

**THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2008**

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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**2008 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)**

**Mailing Address:**

STREET ADDRESS	CITY	STATE	ZIP
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**Physical Address:**

STREET ADDRESS	CITY	<b>AL</b>	ZIP
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**County of Location:**

\_\_\_\_\_

**Facility Telephone:**

\_\_\_\_\_ (AREA CODE) & TELEPHONE NUMBER

**Facility Fax:**

\_\_\_\_\_ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for October 1, 2007, through September 30, 2008\*; or for partial year of operation beginning \_\_\_\_\_ and ending \_\_\_\_\_ a period of \_\_\_\_\_ days.

MONTH DAY MONTH DAY

\*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

***We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.***

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
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DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
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***A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.***

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
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DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS
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**FOR OFFICE USE ONLY**

Facility Verified: _____	Initial Scan: _____	Completed: _____
Entered: _____	Final Scan: _____	Audited: _____

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**I Ownership**

<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Partnership
<input type="checkbox"/> Individual	<input type="checkbox"/> Healthcare Authority	<input type="checkbox"/> LLC
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Government	<input type="checkbox"/> Other (specify)
		_____

**II Facilities**

Total number of operating rooms \_\_\_\_\_

Number of operating rooms for general anesthesia \_\_\_\_\_

Number of beds available for extended recovery (less than 24 hours) \_\_\_\_\_

Total number of operations (cases) \_\_\_\_\_

Total number of procedures performed \_\_\_\_\_

Is this facility a designated separate/organized outpatient surgical unit of a hospital? \_\_\_\_\_

YES                      NO

**III SERVICES PROVIDED**

	Number of Operations (cases)	Number of Procedures
General Surgery	_____	_____
Dentistry	_____	_____
Dermatology	_____	_____
Eye, Ear, Nose & Throat	_____	_____
Gastroenterology	_____	_____
Gynecology	_____	_____
Neurosurgery	_____	_____
Ophthalmology	_____	_____
Orthopedic	_____	_____
Pain Management	_____	_____
Plastic Surgery	_____	_____
Podiatry	_____	_____
Urology	_____	_____
Other (specify) _____	_____	_____
<b>TOTALS</b> <i>(note: these totals should equal the totals as reported in Section II)</i>	_____	_____

**IV SOURCE OF PRINCIPAL PAYMENT**

	<b>Number of Operations (cases)</b>
Self Pay	
Workman's Compensation	
Medicare	
Medicaid	
Tricare	
Blue Cross	
Other Insurance Companies	
No Charge (charity & others)	
Health Maintenance Organization (HMO)	
All Kids	
Other (specify) _____	
<b>TOTALS</b> <i>(note: These totals should equal the total reported in Section II)</i>	

**V. REVENUES AND EXPENSES**

**Only those costs related to Ambulatory Surgical Centers should be reported.**  
These amounts **DO NOT** have to be audited prior to reporting.

<b>TOTAL EXPENSES</b>	\$	.00
<b>TOTAL REVENUES</b>	\$	.00
<b>TOTAL BAD DEBT</b>	\$	.00
<b>TOTAL CHARITY</b>	\$	.00