

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2009

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2009 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

Mailing Address:

STREET ADDRESS	CITY	STATE	ZIP
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Physical Address:

STREET ADDRESS	CITY	AL	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, 2008, through September 30, 2009*; 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) _____	_____	_____
TOTALS <i>(note: these totals should equal the totals as reported in Section II)</i>	_____	_____

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 <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.

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