

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2007

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2007 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, 2006, through September 30, 2007*; 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.***

_____ PRINTED NAME OF ADMINISTRATOR _____ SIGNATURE OF ADMINISTRATOR _____ DATE

_____ WEB SITE ADDRESS _____ E-MAIL ADDRESS

I hereby affirm and attest that I am the sole owner of this facility.

I hereby affirm and attest that I am the chief operator/administrator of this facility.

NOTE: If both boxes are not checked, a second individual as indicated below MUST sign and complete the following statement: I hereby affirm and attest, to the best of my knowledge, that the information contained in this report is a true and correct representation of the services, equipment, and utilization of this facility.

_____ SIGNATURE OF CEO/COO/CFO/OWNER _____ TITLE _____ DATE

_____ PRINTED NAME

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

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 <i>(note: these totals should equal the totals as reported in Section II)</i>	_____	_____

IV SOURCE OF PRINCIPAL 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: These totals should equal the total reported in Section II)</i>	

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