STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

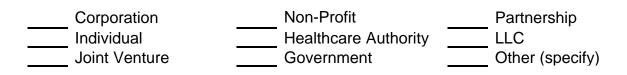
MAILING ADDRESS (U.S. Postal Service) PO BOX 303025 MONTGOMERY AL 36130-3025 TELEPHONE: (334) 242-4103 www.shpda.alabama.gov STREET ADDRESS (Commercial Carrier) 100 NORTH UNION STREET STE 870 MONTGOMERY AL 36104 FAX: (334) 242-4113 bradford.williams@shpda.alabama.gov

2013 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

L				
Mailing Address:	STREET ADDRESS	CITY	STATE	ZIP
Physical Address:	UTILET AUSTLES		AL	<u> </u>
County of Location:	STREET ADDRESS	CITY		ZIP
Facility Telephone:		Facility Fax:		
This reporting period is for	(AREA CODE) & TELEPHONE NUMI	BER Dtember 30, 2013*; or for partial	(AREA CODE) & TELEPH	
	and ending	a period of	year of operation seg	days.
data should be reported. If reported by the current own We hereby affirm and atte information contained in	there was a change in owne er. est that the reported inform the following pages of this	specified, may be provided, but no prship during the reporting period mation has been verified, and t is report is a true and accurate	od, data for the full ye	ear should be owledge, the
equipment, and utilization	1 of this facility.			
PRINTED NAME OF PREP.	ARER SIGN	IATURE OF PREPARER	DATE	
DIRECT TELEPHONE NUM	DIRECT TELEPHONE NUMBER TITLE		E-MAIL ADDRESS	
	ion <u>MUST</u> also sign below v listed above; and must be s	verifying the accuracy of the ir separate from the preparer.	nformation contained	l herein, as
PRINTED NAME OF ADMINISTRAT	ION OFFICIAL SIGNATURE	OF ADMINISTRATION OFFICIAL	DATE	
DIRECT TELEPHONE NUM	/BER TITLE OF	ADMINISTRATION OFFICIAL	E-MAIL ADDRES	S
DIRECT TELEPHONE NUM		ADMINISTRATION OFFICIAL	E-MAIL ADDRES	s
DIRECT TELEPHONE NUM		DFFICE USE ONLY	E-MAIL ADDRES	S

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2013

I. OWNERSHIP



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)		

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 <u>DO NOT</u> have to be audited prior to reporting.

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