GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2015 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC015

Facility Name: Northside/Dunwoody Surgery Center

County: DeKalb

Street Address: 4553 N. Shallowford Road, #60-C

City: Atlanta

Zip: 30338

Mailing Address: 4553 N. Shallowford Road, #60-C

Mailing City: Atlanta

Mailing Zip: 30338

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: Brian J. Toporek

Contact Title: Senior Planner, Northside Hospital, Inc.

Phone: 404-851-6821

Fax: 404-303-3820

E-mail: brian.toporek@northside.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
Northside Hospital, Inc.	Not for Profit	3/22/2004

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Health Services, Inc.	Not for Profit	11/1/1991

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Hospital, Inc.	Not for Profit	3/22/2004

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Health Services, Inc.	Not for Profit	3/22/2004

E. Management Contractor

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

F. Management's Parent Organization

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

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

Full Name	License Number

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	98	90

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	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Unknown	90	98
Total	**90**	**98**

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	12	14
Female	78	84
Total	**90**	**98**

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
15828	REMOVAL OF FACE WRINKLES	41	1,595.00
15829	REMOVAL OF SKIN WRINKLES	23	1,517.00
15877	SUCXTION LIPECTOMY TRUNK	7	1,241.00
15822	REVISION OF UPPER EYELID	4	1,065.00
19316	SUSPENSION OF BREAST	2	2,260.00
19371	REMOVAL OF BREAST CAPSULE	2	1,270.00
30400	RECONSTRUCTION OF NOSE	2	1,310.00
30410	RECONSTRUCTION OF NOSE	2	1,430.00
30420	RECONSTRUCTION OF NOSE	2	2,579.00
30140	RESECT INFERIOR TURBINATE	1	1,515.00

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)*:

PLASTIC SURGERY, RECONSTRUCTIVE SURGERY, GENERAL SURGERY, ORAL SURGERY, OTOLARYNGOLOGY (ENT) SURGERY

Services Provided:

PLASTIC SURGERY, RECONSTRUCTIVE SURGERY, ENT 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	0	0	0	0
Medicaid	0	0	0	0
PeachCare for Kids	0	0	0	0
Third Party	67	67	102,100	94,940
Self Pay	23	31	37,327	31,335
Other Payer	0	0	0	0
Total	**90**	**98**	**139,427**	**126,275**

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	0	0
Charity	0	0
Total	**0**	**0**

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.

05/01/1995

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.

Joseph Dagostino - Administrator

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 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	139,427
Medicare Contractual Adjustments	0
Medicaid Contractual Adjustments	0
Other Contractual Adjustments	6,967
Total Contractual Adjustments	**6,967**
Bad Debt	6,185
Indigent Care Gross Charges	0
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**0**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**126,275**
Other Revenue	0
Total Net Revenue	**126,275**
Total Expenses	222,121
Adjusted Gross Revenue	**133,242**
Total Uncompensated I/C Care	**0**
Percent Uncompensated Indigent/Charity Care	**0.00%**

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
Carroll	1
Cherokee	3
Cobb	8
Dawson	2
DeKalb	9
Dougherty	2
Fayette	2
Florida	3
Forsyth	3
Fulton	26
Gilmer	1
Greene	1
Gwinnett	15
Hall	2
Henry	2
North Carolina	1
Other- Out of State	4
Rabun	1
South Carolina	2
Walker	1
Walton	1
Total	**90**

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)	3.50	0.00	0.00
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: Joseph Dagostino

Date: 3/4/2016

Title: Administrator

Comments:

Note: The facility was operational for all of 2015. However, due to a changeover in data and financial systems, only data for 9/1/2015 through 12/31/2015 could be captured.