GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2009 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC059

Facility Name: North Atlanta Orthopaedic Surgery Center, LLC

County: Fulton

Street Address: 10670 Medlock Bridge Road

City: Duluth

Zip: 30097

Mailing Address: 10670 Medlock Bridge Road

Mailing City: Duluth

Mailing Zip: 30097

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: Fred Woestmann

Contact Title: CFO

Phone: 770-814-0323

Fax: 770-814-8897

E-mail: fwoestmann@comcast.net

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 Atlanta Orthopaedic Surgery Center, LLC	For Profit	06/03/1998

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
OrthoPartners, LLC	For Profit	01/13/1998

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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

Full Name	License Number
Rick K. St.Pierre	022646
Thomas R. Cadier	016320
Bennett J. Axelrod	026442
David A. Stokes	053037
Richard A. Hurd	011962

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	599	599

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	1	200	200
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	599	599
Total	**599**	**599**

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	340	340
Female	259	259
Total	**599**	**599**

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
29888	Knee Arthr./ACL Reconstruction	23	9,522.00
29881	Knee Arthroscopy	137	4,830.00
29827	Shoulder Arthroscopy	128	7,074.00
29880	Knee Arthroscopy	49	4,934.00
64721	Carpal Tunnel Release	30	3,880.00
29826	Shoulder Arthroscopy	18	5,616.00
29807	Shoulder Arthroscopy	14	6,775.00
29838	Elbow Arthroscopy	12	4,784.00
29879	Knee Arthroscopy	12	4,961.00
64483	Lumbar Epidural	200	1,263.00

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)*:

Orthopaedic Procedures

Services Provided:

Orthopaedic outpatient surgical & orthopaedic pain management procedures

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	91	91	625,451	114,684
Medicaid	0	0	0	0
PeachCare for Kids	0	0	0	0
Third Party	663	663	5,149,114	2,365,466
Self Pay	21	21	132,603	10,389
Other Payer	24	24	159,017	21,877
Total	**799**	**799**	**6,066,185**	**2,512,416**

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	13	13
Charity	25	25
Total	**38**	**38**

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.

04/21/2004

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.

Fred Woestmann, CFO

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 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	6,066,185
Medicare Contractual Adjustments	510,767
Medicaid Contractual Adjustments	0
Other Contractual Adjustments	2,783,648
Total Contractual Adjustments	**3,294,415**
Bad Debt	17,162
Indigent Care Gross Charges	86,248
Indigent Care Compensation	3,025
Uncompensated Indigent Care (Net)	**83,223**
Charity Care Gross Charges	148,450
Charity Care Compensation	7,634
Uncompensated Charity Care (Net)	**140,816**
Other Free Care	18,153
Total Net Patient Revenue	**2,512,416**
Other Revenue	0
Total Net Revenue	**2,512,416**
Total Expenses	2,407,547
Adjusted Gross Revenue	**5,538,256**
Total Uncompensated I/C Care	**224,039**
Percent Uncompensated Indigent/Charity Care	**4.05%**

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
Other- Out of State	599
Total	**599**

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)	4.00	1.00	1.00
Licensed Practical Nurses (LPNs)	0.00	0.00	0.00
Aides/Assistants	2.00	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	30 Days or Less
Licensed Practical Nurse	Not Applicable
Aides/Assistants	30 Days or Less
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: Rick K. St.Pierre, M.D.

Date: 5/6/2010

Title: Executive / Medical Director

Comments:

Our facility does not register and/or record the information requested for Part D:(3) and Part I:(1). The information entered on both items was done as a default to allow the report to process.