



2008 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:LNRASC217

Facility Name: NORTH CRESCENT SURGERY CENTER

County: Fulton

Street Address: 11975 MORRIS ROAD, SUITE 160

City: ALPHARETTA

Zip: 30005

Mailing Address: 11975 MORRIS ROAD, SUITE 160

Mailing City: ALPHARETTA

Mailing Zip: 30005

2. Report Period

Report Data for the full twelve month period, January 1, 2008 - December 31, 2008 (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: Jo O'Neal

Contact Title: Director Of Nursing

Phone: 770-360-9916

Fax: 770-360-9937

E-mail: onealj@awhg1.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 Crescent Surgery Center, LLC	For Profit	10-2004

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Atlanta Women's Health Group, P.C.	For Profit	07-1999

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
North Crescent Surgery Center, LLC	For Profit	10-2004

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Atlanta Women's Health Group, P.C.	For Profit	07-1999

E. Management Contractor

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

F. Management's Parent Organization

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

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

Full Name	License Number
Charles D Allen	016853
Stacy Anand	045698
Stephen Ayres	030947
Christopher Bassil	060557
Dale Bearman	030432
Gary Bodner	018205
Katia Castillo	035581
Keisha Dennard-Hall	058877

Michelle Dodder	040784
John Donnelly	028398
Anissa Durairaj	049999
Genevieve Fairbrother	037531
Kirsten Franklin	039797
Meera Garcia	046101
Jose Garcia	022227
Susan Glander	042579
Heath Graham	047087
Staphanie Grogan	044224
Arthur Gumer	031010
Kel Harper	028274
Jill Henke	052955
Robert Hirsch	022238
Kit Howard	027069
Jenny Jo	052751
Jeanette Leader	051283
Bret Lewis	033384
Jeffrey Marcus	037283
Lori Marshall	054625
Michael McDaniel	057398
Courtney Middleton	057295
Shapour Mobasser	016743
John Moore	024303
Azadeh Nezhat	047630
Angela Nix	057226
Claire Parker	046201
Melissa Parker	043012
Richard Robbins	025262
Stephen Rosenberg	025661
Michael Scott	034051
Thomas Sharon	035757
Shannon Sugarman	060490
Sherry Taylor	035151
Jacqueline Walters	040275
Michael Wolfson	019463
Charles Wootten	035790
Richard Zane	022196
Julie Zimmermann	049826
Michael Echemendia	019880

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 Human Resources pursuant to Rule 290-5-33-01(u).

Room Type	Number of Rooms	Number of Procedures	Number of Patients
Operating Procedure Rooms	2	2,343	2,343

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	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	2,343	2,343
Total	2,343	2,343

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	2,343	2,343
Total	2,343	2,343

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
58563	Hysteroscopy with Endometrial Ablation	661	4,420.00
59820	D&C for Missed Abortion	496	2,343.00
58558	Hysteroscopy with Sampling of Endometrium	378	3,205.00
58670	Laparoscopic Tubal Ligation	159	3,579.00
57461	Colposcopy with LOOP electrode conization	156	2,204.00
58662	Laparoscopy with Fulgaration or excision of lesions	112	5,404.00
58661	Laparoscopy with removal of adnexal structures	110	5,952.00
58565	Essure Procedure	69	4,500.00
49320	Diagnostic Laparoscopy	50	5,000.00
58561	Hysteroscopy with removal of leiomyomata	48	4,022.00

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 Office of Regulatory Services permit):

Obstetrical and Gynecological

Services Provided:

Dx Lap LEEP Endometrial Ablation D&C Non OB Laparoscopic Surgery Myo. 250g/less DX Hysterscopy Hysterscopy with Biopsy Hysterscopy with Polypectomy Hysterscopy Lysis Hysterscopy with Septum Hysterscopy Leiomyomata Hysterscopy Foreign Hysterscopy with Ablation Laparoscopic Surgical Laparoscopic Surgical with Rem. Adnex Laparoscopic Fulgaration BTL LTL Essure procedure Bladder Sling Excision of skin tag/lesion D&C for Missed AB Excision of Bartholinâ€™s gland or cyst Marsupialization of a Bartholinâ€™s gland cyst I/D of Bartholinâ€™s gland abscess Colposcopy w/loop electrode conization Colposcopy w/biopsy of cervix I/D of vulva or peri abscess Excision vaginal cyst Perineorrhaphy Insertion of IUD Removal of IUD Lysis of labial adhesions Destruction of vaginal lesion Biopsy of vulva or perineum Dilation of vagina under anesthesia Administration of local anesthesia Administration of regional anesthesia

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	2,319	2,319	9,606,050	3,026,539
Self Pay	24	24	90,996	90,996
Other Payer	0	0	0	0
Total	2,343	2,343	9,697,046	3,117,535

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 2008.

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 2008 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	9,697,046
Medicare Contractual Adjustments	0
Medicaid Contractual Adjustments	0
Other Contractual Adjustments	6,579,511
Total Contractual Adjustments	6,579,511
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
Total Net Patient Revenue	3,117,535
Other Revenue	0
Total Net Revenue	3,117,535
Total Expenses	0
Adjusted Gross Revenue	9,697,046
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
Barrow	4
Bartow	2
Carroll	8
Cherokee	172
Clarke	1
Clayton	9
Cobb	335
Coweta	7
Dawson	21
DeKalb	289
Douglas	15
Fannin	2
Fayette	3
Floyd	1
Forsyth	277
Franklin	1
Fulton	704
Gilmer	2
Gwinnett	375
Hall	40
Henry	8
Jackson	8
Lumpkin	3
Newton	5
Other- Out of State	17
Paulding	7
Pickens	1
Polk	2
Putnam	1
Rockdale	3
Spalding	1
Troup	1
Union	2
Walton	14
White	1
Whitfield	1
Total	2,343

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 12-31-2008.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	5.00	0.00	3.00
Licensed Practical Nurses (LPNs)	1.00	0.00	0.00
Aides/Assistants	4.00	0.00	1.00
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	31-60 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: Ross D. Rohde, MBA, CMPE

Date: 6/2/2009

Title: Chief Operating Officer

Comments: