



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2015 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC008

Facility Name: Feminist Women's Health Center

County: DeKalb

Street Address: 1924 Cliff Valley Way NE

City: Atlanta

Zip: 30329-2421

Mailing Address: 1924 Cliff Valley Way NE

Mailing City: Atlanta

Mailing Zip: 30329-2421

2. Report Period

Report Data for the full twelve month period, January 1, 2015 - December 31, 2015 (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: Soknetra Gunnells

Contact Title: Director of Finance

Phone: 404-248-5448

Fax: 404-417-0878

E-mail: soknetra@feministcenter.org

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
Feminist Women	Not for Profit	09/09/1999

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Feminist Women	Not for Profit	09/09/1999

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

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

Full Name	License Number
Not Applicable	

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	2,383	2,383

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	93	93
Black/African American	1,293	1,293
Hispanic/Latino	252	252
Pacific Islander/Hawaiian	38	38
White	641	641
Multi-Racial	35	35
Unknown	22	22
Total	2,383	2,383

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	0	0
Female	2,383	2,383
Total	2,383	2,383

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
ASC008598040	1st Trimester abortion	1,467	6,593.00
ASC008598041	2nd Trimester Abortion	916	24,418.00

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):

Services Provided:

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	0	0	0	0
Medicaid	0	0	0	0
PeachCare for Kids	0	0	0	0
Third Party	128	128	589,158	94,745
Self Pay	1,690	1,690	3,298,324	1,667,899
Other Payer	565	565	426,978	304,687
Total	2,383	2,383	4,314,460	2,067,331

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	1078	1078
Charity	848	848
Total	1926	1926

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 2015. ☒

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

01/01/2015

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.

Joline Milord, Clinic Director

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 2015 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	4,314,460
Medicare Contractual Adjustments	0
Medicaid Contractual Adjustments	0
Other Contractual Adjustments	379,529
Total Contractual Adjustments	379,529
Bad Debt	2,059
Indigent Care Gross Charges	2,197,356
Indigent Care Compensation	823,795
Uncompensated Indigent Care (Net)	1,373,561
Charity Care Gross Charges	52,369
Charity Care Compensation	16,795
Uncompensated Charity Care (Net)	35,574
Other Free Care	456,406
Total Net Patient Revenue	2,067,331
Other Revenue	600,317
Total Net Revenue	2,667,648
Total Expenses	2,345,027
Adjusted Gross Revenue	4,912,718
Total Uncompensated I/C Care	1,409,135
Percent Uncompensated Indigent/Charity Care	28.68%

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
Alabama	130
Baldwin	5
Barrow	18
Bartow	6
Ben Hill	1
Berrien	1
Bibb	32
Bulloch	3
Butts	3
Calhoun	10
Camden	1
Carroll	22
Chatham	6
Chattahoochee	1
Chattooga	1
Cherokee	30
Clarke	37
Clayton	88
Cobb	178
Colquitt	2
Columbia	2
Cook	1
Coweta	20
Dawson	3
DeKalb	435
Dooly	1
Dougherty	12
Douglas	39
Effingham	1
Elbert	2
Emanuel	1
Fannin	1
Fayette	16
Florida	21
Floyd	9
Forsyth	16
Franklin	1
Fulton	494
Gordon	4

Greene	1
Gwinnett	264
Habersham	3
Hall	20
Haralson	3
Harris	3
Hart	1
Henry	63
Houston	20
Irwin	1
Jackson	9
Jasper	2
Jeff Davis	1
Jefferson	22
Johnson	1
Jones	1
Lamar	2
Laurens	2
Lee	17
Liberty	1
Lowndes	3
Lumpkin	1
Macon	1
Madison	9
McDuffie	1
McIntosh	1
Meriwether	2
Monroe	5
Montgomery	10
Morgan	2
Murray	2
Muscogee	28
Newton	23
North Carolina	54
Oconee	6
Paulding	7
Peach	7
Pickens	4
Pike	4
Polk	1
Putnam	2
Randolph	3
Richmond	2
Rockdale	19

South Carolina	7
Spalding	8
Stephens	2
Stewart	1
Sumter	6
Towns	1
Troup	4
Turner	2
Twiggs	1
Union	4
Upson	4
Walker	8
Walton	20
Ware	2
Warren	3
Washington	7
Wayne	1
Wheeler	1
White	2
Whitfield	6
Wilcox	1
Wilkinson	3
Worth	1
Total	2,383

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 12-31-2015.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	3.00	1.00	0.00
Licensed Practical Nurses (LPNs)	0.00	0.00	0.00
Aides/Assistants	3.00	1.00	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	More than 90 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: Janelle Yamarick

Date: 2/18/2016

Title: Executive Director

Comments: