



2009 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC019

Facility Name: Northwoods Surgery Center, LLC

County: Forsyth

Street Address: Suite S 1230 Bald Ridge Marina Rd.

City: Cumming

Zip: 30131-8494

Mailing Address: 1230 Bald Ridge Marina Road Suite S

Mailing City: Cumming

Mailing Zip: 30131-8494

2. Report Period

Report Data for the full twelve month period, January 1, 2009 - December 31, 2009 (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: Bonnie Goodwin

Contact Title: Group Vice President - Nueterra Healthcare

Phone: 913-485-9033

Fax: 913-387-0771

E-mail: bgoodwin1@nueterra.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
Northwoods Surgery Center, LLC	For Profit	09/07/2005

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northwoods Ambulatory Surgery Center	For Profit	09/07/2005

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
n/a	NA	

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Tenet Healthcare	Not for Profit	09/07/2005

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
Nueterra Healthcare	For Profit	09/07/2005

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

Full Name	License Number
Andrew Diamond	050878
Joel Hoffman	037833
David Pitts	051415
Craig Richman	048710
Raymond Schettino	032814
Mark Yanta	043827
Mark Dunbar	022750
Suzanne Hewitt	050963

Richard Pare	034918
Wendell Phillips	012739
Brett Butz	
Brian Howard	045244
Linda Jackson	040928
James Copher	034798
Thomas Fitzsimmons	056566
Dolford Payne	021570
Jeffrey Tucker	034068
Brian Holcomb	POD000536
Clive Albert	035800
Jay Cherner	023144
Chirs Sarzen	034462

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	3	5,336	2,896

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	1	88	88

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	2,896	5,424
Total	2,896	5,424

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	1,363	3,254
Female	1,533	2,170
Total	2,896	5,424

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
45384	COLONOSCOPY	1,627	2,646.00
43235	UPPER GI	589	3,137.00
66985	CATARACT	562	5,871.00

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):

Multispecialty ASC

Services Provided:

ENT, ORTHO, OPHTHO, PLASTIC, GI, GENERAL, UROLOGY, PAIN MANAGEMENT, PODIATRY, GYN

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	812	1,589	4,692,207	225,737
Medicaid	8	26	145,026	1,331
PeachCare for Kids	0	0	0	0
Third Party	0	0	0	0
Self Pay	132	202	394,051	237,089
Other Payer	2,032	3,695	14,291,780	3,578,364
Total	2,984	5,512	19,523,064	4,042,521

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		
Charity	23	32
Total	23	32

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 2009.

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

12/05/2005

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.

Lynda Rexroat

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 2009 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	19,523,064
Medicare Contractual Adjustments	4,466,470
Medicaid Contractual Adjustments	143,695
Other Contractual Adjustments	9,946,894
Total Contractual Adjustments	14,557,059
Bad Debt	162,697
Indigent Care Gross Charges	0
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	0
Charity Care Gross Charges	760,787
Charity Care Compensation	0
Uncompensated Charity Care (Net)	760,787
Other Free Care	0
Total Net Patient Revenue	4,042,521
Other Revenue	0
Total Net Revenue	4,042,521
Total Expenses	0
Adjusted Gross Revenue	14,750,202
Total Uncompensated I/C Care	760,787
Percent Uncompensated Indigent/Charity Care	5.16%

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
Bartow	1
Charlton	10
Cherokee	117
Cobb	33
Dawson	342
Decatur	15
Forsyth	1316
Fulton	417
Gwinnett	395
Habersham	10
Hall	132
Jackson	10
Lumpkin	71
Pickens	24
Rockdale	3
Total	2,896

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 12-31-2009.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	9.00	0.00	0.00
Licensed Practical Nurses (LPNs)	1.00	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	Not Applicable
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: Clay Copher,MD

Date: 3/11/2010

Title: Board Chairman

Comments: