#### STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

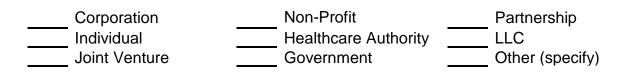
MAILING ADDRESS (U.S. Postal Service) PO BOX 303025 MONTGOMERY AL 36130-3025 TELEPHONE: (334) 242-4103 www.shpda.alabama.gov STREET ADDRESS (Commercial Carrier) 100 NORTH UNION STREET STE 870 MONTGOMERY AL 36104 FAX: (334) 242-4113 bradford.williams@shpda.alabama.gov

## 2015 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

This rep	port should be typewritten or completed	d in ink only; no pencil su	bmissions	
	<b>,</b>	• • •		
Mailing Address:	STREET ADDRESS	CITY	STATE	ZIP
Physical Address:	UNLETABALOO	011	AL	2
-	STREET ADDRESS	CITY		ZIP
County of Location:				
Facility Telephone:		Facility Fax:		
This reporting pariod in for (	(AREA CODE) & TELEPHONE NUMBER		(AREA CODE) & TELEPHONE	
This reporting period is for t	October 1, 2014, through September 3			-
MONTH DAY	and ending	a period	of	days.
*Data for the agency's fiscal ye	ear, other than the time frame specified, ma vas a change in ownership during the re			
	est that the reported information ha the following pages of this report i of this facility.			
PRINTED NAME OF PREPAR	RER SIGNATURE OF PR	EPARER	DATE	
DIRECT TELEPHONE NUME	BER TITLE OF PREP	ARER	E-MAIL ADDRESS	;
	on <u>MUST</u> also sign below verifying listed above; and <u>must be separate</u>		ormation contained	l herein, as
PRINTED NAME OF ADMINISTRATIC	DN OFFICIAL SIGNATURE OF ADMINISTR	RATION OFFICIAL	DATE	
DIRECT TELEPHONE NUME	BER TITLE OF ADMINISTRAT	ION OFFICIAL	E-MAIL ADDRESS	
	FOR OFFICE US	E ONLY		
Facility Verified:	Initial Scan:		Completed:	
Entered:	Final Scan:		Audited:	

#### THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2015

#### 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

Make and keep a copy of the completed report for the facility's records before submitting to SHPDA.

This report should be submitted to SHPDA only once via electronically, hard copy, or fax. The preferred method is electronic submission to <u>bradford.williams@shpda.alabama.gov</u>. If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.