

THIS REPORT IS DUE ON OR BEFORE DECEMBER 16, 2024

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2024 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

SHPDA ID NUMBER
FACILITY NAME

Mailing Address:

_____ STREET ADDRESS _____ CITY _____ STATE _____ ZIP

Physical Address:

_____ STREET ADDRESS _____ CITY _____ **AL** _____ ZIP

County of Location:

Facility Telephone:

Facility Fax:

This reporting period is for _____ (AREA CODE) & TELEPHONE NUMBER
10/1/2023, through 9/30/2024; 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; 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

- | | | |
|--|---|--|
| <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

- 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
- G. Number of weekdays procedures are routinely performed _____

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 (<i>NOTE: This total should equal the total reported in Section II</i>)	

V. PATIENT ADMISSION DEMOGRAPHICS

A. ADMISSIONS BY AGE AND GENDER (*entire reporting period*)

	MALE	FEMALE	TOTAL
18 & under			
19 – 34 years of age			
35 – 54 years of age			
55 – 64 years of age			
65 – 74 years of age			
75 – 84 years of age			
85 years and older			
TOTALS			*

** This total should equal the total reported in Section V-B.*

B. ADMISSIONS BY RACE *(entire reporting period)*

	TOTAL
White/Caucasian	
Black/African American/Negro	
Hispanic/Spanish/Latino	
Asian	
American Indian/Alaskan Native	
Pacific Islander	
India	
Middle Eastern	
Other (please specify other race category):	
TOTALS	*

**** This total should
equal the total
reported in Section
V-A.***

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VI. PATIENT ORIGIN BY ZIP CODE (entire reporting period)

Please report, by zip code of residence, the total number of cases treated by this provider. (This total should equal the total reported in Section II-D). This data shall be submitted as a Microsoft Excel (v. 2003 or later) or CSV formatted file, and shall be submitted at the same time as the remainder of this report. The annual report will not be deemed received by the Agency on behalf of the submitting provider unless and until both the PDF document containing the first four pages of the report and the Excel or CSV file containing the data for this section are received.

The submitted file should contain the column headers and data formatting shown in the example provided below:

Please submit only a 5-digit zip code, not the full 9-digit zip code if supplied. Also, please ensure that the Facility ID Number supplied in the first column and the Facility ID Number reported on Page 1 are the same, and are correct.

FacilityIDNumber	PatZipCode	NumberOfPatientCases
999-U9999	99999	9999