payer	366	964	227,253	54,843
Total	**722**	**1,892**	**6,430,283**	**567,004**

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	3	10
Charity	5	14
Total	**8**	**24**

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 2013. ☐

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 2013 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	6,430,283
Medicare Contractual Adjustments	2,573,509
Medicaid Contractual Adjustments	431,008
Other Contractual Adjustments	2,716,406
Total Contractual Adjustments	**5,720,923**
Bad Debt	0
Indigent Care Gross Charges	48,140
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**48,140**
Charity Care Gross Charges	98,715
Charity Care Compensation	4,499
Uncompensated Charity Care (Net)	**94,216**
Other Free Care	0
Total Net Patient Revenue	**567,004**
Other Revenue	0
Total Net Revenue	**567,004**
Total Expenses	0
Adjusted Gross Revenue	**3,425,766**
Total Uncompensated I/C Care	**142,356**
Percent Uncompensated Indigent/Charity Care	**4.16%**

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 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
Bulloch	1
Catoosa	26
Cherokee	1
Cobb	1
Dade	8
Florida	2
Gordon	8
Marion	1
Murray	26
Polk	5
Tennessee	173
Walker	51
Whitfield	64
Total	**367**

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 12-31-2013.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	1.00	0.00	1.00
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: DAVID HELFMAN, DPM

Date: 3/14/2014

Title: CEO

Comments: