FORM ASC-1
Revised 9/2013

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2013

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
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MONTGOMERY AL 36104
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bradford.williams@shpda.alabama.gov

2013 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, 2012, through September 30, 2013*; 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; and must be separate from the preparer.

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

A. Total number of operating rooms _____

B. Number of operating rooms for general anesthesia _____

C. Number of beds available for extended recovery (less than 24 hours) _____

D. Total number of operations (cases) _____

E. Total number of procedures performed _____

F. 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: This total 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