Certificate of Need 2021 Ambulatory Surgical Center Annual Report

This is a sample of the online form. Please use this form to gather the information you will need for submitting the online version.

Facility Information

Please complete this report for the previous year no later than January 31, 2022

This report is a: ☐ New Report ☐ Corrected Report

Name of Facility _____

Address of Facility

Address Line 1 _____

Address Line 2 _____

City _____ State _____ ZIP _____

Reporting Period

Required reporting period is January 1 through December 31, 2021.

Was the facility in operation 12 full months at the end of the period? ☐ Yes ☐ No

If no, please report the number of days in operation. _____

Classification

The following definitions apply to this section of the report:

- **Not for Profit** - Excess revenue retained by the corporation; exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954.
- **For Profit (Proprietary)** - Excess revenue distributed to owners or shareholders or held as retained earnings, subject to federal taxation.

Classification ☐ Not for Profit ☐ For Profit

Governmental entity (state, city, county or federal), corporation, company, etc. responsible for the ownership and management of the agency _____

Name of management firm of facility (N/A if management is not provided through contract)

_____

Is the facility operated as part of a chain, whether for profit or not? ☐ Yes ☐ No

If Yes, please give name and address of the PARENT organization

Parent organization _____

Parent organization Address

Address Line 1_____

Address Line 2_____

City_____ State_____ ZIP_____

Utilization of Suites and Services

Report utilization for a full 12-month period.

Total Number of Procedures performed (Excluding exploratory/diagnostic endoscopies) _____

Total Number of Exploratory/ Diagnostic Endoscopies Performed _____

"Total number of surgical suites" should include the number of suites licensed and certified on the last day of the reporting period. A laser or procedure room not meeting physical plant requirements as an ambulatory surgical center suite should not be included.

Total Number of Surgery Suites _____

Total Number of Patients (Patients should be counted only once for multiple procedures performed during same day visit) _____

Total Number of Patients Transferred to Acute Care Hospital During Report Period _____

Type of Surgery Performed (List 12 most frequently performed)

If there are less than 12 surgeries performed, please enter 0 in remaining fields.

1. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
2. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
3. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
4. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
5. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
6. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
7. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
8. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
9. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
10. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
11. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____
12. Surgery Type_____ CPT CODE Number_____ Number of Procedures Performed_____

Personnel Data

Exclude volunteers and all personnel whose salary is financed entirely by outside research grants. For combined facilities, report **only** the personnel for the ambulatory surgical facility.

Nursing (RN/LPN) - Full Time (35 hrs/wk) _____ Nursing (RN/LPN) - Part Time (<35 hrs/wk) _____

Aides/Technologists - Full Time (35 hrs/wk) _____ Aides/Technologists - Part Time (<35 hrs/wk) _____

Administration - Full Time (35 hrs/wk) _____ Administration - Part Time (<35 hrs/wk) _____

Other - Full Time (35 hrs/wk) _____ Other - Part Time (<35 hrs/wk) _____

Total Full Time Employees _____ **Total Part Time Employees** _____

Financial Data

Report expenses for the full 12-month period. If actual figures are not available, please estimate (indicate which figures are estimated by checking the box after the amount). Round all figures to the nearest dollar. Do not use commas.

Total gross revenue: Includes total revenues from direct patient care and all other sources.

Total Gross Revenue $_____ ☐ Estimated?

Payroll expenses: Report salaries for full-time and part-time personnel as reported in Personnel Data Tab.

Non-payroll expenses: Include all costs for goods and services that have been used or consumed during the reporting period.

Payroll Expenses $_____ ☐ Estimated?

Non-payroll Expenses $_____ ☐ Estimated?

Total Expenses $_____

Compare financial data with previous year Annual Report financial data and explain any differences exceeding 10%.

_____

Fiscal year ending date _____

Facility's average cost and average charge from most recent financial statement:

Average cost $_____ Average charge $_____

Procedures and revenue breakdown by payor source:

MEDICARE Number of Procedures	_____	MEDICARE Percent of Operating Revenue	_____ %
MEDICAID Number of Procedures	_____	MEDICAID Percent of Operating Revenue	_____ %
INSURANCE Number of Procedures	_____	INSURANCE Percent of Operating Revenue	_____ %
PRIVATE PAY Number of Procedures	_____	PRIVATE PAY Percent of Operating Revenue	_____ %
UNFUNDED Number of Procedures	_____	UNFUNDED Percent of Operating Revenue	_____ %
OTHER Number of Procedures	_____	OTHER Percent of Operating Revenue	_____ %
Total number of procedures	_____	Total	_____ %

Please make sure the Total Percent of Operating Revenue equals 100%.

Patient Origin Data:

Report all patients served by the facility for the reporting year by county of origin. The total **must** equal the total number of patients reported in "Utilization" tab.

Beaverhead _____ Big Horn _____ Blaine _____

Broadwater		Carbon		Carter	
Cascade		Chouteau		Custer	
Daniels		Dawson		Deer Lodge	
Fallon		Fergus		Flathead	
Gallatin		Garfield		Glacier	
Golden Valley		Granite		Hill	
Jefferson		Judith Basin		Lake	
Lewis and Clark		Liberty		Lincoln	
Madison		McCone		Meagher	
Mineral		Missoula		Musselshell	
Park		Petroleum		Phillips	
Pondera		Powder River		Powell	
Prairie		Ravalli		Richland	
Roosevelt		Rosebud		Sanders	
Sheridan		Silver Bow		Stillwater	
Sweet Grass		Teton		Toole	
Treasure		Valley		Wheatland	
Wibaux		Yellowstone		Unknown/In State	
Out of State				Total	

Please complete this report no later than January 31, 2022

Report Completion Data

Date Report Completed _____

Administrator's Name _____ Administrator's Email Address _____

If there are questions about any of the responses to this report, who should be contacted?

Contact Name _____

Contact Phone Number _____ Contact Email _____

If you have any questions, please contact:

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