FORM ASC-1
Revised 8/2010

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2010

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2010 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

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, 2009, through September 30, 2010*; 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)***		

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IV. PRINCIPAL SOURCE OF 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)***	

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