

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2026

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2026 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

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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 10/1/2025, through (AREA CODE) & TELEPHONE NUMBER 9/30/2026; 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: _____
Entered: _____

Initial Scan: _____
Final Scan: _____

Completed: _____
Audited: _____

I. OWNERSHIP

- | | | |
|-------------------------------------|--|---------------------------------------|
| ☐ Corporation | ☐ Non-Profit | ☐ Partnership |
| ☐ Individual | ☐ Healthcare Authority | ☐ LLC |
| ☐ Joint Venture | ☐ Government | ☐ Other (specify) |

II. FACILITIES

- | | | |
|----|--|--|
| A. | Total number of operating rooms | <u>0</u> |
| B. | Number of operating rooms for general anesthesia | <u>0</u> |
| C. | Number of beds available for extended recovery (less than 24 hours) | <u>0</u> |
| D. | Total number of operations (cases) | <u>0</u> |
| E. | Total number of procedures performed | <u>0</u> |
| F. | Is this facility a designated separate/organized outpatient surgical unit of a hospital? | ☐ YES ☐ NO |
| G. | Number of weekdays procedures are routinely performed | <u>0</u> |

III. SERVICES PROVIDED

	Number of Operations (cases)	Number of Procedures
General Surgery	<u>0</u>	<u>0</u>
Dentistry	<u>0</u>	<u>0</u>
Dermatology	<u>0</u>	<u>0</u>
Eye, Ear, Nose & Throat	<u>0</u>	<u>0</u>
Gastroenterology	<u>0</u>	<u>0</u>
Gynecology	<u>0</u>	<u>0</u>
Neurosurgery	<u>0</u>	<u>0</u>
Ophthalmology	<u>0</u>	<u>0</u>
Orthopedic	<u>0</u>	<u>0</u>
Pain Management	<u>0</u>	<u>0</u>
Plastic Surgery	<u>0</u>	<u>0</u>
Podiatry	<u>0</u>	<u>0</u>
Urology	<u>0</u>	<u>0</u>
Other (specify) _____	<u>0</u>	<u>0</u>
TOTALS (note: these totals should equal the totals as reported in Section II)	<u>0</u>	<u>0</u>

IV. PRINCIPAL SOURCE OF PAYMENT

	Number of Operations (cases)
Self Pay	0
Workman's Compensation	0
Medicare	0
Medicaid	0
Tricare	0
Blue Cross	0
Other Insurance Companies	0
No Charge (charity & others)	0
Health Maintenance Organization (HMO)	0
All Kids	0
Other (specify) _____	0
TOTALS (NOTE: This total should equal the total reported in Section II)	0

V. PATIENT ADMISSION DEMOGRAPHICS

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

	MALE	FEMALE	TOTAL
18 & under	0	0	0
19 – 34 years of age	0	0	0
35 – 54 years of age	0	0	0
55 – 64 years of age	0	0	0
65 – 74 years of age	0	0	0
75 – 84 years of age	0	0	0
85 years and older	0	0	0
TOTALS	0	0	* 0

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

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

	TOTAL
White/Caucasian	0
Black/African American/Negro	0
Hispanic/Spanish/Latino	0
Asian	0
American Indian/Alaskan Native	0
Pacific Islander	0
India	0
Middle Eastern	0
Other (please specify other race category):	0
TOTALS	* 0

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

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