FORM ASC-1
Revised 8/2010

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2010

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
bradford.williams@shpda.alabama.gov

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

______ 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
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

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
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