GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2018 Freestanding Ambulatory Surgery Center Survey for Single Specialty, Physician Owned, Office Based Centers

Part A : General Information

1. Identification

UID:LNRASC145

Facility Name: Plastic Surgery Ctr Of West Ga

County: Carroll

Street Address: 150 Henry Burson Drive, Suite 200

City: CARROLLTON

Zip: 30117

Mailing Address: 150 Henry Burson Drive, Suite 200

Mailing City: CARROLLTON

Mailing Zip: 30117

2. Report Period

Report Data for the full twelve month period, January 1, 2018 - December 31, 2018 (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.

01/2018-02/2018

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: JILL RAGSDALE

Contact Title: VICE PRESIDENT OF FINANCE

Phone: 770-838-8302

Fax: 770-838-8563

E-mail: JRAGSDALE@TANNER.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
TANNER MEDICAL GROUP INC	Not for Profit	09/01/2015

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

Full Name	License Number
NONE	

Part D : Ambulatory Surgery Rooms, Procedures and Patients

1. Rooms, Procedures and Patients in 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
Licensed Operating Rooms	1	22	7

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. If race/ethnicity data is unavailable, please report as unknown, but not all patients and/or procedures can be reported as uknown.

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	7	22
Multi-Racial	0	0
Unknown Race/Ethnicity	0	0
Total	**7**	**22**

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. If gender data is unavailable, please report as unknown, but not all patients and/or procedures can be reported as unknown.

Gender	Number of Patients	Number of Procedures
Male	0	0
Female	7	22
Unknown	0	0
Total	**7**	**22**

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. Report as many of the top procedures up to 10 as appropriate.

CPT Code	Procedure Name	Number of Procedures	Average Charge
15822	Blepharoplasty, upper eyelid	2	1,444.00
19380	Revision of reconstructed breast	2	1,975.00
11401-11446	Cosmetic Lesion Excision	1	788.00
15829	Facelift, Necklift, Fat Grafting to Tear Troughs	1	9,975.00
	PALAD	1	1,050.00
15788	TCA Peel Perioral	1	788.00
19325	Breast Augmentation; Silicone	4	1,725.00
19316	Mastopexy	4	2,160.00
15830	Abdominoplasty; Classical	3	4,680.00
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy),	3	3,510.00

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

Services Provided:

Breast Augmentation, Breast Lift(mastopexy)Facelift, Necklift, Cheek Lift, Brow Lift, Blepharolpasty, Canthopexy, Chin Augmentation, Abdominoplasty, Power-assisted Lipoplasty, Breast Implant Revision, Capsulotomies, Brachioplasty, Fat Grafting, Rhinoplasty, Otoplasty, Scar Revision, TCA Chemical Peel, Thigh Lift, Buttock Lift, Lesion Biopsy, Lesion Excision, Breast Reduction.

Part F : Utilization & Revenue by Payer Source for Ambulatory Surgery Services

1. Utilization by Payer Source

Please report the number of patients and procedures and Gross Patient Revenue during the report period according to Payer Source. Please note that the Total Gross Revenue should balance to Gross Revenue reported in Part G.

Payer Source	Patients	Procedures	Gross Revenue
Medicare	0	0	0
Medicaid	0	0	0
PeachCare for Kids	0	0	0
Third Party	0	0	0
Self Pay	7	22	62,208
Other Payer	0	0	0
Total	**7**	**22**	**62,208**

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 2018. ☑

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

09/15/2015

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.

SUSAN FOX SENIOR VICE PRESIDENT OF OPERATIONS

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 2018 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	62,208
Medicare Contractual Adjustments	0
Medicaid Contractual Adjustments	0
Other Contractual Adjustments	0
Total Contractual Adjustments	**0**
Bad Debt	0
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
Other Revenue	0
Total Expenses	0
Adjusted Gross Revenue	**62,208**
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	6
DeKalb	1
Total	**7**

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: Jillian Ragsdale

Date: 4/10/2019

Title: Vice President of Finance and Analytics

Comments:

This practice is owned by Tanner Medical Group Inc which is owned by Tanner Medical Center.