APA-3

CERTIFICATION OF ADMINISTRATIVE RULES
FILED WITH THE LEGISLATIVE SERVICES AGENCY
OTHNI LATHRAM, DIRECTOR

(Pursuant to Code of Alabama 1975, §41-22-6, as amended).

I certify that the attached is/are correct copy/copies of rule/s as promulgated and adopted on the **19th** day of **September**, 20**18**, and filed with the agency secretary on the **19th** day of **September**, 20**18**.

AGENCY NAME: **State Health Planning and Development Agency**
(Certificate of Need Review Board, "CONRB")
X Amendment _____ New _____ Repeal (Mark appropriate space)

Rule No. **410-1, Pages 1 and 5**
(If amended rule, give specific paragraph, subparagraphs, etc., being amended)

Rule Title: **Appendix, Annual Report for Ambulatory Surgery Centers**

ACTION TAKEN: State whether the rule was adopted with or without changes from the proposal due to written or oral comments:

No public comments were received; the rule was adopted without changes and as published for comment in the Alabama Administrative Monthly.

NOTICE OF INTENDED ACTION PUBLISHED IN VOLUME **XXXVI**, ISSUE NO. **10**, AAM, DATED **July 31**, 20**18**.

Statutory Rulemaking Authority: **Code of Alabama §§ 22-4-34 and -35.**

(Date Filed)
(For LRS Use Only)

Alva M. Lambert
Certifying Officer or his or her Deputy

(NOTE: In accordance with §41-22-6(b), as amended, a proposed rule is required to be certified within 90 days after completion of the notice.

RECEIVED
2018 SEP 19 AM 11:07
LEGISLATIVE SVC AGENCY

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

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

20-- 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: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for 10/1/20--, through 9/30/20--; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

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:	

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

I. OWNERSHIP

____ Corporation	____ Non-Profit	____ Partnership
____ Individual	____ Healthcare Authority	____ LLC
____ Joint Venture	____ Government	____ 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***)		

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

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. 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.***

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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.***

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

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

Author: Alva M. Lambert
Statutory Authority: §§ 22-4-34 and -35, Code of Alabama, 1975.
History: New Rule. Filed: March 18, 2016; effective May 2, 2016. Filed: September 19, 2018; effective November 3, 2018.