FORM ASC-1
Revised 8/2009

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2009

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
paul.may@shpda.alabama.gov

2009 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

ENTER ID NUMBER ASSIGNED BY SHPDA

ENTER FACILITY NAME HERE

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Physical Address: _____ (STREET ADDRESS) _____ (CITY) **AL** _____ (ZIP)

County of Location: _____

Facility Telephone: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for October 1, 2008, through September 30, 2009*; or for partial year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*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
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

A member of administration <u>MUST</u> 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
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

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

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I Ownership

○ Corporation	○ Non-Profit	○ Partnership
○ Individual	○ Healthcare Authority	○ LLC
○ Joint Venture	○ Government	○ 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) _____		
TOTALS (***note: these totals should equal the totals as reported in Section II)***	0	0

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IV SOURCE OF PRINCIPAL PAYMENT

	Number of Operations (cases)
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) _____	
TOTALS ***(note: These totals should equal the total reported in Section II)***	0

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.

TOTAL EXPENSES	$ .00
TOTAL REVENUES	$ .00
TOTAL BAD DEBT	$ .00
TOTAL CHARITY	$ .00