Single-Specialty Ambulatory Surgery Center Demonstration Project

Annual Evaluation DRAFT April 10, 2012

Instructions: Complete all sections of this evaluation form, and return by _____ to the Division of Health Services Regulation.

Evaluation for

Year 1 Year 2 Year 3 Year 4 Year 5

Reporting Period: _____ through December 31, _____

Facility Information

Facility Name _____

CON Project ID_____ Surgical Specialty _____

Care to Self-Pay and Medicaid-funded Patients

Was the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases at least *seven percent of the total revenue* collected for all surgical cases performed in the facility? Complete the attached template and submit as part of this report.

Report to Statewide Data Processor

Confirm that utilization and payment data was submitted to the statewide data processor as required by G.S. 131E-214.2.

Surgical Safety

Provide documentation of the percentage of surgeries for which a Surgical Safety Checklist was completed.

Patient Outcomes

Describe the system you chose or developed to measure patient outcomes.

Note: At a minimum, patient outcome measures *must* include: wound infection rate; number and percentage of post-operative infections; number and percentage of post-procedure complications; number and percentage of readmissions; and the number and percentage of medication errors.

Interoperability with Other Providers

Describe your system, such as electronic medical records, for enhancing communication and facilitating data collection or exchange with other providers.

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Open Access to Physicians

1. Do you provide for open access to non-owner physicians? Yes ____ No _____
2. Is there a formal process for non-owner physicians to affiliate with the facility? Yes _____ No _____ If yes, please describe.
3. How many non-owner affiliated physicians performed surgery at the facility during the reporting period? _____

Physician Responsibilities

1. How many physicians, both owner and non-owner, were affiliated with the facility during the reporting period? _____
2. How many physicians affiliated with the facility established or maintained hospital staff privileges with at least one hospital during the reporting period? _____
3. How many physicians affiliated with the facility began or continued to meet Emergency Department coverage responsibilities with at least one hospital? _____
4. Other physician information:

Name of Physician Affiliated with Facility	Nights on Call at a Hospital	Did the physician provide annual data to the Agency related to meeting their hospital staff privilege and Emergency Department coverage responsibilities?
_____	_____	Yes ____ No _____
_____	_____	Yes ____ No _____
_____	_____	Yes ____ No _____
_____	_____	Yes ____ No _____
_____	_____	Yes ____ No _____
_____	_____	Yes ____ No _____

Authenticating signature of the facility's official certifying the accuracy of this information:

Signature: _____ Date: _____

Print Name and Title _____

	From ___/___/___ To ___/___/___
# of Surgical Cases	
REVENUE	
Gross Patient Revenue	
Self Pay/ Indigent/ Charity	
Medicare / Medicare Managed Care	
Medicaid	
Commercial Insurance	
Managed Care	
Other (Specify)	
Total	$ -
Deductions from Gross Patient Revenue	
Charity Care	
Bad Debt	
Medicare Contractual Adjustment	
Medicaid Contractual Adjustment	
Other Contractual Adjustments	
Total Deductions from PatientRevenue	$ -
Net Patient Revenue	$ -
Other Revenue	
Total Revenue	$ -
EXPENSES	
Direct Expenses	
Salaries - Clinical Personnel	
Salaries - Other Personnel	
Total Salaries	$ -
Payroll Taxes and Benefits	
Medical Supplies	
Other Supplies	
Raw Food	
Other Direct Expenses (specify)	
Total Direct Expenses	$ -
Indirect Expenses	
Housekeeping/Laundry	
Equipment Maintenance	
Building & Grounds Maintenance	
Utilities	
Insurance	
Professional Fees	
Interest Expense	
Rental Expense	
Property and other Taxes (except Income)	
Depreciation - Buildings	
Depreciation - Equipment	
Other Indirect Expenses (specify)	
Total Indirect Expenses	$ -
Total Expenses	$ -
Net Income	$ -
Federal & State Income Taxes	

		Self-Pay	Medicaid	Total
A	# of Surgical Cases			
B	Medicare Allowable Amount			
C	Revenue (A x B)			
D	Revenue Collected			
E	Difference (C - D)			
F	Total Net Revenue			
G	Percentage (E / F)			