FORM ASC-1
Revised 09/25

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2025

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

2025 ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

Save

Print

Submit

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 10/1/2024, through 9/30/2025; 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 <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and <u>must be separate from the preparer</u>.

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 09/25

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2025

I. OWNERSHIP

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

II. FACILITIES

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

III. SERVICES PROVIDED

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2025

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.***

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2025

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.***

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2025

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